EXAMINING THE ISSUE OF SUICIDES IN SAN DIEGO JAILS

SUMMARY

The suicide rate in San Diego County jails is the highest in all of California's large county jail systems. According to the San Diego County Sheriff's Department (Sheriff's Department), 46 people have committed suicide in San Diego County jails in the past 12 years. The 2016/2017 San Diego County Grand Jury (Grand Jury), responding to public concern, investigated why the number of suicides in San Diego County jails is so high.

The Grand Jury noted during its detention facilities inspections that, in an attempt to reduce suicides in the jails, the Sheriff's Department has recently added enhanced observation housing modules, new safety cells, and medical isolation cells. In March 2016, the Sheriff's Departments Detention Services Bureau updated its Policy and Procedures Manual (P&PM) to include procedures for the use of these units. In spite of these efforts, the suicide rate remains high.

The Grand Jury found that the P&PM lacks detailed training procedures required for correctional officers to effectively reduce suicides and believes that training must address the specialized communication skills required to be effective. Further, the P&PM does not clearly show the inclusion of nationally recognized protocols or a clear policy statement for suicide prevention.

The Grand Jury also learned that the Sheriff Department's Chief Medical Officer does not employ an in-house staff supervisor for the contract mental health workers and instead relies on contracted supervision.

Finally, the Grand Jury did not find a process that calls for continuous oversight as part of a suicide-prevention policy. In light of these findings, the Grand Jury recommends an update to the Policy and Procedures Manual, the hiring of a full-time professional mental health staff member to supervise all professional mental health workers, and the establishment of a suicide-prevention oversight group.

INTRODUCTION

California Penal Code §919b mandates that the Grand Jury annually inquire into the condition and management of all public jails within the county. As part of its inquiry, the Grand Jury paid particular attention to the number and frequency of suicides within the jails and examined the policies and procedures the Sheriff's Department employs as preventive measures. The Grand Jury's intent was to identify the reasons that San Diego County's jails are experiencing a higher suicide rate than jails in other California counties.

PROCEDURE

The Grand Jury examined a large volume of jail suicide-prevention research, including published policies, procedures, and recommendations, including the following:

- The San Diego County Sheriff's Department Detention Services Bureau Policy and Procedures Manual
- The San Diego County Sheriff's Department Medical Services Divisions Policy and Procedures Manual.

The Grand Jury also interviewed officials from the San Diego Sheriff's Department medical staff and re-entry services and asked many questions of detention officers during visits to all detention facilities.

DISCUSSION

The suicide rate in San Diego County jails is the highest in all of California's large county jail systems. Data from the U.S. Bureau of Justice Statistics show five suicides in San Diego County jails in 2013, six in 2014, seven in 2015, and the San Diego County Sheriff's Department confirmed five in 2016. By contrast, since 2014, San Bernardino County has had three jail suicides; Los Angeles and Santa Clara counties have had one each. Orange and Sacramento counties have had none.

During the last several years, media sources have focused intently on the number of suicides in San Diego jails. All of these news reports have an effect on what the community thinks about the correctional staff's ability to control suicides and keep inmates safe. According to numerous news stories, a 21-year-old Marine in 2014 hanged himself in the Vista Detention Facility despite jail officials' knowledge of numerous previous suicide threats. Other news stories reported that, in 2015, another inmate's family repeatedly cautioned jail officials that their relative was suicidal, yet the inmate did not receive the necessary oversight to prevent him from hanging himself in his cell.

In order to clarify and understand the issue of suicides in the San Diego County jails, the Grand Jury investigated the issue. The Grand Jury's goal in its investigation was to identify and recommend tested, successful methods for preventing jail suicides not fully implemented in our jails.

The Grand Jury acknowledges that the Sheriff's Department is experiencing unprecedented challenges in accommodating and treating inmates with mental health problems. Estimates by recognized experts suggest about 15 percent to 20 percent of jail

inmates nationwide may be suffering from serious mental illness.[1] With an average daily population of about 5,000, that means approximately 800 inmates with serious mental illness could be in San Diego County jails at any given time.

Clearly, dealing with mental illness and suicide prevention within the county jails is an ongoing concern. According to the National Institute of Corrections, properly trained correctional staff is essential. Just having adequate mental health, medical, or other professional staff available seldom prevents suicides because suicides typically take place in inmate housing units. Furthermore, suicides commonly occur at night or on weekends, when mental health staff may not be readily available or on-site. Therefore, guards and correctional staff trained in suicide-prevention techniques and who have subsequently developed an intuitive sense about the inmates under their care must be counted on to prevent these incidents.

"The greatest challenge for those who work in the correctional system is to view the issue as one that requires a continuum of comprehensive suicide-prevention services aimed at the collaborative identification, continued assessment, and safe management of inmates at risk for self-harm."[2] The Grand Jury believes this statement indicates that all corrections staff must be focused on suicide prevention at all times.

Recognized experts say that, to be effective, suicide-prevention training must include consistent and thorough communication among all jail staff. They recommend suicide-prevention efforts start at the point of arrest and continue until the inmate is released. During this time, inmates may exhibit certain behaviors that indicate a risk of suicide. If these behaviors are detected and communicated to others, the likelihood of a completed suicide will be reduced. Additionally, corrections staff, with proper training, can prevent suicide by establishing trust and communication with inmates in order to observe their actions and pass along what they hear and see to other corrections staff.

The Grand Jury believes that effective communication must exist in several areas and that this is key in suicide prevention. These areas include the following:

- Communication between people who come in contact with the inmate before booking (arresting officer and transport officers) and the people receiving the inmate (nurses and gatekeepers) at the jail during intake
- Communication between intake personnel and the internal correctional staff, including professional staff (medical and mental health personnel)
- Communication between all staff and the potentially suicidal inmate in order to ensure the safety of all involved

[1] "More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States," Treatment Advocacy Center, May 2010, http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf (accessed August 2016).
[2] "National Study of Jail Suicide: 20 Years Later," National Institute of Corrections (U.S. Department of Justice), 2010, http://static.nicic.gov/Library/024308.pdf (accessed September 2016).

In addition to saving lives, the County avoids unnecessary human suffering and liability when an effective training program is in place.

In studying the P&PM, the Grand Jury concentrated on the policies and procedures pertaining to suicide-prevention training. The Grand Jury then examined national jail suicide data because it provided more research reports. The increased number of suicide victims studied allowed the demographic data to be more comprehensive.

The findings in the documentation for jail suicides and the training to prevent jail suicides were similar in content. Table 1 summarizes the reports:

Published Protocols Related to Jail Suicides	National Study of Jail Suicides: 20 Years Later[3]	Writing a Suicide Prevention Policy[4]	Prison Suicide: An Overview & Guide to Prevention[5]	Developing & Revising Suicide Prevention Protocols within Jails & Prisons[6]	Preventing Suicide in Jails & Prisons[7]
Training in suicide prevention	X	X	X	X	X
Identification of suicide risk	X	X	X	X	X
Communication needed between all staff and inmate	X	X	X	X	X
Housing for safety of suicidal inmate	X	X	X	X	X
Observation plan	X	X	X	X	X
Evaluation by mental health staff	X	X	X	X	
Referral by mental health staff	X	X	X	X	
Reporting, all staff to submit statements	X	X	X	X	
Mortality-morbidity review to look at facts and make recommendations	X	X	X	X	
Notification to all appropriate staff	X	X	X		
Critical Incident Stress Debriefing (CISD): talk to involved staff within 72 hours	X	X			
Treatment plan	X				X
Social intervention: do not cut off social contacts					X
Intervention by trained staff with first aid knowledge and assume inmate is alive		X	X	X	

Table 1

[3] "National Study of Jail Suicide: 20 Years Later," National Institute of Corrections (U.S. Department of Justice), 2010.
[4] Marty Drapkin, "Writing a Suicide Prevention Policy," *CorrectionsOne*, October 20, 2007.
[5] Lindsay M. Hayes, "Prison Suicide," An Overview and Guide to Prevention, National Institute of Corrections, June 1995.
[6] Lindsay M. Hayes, "Guide to Developing and Revising Suicide Prevention Protocols within Jails and Prisons," National Center on Institutions and Alternatives, 2011.
[7] "Preventing Suicide in Jails and Prisons," World Health Organization, Department of Mental Health and Substance Abuse, 2007.

In Section A.1, the Sheriff's Department's P&PM states, "The Sheriff's detention facilities shall be operated in accordance with established Department Policy and Procedures, California State Law, applicable case law and acceptable professional standards."[8]

The Grand Jury believes that Table 1 highlights the minimum protocols required for a detention facility's policy and procedures manual. Each report lists the protocols needed for a comprehensive suicide-prevention program. Five of the protocols were used in all five reports, four of the protocols were used in four, and three of the protocols were used in two or fewer of the reports. (Because these three protocols are not unique to suicide prevention, they could have been included in another section of the policy and procedures manual.)

The Grand Jury believes that the San Diego Sheriff's Department P&PM does not include adequate policy regarding suicide prevention, and there is no discussion on protocols to be used or how compliance will be ensured. The Grand Jury believes the suicide-prevention policy should be clearly stated for the P&PM users to know what attitude to have and what actions to take. The policy should state the attitude of management toward suicide prevention, the protocols to be used, and how oversight will be enforced.

The Grand Jury also noted that the assumed triggers for suicide varied. Experts claim that two main causes exist for suicide in jail: First, the jail's environment itself contributes to suicidal tendencies. Second, the inmate is in a crisis situation, a condition that jail staff repeatedly verified during the Grand Jury's visits to detention facilities. Inmates are fearful of the immediate future and the consequences of their crime, they have lost control over their lives, and they are isolated from family and friends. The psychological effect of incarceration, combined with drug and alcohol use and withdrawal, exacerbate mental illness symptoms and can lead to suicide. Incarceration is stressful on every level, and that alone is enough to provoke suicide ideation.[9]

One study showed that 65 percent of suicides occur in the first 30 days of incarceration and 85 percent in the first four months, but it also shows suicide can occur at any time.

The Grand Jury believes increased efforts in suicide prevention are required. The Grand Jury understands that the P&PM contains documentation that outlines procedures that are formulated to direct the staff on the process to carry out a desired objective. However, these standalone procedures are not a suicide-prevention plan. A suicide-prevention plan incorporates training, intervention, communications, and supervision in a dynamic way

[8] Policy and Procedure Manual, Detention Services Bureau, San Diego County Sheriff's Department, https://www.sdsheriff.net/documents/pp/dsb-20160310.pdf, (accessed October 2016).
[9] "National Study of Jail Suicid: 20 Years Later," National Institute of Corrections (U.S. Department of Justice), 2010.

that will ensure the correctional officers are focused on seeing the triggers that alert them of a possible suicide.

According to the P&PM, Section D.1, "The Detention Facility Training Program will have policies and procedures to ensure training programs for all employees are specifically planned, coordinated, supervised, and evaluated."[10]

The Grand Jury believes that suicide-prevention training should not be just a scheduled class. Instead, it should be a continuous charge to be mindful of suicide characteristics. Effective suicide-prevention communication should not be just a comment posted to the Jail Information Management System (JIMS). It should also be the mental health nurse talking to the on-duty jail staff about the condition of an inmate. A suicide plan should foster the belief by all workers that "a suicide will not happen on my watch."

The National Institute of Corrections strongly recommends that all correctional, medical, and mental health personnel receive eight hours of initial suicide-prevention training and two hours of refresher training in subsequent years.

"The initial training should include instruction regarding administrator and staff attitudes about suicide and how negative attitudes impede suicide-prevention efforts, why correctional facilities' environments are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, how to identify suicidal inmates despite a denial of risk, components of the facility's suicide-prevention policy, and liability issues associated with inmate suicide. The two-hour refresher training should review the topics discussed during the initial training and also describe any changes to the facility's suicide prevention plan. The annual training should also include a general discussion of any recent suicides and/or suicide attempts in the facility."[11]

On several occasions, the San Diego County jail staff stated that they visited the Texas prison system to discover lessons learned in lowering its suicide rates. A *Dallas Morning News* article cited changes made to mental health training for Texas prison system officers: "This year, the criminal justice department beefed up mental health training for officers. New cadets receive more than 33 hours of mental health training, and those already on the job get monthly sessions . . . The training is designed to help officers recognize signs of a mental health crisis."[12]

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[10] Policy and Procedure Manual, Detention Services Bureau, San Diego County Sheriff's Department, https://www.sdsheriff.net/documents/pp/dsb-20160310.pdf, (accessed October 2016).
[11] "National Study of Jail Suicide: 20 Years Later," National Institute of Corrections (U.S. Department of Justice), 2010, http://static.nicic.gov/Library/024308.pdf (accessed September 2016).
[12] Brandi Grissom, "Suicides and Attempts on the Rise in Texas Prisons," *Dallas Morning News*, August 29, 2016, http://www.dallasnews.com/news/texas/2015/11/28/suicides-and-attempts-on-the-rise-in-texas-prisons (accessed September 2016).

The Grand Jury concurs with the *Dallas Morning News* article and believes annual training of two hours may be inadequate. (However, after the correctional staff has been trained in constant awareness of the signs of potential suicide risk and regular, periodic on-the-job training is in place, then two hours of formal training per year may be adequate.) In order to keep suicide-prevention skills fresh, the training must be timely. In fact, the Grand Jury believes the training could include a brief reminder every week by the watch captain about suicide-prevention skills.

The Grand Jury reviewed a Sheriff's Department training document containing a detailed list of factors indicating a risk for inmate suicide, along with possible characteristics of a suicidal inmate. The list was good, but the document did not state how often the training might take place.

There are at least three different stages where at-risk suicidal inmates can be identified: at the time of arrest and intake, at the time the inmate is housed in a secure cell, and at the time the inmate is in mainline housing. The requirements for safety cell use in the P&PM, Section J, clearly state that the safety cell is temporary housing, typically lasting for only a few hours. This is a clear suggestion that inmates should remain in suicide counseling and observation as they are moved to more appropriate housing. The Grand Jury recognizes that these three different stages call for three training scenarios that require different training for each one, but it would support a consistent suicide-prevention plan.

In San Diego County jails under the jurisdiction of the San Diego County Sheriff's Department, those working in suicide prevention include private contract personnel and jail staff. The Grand Jury believes it is important that they are working from the same plan; therefore, it is important they receive the same training. The training period is when all suicide-prevention workers will learn about the jail staff's attitude about enforcement of the suicide policy.

The Grand Jury found that most County health departments use private contract personnel as their mental health workers. In the jails, psychiatrists are contract workers, including the supervisor, who reports to the Chief Medical Officer. The jail has responsibility for all services for all inmates with mental health problems (including drug and alcohol abuse), suicide prevention, and inmates in the re-entry facility. The Grand Jury believes coordinating these functions should be the responsibility of a full-time employee, specifically, a mental health professional.

The P&PM in Section M.7 states that after an inmate death in the detention facility, "A meeting shall be held after all autopsy and other pertinent reports have been received to discuss findings with the Detention Services Bureau and facility command staff, Sheriff's legal counsel, and medical services administration. As appropriate, the detention facility

supervising nurse, psychiatric director, and other staff who are relevant to the incident, as deemed appropriate by the medical services administrator, shall also be included."[13]

Section M.7 does not appear to provide for any input regarding the policies and procedures or training group, nor does it provide for any real-time monitoring or updating of the suicide plan, which the Grand Jury believes is a necessary component of suicide-prevention efforts.

The Grand Jury noted that the Sheriff's Department instituted new protocols in early 2015 to reduce suicides in the jails. These new protocols affected various procedures and resulted in changes to the facilities. The Grand Jury does not believe these changes were an indication of operational problems in the jails; on the contrary, a new emphasis was instituted. In the same manner, the Grand Jury's recommendations merely suggest a change in emphasis is needed.

The 2015 changes did coincide with a seven-month period with no suicides. Yet, after that seven-month period, suicides returned to previous levels. The Grand Jury believes that the new protocols showed that management placed an increased importance on suicide prevention, which could have motivated the jail staff to increase attention to suicide prevention. But because there was no sustained effort to maintain that motivation, the number of suicides returned to previous levels.

As the Grand Jury conducted research to find an approach for suicide prevention that was not in use at the jails, a scheduled inspection by the Grand Jury took place at one of the San Diego jails. Near the end of the inspection, a correctional officer was asked if a suicide had occurred in that facility. The answer was no, then a pause, and then "No, there have been no suicides in this facility. You are not allowed to die in this facility." This was the only time the Grand Jury heard a correctional officer with the attitude that suicides are not acceptable in jail. As a result, the Grand Jury looked for a way to instill in the minds of all correctional staff the attitude that suicides are unacceptable. During this process, the Grand Jury concluded that procedures alone would not change attitudes, but policy could, and continuing training on multiple levels is necessary to change attitudes.

The Grand Jury offers three simple recommendations:

- Senior management needs to adopt a clear policy stating the attitude and protocols needed to minimize suicides in the jails.
- The training needs to include ongoing instruction for all staff and mental health personnel working with at-risk inmates.
- Supervisors need to oversee the training to ensure compliance with the policy.

[13] Policy and Procedure Manual, Detention Services Bureau, San Diego County Sheriff's Department, https://www.sdsheriff.net/documents/pp/dsb-20160310.pdf, (accessed October 2016).

The Grand Jury believes these recommendations can be implemented quickly at low cost and will reduce suicides.

FACTS AND FINDINGS

Fact: The Sheriff's Department P&PM, Section A.1, Purpose, states that operation of detention facilities shall comply with its own policy and procedures, state law, case law, and professional standards.

Fact: The Sheriff's Department P&PM states that inmates who are recognized and observed as being a potential suicide risk shall be assessed for consideration of placement into an Inmate Safety Program housing option. Sworn staff shall immediately notify medical staff and the watch commander of any inmate that presents a potential danger to self, danger to others, or unable to care for self.

Finding 01: The Policy and Procedures Manual does not contain a comprehensive overall suicide-prevention plan with a policy statement listing the protocols (professional standards) to be used, nor does it clearly state that suicide-prevention principles must be in effect at all times.

Fact: The Sheriff's Department P&PM requires training programs for all employees.

***Fact*:** The Sheriff's Department P&PM states that training is defined as an organized, planned, and evaluated activity designed to achieve specific learning objectives through classroom studies and closely supervised on-the-job training.

***Fact*:** The Sheriff's Department P&PM states that staff development is defined as an organized, planned, and evaluated activity designed to further increase the staff members' level of competence, which enables them to function more effectively.

Finding 02: The P&PM shows provisions for various training and development but does not show adequate and sustained training programs to ensure a continuum of comprehensive suicide-prevention services.

Fact: The Sheriff's Chief Medical Officer does not have a full-time Mental Health Officer on staff.

Finding 03: There is a need great enough for mental health services supervision in the Detention Services Bureau that a full-time Mental Health Officer for the jails should be a requirement.

Fact: The P&PM requires a post-suicide meeting of all appropriate staff to discuss findings.

Fact: In the P&PM, none of the procedures pertain to the oversight of the suicide-prevention plan.

Finding 04: A continuous oversight of the suicide-prevention plan is needed in order to ensure that the suicide-prevention plan, the P&PM, and the facilities' physical features are kept current with suicide methods used by the inmates.

RECOMMENDATIONS

The 2016/2017 San Diego County Grand Jury recommends the San Diego County Sheriff's Department:

17-24: Update the Policy and Procedures Manual to include a detailed suicide-prevention policy noting the nationally recognized protocols used in the jails for suicide prevention.

17-25: Update the Policy and Procedure Manual to include appropriate and ongoing training for all staff and mental health personnel who observe or counsel suicide-risk inmates.

17-26: Create and fill the position of a full-time Mental Health Director for the County jails.

17-27: Create a suicide-prevention oversight group that recommends changes to the P&PM, verifies that suicide-prevention training is taking place, and implements any changes needed to keep the facilities as suicide-proof as possible.

REQUIREMENTS AND INSTRUCTIONS

The California Penal Code §933(c) requires any public agency which the Grand Jury has reviewed, and about which it has issued a final report, to comment to the Presiding Judge of the Superior Court on the findings and recommendations pertaining to matters under the control of the agency. Such comment shall be made *no later than 90 days* after the Grand Jury publishes its report (filed with the Clerk of the Court); except that in the case of a report containing findings and recommendations pertaining to a department or agency headed by an elected County official (e.g. District Attorney, Sheriff, etc.), such comment shall be made *within 60 days* to the Presiding Judge with an information copy sent to the Board of Supervisors.

Furthermore, California Penal Code §933.05(a), (b), (c), details, as follows, the manner in which such comment(s) are to be made:

(a) As to each grand jury finding, the responding person or entity shall indicate one of the following:

(1) The respondent agrees with the finding

(2) The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

(b) As to each grand jury recommendation, the responding person or entity shall report one of the following actions:

(1) The recommendation has been implemented, with a summary regarding the implemented action.

(2) The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.

(3) The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This time frame shall not exceed six months from the date of publication of the grand jury report.

(4) The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

(c) If a finding or recommendation of the grand jury addresses budgetary or personnel matters of a county agency or department headed by an elected officer, both the agency or department head and the Board of Supervisors shall respond if requested by the grand jury, but the response of the Board of Supervisors shall address only those budgetary or personnel matters over which it has some decision making authority. The response of the elected agency or department head shall address all aspects of the findings or recommendations affecting his or her agency or department.

Comments to the Presiding Judge of the Superior Court in compliance with the Penal Code §933.05 are required from the:

Responding Agency	**Recommendations**	**Date**
San Diego County Sheriff's Department	**17-24 through 17-27**	**07/03/17**