Sacramento County Jail Health Inmate Psychiatric Services

Issue

As part of the Sacramento County Grand Jury's responsibility to review county detention facilities, it was decided to determine if psychiatric services are being administered in an efficient and effective manner at the Sacramento County Main Jail. The number of suicides that occurred early in 2002 was also a concern. In addition, the Grand Jury examined whether the recommendations made in the Lindsay M. Hayes Report concerning these suicides have been addressed.

Method of Investigation

The following reports and documents were reviewed:

- "Technical Assistance Report on Jail Suicide Prevention Practices Within the Sacramento County Sheriff's Department," by Lindsay M. Hayes, May 30, 2002.
- "Recommendations and Response to Technical Assistance Report by The Suicide Prevention Task Force," June 26, 2002.
- "Suicide Prevention Task Force Action Summary," January 21, 2003.
- "The Medical-Mental Health Inspection Report, Main Jail," December 5, 2003.
- "Medical-Mental Health Inspection Report," January 14, 2004.
- "Main Jail Inmate Handbook," February 2003.
- Local Detention Facility Health Inspection Report, 2003.
- Revised intake and screening forms.
- An incident report of an attempted suicide.

The following individuals were interviewed:

- Medical Director, Correctional Services.
- Commander of Staff Services Division.
- Chief of Correctional Health Services.
- Sacramento County Sheriff's Department Training Manager and Training Assistant.
- Assistant Chief, Director of Nursing, Correctional Health Services.
- Interim Medical Director, Jail Psychiatric Services, University of California at Davis.
- Chairperson of the Suicide Prevention Task Force.

The following sites were visited at the Main Jail:

- Intake Unit.
- Psychiatric Care Unit.
- Medical Housing Unit.

Background and Facts

In 2002, public attention was focused on the increase of suicides at the county's Main Jail. In the short period from January through April, four suicides occurred. In 2003, a significant organizational shift took place, taking the responsibility for inmate health care from the Coroner's Office and putting it under the direct authority of the Sacramento County Sheriff's Department (SCSD). The Grand Jury was interested in determining what kind of impact this made regarding the health care of inmates, particularly in the area of mental health.

In an effort to be pro-active in stopping suicides at the Main Jail, the Sheriff's Department sought the assistance of an outside consultant to conduct an assessment of jail practices and to make recommendations regarding its suicide prevention policies and procedures. The Assistant Director of the National Center on Institutions and Alternatives, Lindsay M. Hayes, was selected.

In addition to hiring a consultant, the Sheriff's Department formed a Suicide Prevention Task Force in February of 2002. The multidisciplinary task force is chaired by the Clinical Director of Psychiatric Services. It includes as its members the Medical Director and staff of Jail Psychiatric Services (JPS), two representatives from the Sheriff's Citizen Advisory Committee and jail management staff from custody, health care and mental health.

The report by consultant Lindsay M. Hayes was completed in May of 2002. The report determined that the spike of suicides was a statistical aberration, based on the average daily jail population during the time period of January through April 2002. During the years from 1996 through May 2002, the average rate of suicides in the Main Jail was 51.5 per 100,000 inmates. Recent national data on county jail suicides is approximately 54 deaths per 100,000 inmates. The Sacramento County Main Jail was below the national average.

Consultant Hayes noted that the general population of the Main Jail includes: 1) pre-trial inmates awaiting adjudication, and 2) other inmates transferred from the Rio Cosumnes Correctional Center because of special needs such as mental health, suicidal behavior, administrative segregation, disciplinary confinement, etc. These "special needs" inmates are recognized as being at a much higher risk of suicide. It should also be noted all the suicides occurred in the cells of the general inmate population. The responsibility for direct observation of these inmates falls to the custodial officers. Inmates housed separately under JPS supervision were not casualties of suicide. Hence, it would seem

the initial screening of inmates in conjunction with the mental health training and increased awareness of the custodial officers are two of the most important factors in preventing jail suicides. Mental health assessment of inmates remains key to preventing future incidents.

In October 2002, the Suicide Prevention Task Force issued a response to the recommendations made in the Lindsay M. Hayes Report. The task force followed up in January 2003 with an "Action Summary" describing the continuing efforts to meet the recommendations in the Lindsay M. Hayes Report. On January 14, 2004, a state-mandated, bi-annual inspection report evaluating the current health conditions at the Main Jail was released. The Jury used these three reports as a benchmark in determining improvements in jail health services.

Findings and Recommendations

In its investigation, the Grand Jury looked into: A) inmate screening, B) training, C) inmate monitoring and assessment, D) prescription drug storage and dispensing, and E) reorganization and delivery of jail health services pertaining to suicide prevention specifically, and mental health generally.

A. INMATE SCREENING

Finding 1. The Lindsay M. Hayes Report found that the intake forms being utilized were inadequate. In addition, these forms were not automatically being forwarded to the Jail Psychiatric Services (JPS).

In response, the Main Jail staff has revised its current intake forms in accordance with national standards. All appropriate and relevant medical screening forms are now transmitted by fax to the JPS in a timely manner. Also, arresting officers complete newly developed forms to communicate medical information to the county jail medical staff.

Recommendation 1. A yearly review should be conducted to determine the effectiveness of intake screening forms.

Finding 2. The Lindsay M. Hayes Report stated that classification deputies conduct inmate interviews, examine forms and review two screening fields to capture information on an inmate's prior history. These deputies then use individual discretion to make referrals to the JPS staff. These referrals are not always made on consistent criteria.

In response to the Lindsay M. Hayes Report, new classification forms have been implemented, which include questions regarding mental health and suicide.

Recommendation 2. A software program should be developed to access quickly and accurately an inmate's prior health history for use by the classification deputies to ensure consistency in evaluation and referral.

Finding 3. The Lindsay M. Hayes Report states that contrary to some national correctional standards, JPS staff does not conduct a mental health assessment on each inmate within 14 days of confinement.

In response, the Suicide Task Force indicated that it would be cost prohibitive to conduct reviews of health records for every inmate. However, there is a mental health screening of all inmates at intake.

Recommendation 3. Inmates who have been in the system before should have their records checked for mental health issues within 14 days.

B. TRAINING

Finding 1. The Lindsay M. Hayes Report found that only two hours of suicide prevention training was included in the basic Sacramento County Sheriff's Department academy training. The burden of suicide prevention falls on the custodial officers. Intensive training of custodial officers is essential in detecting mental health issues and in the prevention of suicides. The national recommendation for such initial training is eight hours.

In response, the Main Jail staff has since instituted a multi-session approach for new officers consisting of eight hours of suicide prevention training. These sessions are divided between the academy and the Main Jail orientation of new custodial officers. Suicide prevention training for all other jail staff consists of one-hour yearly training in addition to fifteen-minute quarterly sessions offered during briefings.

Recommendation 1. The quarterly trainings should be increased from 15 minutes to one half hour. Attendance should be required and records kept in each officer's training file. Attendance at makeup sessions should be required.

Finding 2. One area of concern identified by the jail staff is the line of communication between the courts and the correctional staff when the inmate is returned to jail after court proceedings. Court actions can have a detrimental effect on the mental state of an inmate.

Recommendation 2. A process of communication should be developed that alerts the correctional staff to the result of court proceedings regarding a particular inmate, when the inmate is returned to the Main Jail.

Finding 3. The SCSD should be commended for its efforts in evaluating and revamping its training program and increasing the attention focused on suicide prevention. In addition to the increased training, they have created a "Suicide Risk" informational pocket card for officers and correctional health staff. A workshop for public defenders has also been developed and will be given annually. Great efforts have been made to improve communications between the correctional staff and the JPS.

Recommendation #3. None.

C. INMATE MONITORING AND ASSESSMENT

Finding 1. The Lindsay M. Hayes Report stated that monitoring of the inmate population is the primary responsibility of the custodial officers. Inmates housed in special housing units, where most suicides have occurred, are presently required to be observed once an hour. The Lindsay M. Hayes Report recommended that the custodial staff be required to physically observe inmates placed in special housing units at 30-minute intervals.

In response, Main Jail staff concluded that to conduct 30-minute cell checks in designated high-risk special housing units would demand an additional 35 custodial deputies. The Suicide Prevention Task Force stated it was unknown what the financial effects or feasibility of such an increase would be. Correctional officers have since been directed to walk the floors and observe inmates with greater frequency.

Recommendation 1. Main Jail staff should adopt the suggested standard of observation of the Lindsay M. Hayes Report due to the possibility of suicide among high risk inmates.

Finding 2. The Lindsay M. Hayes Report noted that inmates discharged from the JPS acute inpatient psychiatric unit back to the general population of the Main Jail should have regular follow-up assessment.

In response, JPS does a follow-up within 72 hours but has not adopted the standard as outlined due to the cost of additional personnel. However, there has been an effort to centralize outpatients so they can be more closely monitored. Inmates with suicidal ideation assigned to the medical unit receive a 15-minute check.

Recommendation 2. An effort should be made to develop a regular monitoring and assessment schedule for every inmate released from the acute psychiatric unit. Currently, the nurse doing pill delivery has been delegated the added responsibility of assessing the inmate's condition. This policy is unsatisfactory due to the time constraint on nurses.

Finding 3. The Lindsay M. Hayes Report noted the need for more beds designated for outpatient mental health housing. This need was corroborated by the "Medical-Mental Health Inspection Report" of December 5, 2003.

In response, the jail staff has stated that space limitations of the present jail and budget restraints are barriers to fully address this issue. However, additional beds have been found for inmates discharged from acute psychiatric care, and needing closer supervision than can be supplied in a regular jail unit.

Recommendation 3. Since space at the jail is at a premium, the County should aggressively pursue plans to build another tower to accommodate the general need, as

well as the need for appropriate housing for inmates requiring medical and psychiatric care.

D. PRESCRIPTION DRUG STORAGE AND DISPENSING

Finding 1. The "Medical-Mental Health Inspection Report" indicated that there are some serious problems with the storage of drugs and the dispensing program at the Main Jail. Recommendations made over the past several years have not been fully implemented. The County has contracted with a software company to develop a database program to aid the health staff with prescription records. This program has yet to be developed.

Recommendation 1. The County should explore other contractors to develop this database program if the contracted company cannot deliver in a specified period of time.

E. REORGANIZATION AND DELIVERY OF JAIL HEALTH SERVICES

Finding 1. In the spring of 2003, the reorganization of Jail Health Services resulted in the transfer of management from the Coroner to the Sheriff. The improvement in coordination and communication between the health and custodial staff has been noted by the chief administrators and staff members, and is verified by the less frequent health care complaints made by inmates. In its December 2003 report, the Medical-Mental Health Inspection team also commented on the improvements in jail health services. Training is better coordinated as well as the communication between custodial and health care staff regarding the status of inmate health issues.

Most importantly, the health care providers have been given more autonomy in the areas of health issues and decision making. Problems are solved more rapidly because of the open lines of communication and the frequent meetings between health care and custodial staff and their administrators. The creation of a Suicide Prevention Task Force, including a mortality review of inmate suicides, has been a force for change. Medical staff has been increased as their needs were communicated. All of these changes have contributed to improvements in jail health care and hopefully the lessening of future suicide attempts.

Recommendation 1. Even though the County of Sacramento is facing budget cuts, the Board of Supervisors should maintain the present level of staffing of the Medical Housing Unit and its support of Jail Psychiatric Services.

Recommendation 2. The Suicide Prevention Task Force should remain in service and continue to review the progress of implemented changes and to monitor jail policies and procedures.

Response Required

Penal Code Section 933.05 requires that specific responses to both the findings and recommendations contained in this report be submitted to the Presiding Judge of the Sacramento Superior Court by September 30, 2004 from:

- **Sacramento County Board of Supervisors**
- **Sacramento County Sheriff**
- **Medical Director, Correctional Services**
- **Medical Director, Jail Psychiatric Services, UCD**