# OVERVIEW OF RECOMMENDATIONS BY MENTAL HEALTH EXPERT, BRUCE C. GAGE, M.D., WITHIN THE SANTA CLARA COUNTY DEPARTMENT OF CORRECTION

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## Introduction

On December 15, 2016, the Board of Supervisors approved an agreement with Sabot Consulting to administer a comprehensive gap analysis to assess and evaluate the provision of health care within the Santa Clara County Department of Correction (DOC). I retained five consultants to conduct the gap analysis and that work is still in progress. In an effort to keep the County updated on the progress of the gap analysis as the information becomes available, I have already provided the recommendations of the Suicide Prevention Consultant, Lindsay M. Hayes; and the Dental Consultant, Dr. Jay Shulman. I am now providing information from Dr. Bruce C. Gage, who recently completed his assessment of the DOC's mental health services.

## Dr. Gage's Qualifications

Dr. Gage is a board certified psychiatrist licensed to practice in the State of Washington. He is certified in General Psychiatry and Forensic Psychiatry by the American Board of Psychiatry and Neurology. He completed his undergraduate training at the Massachusetts Institute of Technology, receiving a degree in chemistry. He then went to medical school at the University of Washington, completing his degree in 1983. Following a year of post-doctoral training in physiology, he completed a general psychiatry residency at Cambridge Hospital/Harvard Medical School, where as chief resident he did specialty training in forensic psychiatry.

After two years in a clinical and teaching position with UCLA at the Sepulveda Veterans Hospital, Dr. Gage joined the University of Washington (UW) at the Washington Institute for Mental Health Research and Training located at Western State Hospital. He remained at these institutions in various roles until 2008, when he became Chief of Psychiatry for the Washington State Department of Corrections (WA DOC). He was the founder and Program Director of the UW Forensic Psychiatry Fellowship until 2008. He holds an appointment as Clinical Associate Professor at the UW.

Throughout Dr. Gage's career, he has evaluated and treated thousands of patients for behavioral disorders, including numerous mood and psychotic disorders. Currently, he provides direct care, consults on challenging clinical cases for WA DOC, conducts forensic evaluations (including private cases), provides monitoring services and consultation, and teaches residents and other trainees in the areas of mental illness and forensics. He is a member of the Psychopharmacology Committee of the American Academy of Psychiatry and the Law.

## Background Information

### Jail Population

The Santa Clara County jail has a total capacity of 2600 males at the Elmwood Complex, 1450 males at the Main Jail, and 600 females at the Correctional Center for Women (CCW), which is part of the Elmwood complex. The jail books approximately

49,000 inmates per year. As of December 2015, there was an average daily census of 3507. The average length of stay showed a slight decline during 2015 from a little more than 250 days to 205 days. There is a large population that cycles through the jail rapidly with very short lengths of stay but the vast majority of inmates are there for 30 days or longer. AB 109, which provides for inmates who previously would have been sentenced to prison to be housed in county jails, is expected to increase the number of long-term stays. While this population focuses on lower-level commitment offenses, Dr. Gage does not expect these inmates to have lower mental health needs.

## Dr. Gage's Recommendations

Dr. Gage provided the following recommendations:

### Organizational Structure

Mental health staff, except psychiatric prescribers, report to the Director of Custody Health Services, who in turn reports to the Executive Director of Santa Clara Valley Health & Hospital System (SCVHHS). Psychiatric prescribers report to the Medical Director of Behavioral Health Services, who is not located at the jail and reports through the Chief Medical Officer at the Santa Clara Valley Medical Center and then to the Executive Director of SCVHHS.

Dr. Gage recommended the creation of a position for a Director of Mental Health. This position would oversee all aspects of mental health services in the jail, including psychiatric prescribers and psychiatric nurses. This position should not be filled by an administrator but rather a clinical manager who retains limited clinical caseload responsibilities in order to assure his or her continued clinical involvement and awareness of clinical needs in the jail.

Although he opines that the exact discipline is not critical, Dr. Gage recommended that the Director of Mental Health should have a doctoral degree in a mental health field with clinical experience, a robust clinical administration background, and correctional (or at least institutional) experience. This is a very difficult and vital position that requires knowledge of clinical services, the law, and administration. A person with additional forensic training would be ideal. Dr. Gage acknowledged that having the Director of Mental Health report directly to a SCVHHS position outside the jail was reasonable and emphasized the jail's rightful and substantial place in the larger mental health system. However, the Sheriff/DOC must have ready access to the Director's supervisor and have a formal "dotted line" relationship to the Director.

### Intake Process

Dr. Gage recommended a complete redesign of the intake screening form for nurses. The content must identify the most acute and risk-laden mental health conditions to allow rapid identification of these conditions by the nurse and the mental health clinician reviewing the form. Inmates should then be prioritized for assessment based on

their acuity and risk. Inmates who have emergent needs should be seen within four hours, those with urgent needs within 72 hours, and those with routine needs within 10 working days. Medications for inmates identified as being on medications in the community should be ordered on the day of admission, but at least within 72 hours.

Dr. Gage emphasized the importance of conducting the mental health intakes under maximal conditions of confidentiality. Without confidentiality, the completeness and accuracy of the information obtained will be seriously compromised in many, if not the majority, of cases. The screenings must not be done within the earshot of other inmates, and officers should only be close enough to hear if there are no other reasonable means for assuring the safety of the inmate and the clinician.

**Conditions of Confinement**

Dr. Gage's primary recommendation was to follow through with the plan to get expert consultation regarding the classification system. Dr. Gage noted that it was vitally important to recognize that some mentally ill inmates who may score at low classification security levels may nonetheless be quite dangerous, especially until treated. And this must be accommodated; but not through infractions and sanctions (this may amount to punishing inmates for being mentally ill) or by universally placing the mentally ill in restrictive settings.

Dr. Gage noted that inmates committed pursuant to the Lanterman-Petris-Short (LPS) Act[1] need to have the opportunity to progress in privileges as permitted by their clinical condition, rather than being simply placed at the highest level of confinement. This allows a determination of their readiness to step-down from an acute level of care.

In some cases, mental health staff input may be important to establish the type of sanctions, which would be designed to both limit the chances of worsening the mental illness and, when possible, to help the inmate reduce the behavior (e.g., completion of a program module such as anger management or a workbook). Dr. Gage remarked that because the mentally ill are not immune from instrumental and other problem behavior not related to their mental illness, it is unreasonable to preclude sanctions of the mentally ill; sanctions must be considered in light of the relationship, or lack thereof, between the illness and the behavior.

Dr. Gage recommended requiring more uniform conditions that are policy driven throughout the jail for each security level. It is important to provide for regular, random cell searches of mental health Special Management Units (and perhaps for all units) at an established frequency that is not discretionary. This should specifically include attention to hoarding and potentially dangerous contraband. It is also important for mental health staff to be involved in the determination of conditions and restrictions, many of which custody exclusively determines, with no expectation of mental health consultation.

[1] The LPS Act pertains to involuntary civil commitment to a mental health institution.

Lastly, Dr. Gage noted that mixing the mentally ill with other populations that have their own intrinsic limitations resulted in restrictions on their privileges that unfairly and disproportionately affected them. This may require rethinking how protective custody functions, which may also be considered in the context of modifying the classification system.

**Treatment**

Dr. Gage stated that the most important populations to treat are those with severe illnesses and those who represent a danger to self or others by virtue of their mental illness. Crisis response is only a first step, and continued care is necessary.

To provide appropriate care, Dr. Gage noted that good assessments in all cases were an indispensable first step. There must be sufficient resources and access to allow for a thorough assessment before initiation of treatment, absent an emergency (and then assessment must ensue).

For inmates with psychotic disorders, highly structured activities, treatment, and avoidance of isolation while also limiting stimulation, are the key elements in addition to medication. These inmates cannot organize themselves and readily fall more deeply into their psychotic thinking when isolated, and they become more agitated or disorganized when overstimulated. Psychosis itself is a destructive condition that must be alleviated. Treatment does not seek to achieve deep psychological insight but rather to reduce symptoms, develop self-management skills (e.g., symptom and emotion management), develop capacities to interact sufficiently to meet needs and limit conflict, provide education about mental illness and medications, and expand living skills (activities of daily living, self-care, and accessing jail and community services, etc.).

Dr. Gage noted that it was reasonable for the jail to focus its treatment services on those aspects most relevant to correctional interests: reducing recidivism and jail misbehavior, successful reentry (in that it contributes to reduced recidivism and inmate mortality), treatment adherence (in that it improves all outcomes), and coping with the jail environment. These services are not highly technical interventions and do not take extensive resources; most can be done by master's clinicians (social workers, psychologists) or others with special training (recreational therapists, occupational therapists, and bachelor's level staff with appropriate training, experience, and supervision). These services are most efficiently delivered in group settings. This necessitates having adequate staff to provide the treatment, to move the inmates, and to develop policies and procedures to support such activities.

Dr. Gage noted that inmates with serious mood disorders often need much of the above-mentioned services. Inmates with depression may also require some individual or group treatment focused specifically on depression. Many "off the shelf" short-term group and individual treatment modules are readily run in correctional settings. While many of these employ cognitive behavioral therapy, Dr. Gage noted that other methods are also effective.

Dr. Gage explained that inmates with recurrent and severe self-injurious behavior require different approaches. It is essential to be able to develop and implement behavior management plans to decrease the inadvertent reinforcement of such behavior that occurs in the correctional setting. One of the most common dynamics is that when the system is crisis-driven, crises are reinforced as they are the only sure way to get both correctional and clinical staff to respond. Developing plans to limit this dynamic is important and can be expanded to other populations exhibiting acting-out behavior as well. This population also needs interventions focused on self-management rather than the development of insight or addressing psychological traumas, which is beyond the reasonable scope of what a correctional setting can be expected to offer. Dr. Gage advised that there are simple and low cost "off the shelf" treatments for this population suited to the correctional setting.

Dr. Gage pointed out that such treatment of inmates with recurrent and serious self-injurious behavior, which will almost exclusively occur in residential mental health settings, requires about 10 hours of structured activities per week. This can consist of both treatment and other structured activities, such as educational services or other correctional programs. Dr. Gage opined that it is also necessary for this population to have 10 hours of unstructured out-of-cell time, with others as much as possible, to limit the deleterious effects of isolation and inactivity. Such activities also provide the data for determining readiness to step down to a lower acuity/security setting.

**Medico-Legal Considerations**

Dr. Gage recommended that the County carefully review its options for involuntary medications under both emergent and non-emergent situations, which should include the jails as well as those committed under LPS. Dr. Gage also recommended review of the limited use of temporary and permanent conservators, which he opined were likely underutilized. Related to this is a need for thorough examination of policies and practices related to the evaluation of competency and securing informed consent. This should include examination of the current practice of permitting incompetent patients to refuse any health treatment including medical, dental, and mental health treatment. Further, Dr. Gage recommended development of the Prison Rape Elimination Act policies and procedures for mental health clinicians.

**Medical Records**

Dr. Gage found that there was no unitary medical record system. The records were accordingly fragmented. Dr. Gage recommended that the medical records system be completely revamped, and noted that there are plans to do so.

**Restrictive Housing**

Dr. Gage recommended that inmates admitted to restrictive housing be promptly screened. It is reasonable for nursing staff to conduct the initial screening, but mental

health staff should screen new arrivals by the next working day. Mental health staff should also do at least weekly rounds in restrictive settings. At a minimum, inmates identified as suicidal must be appropriately treated and managed and those needing commitment identified and admitted to Unit 8A.[2] Other inmates may be treated in place but consideration for diversion to mental health Special Management Units is something the County should consider in cases involving the seriously mentally ill inmates. It is especially important to consider this when inmates with mental illness are deteriorating in this isolated setting before becoming so ill that they must be committed. Once the jail staff becomes aware of an inmate's deteriorating condition, a meaningful response of some sort is obligatory.

**Medication Monitoring**

Dr. Gage recommended adequate monitoring of prescribed antipsychotics. He stated that drug levels and laboratories for mood stabilizers, baseline studies before initiating treatment, and electrocardiograms for certain medications need to be done routinely.

**Medication Administration**

Dr. Gage recommended that medication administration by nursing staff be standardized and include appropriate identification checks. Further, mouth checks for establishing adherence should be done by clinical staff, but custody can also perform mouth checks for safety and security reasons.

**Reentry Services**

Dr. Gage noted that the current initiative to step up reentry services was welcome and necessary. Nevertheless, these services do not need to be provided to all inmates who are mentally ill or receiving treatment. The key is to identify inmates who, by virtue of their serious mental illness, are unable to arrange aftercare themselves. It is also unreasonable to expect jails to provide robust reentry services to those who are incarcerated for short periods. Dr. Gage stated that the longer inmates are in jail, the further down the following list the reentry services need to extend to the inmate. Dr. Gage recommended the following for reentry services for the seriously mentally ill:

- Assure medication continuity until community services take over (in all cases). This will almost certainly require that medications be given to releasing inmates who do not have their own supply of medications in the community.
- Assure that a mental health appointment is in place within a period of time that will allow medications not to lapse (those incarcerated for more than two weeks).
- Assist in applying for or restoring medical insurance and benefits (those incarcerated for more than one month).
- Assist in securing housing (those incarcerated for more than two months).

[2] Unit 8A is the acute psychiatric mental health unit, which also houses inmates committed under the LPS Act.

Dr. Gage believes that securing housing should be more possible in the Santa Clara system than in most jails given that SCVHHS mental health has its own housing capacity. This should include access to secure settings as well as traditional board and care homes and similar settings.

**Restraint and Seclusion**

Dr. Gage recommended that inmates in restraints, whether in the restraint chair for behavioral reasons or clinical restraints on 8A, should be on constant watch rather than periodic checks (or constant video monitoring with direct visualization every 15 minutes). Nurses must check inmates in restraints at least every two hours for vital signs (the current policy specifies hourly), neurovascular assessment (under current policy only vascular assessment is specified and the frequency is not specified), and limb range of motion and movement, including the legs (which custody can do). Toilet and fluids should be offered at least every four hours and meals at least at meal times. Every four hours there should be a more thorough clinical assessment to determine the need for continued restraint and whether there are new or previously undetected health problems.

Dr. Gage further recommended that the County modify its policy on prone restraint, which should be avoided absent clear evidence that prone restraint is indicated for certain medical conditions.

Dr. Gage also recommended that restraint chairs be utilized for no more than four hours. Additional restraint should involve mental health assessment and include consideration for placement in a mental health setting. Similarly, clinical restraint should be ordered every four hours for the first twelve hours. The current limitation of 24 hours is reasonable. Exceptions for longer restraint may be necessary in some cases but this should require special oversight and in-person evaluation by the ordering clinician and authorization by a supervisor. Dr. Gage noted that isolation in cells in what amounts to seclusion is not a good alternative approach. Dr. Gage's previous comments regarding emergency and long-term involuntary medication are pertinent to this issue in that the proper use of involuntary medication is often a preferable, faster, more humane, and more clinically sound approach to address the out-of-control behavior of the acutely mentally ill.

Finally, Dr. Gage recommended that the type of clothing afforded inmates in restraint and seclusion be individualized and based on an assessment of risk. As those in restricted settings improve, it is important to restore items noted to be potentially risky to ascertain their readiness to manage themselves in less restrictive settings.

**Confidentiality**

Dr. Gage recommended that confidentiality be provided in all settings to the maximum degree possible. All written documents, including personal health information should be processed by health care staff, including administrative staff (sealed or otherwise protected materials can be handled by any staff, e.g., for the purposes of transport) or custody staff who are bound by the same confidentiality strictures. Patient-

clinician encounters should be confidential to the maximum extent possible, absent an identified (not potential) risk. It is reasonable and desirable for officers to be able to observe intake screenings but the content of the conversation should remain confidential. Relevant grievances should be marked as medical or mental health and should be so directed and not reviewed by any custody staff.

**Training for Custody Staff**

Dr. Gage noted that the correctional environment is unique, and community experience does not prepare clinicians for its challenges and limitations in this setting. Training needs to cover confidentiality (and its limits), reporting requirements, safety and security requirements, civil commitment and emergency treatment, competency and informed consent, referral to other health care providers, behavior management, and reentry. Dr. Gage recommended that staff on 8A, at a minimum, and preferably on all mental health Special Management Units, receive more detailed training about serious mental illness, providing relevant observations, special medico-legal considerations, and specialized management techniques.

Dr. Gage recommended that all custody staff receive more extensive training on the nature of mental illness, including identification of markers for potentially serious problems in addition to suicidality such as psychosis, depression, mania, delirium, catatonia, cognitive disorders, and serious adverse medication reactions. Dr. Gage noted that the purpose of this training is to identify markers for these conditions and then to make an appropriate referral, but not to diagnose.

Custody staff should also have specific training in the differences between personality disorders and mental illness with an emphasis on Cluster B personality disorders and psychopathy. Training in behavior management plans and the basic behavioral principles that underlie them is also critical. The CIT training must be specifically tailored to custody settings: crisis interviewing, verbal interventions over use of force, techniques for interacting with the mentally ill in a custody setting where there is almost always more time (less urgency), and how to access and use additional help (other officers, mental health, etc.). This must be done in light of the fact that long-term management of this population is the rule.

**Quality Assurance and Quality Improvement (QA/QI)**

Dr. Gage recommended the dedication of more resources to QA/QI, including staff resources, IT support, and analytic support. He further recommended that the QA/QI programs include formal provision for clinical supervision and/or peer review.

Dr. Gage also recommended a more robust review of sentinel events, including near miss events, serious self-harm, assaults involving injury in mental health Special Management Units and LPS-certified units, injuries during episodes of restraint, and emergent use of force involving the mentally ill (controlled use of force should be reviewed through standard processes for use of force review). The review must be

prompt; and involve QA/QI staff and leadership from custody, mental health, and medical (and any other pertinent staff). Dr. Gage noted that there should be an analysis of the case, and any systems issues identified should be addressed through a corrective action plan with specific tasks assigned to individuals with due dates that are tracked to completion.

Dr. Gage noted that QA/QI needed to be tasked with monitoring service provision such as encounters, patterns of psychotropic medication administration, numbers of LPS commitments and other LPS statuses, length of stay in various units, diagnostic categorization of the mental health population, and adherence to the mental health plan or benefit (if established). He noted that routine monitoring of other problems such as medication errors and a variety of other standard surveillance is also a part of basic QA/QI.