In April of 2018, the San Diego Office of County Counsel requested Lindsay Hayes to independently assess suicide prevention practices within the Sheriff's Jail system, as well as, to offer any appropriate recommendations for the revision of suicide prevention policies and procedures. Mr. Hayes is nationally regarded as an expert in the field of suicide prevention within jails, prisons and juvenile facilities, and has been appointed as a Federal Court Monitor (and expert to special masters/monitors) in the monitoring of suicide prevention practices in several adult and juvenile correctional systems under court jurisdiction. Mr. Hayes conducted an on-site assessment at four Sheriff's jail facilities from April 23 thru April 28, 2018.

In June of 2018, the Sheriff's Department received Mr. Hayes report entitled "Report on Suicide Prevention Practices within the San Diego County Jail System." The report focused on eight (8) critical components of a suicide prevention policy which include staff training, identification/screening, communication, housing, levels of supervision/management, intervention, reporting, and follow-up/mortality-morbidity review. Based on his on-site assessment, as well as a review of various San Diego County Sheriff's Department policies and procedures related to suicide prevention, Mr. Hayes' produced a report containing 32 actionable recommendations.

Since receiving Mr. Hayes' report, the Sheriff's Department has been diligently working to address each of the recommendations. The following is a list of the recommendations contained within the Hayes report, as well as a synopsis as to what the Sheriff's Department has done to implement the recommendations, and the current status of those recommendations that have yet to be completed. The italicized and bolded language below is taken from the "Summary of Recommendations" from the Lindsay Hayes report.

Mr. Lindsay Hayes' full report begins on page 15.

Staff Training

1) It is strongly recommended that the ISP policy be revised to include a more robust description of the requirements for both pre-service and annual suicide prevention training, to include the duration of each workshop and an overview of the required topics.

Detentions Policy and Procedure was updated to require "Suicide Detection and Prevention" training annually. This is accomplished in an 8 hour initial training as well as a 2 hour refresher course. In addition, professional staff members receive training on "Suicide Detection and Prevention" as part of their orientation.

2) It is strongly recommended that the joint efforts of the Medical Services Division (MSD) and Detention In-Service Training unit (DTU) to consolidate this writer's 10-hour Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison

Facilities into an 8-hour classroom training for all current SDCSD deputies be expanded to include all new employees (i.e., medical and mental health personnel) working within the San Diego County Jail System.

This recommendation was implemented through a collaborative effort between the Detentions Training Unit, Sheriff's mental health staff, and contracted mental health staff to create a curriculum of training utilizing the Lindsay Hayes program guide. This course is required for all Sheriff's Detention assigned staff.

3) It is strongly recommended that the MSD and DTU jointly collaborate on the development of a 2-hour annual suicide prevention curriculum based upon this writer's Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities. At a minimum, the curriculum should include a review of: 1) avoiding obstacles (negative attitudes) to prevention, 2) predisposing risk factors, 3) warning signs and symptoms, 4) identifying suicidal inmates despite the denial of risk, and 5) review of any changes to the ISP policy. The annual training should also include general discussion of any recent suicides and/or serious suicide attempts in the San Diego County Jail System.

This recommendation was implemented. A two hour curriculum was separated into four 30 minute parts and will be required briefing training to meet the refresher training recommendation.

4) It is strongly recommended that the annual suicide prevention training be required for all custody, medical, and mental health personnel (including LHC contracted psychologists and psychiatrists). Suicide prevention is all about collaboration, and requiring custody, medical, and mental health personnel to sit together in a classroom environment is not only symbolically appropriate, but instills the philosophy that all professionals, regardless of credentials, have an equal responsibility for inmate suicide prevention and can learn from one another's backgrounds, insights, and experiences.

This recommendation was implemented. All staff listed above are required to attend the course that was collaboratively designed utilizing the Lindsay Hayes curriculum.

<u>Intake Screening/Assessment</u>

5) It is strongly recommended that Detention Services Bureau (DSB) and MSD officials look at options to better ensure reasonable sound privacy in the booking areas of the three intake facilities when multiple nurses are conducting intake screening at the same time. As demonstrated in the SDCJ, if the inmate is secured within the nursing booth and the door is closed with the officer stationed outside, reasonable privacy and confidentiality can occur while ensuring staff safety.

This recommendation has been partially implemented. The only remaining booking facility that does not allow for private interview space at booking is the Vista Detention Facility (VDF). The project is currently on the capital improvement list.

6) It is strongly recommended that the current suicide risk inquiry contained in the "Medical Intake Questions" form embedded in the JIMS be revised to include the following:

- ***Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?***
- ***Has a family member/close friend ever attempted or committed suicide?***
- ***Do you feel there is nothing to look forward to in the immediate future (inmate expressing helplessness and/or hopelessness)?***

This recommendation has been implemented. The questions listed above were added to the Jail Information Management System and are asked during the booking process by nursing staff.

7) It is strongly recommended that MSD officials reconsider the utility of the Columbia-Suicide Severity Rating Scale (C-SSRS) during the intake screening process. Although the C-SSRS has become a popular screening form in some jail facilities throughout the country, its effectiveness remains questionable. It is this writer's opinion that the structure of the questions creates awkwardness between the screener and inmate, and more importantly, questions that limit responses to the "past month" are potentially very dangerous (e.g., the suicidal ideation of an inmate that was experienced more than a month ago would not be captured during the screening process). Intake screening questions by nursing staff should be open-ended and not time-sensitive; it is responsibility of a mental health clinician during a subsequent assessment to determine the degree of relevancy of prior suicide risk to current risk. With addition of the three questions offered above, the current intake screening form would be more than adequate without the necessity of the C-SSRS.

This recommendation has been completed. The Sheriff's Department has reconsidered the utility of the Columbia-Suicide Severity Rating Scale (C-SSRS) during the intake process and determined that it will continue to utilize the C-SSRS, in addition to the questions added in the previous recommendation. The C-SSRS has been normed for the correctional environment and is a tool to drive further assessment by a qualified mental health provider. Further, the C-SSRS is part of the County of San Diego suicide prevention strategic plan and utilized by other justice partners.

8) Although this writer would defer to MSD officials as to whether to designate either a charge nurse or mental health clinician to be the ISP gatekeeper, it is strongly recommended that, if the charge nurse is a gatekeeper, they should always immediately notify an on-site mental health clinician when an inmate has been identified as potentially suicidal. The clinician, in turn, should respond and conduct the suicide risk assessment and determine the appropriateness of suicide precautions. Unless exigent circumstances exist and/or mental health personnel are not on-site, the determination of placing a potentially suicidal inmate in either a safety cell and/or the EOH unit should be made by the mental health clinician.

Detentions Policy and Procedure has been updated to reflect the recommendation related to the roles of a qualified mental health provider. The service hours of the mental health clinicians have been expanded for greater coverage and plans to have mental health staff available 24/7 at the intake facilities (San Diego Central Jail, Vista Detention Facility and Las Colinas Detention and Reentry Facility) are in the works and will be accomplished through the hiring of new staff as well as through expanded hours of contract staff.

9) It is strongly recommended that DSB and MSD officials revise the "automatic triggers" criteria contained within the ISP policy to require only criteria No. 3 ("The inmate states he/she is suicidal and or made suicidal statements to sworn staff, medical, family, etc.) to result in placement on suicide precautions. Although the other four criteria could be potential suicide risk factors, they should be considered criteria for a mental health referral, and not necessarily automatic placement on suicide precautions.

This recommendation is not necessary. The "automatic triggers" referred to in the recommendation report were not triggers for placement on suicide precautions. They were triggers to require an assessment for the need for placement on suicide precautions. These triggers give both sworn and medical staff a tool in determining if a referral for assessment is needed, and are consistent with the recommendation.

10) Consistent with the SDCSD philosophy that a previous suicide attempt documented in JIMS could be a factor for current suicide risk, an inmate's previous placement on suicide precautions within the San Diego County Jail System is equally important. As such, regardless of the inmate's behavior or answers given during intake screening, a mental health referral should always be initiated based on documentation reflecting possible serious mental illness and/or suicidal behavior during an inmate's prior confinement within the San Diego County Jail System. As such, it is strongly recommended that determination of whether the inmate was "on suicide precautions during prior confinement in a SDCSD facility?" should be independently verified through review of the JIMS by nursing staff. An "alert" screen on JIMS and protocol should be created according to the following procedures:

- ***Any inmate placed on suicide precautions should be tagged on the JIMS "alert" screen by mental health staff (e.g., "ISP June 2018");***

- ***Nursing staff conducting intake screening should always review the inmate's "alert" screen to verify whether they were previously confined in a SDCSD facility and had any history of suicidal behavior/placement on suicide precautions during a prior confinement; and***

- ***Regardless of the inmate's behavior or answers given during intake screening, further assessment by mental health staff should always be initiated based on documentation reflecting suicidal behavior/ placement on suicide precautions during the inmate's prior SDCSD confinement.***

Changes to Detentions Policy and Procedure are in process to reflect the recommendation regarding a mental health referral for a previous suicide attempt during an inmate's prior confinement in the San Diego County Jail system. Alert flags in the Jail Information Management System advise nursing staff of previous in custody suicide attempts, and Psychiatric Stabilization Unit housing, which will alert nursing staff to schedule an urgent Qualified Mental Health Provider assessment. These flags, in addition to a newly created flag for those previously housed within the Inmate Safety Program will be within the Electronic Health Record system once operational in mid-September. These flags will alert both nursing and mental health providers of the patient's prior and current mental health status.

11) It is strongly recommended that MSD officials initiate a continuous quality assurance plan to periodically audit the intake screening process to ensure that nursing staff are accurately completing the "Medical Intake Questions" form, and not using abbreviated inquiry, as well as soliciting responses to the four arresting officer questions.

This recommendation has been implemented. Nursing audits by supervising nurses have been adjusted to include periodic audits of the intake screening process at intake facilities. The results of these audits are reported at quarterly quality assurance meetings.

12) It is strongly recommended that MSD officials develop a mental health triage and referral protocol. Although there is no standard of care that consistently specifies time frames to respond to mental health referrals, one suggested schedule would be as follows: <u>Emergent</u> - immediate or within 1 hour; <u>Urgent</u> - within 24 hours; and <u>Routine</u> - within 72 hours. In addition, mental health leadership should develop a mental health triage policy that defines response levels, sets timetables for each level, and defines the acuity of behavior(s) that dictates a specific response level. Of course, any inmate expressing current suicidal ideation

and/or current suicidal/self-injurious behavior should result in an <u>Emergent</u> mental health referral.

An acuity referral system for mental health treatment and Inmate Safety Program already exist in policy and will be built into the Electronic Health Record system. Mental Health staff will continue operating under the current protocols as we continue to evaluate and enhance our mental health services.

13) Given the strong association between inmate suicide and special management (e.g., disciplinary and/or administrative segregation, etc.) housing unit placement, it is strongly recommended that medical personnel review the medical section of JIMS to determine whether existing medical and/or mental health needs contraindicate the placement or require accommodation. In addition, a "best practice" would be that any inmate assigned to such a special management housing unit receive a brief assessment for suicide risk by nursing staff upon admission to such placement. The following are recommended questions for the brief assessment:

- ***Are you currently having thoughts of harming yourself?***
- ***Have you previously tried to harm yourself because of a segregation placement?***
- ***Is the inmate speaking incoherently; expressing bizarre thoughts; unable to sit still or pay attention; or is disoriented to time, place, or person?***

Affirmative responses to any of these questions should result in an Emergent mental health referral.

Business processes are being developed, and policies are being updated, to provide for real time notification to Qualified Mental Health Providers so assessments can be accomplished in a timely manner.

<u>Communication</u>

14) It is strongly recommended that the MSD establish a weekly mental health team meeting at each facility that includes MSD mental health clinicians and LHC psychologists and psychiatrists. The primary purpose of the weekly meeting is to identify and manage the treatment needs of suicidal and/or seriously mentally ill patients.

This recommendation will not be implemented. The NCCHC recommendation relating to mental and medical health patient care meetings between staff is that they are to occur once per month. The San Diego County Sheriff's Department exceeds this standard by holding bi-

weekly Multi-Disciplinary Group (MDG) meetings at the San Diego Central Jail, George Bailey Detention Facility, Vista Detention Facility, and Las Colinas Detention and Reentry Facility. In addition, each of these facilities also have monthly Patient Care Coordinating Committee meetings, daily Psychiatric Stabilization Unit meetings (SDCJ, LCDRF), and weekly outpatient stepdown unit meetings (SDCJ,LCDRF). Additionally, ad hoc meetings can be called when urgent inmate care issues arise.

Housing

15) As this writer inspected a vast array of differing physical environments for the housing of suicidal inmates in the four jail facilities (i.e., safety cells, EOH single cells and dormitories, MOB, and PSU observation cells, etc.), it is strongly recommended that DSB officials conduct a comprehensive physical plant review of all jail cells utilized for the housing of suicidal inmates to ensure that they are reasonably suicide-resistant. This writer's "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities," included as Appendix A of this report, can be utilized as a guideline for such an inspection.

A comprehensive physical plant review of all specialty and segregated housing was conducted. Construction plans for modifications to these housing areas were submitted to General Services for implementation.

16) Due to the limited positive attributes of safety cell use, it is strongly recommended that, if utilized, the maximum length of stay in a safety cell be limited to no more than six (6) hours. In addition, use of a safety cell should not be the first option available, rather it should only be utilized in exigent circumstances in which the inmate is out of control and at immediate, continuing risk to self and others. Current SDCSD policies should be appropriately revised.

Revisions were made to the Inmate Safety Cell policy to ensure safety cells are not the first option of placement for those identified as having a suicide risk. The placement criteria was changed in the policy to use safety cells only for inmates who are actively self-harming or actively assaultive. The policy now requires a Qualified Mental Health Provider assessment for retention in a safety cell to be conducted every 4 hours.

17) It is strongly recommended that MSB officials instruct their clinical staff on the appropriate use of safety smocks, i.e., they should not be utilized as a default, and not to be used as a tool in a behavior management plan (i.e., to punish and/or attempt to change perceived manipulative behavior). Rather, safety smocks should only be utilized when a clinician believes that the inmate is at high risk for suicide by hanging. Should an inmate be placed in a safety smock, the goal should be to return full clothing to the inmate prior to their discharge from suicide precautions. Finally, custody personnel should never place an inmate

in a safety smock unless it had been previously approved by medical and/or mental health personnel. Current SDCSD policies should be appropriately revised.

This recommendation has not yet been implemented. The Sheriff's Department has changed the criteria for admission into a safety cell. As a result of these changes, there are fewer placements into a safety cell, and inmates are spending significantly less time. The Department is seeking additional clarification from Mr. Hayes as it relates to the changes and this recommendation.

18) It is strongly recommended that possessions and privileges provided to inmates on suicide precautions should be individualized and commensurate with their level of risk. As such, current SDCSD policies should be appropriately revised, as follows:

- ***All decisions regarding the removal of an inmate's clothing, bedding, possessions (books, slippers/sandals, eyeglasses, etc.) and privileges shall be commensurate with the level of suicide risk as determined on a case-by-case basis by mental health clinicians and documented in JIMS;***
- ***If a mental health clinician determines that an inmate's clothing needs to be removed for reasons of safety, the inmate shall always be issued a safety smock and safety blanket;***
- ***A mattress shall be issued to all inmates on suicide precautions unless the inmate utilizes the mattress in ways in which it was not intended (i.e., attempting to tamper with/destroy, utilize to obstruct visibility into the cell, etc.);***
- ***All inmates on suicide precautions shall be allowed all routine privileges (e.g., family visits, telephone calls, recreation, etc.), unless the inmate has lost those privileges as a result of a disciplinary sanction;***
- ***All inmates on suicide precautions shall be allowed to attend court hearings unless exigent circumstances exist in which the inmate is out of control and at immediate, continuing risk to self and others, and***
- ***Inmates on suicide precautions shall not automatically be locked down. They should be allowed dayroom and/or out-of-cell access commensurate with their security level and clinical judgment of mental health clinicians.***

This recommendation has been implemented in part. Inmates placed in safety cells are not allowed privileges since the only inmates placed in safety cells are those who are actively self-harming or actively assaultive. Inmates placed in Enhanced Observation Housing (EOH) are

allowed dayroom time, television time, and social phone calls. Additionally, inmates in EOH have access to reading materials such as books and periodicals. Inmates who are designated as low risk in EOH may attend court. This recommendation is still being reviewed for its efficacy in our system.

19) Although SDCSD Policy J.4: Enhanced Observation Housing (EOH), Definition and Use requires that "EOH units shall be clean and disinfected using facility approved disinfectants or bleach solution after every use or as needed," this writer's inspection of cells in several facilities found them to be quite dirty and unsanitary. As such, it is strongly recommended that DSB officials reinforce the above directive and that shift supervisors at each facility ensure that cells utilized to house suicidal inmates are reasonably clean and sanitary.

Enhanced Observation Housing policy was updated to add a daily cleaning as well as after each use. Facility supervisor and management staff are required to check for compliance.

<u>Levels of Supervision/Management</u>

20) It is strongly recommended that all DSB and MSD suicide prevention policies be revised to include two levels of observation that specify descriptions of behavior warranting each level of observation. A proposed revision is offered as follows:

- ***Close Observation is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific plan) and/or has a recent prior history of self-destructive behavior and would be considered a low risk for suicide. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 10-15 minutes, and should be documented as it occurs.***

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

This recommendation has been implemented in part. Close observation is conducted for those inmates in Enhanced Observation Housing and in Safety Cells. Constant Observation can be utilized for those inmates in the Psychiatric Stabilization Units when warranted.

21) It is strongly recommended that, with the adaption of the two-level observation system as offered above, reference to the ill-defined "high" and "low" suicide risk categories are no longer necessary and should be deleted from all SDCSD policies.

Levels of observation are currently outlined in policy. After internal discussion and review of this recommendation, SDSD has opted to keep both "high and "low" risk indicators.

22) It is strongly recommended that the narrative of "twice every 30 minutes" currently contained within some SDCSD policies be replaced with "staggered intervals that do not exceed 10-15 minutes."

This recommendation was implemented to include language in Detention Policy and Procedure regarding staggered safety checks not to exceed 15 minutes.

23) It is strongly recommended that SDCSD policies should be revised to eliminate the necessity of "a minimum of two assessments by mental health provider with time interval between assessments and for clearance based on high/low risk designation after first assessment." In other words, consistent with the standard of care, an inmate identified as potentially suicidal (or placed on suicide precautions after hours by non-mental health personnel) should be immediately referred to a mental health clinician for completion of a suicide risk assessment. The assessment should be completed immediately if mental health personnel are on-site or during the next business day morning if they are off-site at the time of the referral. Should the clinician's initial suicide risk assessment find that the inmate is not suicidal and does not require either initiation/continuation of suicide precautions, the inmate should be released to appropriate rehousing. Should the clinician's suicide risk assessment find that the inmate is suicidal, the inmate should be placed on suicide precautions and seen on a daily basis by a mental health clinician until a determination is made that they are no longer suicidal. Daily assessments of suicide risk should be documented in SOAP-formatted progress notes. When the clinician determines that an inmate is no longer suicidal and can be discharged from suicide precautions, documentation of such clinical judgment should occur in a suicide risk assessment form. In addition, the MSD document entitled "ISP Clarifications, March 29, 2018" (which speaks to "two consecutive low risk assessments by two different providers," as well as assessments occurring between 4 and 6 hours of each other) should also be deleted from SDCSD policies as it will no longer be relevant.

This recommendation was implemented in part. Policy and Procedure revisions were made to require an assessment to be completed immediately if mental health personnel are on-site or during the next business day morning if they are off-site at the time of the referral. As it relates to a second assessment, the second assessment will occur within 12-24 hours but no more than 24 hour intervals between assessments.

24) It is strongly recommended that the MSD utilize only one version of the suicide risk assessment forms currently being utilized by MSD mental health clinicians and LHC psychologists (i.e., LMHC ISP Risk Assessment Form, Psychologist EOH Evaluation, Psychologist ISP Evaluation, etc.). The Psychologist ISP Evaluation template that this writer reviewed at GBDF appears to be the most comprehensive. As recommended above, the selected suicide risk assessment form template should be utilized as justification for an inmate's initial placement on suicide precautions, as well as justification for an inmate's discharge from suicide precautions.

The Chief Mental Health Clinicians developed a standardized suicide risk assessment template which will be embedded into the Electronic Health Record system. Training was provided to all QMHP's and contracted mental health staff.

25) It is strongly recommended that, consistent with NCCHC and other national correctional standards, all clinicians develop treatment plans for inmates discharged from suicide precautions that describe signs, symptoms, and the circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur. A treatment plan should be contained in the discharging suicide risk assessment.

The Chief Mental Health Clinicians developed a standardized treatment plan template which will be embedded into the Electronic Health Record system. Training was provided to all QMHP's and contracted mental health staff.

26) It is strongly recommended that reasonable efforts should be made, particularly when considering the discharge of an inmate from suicide precautions, to avoid a cell-side encounters; rather, suicide risk assessments should be made in a private and confidential setting. Should an inmate refuse a private interview, the reason(s) for the refusal should be documented in JIMS.

This recommendation has been implemented in part Policy and procedure changes were made to eliminate cell-side encounters except in situations where doing so could jeopardize the safety of the inmate or staff. There is a pending construction project at the Vista Detention Facility that will provide additional confidential setting options in the booking area.

27) It is strongly recommended that, in order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on the mental health caseload and receive regularly scheduled follow-up assessments by clinicians until their release from custody. As such, unless an inmate's individual circumstances directs otherwise (e.g., an inmate inappropriately placed on suicide precautions by non-mental health staff and released less than 24 hours later following an assessment), it is recommended that the follow-

up schedule be simplified and revised as follows: follow-up within 24 hours, again within 72 hours, again within 1 week, and then periodically as determined by the clinician until release from custody.

This recommendation has been implemented. All inmates placed into and subsequently released from the Inmate Safety Program are maintained on a Qualified Mental Health Provider's caseload and are followed up with as clinically indicated.

28) Given the strong association between inmate suicide and segregation housing and consistent with national correctional standards, it is strongly recommended that DSB officials give strong consideration to increasing deputy rounds of such housing units from 60-minute to 30-minute intervals.

This recommendation has been implemented. The Sheriff Department has given strong consideration to increasing deputy rounds of restricted housing units from 60 minutes to 30 minute intervals. However, given the challenges regarding the physical layout of jail facilities, the numbers of inmates, and care necessary to properly conduct these checks, the Department has determined that it would not be feasible at this time to make this change. This recommendation requires the potential of cohorting inmates in administrative segregation, and disciplinary isolation areas of facilities to make implementation feasible. The Department continues to assess the feasibility of this recommendation.

29) It is strongly recommended that both mental health and nursing personnel be instructed to refrain from utilizing terms such "contracting for safety" or "vouching for his safety" with patients when assessing suicide risk. SDCSD policy should also be revised accordingly to prohibit its use.It is strongly recommended that both the SCSD and JPS suicide prevention policies be revised to include two levels of observation that specify descriptions of behavior warranting each level of observation. A proposed revision is offered as follows:

This recommendation was implemented by a directive to contract mental health staff and Sheriff's mental health clinicians to eliminate the use of "contracted for safety" or "vouching for his safety" practices and verbiage from their clinical notes.

Intervention

None

Reporting

None

Follow-Up/Mortality-Morbidity Review

30) It is strongly recommended that either the Critical Incident Review Board (CIRB) or the Suicide Prevention and Focused Response Team (SPFRT) be responsible for conducting mortality reviews of any inmate suicide, as well as morbidity reviews of any serious suicide attempts (defined as necessitating medical treatment outside the facility). Such reviews should include: 1) review of the circumstances surrounding the incident; 2) review of procedures relevant to the incident; 3) review of all relevant training received by involved staff; 4) review of pertinent medical and mental health services/reports involving the victim; 5) review of any possible precipitating factors that may have caused the victim to commit suicide or suffer a serious suicide attempt; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. When recommendations are accepted for implementation, a corrective action plan should be created that identifies each recommendation, followed by identified responsible staff, status(s) and deadline(s) for implementation. Every effort should be made to complete mortality-morbidity review process within 30 days of the incident. As such, should the mortality-morbidity review process become the responsibility of the CIRB, review of the suicide should be moved from the current 14-day deadline to a more reasonable 30-day deadline. Both the DSB's Policy M.7: Inmate Deaths and MSD's Policy Death of an Inmate On-Site should be revised to reflect the above 6-step review process. To assist either of the CIRB or SPRFT in these processes, this writer's "Mortality-Morbidity Review of Inmate Suicides/Serious Suicide Attempts Checklist" is offered for consideration in Appendix B.

MSD's Policy titled "Death of an Inmate On-Site" has been revised to require a mortality review within 30 days as recommended for cases involving suicide and serious suicide attempts.

31) It is strongly recommended MSD's clinical review of an inmate suicide that is currently entitled "psychological autopsy" be renamed as either a "suicide report" or "clinical suicide report." In the alternative, should MSD officials decide to commit to a psychological autopsy process, consistent with NCCHC standards, the review should include the MSD chief mental health clinician's prompt examination of the suicide site (including cell contents), as well as interviews with relevant staff, inmates, and family members of the decedent (when appropriate). Every effort should be made to complete the psychological autopsy within 30 days of the incident for presentation at the mortality review meeting.

The Chief Mental Health Clinicians will be collaborating with the Sheriff's Homicide Unit in conducting and completing a "suicide death report" within 30 days. In the event that the 30 day timeline cannot be adhered to, at a minimum, an administrative mortality review will be conducted.

32) It is strongly recommended that SDCSD officials consider slightly revising the SPFRT responsibility to "track and review all self-harm incidents, attempt suicides and suicides."

Although it would be reasonable to "track" all incidences of self-harm and attempted suicides, given the large size of the San Diego County Jail system, it would be unreasonable to expect that the SPRFT could adequately "review" all incidents of self-harm and attempted suicide. As such, the following revision is offered: "Track all incidents of self-harm and attempted suicide; Review all serious suicide attempts (defined as incidents of self-harm and/or attempted suicide that result in medical treatment outside of the jail facility) and suicides."

The Detention Services Bureau Policy and Procedure was revised to reflect the recommendation.

While it is impossible to prevent all suicides, the Sheriff's Department is committed to reducing suicide risk and self-harm incidents in our jail system. It is important to note that the Sheriff's Department has always been compliant with meeting State standards related to the operation of our detention facilities and that we remain steadfast in our pursuit of implementing best practices for a safe and humane environment. The assessment by Lindsay Hayes and his ensuing report, as well as the changes made by the Department based on his recommendations, are examples of the Department's ongoing commitment to continuously improve how we manage our jails and work to enhance the safety of our inmate population.

REPORT ON SUICIDE PREVENTION PRACTICES WITHIN THE SAN DIEGO COUNTY JAIL SYSTEM

San Diego, California

by

Lindsay M. Hayes
40 Lantern Lane
Mansfield, MA 02048
(508) 337-8806
e-mail: Lhayesta@msn.com

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REPORT ON SUICIDE PREVENTION PRACTICES WITHIN THE SAN DIEGO COUNTY JAIL SYSTEM
San Diego, California

A. INTRODUCTION

The following is a summary of the observations, findings, and recommendations of Lindsay M. Hayes following an assessment of suicide prevention practices within the San Diego County Jail System operated by the San Diego County Sheriff's Department in San Diego, California. Due to a high number of inmate suicides in the jail system beginning in approximately 2013 and as reported in the local media, Disability Rights California (DRC) initiated an investigation that included an initial tour of several facilities in May 2015. DRC subsequently enlisted two subject matter experts to review all inmate suicides in the San Diego County Jail System from 2014 through 2016, as well as critique relevant policies and procedures in the area of mental health care and suicide prevention. The subject matter expert review did not include an on-site assessment of suicide prevention practices within the jail system. A draft copy of the DRC report, entitled *Suicides in San Diego County Jail: A System Failing People with Mental Illness*, was presented to both the San Diego County Sheriff's Department and the Office of the County Counsel for San Diego County in early March 2018.[1]

As a result of the findings within the draft DRC report, the Office of the County Counsel requested this writer's services to independently assess *current* suicide prevention practices, as well as offer any appropriate recommendations for the revision of suicide prevention policies and procedures. In conducting the on-site assessment, this writer met with and/or interviewed

[1]The final DRC report was released on April 25, 2018. Of note, this writer is well acquainted with the DRC lead Litigation Counsel in this case, as well as the two subject matter experts. They are all well-respected within their fields of expertise.

numerous correctional, medical, and mental health officials and staff from the San Diego County Sheriff's Department (SCDSD), Medical Services Division (MSD), and Liberty Healthcare Corporation (LHC);[2] reviewed numerous policies and procedures related to suicide prevention, screening/assessment protocols, and training materials; reviewed various medical charts, incident reports, and available investigative reviews of six (6) inmate suicides between 2016 and 2017;[3] reviewed various medical charts of inmates on suicide precautions during the on-site assessment; and toured four jail facilities: San Diego Central Jail (SDCJ), Las Colinas Detention and Reentry Facility (LCDRF), Vista Detention Facility (VDF), and George Bailey Detention Facility (GBDF). This writer's on-site assessment was conducted from April 23 thru April 28, 2018.[4]

As of May 2018, the San Diego County Jail System had a yearly average daily population of 5,621 inmates, making it one of the largest county jail systems in California, as well as in the United States. As shown by Table 1, the San Diego County Jail System had 20 inmate suicides during the 5-year period of 2014 thru May 2018. Based upon the average daily population during this same time period, the suicide rate within the San Diego County Jail System was 73.2 deaths per 100,000 inmates -- a rate that was higher than that of county jails of varying size throughout the United States.[5]

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[2]Medical and mental health services are provided to inmates by the SDCSD's Medical Services Division. Since February 2017, psychologists (doctorate-level) and psychiatrists have provided additional mental health services to inmates through the SDCSD's contractual agreement with Liberty Healthcare Corporation. A previous contractor, Correctional Physicians Medical Group, provided psychiatric care to inmates from approximately 2014 through 2016.

[3]Of note, the San Diego County Jail System sustained two additional suicides in March and May 2018. Complete records from those deaths were not available for review at the time of the writing of this report.

[4]It is important to note that, with the exception of reviewing the inmate suicides in 2016-2017, the assessment encompassed review of suicide prevention practices *currently* in operation within the San Diego County Jail System as of April 2018, and did not include review of practices prior to that date.

[5]By comparison, the most recent data on jail suicide in county jails throughout the country is approximately 46 per 100,000 inmates, Noonan, M., Rohloff, H. and Ginder, S. (2015), *Mortality in Local Jails and State Prisons, 2000-2013 - Statistical Tables*, Washington, DC: Bureau of Justice Statistics (BJS), U.S. Department of Justice, Office of Justice Programs. As of June 2018, more recent BJS data was unavailable.

TABLE 1
AVERAGE DAILY POPULATION, YEARLY ADMISSIONS, SUICIDES, AND SUICIDE RATE
WITHIN THE SAN DIEGO COUNTY JAIL SYSTEM
2014 THRU 2018[6]

Year	ADP	Yearly Admissions	Suicides	Suicide Rate
2014	5,649	85,503	6	106.2
2015	4,986	81,313	6	120.3
2016	5,360	80,005	5	93.2
2017	5,687	80,286	1	17.6
2018 (May)	5,621	19,884	2	35.6
2014-2018 (May)	27,303	346,991	20	73.2

A Word About Suicide Rates

There has been a great deal of discussion and controversy regarding the calculation of inmate suicide rates within the San Diego County Jail System. The DRC report, as well as local media coverage of the jail system, utilized the methodology commonly cited by the U.S. Justice Department's Bureau of Justice Statistics (BJS) in its annual mortality review reports (as cited above).[7] As shown in Table 1 above, that methodology uses the average daily population (ADP) of the jail system as the denominator. Based upon the BJS methodology, the DRC report concluded that "San Diego County's inmate suicide rate has been staggeringly high compared with national, statewide, and local data" from 2014 through 2016, and that the jail system was in "crisis." In response, the Office of the County Counsel had previously retained a statistical

[6]Data regarding average daily population, yearly admissions, and number of inmates suicides made available by the San Diego County Sheriff's Department.
[7]See Footnote 5.

consultant (Colleen Kelly, PhD) to provide an alternative method for calculating the jail suicide rate, who subsequently opined that the ADP "method used to calculate the suicide rate does not yield a meaningful measure and is not appropriate for comparisons across diverse counties……Unfortunately, the ADP suicide rate has several flaws that make it inappropriate for comparing diverse jail systems….The 'at-risk' suicide rate calculation should be used instead of the ADP calculation."[8] According to Dr. Kelly, when the "at risk" methodology is utilized, the inmate suicide rate within the San Diego County Jail System is not statistically different from the average of other large California county jail systems.

This writer does not offer any opinion regarding the preferred methodology for calculating suicide rates (i.e., ADP v. "at-risk"). However, it is ironic that lost in the controversy is the fact that there has been a dramatic decrease in the number of inmate suicides in the San Diego County Jail System during the past few years. As noted in Table 1, there were 17 inmate suicides from 2014 through 2016, arguably a high number that was cited throughout the DRC report. Since that time, however, data from January 2017 through May 2018 indicates only three (3) inmate suicides. Although a small snapshot, this reduction is significant.

Of course, caution should always be exercised when viewing inmate suicide data. Suicide rates (regardless of calculation method) are most meaningful when viewed over a sustained period of time and, although the total number of inmate suicides and the corresponding suicide rate in any jail or prison system can be important indicators, they are not the sole barometer by which adequacy of suicide prevention practices should be measured. The best

[8]Kelly, Colleen, "Review and Critique of the Disability Rights California's Report - *Suicides at San Diego County Jail: A System Failing People with Mental Illness*," April 6, 2018.

methodology for determining whether a correctional system has a reasonable suicide prevention program continues to be (1) the on-site assessment of suicide prevention practices within each facility, and (2) a review of each inmate suicide in relation to practices in the facility and determining its degree of preventability.

B. QUALIFICATIONS

This writer is a Project Director of the National Center on Institutions and Alternatives, with an office in Mansfield, Massachusetts. This writer is nationally recognized as an expert in the field of suicide prevention within jails, prisons and juvenile facilities, and has been appointed as a Federal Court Monitor (and expert to special masters/monitors) in the monitoring of suicide prevention practices in several adult and juvenile correctional systems under court jurisdiction. This writer has also served as a suicide prevention consultant to the U.S. Justice Department's Civil Rights Division (Special Litigation Section) and to the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security (Immigration and Customs Enforcement) in their investigations of conditions of confinement in both adult and juvenile correctional facilities throughout the country. This writer also serves as an expert witness/consultant in inmate suicide litigation cases, as well as serving as a technical assistance consultant/expert by conducting training seminars and assessing inmate and juvenile suicide prevention practices in various state and local jurisdictions throughout the country.

This writer has conducted the only five national studies of jail, prison, and juvenile suicide (*And Darkness Closes In...National Study of Jail Suicides* in 1981, *National Study of Jail Suicides: Seven Years Later* in 1988, *Prison Suicide: An Overview and Guide to Prevention* in 1995, *Juvenile Suicide in Confinement: A National Survey* in 2004, and *National Study of Jail Suicide: 20 Years Later* in 2010). The jail and prison suicide studies were conducted through contracts with the National Institute of Corrections (NIC), U.S. Justice Department; whereas the first national study of juvenile suicide in confinement was conducted through a contract with the Office of Juvenile Justice and Delinquency Prevention, U.S. Justice Department.

This writer served as editor/project director of the *Jail Suicide/Mental Health Update*, a quarterly newsletter devoted to research, training, prevention, and litigation that was funded by NIC from 1986 thru 2008; and was a consulting editor and editorial board member of *Suicide and Life-Threatening Behavior*, the official scientific journal of the American Association of Suicidology, as well as current editorial board member of *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, the official scientific journal of the International Association of Suicide Prevention. This writer has authored over 100 publications in the area of suicide prevention within jail, prison and juvenile facilities, including model training curricula on both adult inmate and juvenile suicide prevention. This writer's *Training Curriculum and Program Guide on Suicide Detection and Prevention in Juvenile Detention/Correctional Facilities and Residential Programs: Instructor's Manual* was released in April 2013; whereas the *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities: Instructor's Manual* was released in March 2016.

As a result of research, technical assistance, and expert witness consultant work in the area of suicide prevention in correctional facilities, this writer has reviewed and/or examined over 3,500 cases of suicide in jail, prison, and juvenile facilities throughout the country during the past 38 years. This writer was a past recipient of the National Commission on Correctional Health Care's Award of Excellence for outstanding contribution in the field of suicide prevention in correctional facilities. This writer's work has been cited in the suicide prevention sections of various state and national correctional health care standards, as well as numerous suicide prevention training curricula.

C. FINDINGS AND RECOMMENDATIONS

Detailed below is this writer's assessment of suicide prevention practices within the San Diego County Jail System. It is formatted according to this writer's eight (8) critical components of a suicide prevention policy: staff training, identification/screening, communication, housing, levels of supervision/management, intervention, reporting, and follow-up/mortality-morbidity review. This protocol was previously developed by this writer and is consistent with national correctional standards, including those of the American Correctional Association's *Performance-Based Standards for Adult Local Detention Facilities* (2004); Standard J-G-05 of the National Commission on Correctional Health Care's *Standards for Health Services in Jails* (2014); "Suicide Prevention and Intervention Standard" of the U.S. Department of Homeland Security's *Operations Manual ICE Performance-Based National Detention Standards* (2011),[9] California Board of State and Community Corrections' *Minimum Standards for Local Detention Facilities* (2017) as outlined in Titles 15 and 24, California Code of Regulations,[10] and "312: Suicide Prevention" section of the California Institute for Medical Quality's *Health Care Accreditation*

[9]American Correctional Association (2004), *Performance-Based Standards for Adult Local Detention Facilities*, 4th Edition, Lanham, MD: Author; National Commission on Correctional Health Care (2014), *Standards for Health Services in Jails*, 9th Edition, Chicago, IL: Author; and U.S. Department of Homeland Security (2011), Immigration and Customs Enforcement, *Operations Manual ICE Performance-Based National Detention Standards*, Washington, DC: Author.

[10]See *Title 15 Minimum Standards for Local Detention Facilities*, effective April 1, 2017. According to Section 1030: Suicide Prevention Program – "The facility shall have a comprehensive written suicide prevention program developed by the facility administrator, in conjunction with the health authority and mental health director, to identify, monitor, and provide treatment to those inmates who present a suicide risk. The program shall include the following: (a) Suicide prevention training for all staff that have direct contact with inmates. (b) Intake screening for suicide risk immediately upon intake and prior to housing assignment. (c) Provisions facilitating communication among arresting/transporting officers, facility staff, medical and mental health personnel in relation to suicide risk. (d) Housing recommendations for inmates at risk of suicide. (e) Supervision depending on level of suicide risk. (f) Suicide attempt and suicide intervention policies and procedures. (g) Provisions for reporting suicides and suicides attempts. (h) Multi-disciplinary administrative review of suicides and attempted suicides as defined by the facility administrator."

Standards for Adult Detention Facilities (2013).[11] Where indicated, recommendations are also provided.

Finally, this writer reviewed various San Diego County Sheriff's Department policies and procedures related to suicide prevention, including:

Detention Services Bureau (DSB)

- J.5: Inmate Suicide Prevention Practices and Inmate Safety Program, last revised January 26, 2018;
- J.4: Enhanced Observation Housing (EOH), Definition and Use, last revised December 28, 2017;
- J.1: Safety Cells, Definition and Use, last revised October 9, 2017;
- M.4: Suicide Prevention and Focused Response Team, issued March 14, 2018;
- M.25: Psychiatric Security Units (PSU/WPSU), last revised June 27, 2017;

Medical Services Division (MSD)

- MSD.S.10: Suicide Prevention and Inmate Safety Program, last revised November 30, 2016;
- MSD.S.1: Safety Cells Use, last revised June 30, 2017;
- MSD.P.8: Psychiatric Security Unit (PSU), last revised December 23, 2015;
- MSD.I.3: Intake Receiving/Screening Assessment, last revised March 30, 2017.

The Detention Services Bureau (DSB)'s "J.5: Inmate Suicide Prevention Practices and Inmate Safety Program" and Medical Services Division (MSD)'s "MSD.S.10: Suicide Prevention and Inmate Safety Program" are virtually identical. As such, they will be collectively referred to throughout this report as the "Inmate Safety Program (ISP)" policy.

[11]California Institute for Medical Quality (2013), *Health Care Accreditation Standards for Adult Detention Facilities*, San Francisco, CA: Author. Unfortunately, the Institute for Medical Quality's suicide prevention standards is unhelpful and simply state that "Written policy and defined procedures require a suicide prevention program which is developed by the facility administrator, health authority and mental health professional to identify, monitor, and provide treatment to those inmates who present a suicide risk."

1) Staff Training

> ***All* correctional, medical, and mental health staff should receive eight (8) hours of initial suicide prevention training, followed by two (2) hours of annual training. At a minimum, training should include guiding principles to suicide prevention, avoiding negative attitudes to suicide prevention, inmate suicide research, why correctional environments are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, components of the agency's suicide prevention policy, and liability issues associated with inmate suicide.**

The key to any suicide prevention program is properly trained correctional staff, who form the backbone of any correctional system. Very few suicides are actually prevented by mental health, medical or other professional staff. Because inmates attempt suicide in their housing units, often during late afternoon or evening, as well as on weekends, they are generally outside the purview of program staff. Therefore, these incidents must be thwarted by correctional staff who have been trained in suicide prevention and are able to demonstrate an intuitive sense regarding the inmates under their care. Simply stated, correctional officers are often the only staff available 24 hours a day; thus they form the front line of defense in suicide prevention.

Both the American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC) standards stress the importance of training as a critical component to any suicide prevention program. ACA Standard 4-ALDF-7B-10 requires that all correctional staff receive both initial and annual training in the "signs of suicide risk" and "suicide precautions;" while Standard 4-ALDF-4C-32 requires that staff be trained in the implementation of the suicide prevention program. As stressed in NCCHC Standard J-G-05 --

"All staff members who work with inmates are trained to recognize verbal and behavioral cues that indicate potential suicide, and how to respond appropriately. Initial and at least biennial training are provided, although annual training is highly recommended." Finally, the U.S. Department of Homeland Security's *Operations Manual ICE Performance-Based National Detention Standards* require that all staff receive both pre-service and annual training in the following areas: recognizing verbal and behavioral cues that indicate potential suicide; demographic, cultural, and precipitating factors of suicidal behavior; responding to suicidal and depressed detainees; effective communication between correctional and health care personnel; necessary referral procedures; constant observation and suicide-watch procedures; follow-up monitoring of detainees who have already attempted suicide; and reporting and written documentation procedures."

FINDINGS: The suicide prevention training requirements found within Title 15 are vague, simply stating that correctional officers must complete the "Adult Corrections Officer Core Course" (which includes a 4-hour block on suicide prevention) within one year of employment. Although Title 15 requires annual training, the content of such training is unspecified. The San Diego County Sheriff's Department (SDCSD)'s Inmate Safety Program (ISP) policy does not adequately address the requirements for both pre-service and annual suicide prevention training for SDCSD personnel. Due to the vague language contained within Title 15, the ISP policy, and other agency directives, this writer conferred with several medical and mental health officials, as well as Detention In-Service Training Unit (DTU) personnel, responsible for the provision of suicide prevention training within the SDCSD. Various training

curricula were also reviewed. The review found that, although a bit disjointed, the SDCSD offered numerous opportunities for both suicide prevention and mental health training of its staff.

All new deputies are required to attend the SDCSD Detentions/Court Services Academy at Miramar College in San Diego. Since at least 2005, the mental health (including the 4-hour suicide prevention training block required by Title 15) portion of the "Adult Corrections Officer Core Course" has been instructed by a MSD mental health clinician. This pre-service training curriculum, previously referred to as "Psychiatric Behavior in Custody," was given to new deputies between 2005 and 2014. In late 2014, the curriculum was revised as a 99-slide PowerPoint presentation entitled "Mental Health in Custody." The three-part workshop, which was again revised in 2016, included an Overview of Mental Health Disorders, the Inmate Safety Program, and Multi-Disciplinary Group Meeting and Administrative Segregation Housing.

In addition, a 29-slide PowerPoint presentation entitled "Suicide Prevention in Custody" was developed in November 2006. The curriculum, accompanied by a videotape, was provided to an unknown number of SDCSD personnel from 2006-2007 and then from 2013 to the present. In addition, from 2010 through 2014, a 2-hour suicide prevention workshop entitled "Suicide Prevention and Awareness for Inmates: Briefing Training" was offered. According to the DTU, approximately 1,926 deputies received this training. Further, beginning in 2010, a 2-hour suicide prevention training entitled "Inmate Safety Program: Intensified Format Training" has been offered to SDCSD deputies. The training was revised in September 2017 and approximately 651 deputies have been trained since then. Finally, "Psychiatric Emergency Response Team" (PERT)

training has been provided to all deputies regularly assigned to the psychiatric security units and administrative segregation units within the San Diego County Jail System.

With regard to MSD nursing personnel, the "New Employee Orientation" curriculum is completed by all medical staff and includes instruction on the Inmate Safety Program, Safety Cell Use, and Enhanced Observation Housing. Further, an 8-hour classroom training entitled "Addressing Mental Health Issues in Jail" was provided to medical personnel, as well as custody and mental health personnel in late 2016. The 63-slide PowerPoint presentation was developed by a prior MSD mental health clinician. In addition, a 2-hour, 32-slide PowerPoint presentation entitled "Practical Use of Diagnostic Tools to Identify Medical and Psychiatric Conditions" has also been provided to medical personnel. In addition, approximately 83 percent of nursing personnel have completed an e-learning workshop entitled "Mental Health 1." Developed by Elsevier Publishing, topics include aggressive patients, agitation and disruptive behavior, crisis intervention, suicide assessment and precaution.

With regard to MSD mental health personnel, in addition to the "New Employee Orientation" curriculum that is completed by all mental health clinicians and includes instruction on the Inmate Safety Program, Safety Cell Use, and Enhanced Observation Housing, an extended 16-hour classroom presentation of the above referenced "Addressing Mental Health Issues in Jail" training was completed by clinicians in August 2016. In addition, Dialectic Behavioral Therapy (DBT) training was provided to clinicians in December 2016 by an outside consultant. MSD mental health clinicians have not been provided any agency-sponsored suicide prevention training since then. Finally, according to Liberty Healthcare Corporation (LHC) officials, in

addition to a 1-day SDCSD contractor orientation, LHC psychologists receive new employee training by the contractor that includes instruction on suicide prevention.[12]

Finally, according to SDCSD training data, approximately 31 percent of deputies, 73 percent of medical personnel, and no mental health clinicians received annual suicide prevention training during 2017.

In sum, as indicated above, the SDCSD has historically offered an abundance of both mental health and suicide prevention training to its employees. This training has been offered on both a pre-service and annual basis, although provision of some of the annual training has been inconsistent. In addition, although there has been a plethora of mental health training provided, it was difficult to ascertain the percentage of current personnel that had received training to date. The percentage of SDCSD personnel receiving annual suicide prevention training during 2017 was problematic. In response, the MSD and DTU are jointly working to consolidate this writer's 10-hour *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities*[13] into an 8-hour classroom training workshop for the approximate 1,200 SDCSD deputies working within the jail system. Once launched, the training initiative is scheduled to be completed within three years.

RECOMMENDATIONS: Although the SDCSD appears compliant with most Title 15 requirements, a few recommendations are offered to strengthen both the content and

[12]The curriculum and/or training materials utilized in any LHC suicide prevention training were not available for review.

[13]See Hayes, L. M. (2016), *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities*,www.ncianet.org/suicide-prevention/publications/training-curriculum-and-program-guide-on-suicide-detection-and-prevention-in-jail-and-prison-facilities.

deliverability of suicide prevention training offered to both custody and health care personnel. *First*, it is strongly recommended that the ISP policy be revised to include a more robust description of the requirements for both pre-service and annual suicide prevention training, to include the duration of each workshop and an overview of the required topics. *Second*, it is strongly recommended that the joint efforts of the Medical Services Division (MSD) and Detention In-Service Training unit (DTU) to consolidate this writer's 10-hour *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities* into an 8-hour classroom training for all current SDCSD deputies be expanded to include all new employees (i.e., medical and mental health personnel) working within the San Diego County Jail System.

Third, it is strongly recommended that the MSD and DTU jointly collaborate on the development of a 2-hour annual suicide prevention curriculum based upon this writer's *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities.* At a minimum, the curriculum should include a review of: 1) avoiding obstacles (negative attitudes) to prevention, 2) predisposing risk factors, 3) warning signs and symptoms, 4) identifying suicidal inmates despite the denial of risk, and 5) review of any changes to the ISP policy. The annual training should also include general discussion of any recent suicides and/or serious suicide attempts in the San Diego County Jail System.

Fourth, it is strongly recommended that the annual suicide prevention training be required for all custody, medical, and mental health personnel (including LHC contracted psychologists and psychiatrists). Suicide prevention is all about collaboration, and requiring

custody, medical, and mental health personnel to sit together in a classroom environment is not only symbolically appropriate, but instills the philosophy that all professionals, regardless of credentials, have an equal responsibility for inmate suicide prevention and can learn from one another's backgrounds, insights, and experiences.

2) Intake Screening/Assessment

> **Intake screening for suicide risk must take place immediately upon confinement and prior to housing assignment. This process may be contained within the medical screening form or as a separate form, and must include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/ close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; and transporting officer(s) information regarding inmate's suicide risk. The intake screening process should include procedures for referral to mental health and/or medical personnel. Reasonable efforts should be made to ensure privacy and confidentiality (from both other inmates and non-health care personnel) during the intake screening process. Any inmate assigned to a segregation unit should be screened to ensure that there are no medical and/or mental health contraindications for such placement.**

Intake screening/assessment is also critical to a correctional system's suicide prevention efforts. An inmate can attempt suicide at any point during incarceration -- beginning immediately following reception and continuing through a stressful aspect of confinement. Although there is disagreement within the psychiatric and medical communities as to which factors are most predictive of suicide in general, research in the area of jail and prison suicides has identified a number of characteristics that are strongly related to suicide, including: intoxication, emotional state, family history of suicide, recent significant loss, limited prior incarceration, lack of social support system, psychiatric history, and various "stressors of

confinement."[14] Most importantly, prior research has consistently reported that at least two thirds of all suicide victims communicate their intent some time prior to death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt.[15] In addition, according to the most recent national research on inmate suicide, at least one-third of all inmate suicide victims had prior histories of both mental illness and suicidal behavior.[16] The key to identifying potentially suicidal behavior in inmates is through inquiry during both the intake screening/assessment phase, as well as other high-risk periods of incarceration.

Further, it would not be unusual for an otherwise suicidal inmate to deny suicidal ideation when questioned in a physical environment that lacks both privacy and confidentiality. The booking area of any jail is traditionally both chaotic and noisy; an environment where staff feel pressure to process a high number of arrestees in a short period of time. Two key ingredients for identifying suicidal behavior - time and privacy - are at a minimum. The ability to carefully assess the potential for suicide by asking the inmate a series of questions, interpreting their response (including gauging the truthfulness of their denial of suicide risk), and observing their behavior is grossly compromised by an impersonal environment that lends itself to something quite the opposite. As a result, the clearly suicidal behavior of many arrestees, as well as circumstances that may lend themselves to potential self-injury, are lost. As such, reasonable

[14]Bonner, R. (1992), "Isolation, Seclusion, and Psychological Vulnerability as Risk Factors for Suicide Behind Bars," in R. Maris et. al. (Editors) *Assessment and Prediction of Suicide*, New York, NY: Guilford Press, 398-419.
[15]Clark, D. and S.L. Horton-Deutsch (1992), "Assessment in Absentia: The Value of the Psychological Autopsy Method for Studying Antecedents of Suicide and Predicting Future Suicides," in R. Maris et. al. (Editors) *Assessment and Prediction of Suicide*, New York, NY: Guilford Press, 144-182.
[16]Hayes, L.M. (2012), "National Study of Jail Suicides: 20 Years Later," *Journal of Correctional Health Care*, 18 (3).

efforts should be made to ensure privacy and confidentiality (from both other inmates and non-health care personnel) during the intake screening process.[17]

Finally, given the strong association between inmate suicide and special management (e.g., disciplinary and/or administrative segregation, etc.) housing unit placement, any inmate assigned to such a special housing unit should receive a brief assessment for suicide risk by health care staff upon admission to such placement. For example, both the ACA and NCCHC standards address the issue of assessing inmates assigned to segregation. According to ACA Standard 4-ALDF-2A-45: "When an inmate is transferred to segregation, health care personnel are informed immediately and provide assessment and review as indicated by the protocol as established by the health authority." NCCHC Standard J-E-09 states that "Upon notification that an inmate is placed in segregation, a qualified health care professional reviews the inmate's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation."

FINDINGS: Both the ISP policy and MSD.I.3: Intake Receiving/Screening Assessment policy provided generally adequate procedures regarding the intake screening process to identify suicidal inmates. However, because current practices have evolved since issuance of both policies (in 2016 and 2017), they are in need of further revision. For example, the MSD is currently transitioning from a two-part (pre-screening/standard screening) intake screening process to a "combined medical screening" process. For purposes of clarity, this writer will refer only to the combined medical screening form. In addition, the combined form (entitled "Medical

[17]See Hayes, L.M. (2013), "Suicide Prevention in Correctional Facilities: Reflections and Next Steps," *International Journal of Law and Psychiatry* 36: 188-194.

Intake Questions"), embedded in the medical section of the Jail Information Management System (JIMS), now includes a 6-question Columbia-Suicide Severity Rating Scale (C-SSRS). During the on-site assessment, this writer observed a variety of practices during the transition of the intake screening process.[18]

As previously noted in Table 1, over 80,000 inmates are admitted into the San Diego County Jail System every year. All newly admitted inmates are processed through the booking and intake areas of three facilities: San Diego Central Jail (SDCJ), Las Colinas Detention and Reentry Facility (LCDRF), and Vista Detention Facility (VDF). Nursing staff are available at these facilities 24 hours a day respond to the booking areas and complete the intake screening process. As explained below, the physical location of the intake screening, as well as the degree of privacy and confidentiality, varied at each facility. The "Medical Intake Questions" form contains a variety of medical, mental health, and suicide risk questions, some of which are repetitive. The following mental health and suicide risk questions are contained in the form:

- You have any psychiatric problems?
- Are you a client of the Regional Center for developmentally disabled?
- Are you feeling suicidal?
- Do you have any current psychiatric/mental health problems?
- Do you have any previous mental health history?
- Do you know your psychiatrist/clinic name?
- Any visual hallucinations?
- Any auditory hallucinations?
- Any suicidal ideation?
- Any homicidal ideation?
- Any prior suicide attempts?
- Are you currently taking any psychiatric medications?

[18]Although informed that the C-SSRS was required to be utilized by intake nurses at the three intake facilities, this writer did not observe the form being used.

The following Columbia-Suicide Severity Rating Scale questions are also embedded in the screening form:

- Have you wished you were dead or wished you could go to sleep and not wake up? (Past month)
- Have you had any actual thoughts of killings yourself? (Past month)
- Have you been thinking how you might do this?
- Have you had these thoughts and had some intention of acting on them?
- Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
- Have you ever done anything, started to do anything, or prepared to do anything to end your life? If yes, was this within the past three months?

Further, the screening form includes the following four questions that are directed to the arresting officer:

- Did the arresting officer witness anything to believe the arrestee may be at risk for a medical condition, intellectual disability, or suicide?
- By your observation, does he arrestee appear to be under the influence of drugs or alcohol?
- Was he arrestee combative at the time of arrest?
- Is there any information that you can provide to us to better care for this arrestee and ensure his/her health and safety?

Affirmative responses to any of the above questions related to current suicide risk are required to result in notification to the facility's "gatekeeper," often the charge nurse.[19] Following consultation between the charge nurse and custody shift supervisor, the inmate is normally placed on suicide precautions (often in a safety cell) and referred to a mental health clinician for further assessment.

[19]For reasons that were unclear to this writer, the ISP policy allows for a charge nurse or mental health clinician to be the facility gatekeeper at SDCJ and LCDRF, but only the charge nurse is designated as the gatekeeper at both GBDF and VDF.

Finally, pursuant to the ISP policy and in addition to affirmative responses on the medical screening form, the following criteria are deemed high-risk "automatic triggers" and almost invariably result in placement on suicide precautions:

1) High publicity case with possible evasion of arrest or SWAT/SED standoff with serious felony charges, including but not limited to: homicide, rape, or child victim crimes;
2) Severe, life or death sentences;
3) The inmate states he/she is suicidal and or made suicidal statements to sworn staff, medical, family, etc.;
4) Previous suicide attempts (within the past five years); and
5) Staff observation of depressed/emotional turmoil.

This writer spent considerable time observing the intake screening process at all three facilities.[20] At San Diego Central Jail (SDCJ), two nursing booths were located in the booking and intake area. Each booth was enclosed with a window panel that separated the nurse from the inmate. When the inmate entered the booth, they were situated in a chair, handcuffed and chained to a wall eyebolt. Although each booth contained a windowed door, the door remained open during the screening process, with the arresting officer often either straddling the inmate or remaining in the open doorway. Privacy and confidentiality were compromised by this practice, but could easily be remedied by the door simply being closed, the inmate remaining shackled, and the officer providing security from outside the door.[21] During this writer's observation of the screening process, nurses were observed accessing the JIMS to determine whether the newly admitted inmate had received a chest x-ray in the previous six months, as well as checking the "current problem" list in the medical record to determine whether the inmate had a documented prior suicide attempt within the past five years. A list of the four arresting officer questions was

[20]Although this writer was unable to observe any newly admitted inmates being screened at LCDRF, considerable time was spent in the booking area with multiple nursing staff detailing current practices.
[21]It should be noted that the shield of privacy and confidentiality extends not only between inmate and inmate, but inmate and non-health care personnel (e.g., custody staff).

taped to the wall of each nursing booth and arresting officers were consistently referred to the list for a response. Nurses were observed to be appropriately completing the "Medical Intake Questions" form in each case. Finally, supplemental medical screening was observed on the 2nd floor of the SDCJ. Similar nursing booths were located in the corridor, with doors remaining open and deputies observed in the doorway.

At Las Colinas Detention and Reentry Facility (LCDRF), this writer was informed that the combined medical screening process was scheduled to begin in the near future. Currently, the two-part (pre-screening/standard screening) intake screening process was completed on opposite sides of a large rectangular-shaped nursing station. During the pre-screening process, privacy and confidentiality were compromised with arresting officers said to be positioned behind each newly admitted inmate. Once the inmate was accepted into custody, the standard screening was conducted on the opposite side of the nursing station. This writer was also informed that a current medical examination room adjacent to the nursing station was being converted into an intake area for the combined medical screening. As explained to this writer, the door to this medical room would remain open during the screening process, with the arresting officer stationed in the doorway. Such a proposed practice would also impact privacy and confidentiality. Finally, this writer was also informed that the four arresting officer questions described above were not asked to arresting officer personnel by LCDRF nurses. The reason for this practice was unclear.

At Vista Detention Facility (VDF), medical screening was conducted in a small, congested open area, with no individual nursing booths. Up to two nurses were assigned to

conduct screening at a counter. During the process, numerous law-enforcement officers and inmates were milling around a small area. Prior to being screened, inmates were instructed to sit on a bench which was located less than 6 feet from the nurses' counter. There is no privacy or confidentiality. This writer was informed that a construction project was forthcoming (with funding secured, but no start-up date) to completely renovate the area and make it more "HIPAA-friendly" as coined by one supervisor. Plans were to construct three nursing stations/cubicles, as well as remove the bench (with arrestees remaining in patrol cars in the sally port area until the initiation of their individual screening).

As observed by this writer, VDF nurses did not ask all of the required "Medical Intake Questions" from the combined screening form embedded into JIMS. Rather, nursing staff had previously created an abbreviated hard copy sheet that listed 23 health care issues. Even with this abbreviated sheet, nurses were observed to be asking only limited questions regarding mental health and suicide risk, i.e., consistently simply asking: "Any psych problems, Feeling suicidal?" Nurses were observed reviewing the JIMS to determine if the inmate had a documented prior suicide attempt. In addition, the four arresting officer questions described above were not asked to arresting officer personnel by VDF nurses. The observed screening process was very problematic.

Further, and as noted above, all three intake facilities (SDCJ, LCDRF, and VDF) utilized charge nurses as gatekeepers for an inmate's placement on suicide precautions. However, despite the fact that mental health clinicians were on-site during normal business hours, consultation was normally only between the charge nurse and custody shift supervisor, with mental health

personnel often excluded from the process until the inmate was already placed on suicide precautions. As witnessed by this writer, the following two examples reflected current practices, albeit inconsistent.

At SDCJ, a nurse was completing the medical screening of an inmate arrested on several sexual assault charges. The inmate denied any current or prior mental health issues, as well as denying any current or prior suicidal behavior. The nurse's review of JIMS did not find any documented prior suicide attempts. However, due to the seriousness of his charges, the protocol required that the inmate be considered "high risk" for suicide, with further medical assessment needed to determine if placement on suicide precautions was necessary, either in a safety cell or the Enhanced Observation Housing (EOH) unit. The inmate was escorted up to the 2nd floor, received further screening by a second nurse and, as explained to this writer by a custody shift supervisor, was presumably going to be placed in a safety cell. According to the second nurse, the inmate reported some anxiety and prior treatment for post-traumatic stress disorder (PTSD), and was going to be referred to a mental health clinician for further assessment. Shortly thereafter, a mental health clinician arrived at the 2nd floor nursing station and completed an assessment of the inmate. As the clinician subsequently informed this writer, the screening found that the inmate was not currently suicidal nor did he have a history of suicidal behavior. To the apparent surprise of the custody shift supervisor, the inmate was not placed in either a safety cell or the EOH unit, rather he was cleared for classification. This writer was subsequently informed by the shift supervisor that what we observed was unusual, and that on-site mental health clinicians were not automatically called down to the nurses' station for further assessment. Rather, inmates were initially placed in a safety cell or the EOH unit and then referred to mental

health. In fact, if the above inmate had arrived at SDCJ when mental health personnel were not on-site, he would have been automatically placed on suicide precautions based solely on the severity of his charges.

In the second case, an inmate arrived at VDF and during the medical screening process, became very demonstrative, claimed to be suicidal and wanted to be "5150'd" to a private hospital. The inmate appeared to be under the influence of an unknown substance, and was arguably manipulative. As observed by this writer, the intake nurse subsequently conversed with both the charge nurse and shift supervisor in separate telephone conversations. As a result, the inmate was placed in a safety cell. Although mental health personnel were on-site, they were not consulted during this process. This writer was informed that a mental health clinician would probably assess the inmate the following morning. When subsequently discussing the observed case with a VDF clinician, this writer was informed that there was a previous practice by which a LHC psychologist would respond to such a situation and complete an assessment prior to any decision to initiate suicide precautions. For reasons that remained unclear, the practice was stopped, mental health clinicians no longer immediately responded to such situations, and inmates were placed on suicide precautions (in either a safety cell or EOH unit) and then referred to mental health.

Finally, this writer was informed that the MSD had recently initiated a practice of requiring any inmate housed in a segregation unit be assessed by a mental health clinician within 24 hours of placement. In addition, mental health personnel conducted weekly rounds in all

segregation units, whereas nursing personnel conducted segregation unit rounds three times a week. These were all very good practices.

In conclusion, although policies provided generally adequate procedures regarding the intake screening process to identify suicidal inmates, and suicide risk inquiry contained within the "Medical Intake Questions" form was consistent with Title 15 requirements, there were various problems observed relating to privacy and confidentiality, inconsistent practices regarding soliciting arresting officer opinions regarding the health of the inmate, automatic triggers for suicide precautions absent actual suicidal ideation, and a charge nurse "gatekeeping" protocol that often excluded consultation with on-site mental health clinicians.

RECOMMENDATIONS: Several recommendations are offered to improve the intake screening/assessment process within the San Diego County Jail System. *First*, it is strongly recommended that Detention Services Bureau (DSB) and MSD officials look at options to better ensure reasonable sound privacy in the booking areas of the three intake facilities when multiple nurses are conducting intake screening at the same time. As demonstrated in the SDCJ, if the inmate is secured within the nursing booth and the door is closed with the officer stationed outside, reasonable privacy and confidentiality can occur while ensuring staff safety.

Second, it is strongly recommended that the current suicide risk inquiry contained in the "Medical Intake Questions" form embedded in the JIMS be revised to include the following:

- Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
- Has a family member/close friend ever attempted or committed suicide?

- Do you feel there is nothing to look forward to in the immediate future (inmate expressing helplessness and/or hopelessness)?

Third, it is strongly recommended that MSD officials reconsider the utility of the Columbia-Suicide Severity Rating Scale (C-SSRS) during the intake screening process. Although the C-SSRS has become a popular screening form in some jail facilities throughout the country, its effectiveness remains questionable. It is this writer's opinion that the structure of the questions creates awkwardness between the screener and inmate, and more importantly, questions that limit responses to the "past month" are potentially very dangerous (e.g., the suicidal ideation of an inmate that was experienced more than a month ago would not be captured during the screening process). Intake screening questions by nursing staff should be open-ended and not time-sensitive; it is responsibility of a mental health clinician during a subsequent assessment to determine the degree of relevancy of prior suicide risk to current risk. With addition of the three questions offered above, the current intake screening form would be more than adequate without the necessity of the C-SSRS.

Fourth, although this writer would defer to MSD officials as to whether to designate either a charge nurse or mental health clinician to be the ISP gatekeeper, it is strongly recommended that, if the charge nurse is a gatekeeper, they should always immediately notify an on-site mental health clinician when an inmate has been identified as potentially suicidal. The clinician, in turn, should respond and conduct the suicide risk assessment and determine the appropriateness of suicide precautions. Unless exigent circumstances exist and/or mental health personnel are not on-site, the determination of placing a potentially suicidal inmate in either a safety cell and/or the EOH unit should be made by the mental health clinician.

Fifth, it is strongly recommended that DSB and MSD officials revise the "automatic triggers" criteria contained within the ISP policy to require only criteria No. 3 ("The inmate states he/she is suicidal and or made suicidal statements to sworn staff, medical, family, etc.) to result in placement on suicide precautions. Although the other four criteria could be potential suicide risk factors, they should be considered criteria for a mental health referral, and not necessarily automatic placement on suicide precautions.

Sixth, consistent with the SDCSD philosophy that a previous suicide attempt documented in JIMS could be a factor for current suicide risk, an inmate's previous placement on suicide precautions within the San Diego County Jail System is equally important. As such, regardless of the inmate's behavior or answers given during intake screening, a mental health referral should always be initiated based on documentation reflecting possible serious mental illness and/or suicidal behavior during an inmate's prior confinement within the San Diego County Jail System. As such, it is strongly recommended that determination of whether the inmate was "on suicide precautions during prior confinement in a SDCSD facility?" should be independently verified through review of the JIMS by nursing staff. An "alert" screen on JIMS and protocol should be created according to the following procedures:

- Any inmate placed on suicide precautions should be tagged on the JIMS "alert" screen by mental health staff (e.g., "ISP June 2018");

- Nursing staff conducting intake screening should always review the inmate's "alert" screen to verify whether they were previously confined in a SDCSD facility and had any history of suicidal behavior/placement on suicide precautions during a prior confinement; and

- Regardless of the inmate's behavior or answers given during intake screening, further assessment by mental health staff should always be initiated based on documentation reflecting suicidal behavior/ placement on suicide precautions during the inmate's prior SDCSD confinement.

Seventh, it is strongly recommended that MSD officials initiate a continuous quality assurance plan to periodically audit the intake screening process to ensure that nursing staff are accurately completing the "Medical Intake Questions" form, and not using abbreviated inquiry, as well as soliciting responses to the four arresting officer questions.

Eighth, it is strongly recommended that MSD officials develop a mental health triage and referral protocol. Although there is no standard of care that consistently specifies time frames to respond to mental health referrals, one suggested schedule would be as follows: Emergent - immediate or within 1 hour; Urgent - within 24 hours; and Routine - within 72 hours.[22] In addition, mental health leadership should develop a mental health triage policy that defines response levels, sets timetables for each level, and defines the acuity of behavior(s) that dictates a specific response level. Of course, any inmate expressing current suicidal ideation and/or current suicidal/self-injurious behavior should result in an Emergent mental health referral.

Ninth, given the strong association between inmate suicide and special management (e.g., disciplinary and/or administrative segregation, etc.) housing unit placement, it is strongly recommended that medical personnel review the medical section of JIMS to determine whether existing medical and/or mental health needs contraindicate the placement or require accommodation. In addition, a "best practice" would be that any inmate assigned to such a

[22]Other acceptable schedules allow for up to 7 days to respond to a Routine mental health referral.

special management housing unit receive a brief assessment for suicide risk by nursing staff upon admission to such placement. The following are recommended questions for the brief assessment:

- Are you currently having thoughts of harming yourself?
- Have you previously tried to harm yourself because of a segregation placement?
- Is the inmate speaking incoherently; expressing bizarre thoughts; unable to sit still or pay attention; or is disoriented to time, place, or person?

Affirmative responses to any of these questions should result in an Emergent mental health referral.

3) Communication

Procedures that enhance communication at three levels: 1) between the sending institution/arresting-transporting officer(s) and correctional staff; 2) between and among staff (including medical and mental health personnel); and 3) between staff and the suicidal inmate.

Certain signs exhibited by the inmate can often foretell a possible suicide and, if detected and communicated to others, can prevent such an incident. There are essentially three levels of communication in preventing inmate suicides: 1) between the sending institution/arresting-transporting officer and correctional staff; 2) between and among staff (including mental health and medical personnel); and 3) between staff and the suicidal inmate. Further, because inmates can become suicidal at any point in their incarceration, correctional staff must maintain awareness, share information and make appropriate referrals to mental health and medical staff.

FINDINGS: Effective communication between correctional, medical, and mental health staff is not an issue that can be easily written as a policy directive, and is often dealt with more

effectively through examples of multidisciplinary problem-solving. Although on-site for only five days, with one notable exception, this writer sensed that correctional, medical, and mental health personnel had a good working relationship.[23] There were numerous examples of effective communication within the San Diego County Jail System. For example, as previously detailed in this report, the intake nurse is required to ask several questions to the arresting officer regarding any observed health care needs of the newly arrived inmate. In addition, there were multi-disciplinary group (MDG) meetings held at each facility twice a month. The purpose of the MDG meetings is to identify inmates who present various management problems within the facility, and can include inmates housed in segregation, exhibiting serious mental illness, and/or suicidal behavior. In addition, each facility housing a Psychiatric Security Unit (PSU) conducts regular multi-disciplinary treatment team meetings. This writer observed such a meeting in the PSU at LCDRF and found it to be comprehensive and informative. Further, a multi-disciplinary Patient Care Coordination meeting occurs on a monthly basis at each facility. The MSD holds Quality Improvement Committee meetings approximately twice a year at headquarters that is attended by medical and mental health leadership, and includes representation from LHC. This writer's review of meeting minutes from 2016 through 2018, including the most recent meeting on February 21, 2018, found that the meetings routinely discussed the issue of suicide prevention. Finally, as will be discussed later in this report, the SDCSD recently initiated a Suicide Prevention and Focus Response Team (pursuant to Policy M.4: Suicide Prevention and Focused Response Team, issued March 14, 2018). The multi-disciplinary team includes representation from the DSB, MSD, DTU, and LHC, as well as other stakeholders. The first meeting occurred on May 1, 2018.

[23]The notable exception was this writer's finding of an adversarial relationship between MSD mental health clinicians and LHC psychologists in a few facilities. These findings were subsequently shared with MSD officials for expedited resolution.

Finally, the JIMS database contains pertinent records that better ensures communication between deputies and health care personnel, as well as between medical and mental health personnel (i.e., the medical chart). These were all excellent practices.

RECOMMENDATION: Only one recommendation offered. It is strongly recommended that the MSD establish a weekly mental health team meeting at each facility that includes MSD mental health clinicians and LHC psychologists and psychiatrists. The primary purpose of the weekly meeting is to identify and manage the treatment needs of suicidal and/or seriously mentally ill patients.

4) Housing

> **Isolation should be avoided. Whenever possible, house in general population, mental health unit, or medical infirmary, located in close proximity to staff. Inmates should be housed in suicide-resistant, protrusion-free cells. Removal of an inmate's clothing (excluding belts and shoelaces), as well as use of physical restraints (e.g. restraint chairs/boards, straitjackets, leather straps, etc.) and cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is physically engaging in self-destructive behavior.**

In determining the most appropriate location to house a suicidal inmate, there is often the tendency for correctional officials in general to physically isolate the individual. This response may be more convenient for staff, but it is detrimental to the inmate. The use of isolation not only escalates the inmate's sense of alienation, but also further serves to remove the individual from proper staff supervision. National correctional standards stress that, to every extent

possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located in close proximity to staff.

Of course, housing a suicidal inmate in a general population unit when their security level prohibits such assignment raises a difficult issue. The result, of course, will be the assignment of the suicidal inmate to a housing unit commensurate with their security level. Within a correctional system, this assignment might be a "special housing" unit, e.g., restrictive housing, disciplinary confinement, administrative segregation, etc. Yet, housing assignments should not be based on decisions that heighten depersonalizing aspects of incarceration, rather they should be based on the ability to maximize staff interaction with inmates. With that said, *the most important consideration is that suicidal inmates must be housed in suicide-resistant, protrusion-free cells*. Further, cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), removal of clothing (excluding belts and shoelaces), as well as the use of physical restraints (e.g., restraint chairs/boards, straitjackets, leather straps, etc.) should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is physically engaging in self-destructive behavior. Finally, unless exigent circumstances exist, court hearings should not be postponed for inmates on suicide precautions.

FINDINGS: The SDCSD has various policies and procedures that address the housing of suicidal inmates: J.5: Inmate Suicide Prevention Practices and Inmate Safety Program (last revised January 26, 2018); J.4: Enhanced Observation Housing (EOH), Definition and Use (last revised December 28, 2017); J.1: Safety Cells, Definition and Use (last revised October 9, 2017); M.25: Psychiatric Security Units (last revised June 27, 2017); MSD.S.10: Suicide

Prevention and Inmate Safety Program (last revised November 30, 2016); MSD.S.1: Safety Cells Use (last revised June 30, 2017); and MSD.P.8: Psychiatric Security Unit (last revised December 23, 2015). These policies allow for the placement of suicidal inmates in Safety Cells, Enhanced Observation Housing (EOH), Medical Observation Beds (MOB), and Psychiatric Security Units (PSU).

The following is a list of housing options for suicidal inmates in the four inspected jail facilities, including the degree to which this writer found each to be suicide-resistant (i.e., did not contain obvious anchoring points from which an inmate could utilize in a suicide attempt by hanging):

SDCJ

Safety Cells: There were 6 safety cells located at the SDCJ; 4 on the 2nd floor and 2 on the 3rd floor. As the cells were dry (i.e., not containing a sink or toilet), and did not contain bunks, they were suicide-resistant. Each cell had closed circuit television (CCTV) monitoring.

EOH Unit: Located on the 6th floor, with the exception of wall ventilation grills being approximately ¼ inch in diameter (in excess of the industry standard 3/16 of an inch), each cell had tall ceilings, and were otherwise suicide-resistant. Each cell had CCTV monitoring. Inspection of several cells found that they were quite dirty and unsanitary, with feces found on the walls in close proximity to the CCTV monitor.

PSU Observation Cells: 4 wet cells (containing a sink or toilet) were located adjacent to the 30-bed PSU and could be utilized for PSU patients who became suicidal. Each cell had a raised platform with a mattress for sleeping and CCTV monitoring. Because all 4 cells were occupied at the time of the inspection, cell interiors could not be observed to determine if they were suicide-resistant.

MOB Cells: Located in the 3rd floor Medical Unit, Cells 6 and 11 could be utilized for suicide precautions for EOH and PSU patients. Although the cells had CCTV monitoring, they were not suicide-resistant because there were various protrusions conducive to suicide by hanging.

LCDRF

Safety Cells: There were 5 safety cells located at the LCDRF; 3 in Intake and 2 in the Infirmary. As the cells were dry (i.e., not containing a sink or toilet), and did not contain bunks, they were suicide-resistant. Each cell had CCTV monitoring.

EOH Unit: A 5-bed EOH dorm was located across from the nurses' station in the Infirmary. Although not completely suicide-resistant because of individual bunks, this potential hazard was offset by the dormitory environment and good visibility from the nurses' station. There were also two "high-level" wet isolation cells near the nurses' station that could be utilized for EOH patients whose classification status prohibited dormitory housing.

PSU Observation Cells: Two wet cells (No. 23 and No. 26) were located adjacent to the 22-room PSU (with a combination of single and double-occupancy) and could be utilized for PSU patients who became suicidal. Each cell had molded hard plastic beds, a tall ceiling, CCTV monitoring, and was suicide-resistant.

VDF

Safety Cells: There were 6 safety cells located at the VDF; 4 in Intake (with one reserved for female inmates) and 2 in the Medical Unit. As the cells were dry (i.e., not containing a sink or toilet), and did not contain bunks, they were suicide-resistant. Each cell had CCTV monitoring.

EOH Unit: An 8-bed EOH dorm was located on the 2nd floor. Although not completely suicide-resistant because of individual bunks, this potential hazard was partially offset by the dormitory environment.

MOB Cells: Located in the Medical Unit, there were 5 MOB cells that could be utilized for suicide precautions for EOH and PSU patients. Although the cells had CCTV monitoring, they were not suicide-resistant because they contained various protrusions conducive to suicide by hanging (e.g., open metal bunks, ceiling ventilation rates with holes in excess of 3/16 inch in diameter, sprinkler head covers, etc.).

GBDF

Safety Cells: There were 4 safety cells located at the GBDF; 2 in Intake and 2 in the Medical Unit "isolation corridor." As the cells were dry (i.e., not containing a sink or toilet), and did not contain bunks, they were suicide-resistant. Inspection of the 2 safety cells (No. 117 and No.118) in the Medical Unit isolation corridor found that they were quite dirty and unsanitary. Each cell had CCTV monitoring.

EOH Unit: A 12-bed EOH dorm (Cell No. 115) was located on the 1st floor. Although not completely suicide-resistant because of individual bunks, this potential hazard was partially offset by the dormitory environment. There were also 2 "high-level" wet isolation cells (No. 108 and No. 112) in the Medical Unit isolation corridor that could be utilized for EOH patients whose classification status prohibited dormitory housing. The cells were not suicide-resistant because they contained various protrusions conducive to suicide by hanging (e.g., bunk holes, ceiling ventilation grates with holes in excess of 3/16 inch in diameter, conduit piping in the ceiling, gap between the wall and the bunks, etc.).

Use of Safety Cells

It would be this writer's opinion that utilizing a safety cell to house a suicidal inmate beyond a few hours is very problematic. Because they are dry (i.e., lacking both a sink and toilet), safety cells were not designed for long-term use. Because there is no timeclock on the length of an inmate's suicidal ideation, a correctional system cannot make the presumption that a suicidal inmate will only remain suicidal for a specific period of time (e.g., 4 hours, 12 hours, 24 hours, 48 hours etc.). Although Title 15, as well as SDCSD's Safety Cell policy requires that "In no case shall the safety cell be used for punishment or as a substitute for treatment," when current practices reflect inmates housed in safety cells from 12 to 72 hours (as observed by this writer in the four inspected facilities), stripped of their clothing and issued only a safety smock/blanket, forced to defecate in a floor grate, and not permitted to shower, it is hard to imagine how any individual would not feel that their expressed suicidal ideation was being responded to in a punitive, non-therapeutic manner.

Of note, although Title 15 allows for the retention of clothing in a safety cell (specifically stating that "Inmates shall be allowed to retain sufficient clothing, or be provided with a suitably designed 'safety garment'"), SDCSD policy mandates at all inmates placed in safety cells are

required to stripped naked and issued only a safety smock and safety blanket. It would be this writer's opinion that, as long as the cell is suicide-resistant, suicidal inmates assigned to a safety cell should be permitted to retain their clothing unless a clinical decision on an individual case suggests otherwise.

Use of Enhanced Observation Housing (EOH)

Enhanced Observation Housing (EOH) was initiated in February 2015 as part of the Inmate Safety Program. As detailed above, EOH can occur in single cells, multiple occupancy cells or dormitory, or in medical observation beds. With one exception, inmates placed in EOH are stripped of all clothing and issued only a safety smock and safety blanket.[24] Although permitted an initial telephone call and shower prior to cell placement, they are otherwise locked down in their cell 24 hours a day. As such, out-of-cell activities such as dayroom, recreation yard, and family visits are prohibited. Group treatment is not available and individual assessments by mental health clinicians are routinely conducted cell-side, thus compromising reasonable privacy and confidentiality. In addition, court hearings are often canceled for inmates considered to be at "high risk" (which as detailed in the following section is not defined) for suicide. Although data regarding length of stay in EOH was not available, this writer was informed that most inmates generally stay for approximately 48 hours.

Conclusion

In many ways, the conditions for suicidal inmates placed in safety cells and EOH cells (excluding dormitory housing) were harsher than for those on segregation status, and it would be

[24]The exception would be the PSU observation cells located at LCDRF in which inmates on suicide precautions could be clothed in either regular uniforms or safety smocks.

this writer's opinion that current management of inmates placed on suicide precautions under these conditions within the San Diego County Jail System was generally overly restrictive and seemingly punitive. Confining a suicidal inmate to their cell 24 hours a day only enhances isolation and is anti-therapeutic. Under these conditions, it is also difficult, if not impossible, to accurately gauge the source of an inmate's suicidal ideation. Take, for example, the scenario of a clinician interviewing an inmate on suicide precautions. The inmate has been in the cell for a day or two, clothed only in a safety smock. The clinician approaches the inmate cell-side, within easy hearing distance from both other inmates and non-healthcare professionals, and asks: "Are you suicidal?" Given the circumstances he or she finds themselves in, the likelihood of an inmate answering affirmatively to that question, the result of which will be their continued placement under these conditions, is highly questionable. In addition, an additional reason why a suicidal inmate would deny that they were suicidal while placed in either a safety cell or EOH cell is the possibility of their court hearing being canceled due to their status. As such, it is certainly not surprising that the length of stay under these conditions is generally 48 hours.

Recent research suggests that suicidal inmates are often reluctant to discuss their suicidal thoughts because of the likelihood of being exposed to the harsh conditions of suicide precautions, with almost 75 percent of inmates reporting that they did <u>not</u> want to be transferred to an observation cell. According to the authors:

> "Possible reasons inmates dislike observation cells are numerous. For GP patients they can suffer taunting from other inmates with the identification of being in a mental health crisis after they return from the OB (observation). Further, an inmate-patient is removed from his more familiar surroundings of a single cell with his books, writing material, and own clothes, and his normal routine of recreation and work assignment. In the OB he often can no longer wear his clothes, and books and recreation are limited. In an OB cell a patient often is dressed in a special gown and the room may only contain a special mattress.

> Privacy is limited, since often all four sides of the OB are available for observation whereas in his own cell only one side is open for observation. Finally, admission in an OB can create anxiety and fear for the patient as it may be an unknown environment, and because the OB is the place the psychiatrists decide if patient is to be involuntarily transferred to the distant inpatient unit."[25]

This writer was informed by various SDCSD officials and staff that the conditions of suicide precautions were not intentionally punitive, but driven by concern for the safety of the inmate. The SDCSD's commitment to safety is not being challenged here. Safety of the inmate is, of course, of utmost concern when developing a suicide prevention policy. But the number and types of restrictions (e.g., exclusive reliance on safety smocks, denying all out-of-cell, visitation and telephone privileges, court hearings, etc.) imposed in the name of safety must be reasonable and commensurate with the inmate's level of suicide risk.

Officials might also have argued (although they did not to this writer) that the rationale for these restrictions was that suicidal inmates were unpredictable and bad news received during a family visit, telephone call, or court hearing might trigger suicidal ideation and result in an increased risk for suicide. This rationale, however, ignores the obvious -- what better opportunity was there to observe an inmate's reaction to potentially negative news then when they were on suicide precautions, as well as the fact that interaction with the outside world can be therapeutic and reduce isolation -- a leading cause of suicidal behavior. Staff might also have argued (although they did not to this writer) that most inmates who were mentally ill and on suicide precautions were so debilitated by their illness that "they did not care" how they were treated (i.e., the withholding of basic privileges). Of course, this assumption was not only

[25]See Way, B., Kaufman, A., Knoll, J., and Chlebowski, S. (2013), "Suicidal Ideation Among Inmate-Patients in State Prison: Prevalence, Reluctance to Report, and Treatment Preferences," *Behavioral Sciences and the Law*, 30: 230-238.

unsupported but ignored the real possibility that these measures were contributing to an inmate's debilitating mental illness.

Further, some might also argue that these highly restrictive measures were effective in managing those inmates suspected as being manipulative or malingering. As should be discussed during suicide prevention training workshops, although distinguishable, manipulative behavior and suicidal behavior were not mutually exclusive. Both types of behavior could occur (or overlap) in the same individual and cause serious injury and death. Several studies of self-harm and suicide in the correctional environment have found "substantial co-existence of manipulative motive with both suicidal intent and potentially high lethality of self-harming behavior."[26] As one observer has stated, "There are no reliable bases upon which we can differentiate 'manipulative' suicide attempts posing no threat to the inmate's life from those 'true, non-manipulative' attempts which may end in death. The term 'manipulative' is simply useless in understanding, and destructive in attempting to manage, the suicidal behavior of inmates (or of anybody else).[27] Self-harm is often a complex, multifaceted behavior, rather than simply manipulative behavior motivated by secondary gain. At a minimum, any inmate who would go to the extreme of threatening suicide or engaging in self-harming behavior is suffering from at least an emotional imbalance that requires special attention. They may also be seriously mentally ill. Simply stated, inmates labeled as manipulative still commit suicide.

[26]Dear G, Thomson D, Hills A. (2000), "Self-Harm in Prison: Manipulators Can Also Be Suicide Attempters," *Criminal Justice and Behavior*, 27: 160-175.
[27]Haycock J. (1992), "Listening to 'Attention Seekers:' The Clinical Management of People Threatening Suicide," *Jail Suicide Update*, 4 (4): 8-11.

RECOMMENDATIONS: The following recommendations are offered to improve the housing and management of inmates on suicide precautions within the San Diego County Jail System. *First*, as this writer inspected a vast array of differing physical environments for the housing of suicidal inmates in the four jail facilities (i.e., safety cells, EOH single cells and dormitories, MOB, and PSU observation cells, etc.), it is strongly recommended that DSB officials conduct a comprehensive physical plant review of all jail cells utilized for the housing of suicidal inmates to ensure that they are reasonably suicide-resistant. This writer's "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities," included as Appendix A of this report, can be utilized as a guideline for such an inspection.

Second, due to the limited positive attributes of safety cell use, it is strongly recommended that, if utilized, the maximum length of stay in a safety cell be limited to no more than six (6) hours.[28] In addition, use of a safety cell should not be the first option available, rather it should only be utilized in exigent circumstances in which the inmate is out of control and at immediate, continuing risk to self and others. Current SDCSD policies should be appropriately revised.

Third, it is strongly recommended that MSB officials instruct their clinical staff on the appropriate use of safety smocks, i.e., they should not be utilized as a default, and not to be used as a tool in a behavior management plan (i.e., to punish and/or attempt to change perceived manipulative behavior). Rather, safety smocks should only be utilized when a clinician believes that the inmate is at high risk for suicide by hanging. Should an inmate be placed in a safety

[28]Such a limit is consistent with this writer's consultation with a comparably-sized California county jail system, as well as a recommendation cited in the recent DRC report.

smock, the goal should be to return full clothing to the inmate prior to their discharge from suicide precautions. Finally, custody personnel should never place an inmate in a safety smock unless it had been previously approved by medical and/or mental health personnel. Current SDCSD policies should be appropriately revised.

Fourth, it is strongly recommended that possessions and privileges provided to inmates on suicide precautions should be individualized and commensurate with their level of risk. As such, current SDCSD policies should be appropriately revised, as follows:

- All decisions regarding the removal of an inmate's clothing, bedding, possessions (books, slippers/sandals, eyeglasses, etc.) and privileges shall be commensurate with the level of suicide risk *as determined on a case-by-case basis by mental health clinicians and documented in JIMS*;

- If a mental health clinician determines that an inmate's clothing needs to be removed for reasons of safety, the inmate shall always be issued a safety smock and safety blanket;

- A mattress shall be issued to all inmates on suicide precautions unless the inmate utilizes the mattress in ways in which it was not intended (i.e., attempting to tamper with/destroy, utilize to obstruct visibility into the cell, etc.);

- All inmates on suicide precautions shall be allowed all routine privileges (e.g., family visits, telephone calls, recreation, etc.), unless the inmate has lost those privileges as a result of a disciplinary sanction;

- All inmates on suicide precautions shall be allowed to attend court hearings unless exigent circumstances exist in which the inmate is out of control and at immediate, continuing risk to self and others, and

- Inmates on suicide precautions shall not automatically be locked down. They should be allowed dayroom and/or out-of-cell access commensurate with their security level and clinical judgment of mental health clinicians.

Fifth, although SDCSD Policy J.4: Enhanced Observation Housing (EOH), Definition and Use requires that "EOH units shall be clean and disinfected using facility approved disinfectants or bleach solution after every use or as needed," this writer's inspection of cells in several facilities found them to be quite dirty and unsanitary. As such, it is strongly recommended that DSB officials reinforce the above directive and that shift supervisors at each facility ensure that cells utilized to house suicidal inmates are reasonably clean and sanitary.

5) <u>Levels of Supervision/Management</u>

> **Two levels of supervision are generally recommended for suicidal inmates -- *close observation* and *constant observation. Close Observation* is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a plan) and/or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 10-15 minutes. *Constant Observation* is reserved for the inmate who is actively suicidal, either by threatening (with a plan) or engaging in self-injury. This inmate should be observed by a staff member on a continuous, uninterrupted basis. Other supervision aids (e.g., closed circuit television, inmate companions/watchers, etc.) can be utilized as a supplement to, but never as a substitute for, these observation levels. Inmates on suicide precautions should be reassessed on a daily basis. Reasonable efforts should be made, particularly when considering the discharge of an inmate from suicide precautions, to avoid a cell-side encounters; rather, such assessments should be made in a private and confidential setting.**

Experience has shown that prompt, effective emergency medical service can save lives. Research indicates that the overwhelming majority of suicide attempts in custody is by

hanging.[29] Medical experts warn that brain damage from asphyxiation can occur within four minutes, with death often resulting within five to six minutes. In inmate suicide attempts, the promptness of the response is often driven by the level of supervision afforded the inmate. Both the ACA and NCCHC standards address *levels of supervision*, although the degree of specificity varies. ACA Standard 4-ALDF-2A-52 vaguely requires that "suicidal inmates are under continuous observation," while NCCHC Standard J-G-05 requires physical observation ranging from "constant supervision" to "every 15 minutes or more frequently if necessary." According to the Suicide Prevention and Intervention Standard from the U.S. Department of Homeland Security's *Operations Manual ICE Performance-Based National Detention Standards*, "Suicidal detainees will be monitored by the assigned security officers who maintain constant one-on-one visual observation, 24 hours a day, until the detainee is released from suicide watch. The assigned security officer makes notations every 15 minutes on the behavioral observation checklist."

In addition, the component of "Levels of Supervision" encompasses the overall management of the inmate on suicide precautions and includes the appropriate level of observation, timely and comprehensive suicide risk assessments that include reasonable efforts to provide private and confidential settings, downgrading the level of observation following a period of stability, and providing periodic follow-up assessments following discharge from suicide precautions based upon an individualized treatment plan.

FINDINGS: The SDCSD's various suicide prevention policies provide limited guidance regarding the observation of suicidal inmates, simply stating that custody personnel are required

[29]Hayes, L.M. (2010), "National Study of Jail Suicides: 20 Years Later," *Journal of Correctional Health Care*, 18 (3).

to provide direct visual observation of suicidal inmates "at least twice in every thirty (30) minute period" (J.1: Safety Cells, Definition and Use) and "inmates in EOH shall be closely monitored and directly observed by sworn staff at least once every 15-minute period" (J.4: Enhanced Observation Housing (EOH), Definition and Use). There is no option in any SDCSD policy for constant and continuous observation of inmates at the highest risk for suicide. Of note, nursing personnel are required to make rounds every four (4) hours of inmates housed in either a safety cell or EOH.

In addition, although there is language within various SDCSD policies that use terminology of "high" and "low" risk for suicide, these two risk levels are not adequately defined. For example, as previously discussed in this report, there are five (5) criteria defined in the ISP policy as deemed "high suicide risk factors" (i.e., "automatic triggers") that almost invariably result in placement on suicide precautions:

1) High publicity case with possible evasion of arrest or SWAT/SED standoff with serious felony charges, including but not limited to: homicide, rape, or child victim crimes;
2) Severe, life or death sentences;
3) The inmate states he/she is suicidal and or made suicidal statements to sworn staff, medical, family, etc.;
4) Previous suicide attempts (within the past five years); and
5) Staff observation of depressed/emotional turmoil.

It would be this writer's opinion that, although the above five criteria are certainly possible risk factors for suicide, with the exception of No. 3 ("The inmate states he/she is suicidal and or made suicidal statements to sworn staff, medical, family, etc."), there is no research that supports these criteria as exemplifying "high" risk factors for suicide necessitating automatic placement on suicide questions.

Further, as previously discussed in this report, the facility gatekeeper (either the charge nurse or a mental health clinician), in consultation with the watch commander, determines whether the suicidal inmate will be placed in a safety cell or EOH. Following placement on suicide precautions, current ISP policies (and practices observed by this writer) often require completion of at least two assessments before an inmate can be discharged from suicide precautions. (These assessments are often provided cell-side despite the fact that private interview rooms might be available.)[30] In practice, the first assessment is often completed by a MSD mental health clinician, whereas the second assessment is completed by a LHC psychologist. There are also various other procedures (which this writer will not summarize) regarding the completion of these two assessments and their relationship to movement between a safety cell and EOH placement, and for assessing "high" and "low" risk suicidal inmates.

In an effort to clarify a seemingly confusing and cumbersome procedure for the assessment of suicidal inmates, the MSD recently developed a document entitled "ISP Clarifications, March 29, 2018" that apparently supplements SDCSD Policy MSD.S.10: Suicide Prevention and Inmate Safety Program, last revised November 30, 2016. This supplemental document states the following:

> 1) 24-hour limit on safety cell before psychiatrist med/PSU admission eval.
> 2) 72-hour limit on ISP (EOH, or EOH and safety cell combined) before psychiatric med/PSU admission eval.
> 3) Two consecutive low risk assessments by two different providers are needed for clearance from ISP. If only one provider is available,

[30]At VDF, for example, this writer observed six (6) professional interview rooms/booths located on both the 1st and 2nd floors of the facility. Despite the fact that most of these rooms remained unoccupied throughout the day of this writer's on-site assessment, they apparently remained unavailable for use by mental health clinicians.

clearance by that provider (after consecutive low risk assessments) can be done with documentation of phone consult with on-call psychiatrist.
4) Maximum of 6 hours between safety cell assessments when providers are on-site. All safety cell inmates must be assessed no more than 6 hours apart when providers are on-site. Minimum time between safety cell assessments 4 hours, but no more than 6 hours apart when providers are on-site.
5) Safety cell for actively self-harming and/or danger to others only.
6) EOH inmates must be seen daily (already in prior P an P).
7) Assessment placement does NOT count as first assessment. First assessment is the one that occurs AFTER I/P is placed in ISP.

It would be this writer's opinion that the criteria contained within the above "ISP Clarifications, March 29, 2018" document further confuses an already cumbersome process. In addition, conducting assessments within 6 hours of each other is unhelpful because it is unrealistic to expect a suicidal inmate's behavior to substantially change during such a short time period (unless, of course, they are simply denying suicidal ideation in order to be discharged from a seemingly punitive circumstance). This writer also found that, contrary to the above directive, SDCSD Policy MSD.S.10: Suicide Prevention and Inmate Safety Program allowed for subsequent suicide risk assessments of "high risk" inmates assigned to the EOH to be completed after 48 hours of the initial assessment. This practice was confirmed by staff interviews. The rationale for such a policy and practice was unclear, and contrary to the standard of care that requires daily assessments.

Further, the standard of care requires that documentation of a comprehensive assessment of suicide risk includes sufficient description of the current behavior and justification for either placement on, or discharge from, suicide precautions. For example, the assessment should include a brief mental status examination (MSE), listing of chronic and acute risk factors (including prior history of suicidal behavior), listing of any protective factors, level of suicide

risk (e.g., low, medium, or high), and a treatment plan.[31] According to national correctional standards, the "treatment plan" for an inmate discharged from suicide precautions should "describe signs, symptoms, and the circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur" (see NCCHC, 2014).

Within the San Diego County Jail System, this writer's review of several medical charts found that there were varying and slightly different suicide risk assessments utilized by MSD mental health clinicians and LHC psychologists. For example, in reviewing an inmate chart at VDF, one version of an LMHC ISP Risk Assessment Form had the following domains:

- I/P presentation and interaction
- recent substance abuse/withdrawal symptoms
- court date, legal charges and I/P perception of charges if relevant
- self-harm/DTO inquiry
- future orientation
- I/P perception of stability of family/social support
- distress tolerance/coping skills
- risk factors
- protective factors
- current risk designation
- follow-up need

A subsequently completed Psychologist EOH Evaluation for the same patient a short time later had the following slightly different domains:

- history of present illness
- mental health history
- substance abuse history
- support
- current mental status
- diagnostic

[31]See American Psychiatric Association (2003), "Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors," *American Journal of Psychiatry*, (160) 11: 1-60 (Supplement).

- current risk
- risk factors
- protective factors
- plan

At GBDF, the LMHC ISP Risk Assessment Form had slightly different domains:

- I/P presentation and interaction:
- recent substance abuse
- self-harm/DTO inquiry
- court date/legal issues
- risk factors
- coping skills
- family/social support
- protective factors
- future orientation
- risk designation

A subsequently completed Psychologist ISP Evaluation for the same patient the next day had the following domains:

- Identifying data
- review of systems/relevant HX
- chief complaint/reason for placement
- mental status
- prior suicide attempts and/or SIB
- current medications
- medical history
- psychiatric history
- substance abuse history
- family psychiatric history
- legal history
- social history
- risk assessment (risk factors and protective factors)
- provisional diagnostic impression
- plan/recommendations

Of note, the above Psychologist ISP Evaluation template completed at GBDF was slightly different and more comprehensive than the Psychologist EOH Evaluation template completed at VDF.

Further, the ISP policy requires that all inmates released from suicide precautions receive follow-up assessments by a mental health clinician. In practice, follow-up is provided by LHC psychologist. An "ISP Follow-Up Protocol" was created as a supplement to Policy MSD.S.10: Suicide Prevention and Inmate Safety Program, and contains a schedule for follow-up of 24 hours, 3-7 days, and 7-14 days that are based upon various risk factors. Several mental health clinicians and LHC psychologists confided to this writer that the follow-up schedule was confusing and not always consistently performed. In addition, a few psychologists stated that they did not utilize the follow-up schedule, rather they utilized their clinical judgment to determine the schedule, if any, for follow-up that would be provided on a case-by-case basis. This writer would agree that the ISP Follow-Up Protocol is confusing and unnecessarily cumbersome. It is also problematic that clinicians may be creating their own follow-up schedule contrary to the ISP policy.

As previously stated, this writer reviewed the charts of several inmates who were placed on, and subsequently discharged from, suicide precautions. Without critiquing the clinical judgment utilized by any mental health clinician, this writer found that, with a few exceptions, the reviewed ISP assessments (even with their varying templates) provided reasonably adequate documentation of justification for placement on, and discharge from suicide precautions.

One of the exceptions was the lack of treatment planning found in the reviewed medical charts. For example, in one case, the plan contained at the end of the Psychologist ISP Evaluation stated the following: "Patient does not present to be a danger to self/others, or gravely

disabled. Patient vouching for his safety. Patient states he will inform staff if suicidal. Patient agrees with plan." In another case, the plan contained at the end of the Psychologist EOH Evaluation simply stated: "Clear from EOH to classification, follow-up within 3 days." Contrary to NCCHC standards, these were certainly not examples of adequate treatment plans that described signs, symptoms, and the circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur.

In addition, it was noteworthy that review of medical chart documentation from both mental health and nursing personnel found occasional use of the term "contracted for safety" or "vouching for his safety." There are several problems associated with contracting for safety. First, most correctional systems do not have any written policies and procedures authorizing its use. In fact, the issue is not even addressed in any national correctional standards. Most systems do not utilize "safety contracts" because they have been found to be ineffective in the management of suicidal individuals. While there may be some positive therapeutic aspects to safety contracts, most experts agree that once a patient becomes suicidal, their written or verbal assurances are no longer sufficient to counter suicidal impulses.

In addition, most legal experts opine that a safety contract is simply a self-serving sheet of paper that does not provide an agency or clinician with any legal protection. As succinctly stated by several clinicians:

> "The contract for safety is an aspect of suicide risk management that has been given too much weight over the past several decades. What appears to have been created primarily as an assessment tool has become a sort of checkbox, detracting from the clinician's own judgment and formulation of risk. It has been taken out

> of its original context and is now used in virtually any setting, with any type of patient population despite the lack of clinical evidence to prove it is useful and an abundance of literature warning that it is not."[32]

Finally, inmates housed in segregation throughout the San Diego County Jail System were required to be seen by custody personnel at 60-minute intervals, weekly by mental health conditions, and three times a week during nursing rounds. With the exception of 60-minute custody rounds, these were very good practices.

RECOMMENDATIONS: This writer would offer several recommendations to both strengthen and simplify policies and procedures regarding the observation and management of inmates identified as suicidal and/or exhibiting self-injurious behavior within the San Diego County Jail System. *First*, it is strongly recommended that all DSB and MSD suicide prevention policies be revised to include two levels of observation that specify descriptions of behavior warranting each level of observation. A proposed revision is offered as follows:

> ***Close Observation*** is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 10-15 minutes, and should be documented as it occurs.
>
> ***Constant Observation*** is reserved for the inmate who is actively suicidal, either by threatening (with a plan) or engaging in self-injury, *and* considered a high risk for suicide. *This inmate should be observed by an assigned staff member on a continuous, uninterrupted basis.* The observation should be documented at 15-minute intervals.

[32]Garvey, K, Penn, J, Campbell, A, Esposito, C, and A. Spirito (2009), "Contracting for Safety With Patients: Clinical Practice and Forensic Implication," *Journal of the American Academy of Psychiatry and the Law*, 37:363-370.

Second, it is strongly recommended that, with the adaption of the two-level observation system as offered above, reference to the ill-defined "high" and "low" suicide risk categories are no longer necessary and should be deleted from all SDCSD policies.

Third, it is strongly recommended that the narrative of "twice every 30 minutes" currently contained within some SDCSD policies be replaced with "staggered intervals that do not exceed 10-15 minutes."

Fourth, it is strongly recommended that SDCSD policies should be revised to eliminate the necessity of "a minimum of two assessments by mental health provider with time interval between assessments and for clearance based on high/low risk designation after first assessment." In other words, consistent with the standard of care, an inmate identified as potentially suicidal (or placed on suicide precautions after hours by non-mental health personnel) should be immediately referred to a mental health clinician for completion of a suicide risk assessment. The assessment should be completed immediately if mental health personnel are on-site or during the next business day morning if they are off-site at the time of the referral. Should the clinician's initial suicide risk assessment find that the inmate is not suicidal and does not require either initiation/continuation of suicide precautions, the inmate should be released to appropriate rehousing. Should the clinician's suicide risk assessment find that the inmate is suicidal, the inmate should be placed on suicide precautions and seen on a daily basis by a mental health clinician until a determination is made that they are no longer suicidal. Daily assessments of suicide risk should be documented in SOAP-formatted progress notes. When the clinician determines that an inmate is no longer suicidal and can be discharged from suicide

precautions, documentation of such clinical judgment should occur in a suicide risk assessment form. In addition, the MSD document entitled "ISP Clarifications, March 29, 2018" (which speaks to "two consecutive low risk assessments by two different providers," as well as assessments occurring between 4 and 6 hours of each other) should also be deleted from SDCSD policies as it will no longer be relevant.

Fifth, it is strongly recommended that the MSD utilize only <u>one</u> version of the suicide risk assessment forms currently being utilized by MSD mental health clinicians and LHC psychologists (i.e., LMHC ISP Risk Assessment Form, Psychologist EOH Evaluation, Psychologist ISP Evaluation, etc.). The Psychologist ISP Evaluation template that this writer reviewed at GBDF appears to be the most comprehensive. As recommended above, the selected suicide risk assessment form template should be utilized as justification for an inmate's initial placement on suicide precautions, as well as justification for an inmate's discharge from suicide precautions.

Sixth, it is strongly recommended that, consistent with NCCHC and other national correctional standards, all clinicians develop treatment plans for inmates discharged from suicide precautions that describe signs, symptoms, and the circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur. A treatment plan should be contained in the discharging suicide risk assessment.

Seventh, is strongly recommended that reasonable efforts should be made, particularly when considering the discharge of an inmate from suicide precautions, to avoid a cell-side encounters; rather, suicide risk assessments should be made in a private and confidential setting. Should an inmate refuse a private interview, the reason(s) for the refusal should be documented in JIMS.

Eighth, it is strongly recommended that, in order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on the mental health caseload and receive regularly scheduled follow-up assessments by clinicians until their release from custody. As such, unless an inmate's individual circumstances directs otherwise (e.g., an inmate inappropriately placed on suicide precautions by non-mental health staff and released less than 24 hours later following an assessment), it is recommended that the follow-up schedule be simplified and revised as follows: follow-up within 24 hours, again within 72 hours, again within 1 week, and then periodically as determined by the clinician until release from custody.

Ninth, given the strong association between inmate suicide and segregation housing and consistent with national correctional standards,[33] it is strongly recommended that DSB officials give strong consideration to increasing deputy rounds of such housing units from 60-minute to 30-minute intervals.

[33]See American Correctional Association (2004), *Performance-Based Standards for Adult Local Detention Facilities*, 4th Edition, Lanham, MD: "All special management (segregation) inmates are personally observed by a correctional officer at least every 30 minutes on an irregular schedule" (4-ALDF-2A-52).

Tenth, it is strongly recommended that both mental health and nursing personnel be instructed to refrain from utilizing terms such "contracting for safety" or "vouching for his safety" with patients when assessing suicide risk. SDCSD policy should also be revised accordingly to prohibit its use.

6) <u>Intervention</u>

> **A facility's policy regarding intervention should be threefold: 1) all staff who come into contact with inmates should be trained in standard first aid and cardiopulmonary resuscitation (CPR); 2) any staff member who discovers an inmate attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin standard first aid and/or CPR; and 3) staff should never presume that the inmate is dead, but rather initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, all housing units should contain a first aid kit, pocket mask or mouth shield, Ambu bag, and rescue tool (to quickly cut through fibrous material). All staff should be trained in the use of the emergency equipment. Finally, in an effort to ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training for all staff.**

Following a suicide attempt, the degree and promptness of intervention provided by staff often foretells whether the victim will survive. Although both ACA and NCCHC standards address the issue of intervention, neither are elaborative in offering specific protocols. For example, ACA Standard 4-ALDF-4D-08 requires that -- "Correctional and health care personnel are trained to respond to health-related situations within a four-minute response time. The training program...includes the following: recognition of signs and symptoms, and knowledge of action required in potential emergency situations; administration of basic first aid and certification in cardiopulmonary resuscitation (CPR)..." NCCHC Standard J-G-05 states --

"Intervention: There are procedures addressing how to handle a suicide attempt in progress, including appropriate first-aid measures."

FINDINGS: The SDCSD has various policies related to the proper emergency response to a suicide attempt of an inmate, including Policy MSD.M.1: Medical Emergency, last revised March 27, 2013; Policy MSD.F.2: First-Aid Kits/Emergency Response Bags, last revised June 15, 2016, and Policy MSD.C.2: Code Blue: Life Threatening Emergencies, last revised December 23, 2015. In addition, this writer observed that jail deputies had CPR pocket masks and cut-down tools (utilized to quickly cut through fibrous material) on their uniform belts. Oxygen tanks and automated external defibrillators (AEDs) were found in various locations in each of the four inspected jail facilities. According to recent training data reviewed by this writer, approximately 100 percent of both custody and nursing personnel were currently certified in cardiopulmonary resuscitation (CPR) and AED use. This writer's review of investigative files for the six (6) inmate suicides between 2016 and 2017 found that proper emergency responses were found in each case.

RECOMMENDATIONS: None

7) Reporting

In the event of a suicide attempt or suicide, all appropriate correctional officials should be notified through the chain of command. Following the incident, the victim's family should be immediately notified, as well as appropriate outside authorities. All staff who came into contact with the victim prior to the incident should be required to submit a statement as to their full knowledge of the inmate and incident.

FINDINGS: This writer's review of investigative reports and other documentation from the six (6) inmate suicides between 2016 and 2017 found that all reporting requirements appeared to have been appropriately followed.

RECOMMENDATIONS: None

8) Follow-up/Mortality-Morbidity Review

Every completed suicide, as well as serious suicide attempt (i.e., requiring medical treatment outside the facility), should be examined by a morbidity-mortality review. (If resources permit, clinical review through a psychological autopsy is also recommended.) The review, separate and apart from other formal investigations that may be required to determine the cause of death, should include: 1) review of the circumstances surrounding the incident; 2) review of procedures relevant to the incident; 3) review of all relevant training received by involved staff; 4) review of pertinent medical and mental health services/reports involving the victim; 5) review of any possible precipitating factors that may have caused the victim to commit suicide or suffer a serious suicide attempt; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. Further, all staff involved in the incident should be offered critical incident stress debriefing.

Experience has demonstrated that many correctional systems have reduced the likelihood of future suicides by critically reviewing the circumstances surrounding incidents as they occur. While all deaths are investigated either internally or by outside agencies to ensure impartiality, these investigations are normally limited to determining the cause of death and whether there was any criminal wrongdoing. *The primary focus of a morbidity-mortality review should be two-fold: What happened in the case under review and what can be learned to help prevent future incidents?* To be successful, the morbidity-mortality review team must be multidisciplinary and include representatives of both line and management level staff from the corrections, medical and mental health divisions.

FINDINGS: Although DSB's Policy M.7: Inmate Deaths, last revised November 16, 2017, and MSD's Policy Death of an Inmate On-Site, last revised March 30, 2017, provide adequate summaries of the administrative review process for all inmate deaths (including

suicides), the mortality review process for an inmate suicide is only vaguely referenced in SDCSD policies. For example, DSB's Policy M.7: Inmate Deaths requires that the Critical Incident Review Board (CIRB) review inmate suicides and make recommendations, when appropriate, to the Suicide Prevention Oversight Committee. Membership to the CIRB was unclear in the policy, as well as reference to the Suicide Prevention Oversight Committee (which this writer assumes is now related to the recently enacted Suicide Prevention and Focused Response Team, see below).

In practice, all inmate deaths (including suicides) are investigated by the Homicide Detail Team within the SDCSD's Law Enforcement Bureau. The Homicide Detail Team is assisted by both the Detentions Investigations Unit and the Division of Inspectional Services. The investigation includes review of the incident scene (e.g., cell contents) and all relevant custody-related documents pertaining to the inmate, including, but not limited to, arrest, classification, custody records, medical records, housing unit log books, CCTV monitoring, telephone calls between the inmate and others. In addition, relevant inmates, custody, medical, and mental health personnel are interviewed, as well as family members of the decedent (if appropriate). The investigative process can take up to 90 days to complete. This writer reviewed the Homicide Detail Team investigative reports of the six (6) inmate suicides that occurred within the San Diego County Jail System in 2016 and 2017. Each report was quite thorough and comprehensive.

In addition, each inmate suicide is also reviewed by the aforementioned the Critical Incident Review Board (CIRB) within 14 days of the death. The CIRB is composed of DSB command staff, SDCSD legal counsel, homicide investigator, MSD medical director, and MSD

chief mental health clinician. According to DSB's Policy M.7: Inmate Deaths, the CIRB "will carefully review in custody deaths from multiple perspectives, including training, tactics, policies, and procedures with the ultimate goal of identifying problems and recommending remedial actions."

Further, the SDCSD has initiated a "psychological autopsy" review process for inmate suicides. The reports are developed by the MSD chief mental health clinician, the first of which was completed in April 2017 on an inmate suicide that occurred in November 2016. (A few other "psychological autopsy' reports were pending at the time of this writer's report.) The psychological autopsy report reviewed by this writer included reference to the Homicide Detail Team investigative report, JIMS records, and County Behavioral Health records of the decedent. In addition, the report author also reviewed a variety of suicidology research in the community. The report was formatted to include background information, family information, criminal history, housing information (as derived from interviews of other inmates by SDCSD investigators), medical and psychiatric history, the suicide event, hypotheses for the suicide, and systemic areas of concern and recommendations. According to MSD officials, findings from the psychological autopsy report are meant to be subsequently shared with the MSD's Quality Improvement Committee, as well as at quarterly Detentions Commanders meetings.

This writer's review of the 11-page psychological autopsy report (of the November 2016 suicide) found it to be well-written and very comprehensive. The report, however, was not a

"psychological autopsy" as currently envisioned within the correctional community.[34] According to NCCHC standards, the –

> "Psychological autopsy, sometimes referred to as a psychological reconstruction or postmortem, is a written reconstruction of an individual's life with an emphasis on factors that led up to and may have contributed to the individual's death. It is usually conducted by a psychologist or other qualified mental health professional…..A psychological autopsy for each suicide should be completed within 30 days of the event. The typical psychological autopsy is based on a detailed review of all file information on the inmate; a careful examination of the suicide site; and interviews with staff, inmates, and family members familiar with the deceased."[35]

Although very comprehensive, the report written on the November 2016 suicide did not include examination of the suicide site, nor did the clinician interview any staff, inmates, or family members of the decedent. The report should have been more appropriately entitled a "suicide report" or "clinical suicide report."

Finally, it was noteworthy that the SDCSD recently initiated a Suicide Prevention and Focused Response Team (SPFRT) in March 2018. According to DSB Policy M.4: Suicide Prevention and Focused Response Team, the multi-disciplinary SPFRT is composed of representatives from the DSB (including the Division of Inspectional Services, Jail Population Management Unit, Detention In-Service Training Unit, Reentry Services Center, and Detention Support Division, MSD (including medical and mental health personnel), and the Liberty Health Corporation program director or designee. The SPFRT is required to meet on a monthly basis to:

> "1) Ensure compliance with all Department and Bureau policies and procedures related to suicide prevention and response; 2) Review Inmate Safety Program

[34]See, for example, the National Commission on Correctional Health Care (2014), *Standards for Health Services in Jails*, 9th Edition, Chicago, IL: Author; Aufderheide, D.H. (2000), "Conducting the Psychological Autopsy in Correctional Settings," *Journal of Correctional Health Care*, 7 (1): 5-36.
[35]National Commission on Correctional Health Care (2014), *Standards for Health Services in Jails*, 9th Edition, Chicago, IL: Author, pages 22 and 121.

> (ISP) procedures to ensure that they are carried out consistently; 3) Track and review all self-harm incidents, attempt suicides and suicides; 4) Evaluate medical procedures performed (e.g., CPR etc.), as well as cell entry and cut-down procedures to ensure Department and National Commission on Correctional Health Care (NCCHC) standards were met; and 5) Ensure all required documentation for suicide death reporting is reviewed within 30 days in adherence with NCCHC standards."

In addition, the SPFRT would be responsible for working in collaboration with the CIRB in implementing recommendations arising out of inmate suicides. The first SPRFT meeting was held on May 1, 2018. The meeting minutes reflected discussion of current suicide prevention practices, and overview of preliminary findings from this writer's recent on-site assessment, proposed timelines for review of policies and training curricula, and preliminary review of suicides and suicide attempts during 2018.

In conclusion, although the recent DRC report was critical of the SDCSD's review process for inmate suicides, as well as critical of reports issued by the San Diego County Citizens Law Enforcement Review Board (CLERB), this writer would disagree. Although recommendations to strengthen both the mortality review and psychological autopsy processes are offered below, the Homicide Detail Team's investigative review process was very comprehensive, and the Critical Incident Review Board process was adequate. In addition, the DRC report's criticism of the CLERB as it relates to the SDCSD appears to be misplaced because the CLERB is an independent body that, although county-funded, is not affiliated with the SDCSD, and the SDCSD is not responsible for its practices.[36]

[36]Because the SDCSD is not responsible for CLERB practices, this writer did not review any CLERB reports on inmate suicides.

RECOMMENDATIONS: A few recommendations are offered to improve the mortality-morbidity review process for inmate suicides within the SDCSD. *First*, it is strongly recommended that either the Critical Incident Review Board (CIRB) or the Suicide Prevention and Focused Response Team (SPFRT) be responsible for conducting mortality reviews of any inmate suicide, as well as morbidity reviews of any serious suicide attempts (defined as necessitating medical treatment outside the facility). Such reviews should include: 1) review of the circumstances surrounding the incident; 2) review of procedures relevant to the incident; 3) review of all relevant training received by involved staff; 4) review of pertinent medical and mental health services/reports involving the victim; 5) review of any possible precipitating factors that may have caused the victim to commit suicide or suffer a serious suicide attempt; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. When recommendations are accepted for implementation, a corrective action plan should be created that identifies each recommendation, followed by identified responsible staff, status(s) and deadline(s) for implementation. Every effort should be made to complete mortality-morbidity review process within 30 days of the incident. As such, should the mortality-morbidity review process become the responsibility of the CIRB, review of the suicide should be moved from the current 14-day deadline to a more reasonable 30-day deadline. Both the DSB's Policy M.7: Inmate Deaths and MSD's Policy Death of an Inmate On-Site should be revised to reflect the above 6-step review process. To assist either of the CIRB or SPRFT in these processes, this writer's "Mortality-Morbidity Review of Inmate Suicides/Serious Suicide Attempts Checklist" is offered for consideration in Appendix B.

Second, it is strongly recommended MSD's clinical review of an inmate suicide that is currently entitled "psychological autopsy" be renamed as either a "suicide report" or "clinical suicide report." In the alternative, should MSD officials decide to commit to a psychological autopsy process, consistent with NCCHC standards, the review should include the MSD chief mental health clinician's prompt examination of the suicide site (including cell contents), as well as interviews with relevant staff, inmates, and family members of the decedent (when appropriate). Every effort should be made to complete the psychological autopsy within 30 days of the incident for presentation at the mortality review meeting.

Third, it is strongly recommended that SDCSD officials consider slightly revising the SPFRT responsibility to "track and review all self-harm incidents, attempt suicides and suicides." Although it would be reasonable to "track" all incidences of self-harm and attempted suicides, given the large size of the San Diego County Jail system, it would be unreasonable to expect that the SPRFT could adequately "review" *all* incidents of self-harm and attempted suicide. As such, the following revision is offered: "Track all incidents of self-harm and attempted suicide; Review all serious suicide attempts (defined as incidents of self-harm and/or attempted suicide that result in medical treatment outside of the jail facility) and suicides."

D. SUMMARY OF RECOMMENDATIONS

Staff Training

1) It is strongly recommended that the ISP policy be revised to include a more robust description of the requirements for both pre-service and annual suicide prevention training, to include the duration of each workshop and an overview of the required topics.

2) It is strongly recommended that the joint efforts of the Medical Services Division (MSD) and Detention In-Service Training unit (DTU) to consolidate this writer's 10-hour Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities into an 8-hour classroom training for all current SDCSD deputies be expanded to include all new employees (i.e., medical and mental health personnel) working within the San Diego County Jail System.

3) It is strongly recommended that the MSD and DTU jointly collaborate on the development of a 2-hour annual suicide prevention curriculum based upon this writer's Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities. At a minimum, the curriculum should include a review of: 1) avoiding obstacles (negative attitudes) to prevention, 2) predisposing risk factors, 3) warning signs and symptoms, 4) identifying suicidal inmates despite the denial of risk, and 5) review of any changes to the ISP policy. The annual training should also include general discussion of any recent suicides and/or serious suicide attempts in the San Diego County Jail System.

4) It is strongly recommended that the annual suicide prevention training be required for all custody, medical, and mental health personnel (including LHC contracted psychologists and psychiatrists). Suicide prevention is all about collaboration, and requiring custody, medical, and mental health personnel to sit together in a classroom environment is not only symbolically appropriate, but instills the philosophy that all professionals, regardless of credentials, have an equal responsibility for inmate suicide prevention and can learn from one another's backgrounds, insights, and experiences.

Intake Screening/Assessment

5) It is strongly recommended that Detention Services Bureau (DSB) and MSD officials look at options to better ensure reasonable sound privacy in the booking areas of the three intake facilities when multiple nurses are conducting intake screening at the same time. As demonstrated in the SDCJ, if the inmate is secured within the nursing booth and the door is closed with the officer stationed outside, reasonable privacy and confidentiality can occur while ensuring staff safety.

6) It is strongly recommended that the current suicide risk inquiry contained in the "Medical Intake Questions" form embedded in the JIMS be revised to include the following:

- Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
- Has a family member/close friend ever attempted or committed suicide?
- Do you feel there is nothing to look forward to in the immediate future (inmate expressing helplessness and/or hopelessness)?

7) It is strongly recommended that MSD officials reconsider the utility of the Columbia-Suicide Severity Rating Scale (C-SSRS) during the intake screening process. Although the C-SSRS has become a popular screening form in some jail facilities throughout the country, its effectiveness remains questionable. It is this writer's opinion that the structure of the questions creates awkwardness between the screener and inmate, and more importantly, questions that limit responses to the "past month" are potentially very dangerous (e.g., the suicidal ideation of an inmate that was experienced more than a month ago would not be captured during the screening process). Intake screening questions by nursing staff should be open-ended and not time-sensitive; it is responsibility of a mental health clinician during a subsequent assessment to determine the degree of relevancy of prior suicide risk to current risk. With addition of the three questions offered above, the current intake screening form would be more than adequate without the necessity of the C-SSRS.

8) Although this writer would defer to MSD officials as to whether to designate either a charge nurse or mental health clinician to be the ISP gatekeeper, it is strongly recommended that, if the charge nurse is a gatekeeper, they should always immediately notify an on-site mental health clinician when an inmate has been identified as potentially suicidal. The clinician, in turn, should respond and conduct the suicide risk assessment and determine the appropriateness of suicide precautions. Unless exigent circumstances exist and/or mental health personnel are not on-site, the determination of placing a potentially suicidal inmate in either a safety cell and/or the EOH unit should be made by the mental health clinician.

9) It is strongly recommended that DSB and MSD officials revise the "automatic triggers" criteria contained within the ISP policy to require only criteria No. 3 ("The inmate states he/she is suicidal and or made suicidal statements to sworn staff, medical, family, etc.) to result in placement on suicide precautions. Although the other four criteria could be potential suicide risk factors, they should be considered criteria for a mental health referral, and not necessarily automatic placement on suicide precautions.

10) Consistent with the SDCSD philosophy that a previous suicide attempt documented in JIMS could be a factor for current suicide risk, an inmate's

previous placement on suicide precautions within the San Diego County Jail System is equally important. As such, regardless of the inmate's behavior or answers given during intake screening, a mental health referral should always be initiated based on documentation reflecting possible serious mental illness and/or suicidal behavior during an inmate's prior confinement within the San Diego County Jail System. As such, it is strongly recommended that determination of whether the inmate was "on suicide precautions during prior confinement in a SDCSD facility?" should be independently verified through review of the JIMS by nursing staff. An "alert" screen on JIMS and protocol should be created according to the following procedures:

- Any inmate placed on suicide precautions should be tagged on the JIMS "alert" screen by mental health staff (e.g., "ISP June 2018");

- Nursing staff conducting intake screening should always review the inmate's "alert" screen to verify whether they were previously confined in a SDCSD facility and had any history of suicidal behavior/placement on suicide precautions during a prior confinement; and

- Regardless of the inmate's behavior or answers given during intake screening, further assessment by mental health staff should always be initiated based on documentation reflecting suicidal behavior/ placement on suicide precautions during the inmate's prior SDCSD confinement.

11) It is strongly recommended that MSD officials initiate a continuous quality assurance plan to periodically audit the intake screening process to ensure that nursing staff are accurately completing the "Medical Intake Questions" form, and not using abbreviated inquiry, as well as soliciting responses to the four arresting officer questions.

12) It is strongly recommended that MSD officials develop a mental health triage and referral protocol. Although there is no standard of care that consistently specifies time frames to respond to mental health referrals, one suggested schedule would be as follows: Emergent - immediate or within 1 hour; Urgent - within 24 hours; and Routine - within 72 hours. In addition, mental health leadership should develop a mental health triage policy that defines response levels, sets timetables for each level, and defines the acuity of behavior(s) that dictates a specific response level. Of course, any inmate expressing current suicidal ideation and/or current suicidal/self-injurious behavior should result in an Emergent mental health referral.

13) Given the strong association between inmate suicide and special management (e.g., disciplinary and/or administrative segregation, etc.) housing unit placement, it is strongly recommended that medical personnel review the medical section of

JIMS to determine whether existing medical and/or mental health needs contraindicate the placement or require accommodation. In addition, a "best practice" would be that any inmate assigned to such a special management housing unit receive a brief assessment for suicide risk by nursing staff upon admission to such placement. The following are recommended questions for the brief assessment:

- Are you currently having thoughts of harming yourself?
- Have you previously tried to harm yourself because of a segregation placement?
- Is the inmate speaking incoherently; expressing bizarre thoughts; unable to sit still or pay attention; or is disoriented to time, place, or person?

Affirmative responses to any of these questions should result in an Emergent mental health referral.

Communication

14) It is strongly recommended that the MSD establish a weekly mental health team meeting at each facility that includes MSD mental health clinicians and LHC psychologists and psychiatrists. The primary purpose of the weekly meeting is to identify and manage the treatment needs of suicidal and/or seriously mentally ill patients.

Housing

15) As this writer inspected a vast array of differing physical environments for the housing of suicidal inmates in the four jail facilities (i.e., safety cells, EOH single cells and dormitories, MOB, and PSU observation cells, etc.), it is strongly recommended that DSB officials conduct a comprehensive physical plant review of all jail cells utilized for the housing of suicidal inmates to ensure that they are reasonably suicide-resistant. This writer's "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities," included as Appendix A of this report, can be utilized as a guideline for such an inspection.

16) Due to the limited positive attributes of safety cell use, it is strongly recommended that, if utilized, the maximum length of stay in a safety cell be limited to no more than six (6) hours. In addition, use of a safety cell should not be the first option available, rather it should only be utilized in exigent circumstances in which the inmate is out of control and at immediate, continuing risk to self and others. Current SDCSD policies should be appropriately revised.

17) It is strongly recommended that MSB officials instruct their clinical staff on the appropriate use of safety smocks, i.e., they should not be utilized as a default, and not to be used as a tool in a behavior management plan (i.e., to punish and/or

attempt to change perceived manipulative behavior). Rather, safety smocks should only be utilized when a clinician believes that the inmate is at high risk for suicide by hanging. Should an inmate be placed in a safety smock, the goal should be to return full clothing to the inmate prior to their discharge from suicide precautions. Finally, custody personnel should never place an inmate in a safety smock unless it had been previously approved by medical and/or mental health personnel. Current SDCSD policies should be appropriately revised.

18) It is strongly recommended that possessions and privileges provided to inmates on suicide precautions should be individualized and commensurate with their level of risk. As such, current SDCSD policies should be appropriately revised, as follows:

- All decisions regarding the removal of an inmate's clothing, bedding, possessions (books, slippers/sandals, eyeglasses, etc.) and privileges shall be commensurate with the level of suicide risk as determined on a case-by-case basis by mental health clinicians and documented in JIMS;

- If a mental health clinician determines that an inmate's clothing needs to be removed for reasons of safety, the inmate shall always be issued a safety smock and safety blanket;

- A mattress shall be issued to all inmates on suicide precautions unless the inmate utilizes the mattress in ways in which it was not intended (i.e., attempting to tamper with/destroy, utilize to obstruct visibility into the cell, etc.);

- All inmates on suicide precautions shall be allowed all routine privileges (e.g., family visits, telephone calls, recreation, etc.), unless the inmate has lost those privileges as a result of a disciplinary sanction;

- All inmates on suicide precautions shall be allowed to attend court hearings unless exigent circumstances exist in which the inmate is out of control and at immediate, continuing risk to self and others, and

- Inmates on suicide precautions shall not automatically be locked down. They should be allowed dayroom and/or out-of-cell access commensurate with their security level and clinical judgment of mental health clinicians.

19) Although SDCSD Policy J.4: Enhanced Observation Housing (EOH), Definition and Use requires that "EOH units shall be clean and disinfected using facility approved disinfectants or bleach solution after every use or as needed," this writer's inspection of cells in several facilities found them to be quite dirty

and unsanitary. As such, it is strongly recommended that DSB officials reinforce the above directive and that shift supervisors at each facility ensure that cells utilized to house suicidal inmates are reasonably clean and sanitary.

Levels of Supervision/Management

20) It is strongly recommended that all DSB and MSD suicide prevention policies be revised to include two levels of observation that specify descriptions of behavior warranting each level of observation. A proposed revision is offered as follows:

- ***Close Observation*** is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific plan) and/or has a recent prior history of self-destructive behavior and would be considered a low risk for suicide. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 10-15 minutes, and should be documented as it occurs.

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

21) It is strongly recommended that, with the adaption of the two-level observation system as offered above, reference to the ill-defined "high" and "low" suicide risk categories are no longer necessary and should be deleted from all SDCSD policies.

22) It is strongly recommended that the narrative of "twice every 30 minutes" currently contained within some SDCSD policies be replaced with "staggered intervals that do not exceed 10-15 minutes."

23) It is strongly recommended that SDCSD policies should be revised to eliminate the necessity of "a minimum of two assessments by mental health provider with time interval between assessments and for clearance based on high/low risk designation after first assessment." In other words, consistent with the standard of care, an inmate identified as potentially suicidal (or placed on suicide precautions after hours by non-mental health personnel) should be immediately referred to a mental health clinician for completion of a suicide risk assessment. The assessment should be completed immediately if mental health personnel are on-site or during the next business day morning if they are off-site

at the time of the referral. Should the clinician's initial suicide risk assessment find that the inmate is not suicidal and does not require either initiation/continuation of suicide precautions, the inmate should be released to appropriate rehousing. Should the clinician's suicide risk assessment find that the inmate is suicidal, the inmate should be placed on suicide precautions and seen on a daily basis by a mental health clinician until a determination is made that they are no longer suicidal. Daily assessments of suicide risk should be documented in SOAP-formatted progress notes. When the clinician determines that an inmate is no longer suicidal and can be discharged from suicide precautions, documentation of such clinical judgment should occur in a suicide risk assessment form. In addition, the MSD document entitled "ISP Clarifications, March 29, 2018" (which speaks to "two consecutive low risk assessments by two different providers," as well as assessments occurring between 4 and 6 hours of each other) should also be deleted from SDCSD policies as it will no longer be relevant.

24) It is strongly recommended that the MSD utilize only one version of the suicide risk assessment forms currently being utilized by MSD mental health clinicians and LHC psychologists (i.e., LMHC ISP Risk Assessment Form, Psychologist EOH Evaluation, Psychologist ISP Evaluation, etc.). The Psychologist ISP Evaluation template that this writer reviewed at GBDF appears to be the most comprehensive. As recommended above, the selected suicide risk assessment form template should be utilized as justification for an inmate's initial placement on suicide precautions, as well as justification for an inmate's discharge from suicide precautions.

25) It is strongly recommended that, consistent with NCCHC and other national correctional standards, all clinicians develop treatment plans for inmates discharged from suicide precautions that describe signs, symptoms, and the circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur. A treatment plan should be contained in the discharging suicide risk assessment.

26) It is strongly recommended that reasonable efforts should be made, particularly when considering the discharge of an inmate from suicide precautions, to avoid a cell-side encounters; rather, suicide risk assessments should be made in a private and confidential setting. Should an inmate refuse a private interview, the reason(s) for the refusal should be documented in JIMS.

27) It is strongly recommended that, in order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on the mental health caseload and receive regularly scheduled follow-up assessments by clinicians until their release from custody. As such, unless an inmate's individual circumstances directs otherwise (e.g., an inmate inappropriately placed on suicide precautions by non-mental health staff and released less than 24 hours later following an assessment), it is recommended that

the follow-up schedule be simplified and revised as follows: follow-up within 24 hours, again within 72 hours, again within 1 week, and then periodically as determined by the clinician until release from custody.

28) Given the strong association between inmate suicide and segregation housing and consistent with national correctional standards, it is strongly recommended that DSB officials give strong consideration to increasing deputy rounds of such housing units from 60-minute to 30-minute intervals.

29) It is strongly recommended that both mental health and nursing personnel be instructed to refrain from utilizing terms such "contracting for safety" or "vouching for his safety" with patients when assessing suicide risk. SDCSD policy should also be revised accordingly to prohibit its use.It is strongly recommended that both the SCSD and JPS suicide prevention policies be revised to include two levels of observation that specify descriptions of behavior warranting each level of observation. A proposed revision is offered as follows:

Intervention

None

Reporting

None

Follow-Up/Mortality-Morbidity Review

30) It is strongly recommended that either the Critical Incident Review Board (CIRB) or the Suicide Prevention and Focused Response Team (SPFRT) be responsible for conducting mortality reviews of any inmate suicide, as well as morbidity reviews of any serious suicide attempts (defined as necessitating medical treatment outside the facility). Such reviews should include: 1) review of the circumstances surrounding the incident; 2) review of procedures relevant to the incident; 3) review of all relevant training received by involved staff; 4) review of pertinent medical and mental health services/reports involving the victim; 5) review of any possible precipitating factors that may have caused the victim to commit suicide or suffer a serious suicide attempt; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. When recommendations are accepted for implementation, a corrective action plan should be created that identifies each recommendation, followed by identified responsible staff, status(s) and deadline(s) for implementation. Every effort should be made to complete mortality-morbidity review process within 30 days of the incident. As such, should the mortality-morbidity review process become the responsibility of the CIRB, review of the suicide should be moved from the current 14-day deadline to a more reasonable 30-day deadline. Both the DSB's Policy M.7: Inmate Deaths

and MSD's Policy Death of an Inmate On-Site should be revised to reflect the above 6-step review process. To assist either of the CIRB or SPRFT in these processes, this writer's "Mortality-Morbidity Review of Inmate Suicides/Serious Suicide Attempts Checklist" is offered for consideration in Appendix B.

31) It is strongly recommended MSD's clinical review of an inmate suicide that is currently entitled "psychological autopsy" be renamed as either a "suicide report" or "clinical suicide report." In the alternative, should MSD officials decide to commit to a psychological autopsy process, consistent with NCCHC standards, the review should include the MSD chief mental health clinician's prompt examination of the suicide site (including cell contents), as well as interviews with relevant staff, inmates, and family members of the decedent (when appropriate). Every effort should be made to complete the psychological autopsy within 30 days of the incident for presentation at the mortality review meeting.

32) It is strongly recommended that SDCSD officials consider slightly revising the SPFRT responsibility to "track and review all self-harm incidents, attempt suicides and suicides." Although it would be reasonable to "track" all incidences of self-harm and attempted suicides, given the large size of the San Diego County Jail system, it would be unreasonable to expect that the SPRFT could adequately "review" all incidents of self-harm and attempted suicide. As such, the following revision is offered: "Track all incidents of self-harm and attempted suicide; Review all serious suicide attempts (defined as incidents of self-harm and/or attempted suicide that result in medical treatment outside of the jail facility) and suicides."

E. CONCLUSION

It is hoped that the suicide prevention assessment provided by this writer, as well as the recommendations contained within this report, will be of assistance to the San Diego County Sheriff's Department (SDCSD). As previously shared with SDCSD leadership officials, this writer met numerous DSB and MSD officials and supervisors, as well as deputies, nurses, and mental health personnel (both MSD clinicians and LHC psychologists and psychiatrists), who appeared genuinely concerned about inmate suicide and committed to taking whatever actions were necessary to reduce the opportunity for such tragedy in the future. Those efforts have already resulted in a significant decrease in the number of inmate suicides since late 2016. Although there are numerous recommendations contained within this report, as well as the need to revise several ISP policies, this writer found that the San Diego County Jail System had the foundation of a good suicide prevention program. Based upon the recently enacted Suicide Prevention and Focused Response Team, this writer is confident that full implementation of the recommendations contained within this report will result in continued successful efforts to reducing inmate suicides within the San Diego County Jail System.

Finally, this writer was informed that the Board of Supervisors for San Diego County had recently approved funding for the hiring of approximately 15 additional mental health clinician and 4 jail deputy positions to supplement mental health and suicide prevention program services within the San Diego County Jail System. Such a commitment to additional staffing should be applauded. Although a staffing analysis was outside the purview of this writer's suicide prevention assessment, given the anticipated influx of these mental health clinician positions, as well as the fact that the San Diego County Jail System is one of the largest county jail systems in

California (and the United States), *it would be this writer's opinion that the SDCSD's Medical Services Division is in need of a full-time mental health director to oversee the mental health and suicide prevention services provided to jail inmates*. The considerable day-to-day responsibilities of a mental health director could not reasonably be managed by a medical director. This writer would also hope that, with the hiring of additional mental health personnel, an on-site mental health supervisor (or lead clinician) could be designated at each jail facility to coordinate services.

In conclusion, this writer would be remiss by not extending sincere appreciation to John Ingrassia, Assistant Sheriff/DSB, Mike Hernandez, Commander/DSB, Barbara Lee, MSD Medical Administrator, Alfred Joshua, MD, MSD Chief Medical Officer, and Peter Fischetti, MSD Chief Mental Health Clinician. Without the total candor, cooperation and assistance of these individuals, as well as from all other personnel that were interviewed, this writer would not have been able to complete this technical assistance assignment.

Respectfully Submitted By:

/s/ Lindsay M. Hayes
Lindsay M. Hayes

June 22, 2018

APPENDIX A

CHECKLIST FOR THE "SUICIDE-RESISTANT" DESIGN OF CORRECTIONAL FACILITIES

Lindsay M. Hayes

The safe housing of suicidal inmates is an important component to a correctional facility's comprehensive suicide prevention policy. Although impossible to create a "suicide-proof" cell environment within any correctional facility, given the fact that almost all inmate suicides occur by hanging, it is certainly reasonable to ensure that all cells utilized to house potentially suicidal inmates are free of all obvious protrusions. And while it is more common for ligatures to be affixed to air vents and window bars (or grates), *all* cell fixtures should be scrutinized, since bed frames/holes, shelves with clothing hooks, sprinkler heads, door hinge/knobs, towel racks, water faucet lips, and light fixtures have been used as anchoring devices in hanging attempts. As such, to ensure that inmates placed on suicide precautions are housed in "suicide-resistant" cells, facility officials are strongly encouraged to address the following architectural and environmental issues:

1) Cell doors should have large-vision panels of Lexan (or low-abrasion polycarbonate) to allow for unobstructed view of the entire cell interior at all times. These windows should *never* be covered (even for reasons of privacy, discipline, etc.) If door sliders are not used, door interiors should not have handles/knobs; rather they should have recessed door pulls. Any door containing a food pass should be closed and locked.

Interior door hinges should bevel down so as not to permit being used as an anchoring device. Door frames should be rounded and smooth on the top edges. The frame should be grouted into the wall with as little edge exposed as possible.

In older, antiquated facilities with cell fronts, walls and/or cell doors made of steel bars, Lexan paneling (or low-abrasion polycarbonate) or security screening (that has holes that are ideally 1/8 inches wide and no more than 3/16 inches wide or 16-mesh per square inch) should be installed from the *interior* of the cell.

Solid cell fronts must be modified to include large-vision Lexan panels or security screens with small mesh;

2) Vents, ducts, grilles, and light fixtures should be protrusion-free and covered with screening that has holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

3) If cells have floor drains, they should also have holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch (inmates have been known to weave one end of a ligature through the floor drain with the other end tied

around their neck, then lay on the floor and spin in a circular motion as the ligature tightens);

4) Wall-mounted corded telephones should *not* be placed inside cells. Telephone cords of varying length have been utilized in hanging attempts;

5) Cells should *not* contain any clothing hooks. The traditional, pull-down or collapsible hook can be easily jammed and/or its side supports utilized as an anchor;

6) A stainless steel combo toilet-sink (with concealed plumbing and outside control valve) should be used. The fixture should *not* contain an anti-squirt slit, toothbrush holder, toilet paper rod, and/or towel bar;

7) Beds should ideally be either heavy molded plastic or solid concrete slab with rounded edges, totally enclosed underneath.

If metal bunks are utilized, they should be bolted flush to the wall with the frame constructed to prevent its use as an anchoring device. Bunk holes should be covered; ladders should be removed. (Traditional metal beds with holes in the bottom, not built flush to the wall and open underneath, have often been used to attach suicide nooses. Lying flat on the floor, the inmate attaches the noose from above, runs it under his neck, turns over on his stomach and asphyxiates himself within minutes.);

8) Electricity should be turned off from wall outlets outside of the cell;

9) Light fixtures should be recessed into the ceiling and tamper-proof. Some fixtures can be securely anchored into ceiling or wall corners when remodeling prohibits recessed lighting. All fixtures should be caulked or grouted with tamper-resistant security grade caulking or grout.

Ample light for reading (at least 20 foot-candles at desk level) should be provided. Low-wattage night light bulbs should be used (except in special, high-risk housing units where sufficient lighting 24 hours per day should be provided to allow closed-circuit television (CCTV) cameras to identify movements and forms).

An alternative is to install an infrared filter over the ceiling light to produce total darkness, allowing inmates to sleep at night. Various cameras are then able to have total observation as if it were daylight. This filter should be used only at night because sensitivity can otherwise develop and produce aftereffects;

10) CCTV monitoring does *not* prevent a suicide, it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should *only* supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around the housing should be caulked or grouted.

Cells containing CCTV monitoring should be painted in pastel colors to allow for better visibility. To reduce camera glare and provide a contrast in monitoring, the headers above cell doors should be painted black or some other dark color.

CCTV cameras should provide a clear and unobstructed view of the entire cell interior, including ***all*** four corners of the room. Camera lens should have the capacity for both night or low light level vision;

11) Cells should have a smoke detector mounted flush in the ceiling, with an audible alarm at the control desk. Some cells have a security screening mesh to protect the smoke detector from vandalism. The protective coverings should be high enough to be outside the reach of an inmate and far enough away from the toilet so that the fixture could not be used as a ladder to access the smoke detector and screen. Ceiling height for new construction should be 10 feet to make such a reasonable accommodation. Existing facilities with lower ceilings should carefully select the protective device to make sure it cannot be tampered with, or have mesh openings large enough to thread a noose through.

Water sprinkler heads should not be exposed. Some have protective cones; others are flush with the ceiling and drop down when set off; some are the breakaway type;

12) Cells should have an audio monitoring intercom for listening to calls of distress (***only*** as a supplement to physical observation by staff). While the inmate is on suicide precautions, intercoms should be turned up high (as hanging victims can often be heard to be gurgling, gasping for air, their body hitting the wall/floor, etc.);

13) Cells utilized for suicide precautions should be located as close as possible to a control desk to allow for additional audio and visual monitoring;

14) If modesty walls or shields are utilized, they should have triangular, rounded or sloping tops to prevent anchoring. The walls should allow visibility of both the head and feet;

15) Some inmates hang themselves under desks, benches, tables or stools/pull-out seats. Potential suicide-resistant remedies are: (a) Extending the bed slab for use as a seat; (b) Cylinder-shaped concrete seat anchored to floor, with rounded edges; (c) Triangular corner desk top anchored to the two walls; and (d) Rectangular desk top, with triangular end plates, anchored to the wall. Towel racks should also be removed from any desk area;

16) All shelf tops and exposed hinges should have solid, triangular end-plates which preclude a ligature being applied;

17) Cells should have security windows with an outside view. The ability to identify time of day via sunlight helps re-establish perception and natural thinking, while minimizing disorientation.

If cell windows contain security bars that are not completely flush with window panel (thus allowing a gap between the glass and bar for use as an anchoring device), they should be covered with Lexan (or low-abrasion polycarbonate) paneling to prevent access to the bars, or the gap, should be closed with caulking, glazing tape, etc.

If window screening or grating is used, covering should have holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

18) The mattress should be fire retardant and not produce toxic smoke. The seam should be tear-resistant so that it cannot be used as a ligature;

19) Given the fact that the risk of self-harm utilizing a laundry bag string outweighs its usefulness for holding dirty clothes off the floor, laundry bag strings should be removed from the cell;

20) Mirrors should be of brushed, polished metal, attached with tamper-proof screws;

21) Padding of cell walls is prohibited in many states. Check with your fire marshal. If permitted, padded walls must be of fire-retardant materials that are not combustible and do not produce toxic gasses; and

22) Ceiling and wall joints should be sealed with neoprene rubber gasket or sealed with tamper-resistant security grade caulking or grout for preventing the attachment of an anchoring device through the joints.

NOTE: A portion of this checklist was originally derived from R. Atlas (1989), "Reducing the Opportunity for Inmate Suicide: A Design Guide," *Psychiatric Quarterly*, 60 (2): 161-171. Additions and modifications were made by Lindsay M. Hayes, and updated by Randall Atlas, Ph.D., a registered architect. See also Hayes, L.M. (2003), "Suicide Prevention and "Protrusion-Free Design of Correctional Facilities," *Jail Suicide/Mental Health Update*, 12 (3): 1-5. Last revised Lindsay M. Hayes in February 2016.

APPENDIX B

MORTALITY/MORBIDITY REVIEW OF INMATE SUICIDES/ SERIOUS SUICIDE ATTEMPTS CHECKLIST*

Lindsay M. Hayes

1) Training

- Had all correctional, medical, and mental health staff involved in the incident received both basic and annual training in the area of suicide prevention prior to the incident?

- Had all staff who responded to the incident received training (and were currently certified) in standard first aid and cardiopulmonary resuscitation (CPR) prior to the incident?

2) Identification/Referral/Assessment

- Upon this inmate's initial entry into the facility, were the arresting/transporting officer(s) asked whether they believed the inmate was at risk for suicide? If so, what was the response?

- Had inmate been screened for potentially suicidal behavior upon entry into the facility?

- Did the screening form include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; sense of immediate future (inmate expressing helplessness and/or hopelessness); prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); and history of suicidal behavior by family member/close friend?

- If the screening process indicated a potential risk for suicide, was inmate properly referred to mental health/medical personnel?

- Had inmate received any post-admission mental health screening/assessment?

- Was the inmate provided reasonable privacy and confidentiality during the intake screening process, as well as during any subsequent screening and/or assessment?

- Had inmate previously been confined in the facility/system? If so, had the inmate been on suicide precautions during a prior confinement in the facility/system? Was such information available to staff responsible for the current intake screening and mental health assessments?

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*A *morbidity* review should be conducted for a serious suicide attempt, defined here as referring to an incident of self-harm serious enough to require medical treatment outside the correctional facility.

3) Communication

- Was there information regarding inmate's prior and/or current suicide risk from outside agencies that was not communicated to the facility?

- Was there information regarding inmate's prior and/or current suicide risk from correctional, mental health and/or medical personnel that was not communicated throughout the facility to appropriate personnel?

- Did inmate engage in any type of behavior that might have been indicative of a potential risk of suicide? If so, was this observed behavior communicated throughout the facility to appropriate personnel?

4) Housing

- Where was inmate housed and why were they assigned to this housing unit?

- If the inmate was on suicide precautions at the time of the incident, was the inmate housed in a suicide resistant, protrusion-free cell?

- Was inmate on "segregation" status at the time of the incident?

- If placed was on "segregation" or any "special management" (e.g., disciplinary and/or administrative segregation) status, had he/she received a written assessment for suicide risk by mental health and/or medical staff due to this status?

- Was there anything regarding the physical design of inmate's cell that contributed to the incident (e.g., poor visibility, protrusions conducive to hanging attempts, etc.)?

5) Levels of Observation/Management

- What level and frequency of supervision was inmate under immediate prior to the incident?

- Given inmate's observed behavior prior to the incident, was the level of supervision appropriate?

- When was inmate last physically observed by staff prior to incident?

- Was there any reason to question the accuracy of the last reported observation by staff?

- If inmate was not physically observed within the required time interval prior to the incident, what reason(s) was determined to cause the delay in supervision?

- Was inmate on a mental health and/or medical caseload? If so, what was frequency of contact between inmate and mental health and/or medical personnel?

- When was inmate last seen by mental health and/or medical personnel?

- Was there any reason to question the accuracy of the last reported observation by mental health and/or medical personnel?

- If inmate was not on a mental health and/or medical caseload, should he/she have been?

- If inmate was not on suicide precautions at the time of the incident, should he/she have been?

6) <u>Intervention</u>

- Did staff member(s) who discovered the inmate follow proper intervention procedures, i.e., surveyed the scene to ensure the emergency was genuine, called for back-up support, ensured that medical personnel were immediately notified, and initiated standard first aid and/or CPR?

- Did staff initiate standard first aid and/or CPR within four (4) minutes following discovery of the incident?

- Did the inmate's housing unit contain proper emergency equipment for staff to effectively respond to a suicide attempt, i.e., first aid kit, gloves, pocket mask or Ambu bag, and rescue tool (to quickly cut through fibrous material)?

- Were there any delays in either correctional or medical personnel immediately responding to the incident? Were medical personnel properly notified as to nature of emergency and did they respond with appropriate equipment? Was all the medical equipment working properly?

- Were there any delays in notifying outside emergency medical services personnel (i.e., 911)?

7) <u>Reporting</u>

- Were all appropriate officials and personnel notified of incident in a timely manner?

- Were other notifications, including inmate's family and appropriate outside authorities, made in a timely manner?

- Did all staff who came into contact with inmate prior to the incident submit a report and/or statement as to their full knowledge of inmate and incident? Was there any reason to question the accuracy and/or completeness of any report and/or statement?

8) Follow-Up/Mortality-Morbidity Review

- Were all affected staff and inmates offered crisis intervention services following the incident?

- Were there any other investigations conducted (or that should be authorized) into incident that may be helpful to the mortality-morbidity review?

- As a result of this mortality-morbidity review, were there any possible precipitating factors (e.g., circumstances which may have caused victim to commit suicide or engage in the serious suicide attempt) offered and discussed?

- Were there any findings and/or recommendations from previous mortality-morbidity reviews that are relevant to this review?

- As result of this review, what recommendations (if any) are necessary for revisions in policy, training, physical plant, medical or mental health services, and operational procedures to reduce the likelihood of future incidents.

- What are specific corrective active plans (CAP) for each recommendation, who is responsible party for each CAP, and what is expected timeframe to complete each CAP?

Last revised: June 2018