Conditions of Detention Expert Report

On

Otay Mesa Detention Center

This report is a general examination of conditions at the Otay Mesa Detention Center with a specific examination of the issues identified in the following complaints:

- **17-08-ICE-0377**
- **17-06-ICE-0378**
- **16-10-ICE-0582**
- **17-09-ICE-0330**
- **17-09-ICE-0379**

Prepared by:

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I. Summary of Review

On May 15, 2017 the Department of Homeland Security, Office for Civil Rights and Civil Liberties (CRCL) received a complaint via email from the Office of the Inspector General (OIG), from an Immigration and Customs Enforcement (ICE) detainee at the Otay Mesa Detention Center (OMDC), located in San Diego, California, with the following allegations:[1]

- OMDC staff is not sending his mail and he is not receiving important Court documents
- ICE is retaliating against him by transferring him to different ICE facilities

CRCL received an OIG referral on March 15, 2017, concerning an ICE detainee at the OMDC in which the detainee alleged the following:[2]

- He was in protective custody for 18 months and given "very little" access to the law library.

On July 19, 2016, CRCL received correspondence on behalf of an OMDC detainee alleging that:

- Medical treatment was delayed following an appointment with a specialty provider.[3]

On June 1, 2017, CRCL received a referral from DHS OIG alleging that:

- ICE did not send a detainee the Albania Country Report he requested four times.

[1] Complaint No. 17-08-ICE-0377
[2] Complaint No. 17-06-ICE-0378
[3] Complaint No. 16-10-ICE-0582 is being addressed by Dr. (b) (6) the medical expert on the OMDC site inspection. However, during the interview with Dr. (b) (6) the detainee made several allegations that have been investigated and will be addressed in this report.

On June 21, 2017, CRCL received written correspondence from an ICE detainee alleging that:

- The detainee was attacked and kicked in the leg by an officer.

In addition to the five specific complaints identified, the following aspects of the OMDC facility operations were reviewed during this on-site inspection:

- Use of Force Reporting and Accountability
- Special Management Unit (Segregated Housing)
- Sexual Abuse and Assault Prevention and Intervention (SAAPI)
- Detainee Grievances
- Visiting Program
- Recreation Programs
- Mail Services
- Religious Services
- Telephone Access
- Legal Library Services
- Food Services

II. Facility Background and Population Demographics

On the first day of our site visit the ICE detainee population at OMDC was 1,003.[4] The OMDC is owned by the CoreCivic Corporation and is operated under a contract between the United States Marshall's Service, ICE and CoreCivic. OMDC is an American Correctional Association (ACA) accredited facility.

The detainees at OMDC include classification levels from low to high and are housed together in common housing units designated by classification level. The low and low-medium classification level detainees are housed in dormitory style housing units. The medium-high and high classification level

[4] CRCL was on-site at OMDC September 25-27, 2017. The OMDC population consisted of 864 ICE male detainees and 139 ICE female detainees.

detainees are housed in units that are configured in one or two-person cells. All meals are served in common dining rooms separate from housing units and are scheduled by housing unit. Meals are delivered in carts from the main kitchen and served in the segregated housing units. All other services such as visiting, library, religious services and recreation are either provided in common areas throughout the facility that are used by all the detainees, or in multipurpose rooms in the individual housing units. All common area activities are scheduled to accommodate the keeping of detainees with common classification designations together.

Throughout the site inspection process, we toured the OMDC facility, reviewed records, interviewed OMDC employees and ICE officials, as well as, several ICE detainees. All general conditions of confinement were reviewed and considered while on-site at OMDC.

Overall, we found the staff to be professional, courteous and helpful and the general living areas of the facility to be clean and orderly. The OMDC was in full compliance with the PBNDS 2011 standards, with one exception.[5] Recommendations will be offered in this report to improve certain aspects of the operation in the form of "best practices" to build and improve upon the systems employed at OMDC. All opinions and recommendations contained herein are based on my background and experience in the correctional environment, ICE detention standards and generally recognized correctional standards, including those of the American Correctional Association and the American Jail Association.

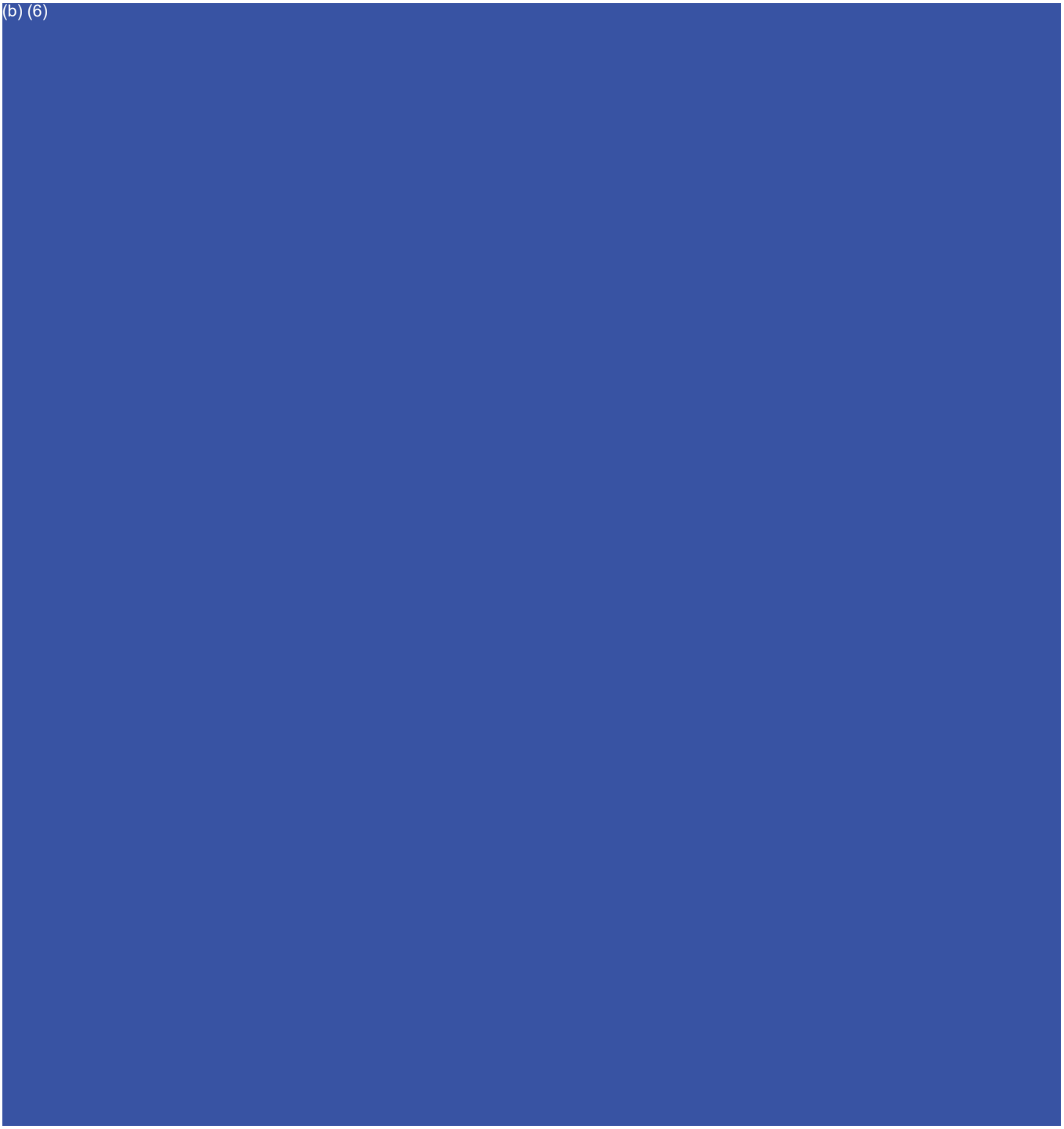
II. Expert Professional Information

(b) (6)

[redacted]

[5] See the section below on the detainee grievance process.

(b) (6)



III. Relevant Standards

- **ICE Detention Standards**

[6] At that time the inmate population in the CDCR was over 160,000 with approximately 120,000 parolees and 57,000 employees.

The 2011 Performance-Based National Detention Standards (PBNDS) apply to OMDC. These are the standards that were relied upon in looking at the specific allegations regarding this facility, as well as, the general review of operations.

- **Professional Best Practices**

In addition to the PBNDS 2011, this review is being conducted based on my correctional experience and nationally recognized best practices.

IV. Review Purpose and Methodology

The purpose of this review is to examine the specific allegations in the complaints cited above and to observe the overall operations of the OMDC as it relates to the care and treatment of the ICE detainees. For this review, I examined detainee records; OMDC policies and procedures; documentation and logs kept on-site depicting such things as detainee grievances, legal mail, visitation and law library usage; interviewed ICE detainees, ICE employees, OMDC employees; and, conducted an on-site tour of the OMDC facility with the managers and supervisors. All the OMDC personnel were professional, cordial and cooperative in facilitating our review. The Warden personally provided unprecedented support during my inspection, providing full access to all areas of the operation, documentation and personnel.

Prior to the preparation of this report I specifically reviewed the following OMDC documents:

- Contract/Intergovernmental Services Agreement
- Grievance logs and detainee grievances (January 2017 – September 2017, random selection)
- Law library logs showing the complete volume of law library usage, including detainees by name (January 2017 – September 2017, random selection)
- Detention Files (random selection and those associated with the complaints)

- Segregation records
- Incidents involving use of force and Force After-Action Reports (January 2017 – September 2017, random selection)
- OMDC and ICE National Detainee handbooks in English and Spanish
- Sexual Abuse and Assault Prevention and Intervention (SAAPI) logs and electronic tracking system, compliance checklists and investigations (September 2016 – September 2017[7])
- Assigned personnel rosters
- OMDC Policies on the following:
    1. Use of Force and Restraints
    2. Disciplinary and Admin. Segregation/Special Management Unit
    3. Grievances
    4. Recreation
    5. Access to Legal Materials
    6. Admission/Orientation
    7. Religious Services
    8. Classification
    9. Disciplinary
    10. Food Service
    11. Property
    12. Sanitation
    13. Facility Management
    14. Life Safety/emergency Response
    15. Detainee Files
    16. Disability, Identification, Assessment and Accommodation
    17. Sexual Abuse Prevention and Response
    18. Mail

2011 PBNDS Standards relevant to this review:

1. Sexual Abuse and Assault Prevention and Intervention
2. Admission and Release

[7] There was a total of 14 SAAPI allegations and investigations during this 12-month period.

3. Use of Force and Restraints
4. Special Management Units (Segregation)
5. Telephone Access
6. Law Libraries and Legal Material
7. Grievance System
8. Visitation
9. Correspondence and Other Mail
10. Recreation
11. Classification
12. Religious Practices

In addition to the above listed activities the on-site inspection on September 25-27, 2017 included the following:

- Toured the Receiving and Discharge area
- Toured the housing units
- Toured the recreation yards
- Toured the law library and satellite law libraries
- Toured the Special Management Units (administrative and disciplinary segregation)
- Toured the Medical Clinic
- Toured the contact visitation area and video visitation stations
- Toured the kitchen and dining rooms
- Inspected all areas of detainee access for information postings
- Interviewed various personnel including command staff, supervisors and line staff[8]
- Interviewed various ICE detainees randomly selected[9]

V. Findings, Analysis and Recommendations

[8] These interviews included, but were not limited to, the PREA coordinator, the Grievance Coordinator, the Law Library Supervisor, the Classification/Intake Coordinator, the Chaplin, the Visiting Officer, the Mail Supervisor, the Chief of Security, the Assistant Wardens, the Warden and the ICE Assistant Field Office Director.
[9] Interviews included the detainees who lodged the complaints listed above and discussed below in this report.

For this report the following definitions are being observed as it relates to the "findings" for the allegations being considered:

- "Substantiated" describes an allegation that was investigated and determined to have occurred substantially as alleged;
- "Unsubstantiated" describes an allegation that was investigated and there was insufficient evidence to determine whether or not the allegation occurred[10]; and
- "Unfounded" describes an allegation that was investigated and determined not to have occurred.

Prior to making "findings" analysis will be offered to establish the evidence relied upon to make a finding. Any recommendations will be assigned a "priority" that is tied to the PBNDS 2011 or to industry "best practices."

The complaints listed above in this report will be specifically reviewed, analyzed and a finding will be opined.

Complaint No. 17-08-ICE-0377

The CRCL received this complaint from detainee #1 on May 15, 2017, via the OIG, alleging the following:[11]

- OMDC staff is not sending his mail and that he is not receiving important Court documents
- ICE is retaliating against him by transferring him to different ICE facilities

Detainee #1 was present at OMDC during our site inspection and was interviewed regarding this complaint. His mail records, detention file and transfer history were also reviewed.

[10] While "Unsubstantiated" can often be the finding because there simply is not enough tangible evidence to "Substantiate" an allegation, I may sometimes offer my expert opinion as to whether, based on other considerations and observations, it is more likely than not that the allegation either happened or did not happen.
[11] See Appendix A for the identity of detainee #1.

Analysis:

A review of the mail history for detainee #1 revealed that between January 24, 2017 and September 22, 2017, Detainee #1 mailed out 42 pieces of legal correspondence to various recipients, including the Courts, the Office of the Inspector General, the ACLU and the Embassy of Tanzania, just to name a few. The record reflects that he also received 36 pieces of legal mail during this same eight-month period.

His record also reflects that in the Spring of 2017 Detainee #1 was temporarily transferred from OMDC to Pennsylvania to go to the Consulate. He was out of OMDC for a 22-day period of time during this temporary removal. The transfer to Pennsylvania involved his movement across the country, overnighting at several detention facilities. Except for this 22-day period, Detainee #1 has been housed at OMDC since January 2017.

During the interview Detainee #1 indicated that his allegation was not that he did not receive legal mail generally, but that there was one piece of legal correspondence from the immigration court that was allegedly sent to OMDC during the 22-day period that he was on the transport to Pennsylvania and return. The mail record indicates that four pieces of correspondence were received between April 25, 2017 and May 3, 2017, while he was in transit. From the mail record it appears these pieces of correspondence were issued to him, presumably upon his return to OMDC on May 17, 2017.

Also during the interview, Detainee #1 indicated that, on one occasion, it took several days from the time he gave staff his outgoing legal mail, until the mail actually left the facility.[12] There is no way to track any possible time-lapse between the time mail is picked up in a housing unit and when it is posted by the U. S. Postal Service. As a matter of practice mail received from detainees is presented to the postal service within 24-48 hours and does not sit around at the facility.

[12] I was unable to ascertain from him how he knows exactly when the mail was presented to or picked up by the postal service.

As indicated above, the only time detainee #1 has left the OMDC since his arrival in January 2017 is when he was temporarily transferred to Pennsylvania to go to the Consulate. This was a 22-day round trip, there and back to OMDC, and did entail layovers at several facilities across the country. We did not find any evidence of retaliation by transferring him to different facilities.

Findings:

- The allegation that OMDC staff is not sending his mail and he is not receiving important Court documents is "**Unsubstantiated**." While it is possible and cannot be ruled out that out of the 78 pieces of legal correspondence sent or received over an eight-month period, there may have been a minor delay or even a mistake in the processing, it is evident that mail is routinely processed in a timely and efficient manner at OMDC. Evidence was not found to substantiate the allegation.
- The allegation that ICE is retaliating against him by transferring him to different ICE facilities is "**Unfounded**." The investigation revealed that Detainee #1 was only transferred temporarily on one occasion since his arrival at OMDC in January 2017 and while that transfer across country involved overnight stays at several facilities, it was for a legitimate purpose. No evidence was found to support the allegation of retaliation.

Recommendations:

- None related to this complaint.

Complaint No. 17-06-ICE-0378

CRCL received this complaint via the OIG on March 15, 2017, from Detainee #2 alleging that:[13]

- He had been retained in protective custody for 18 months with no visitation and very little access to the law library.

[13] See Appendix A for the identity of detainee #2.

Detainee #2 was present at OMDC during our site inspection and was interviewed regarding this allegation. His detention file, law library records and visitation records were also reviewed.

Analysis:

A review of records revealed that Detainee #2 was placed in segregation on several occasions in late 2016 for disciplinary infractions, primarily fighting. In December of 2016, while housed in general population, he was assaulted by another detainee and seriously injured, requiring hospitalization. Upon his return to the facility, he was placed in segregation for his protection. His volatile history, including the serious assault upon his person, required placement on protective custody status until it could be determined if he could safely return to the general population. He remained in segregation from December 2016 through July 2017, when he was returned to the general population. Based on the records, it appears that detainee #2 was in segregation on protective custody status for approximately seven months, not 18 months as alleged.

The Warden was familiar with Detainee #2 and was involved in the decisions to retain him in segregation and finally to release him last July. The Warden indicated that detainee #2 was "on-again-off-again" about being released from protective custody. Apparently, he was uncertain about returning to the general population and changed his mind several times when being considered for release. A determination[14] was made in July 2017 that Detainee #2 could be safely housed in the high custody classification unit that houses the detainees with less of a history of violence and volatile behavior.[15]

Records indicate that while in segregation Detainee #2 attended the law library 30 times. All the housing units at OMDC, including the segregation unit, have satellite law libraries in the unit with Lexus Nexus programs on computer for detainee use. Records also indicate that during his seven months in segregation,

[14] Detainee #2 agreed in writing that he no longer had safety concerns if rehoused in the general population. The detainee he had prior conflicts with was no longer in the population where he was to be rehoused.
[15] At OMDC there are two general population units for housing high custody classification detainees. One houses the detainees who are more prone to violence, many of which have been identified as Security Threat Group (STG) participants, and the other houses those that do not have a history of such affiliations or security concerns.

Detainee #2, in addition to using the law library 30 times, was offered and refused the use of the law library an additional 6 times. From reviewing the logs for law library usage, it was apparent that detainees, even while in segregation, have unfettered access to the legal materials.

While in segregation, Detainee #2 had ten approved visitors and eight of them visited him while housed in the segregation unit. During this time, he received both contact and non-contact visits. There was no information or evidence found to support the allegation that visitation was restricted or denied during the period Detainee #2 was in segregation.

Findings:

- The allegation that Detainee #2 had been retained in protective custody for 18 months with no visitation and very little access to the law library is "**Unfounded**." Evidence indicates that he was in protective custody segregation for seven months, not 18 months. The periods he was in-and-out of segregated housing prior to December 2016 was directly related to his disciplinary misconduct. On each occasion he was in segregation for legitimate reasons and was given the proper consideration for release on a continual basis. While in segregation, he had full access to the law library and was authorized and granted visiting privileges.

Recommendations:

- None related to this complaint.

Complaint No. 16-10-ICE-0582

As indicated above this complaint was received from Detainee #3 and primarily pertained to his medical treatment at OMDC.[16] During the interview regarding the complaint regarding medical care Detainee #3 made the following additional allegations:

[16] See Appendix A for the identity of Detainee #3.

- Legal mail is delayed and not properly processed
- Legal telephone calls are not blocked from monitoring
- The large outdoor recreation yard is not wheelchair accessible

Analysis:

Investigation was conducted into the above allegations. Records reflect that between November 2014 and September 2017, Detainee #3 received 81 separate pieces of in-coming legal mail and sent out an additional 33 separate pieces of out-going legal mail. We reviewed the process for the sending and receiving legal mail at OMDC and found that it is a smooth process, well documented and operates within the expected industry standard for legal mail. We found no indications that mail is delayed either in sending or receiving.

Records indicate that during his time at OMDC between November 2014 and the present, Detainee #3 has made dozens of telephone calls, several of which were designated as legal calls and not recorded by the Telemate phone service at the facility. Just since April 2017, Detainee #3 has made 20 unmonitored calls to a designated number that qualifies for legal confidentiality. It appears that Detainee #3 understands how to use and has appropriately used the process to designate a telephone number as legal/confidential so recording is blocked and calls are not monitored.

Detainee #3 indicated during our interview that he was unable to use the large outdoor recreation yard area because it was not wheelchair accessible. Following the interview with detainee #3, we visited the large outdoor recreation yard and inspected the access. Where the artificial turf meets the yard entrance sidewalk there is a one-inch difference in elevation. There were two wheelchair bound detainees participating in outdoor activity on the recreation yard at the time of our inspection. We did not observe conditions that would obstruct wheelchair access or even make access difficult.

Findings:

The allegations that legal mail is delayed and not properly processed and that legal telephone calls are not blocked from monitoring are "**Unfounded**." The evidence supports the fact that, not only do the legal mail and legal phone call processes function well for the detainees at OMDC, but that Detainee #3 understands and utilizes these services.

The allegation that the large outdoor recreation yard is not wheelchair accessible is also "**Unfounded**." Wheelchair access is adequate as evidenced by the wheelchair bound detainees observed using the large outdoor recreation yard during our inspection.

Recommendations:

None related to this complaint.

Complaint No. **17-09-ICE-0330**

This complaint was received from Detainee #4 alleging that he had requested on four occasions that ICE provide him with the Albania County Report and the report had not been provided to him.[17] Detainee #4 was interviewed regarding his complaint and the ICE AFOD was interviewed as well.

Analysis:

The complaint is rather straight-forward in that detainee #4 did, in fact, request the Albania Country Report be provided to him by ICE at OMDC. The Albania Country Report, and all other Country Reports are available on-line to the general public. Essentially, anyone can go on-line and download a Country Report and print it out. When the ICE AFOD was interviewed he indicated that when the report was requested, ICE legal counsel was contacted to inquire into whether it was appropriate for the ICE authorities to provide the requested public report to the detainee. Apparently, the ICE legal counsel opined that because the report was a public document, it would be inappropriate for ICE to provide a document

[17] See Appendix A for the identity of Detainee #4

to the detainee to use in defense of his case, when the document was available to him without their assistance. Essentially, ICE determined that providing a public document to a detainee could be viewed as assisting the detainee in his case with the Immigration Court.

Findings:

The allegation that detainee #4 requested from ICE and did not receive the Albania Country Report is "**Substantiated**." However, we found no evidence that ICE is required to provide "Country Reports" to detainees on demand. It was also clear that the report in question is a public document and therefore, available to the general public. We found no evidence that the ICE refusal to provide a document that is available through other means, violates any PBNDS standard.

Recommendations:

None related to this complaint.

Complaint No. 17-09-ICE-0379

This complaint was received from Detainee #5 alleging that he was violently attacked by an officer who kicked him in the leg. When we interviewed the detainee and inquired with the OMDC personnel regarding the incident, it was determined that the incident in question happened before Detainee #5 arrived at OMDC. As best we could determine, the incident the detainee was complaining about occurred while he was in the custody of Customs and Border Patrol. Therefore, we did not attempt to investigate the matter further.

VII. Additional review and Findings:

In addition to the specific issues we reviewed related to the above complaints, I reviewed the following general issues and operational areas of the facility:

- Use of Force
- Segregated Housing (Special Management Unit)
- Sexual Abuse and Assault Prevention and Intervention
- Detainee Grievance System

- Visitation
- Recreation Program
- Mail Services
- Religious Services
- Telephones Access
- Law Library Services

These areas of the OMDC operations and my observations of each will be discussed below:

1. Use of Force

The PBNDS 2011 requires that, "an employee submit a written report no later than the end of his or her shift when force was used on any detainee for any reason;[18] all facilities shall have ICE/ERO-approved written procedures for After-Action Review of use-of-force incidents;[19] and, the primary purposed of the After-Action Review is to assess the reasonableness of the actions taken and determine whether the force used was proportional to the detainee's actions."[20]

Analysis:

There was a total of 39 uses of force over the past 12 months.[21] Many of these incident reports documented very minor uses of force. Eight of the use of force incidents were calculated force and 31 were reactive.[22] During the site inspection, I reviewed incident reports that involved use of force by facility personnel.[23] My observation is that force is used sparingly and it is apparent that personnel view use of force as a last resort after other attempts have failed to gain compliance. This is reflected in the relatively few incidents involving significant force over the past year.

[18] PBNDS 2011, 2.15 (Use of Force and Restraints), II. (Expected Outcomes), 11.
[19] PBNDS 2011, 2.15 (Use of Force and Restraints), V. (Expected Practices), P. (After-Action Review…), 1.
[20] PBNDS 2011, 2.15 (Use of Force and Restraints), V. (Expected Practices), P. (After-Action Review…), 1.
[21] September 2016 – September 2017
[22] Reactive force is force used in the spur of the moment, often to break up fights or restrain a detainee while under escort.
[23] I reviewed several randomly selected incidents, including calculated and reactive force incidents, from those occurring in the past 12 months.

In reviewing force incident reports, it is apparent that each officer observing or using force documents his/her actions and observations in a written report and submits that report before leaving shift. In reviewing the officers force reports, it was determined that some training is needed to ensure that catch-phrases like, "using the minimum force necessary," are not included in the reports. The, "minimum force necessary," does not describe the actual force applied. It is more important to describe the actual actions taken and the level of force exerted to overcome resistance, rather than to leave it to the reader to imagine how much force was the "minimum" amount.[24] This was discussed with the Warden who indicated that he intends to follow-up with training on this issue.

The After-Action Review Committee process at OMDC is among the best I have seen in all the reviews I have conducted nationally. The committee is comprised of the proper compliment of administrators and the reviews are thorough and well documented. Several of the after-action reports we reviewed identified procedural violations and/or operational issues that could or should have been better and ordered training or corrective action. This process is a "Best Practice" at OMDC.

The Use of Force and Restraints policy was also reviewed.[25] Under section 9-1.3, Definitions, we found that the definition for "Use of Force" should be reviewed and clarified. While on site, this was discussed with the Warden and it appeared that he also was somewhat confused by the definition in the policy.

The definition reads, "Use of Force – Any incident or allegation of a physical assault perpetuated by staff against a detainee. This includes any incident or allegation of facility staff engaging in an act of violence against a detainee, or any intentional attempt to harm that detainee through force or violence, regardless of whether injury results or a weapon is used."

[24] While the reports have enough detail to determine the officers' actions, the use of the catch-phrases detracts from the specificity and professionalism of the reports.
[25] CoreCivic policy number 9-1.

I would suggest a simple definition of force such as, "Any action taken by staff to physically overcome resistance in an effort to control or restrain a detainee."

Recommendations:

- CRCL recommends that OMDC conduct training with officers and supervisors regarding the use of catch-phrase language in force reports, as given in the above example. (**Best Practices**)
- CRCL recommends that OMDC review and consider revising the definition of use of force in the Use of Force and Restraints policy, 9-1.3. (**Best Practices**)

2. Segregated Housing Unit

The PBNDS 2011 states that, "Any detainee who represents an immediate, significant threat to safety, security or good order shall be immediately controlled by staff and, if cause exists and supervisory approval granted, placed in administrative segregation. ICE and the detainee shall be immediately provided a copy of the administrative segregation order describing the reasons for the detainee's placement in the SMU."[26] It also requires that, "Prior to a detainee's actual placement in administrative segregation, the facility administrator or designee shall complete the administrative segregation order (Form I-885 or equivalent), detailing the reasons for placing a detainee in administrative segregation."[27]

Analysis:

Special Management Unit at OMDC is utilized as a last resort for the safety of detainees and the facility staff. At the time of our visit there were 27 detainees in the SMU.[28] Segregation Orders are completed when a decision is made to place a

[26] PBNDS 2011, 2.12 (Special Management Units), II. (Expected Outcomes), 3.
[27] PBNDS 2011, 2.12 (Special Management Units), V. (Expected Practices), A. (Placement in Administrative Segregation), 2. (Administrative Segregation Order), a.
[28] There are 27 detainees in segregated housing out of a population of over 1000 detainees at the facility, less than 3% of the population.

detainee in administrative segregation.[29] Administrative reviews of administrative segregation placements are being conducted within appropriate timeframes and logs are kept depicting access to recreation, showers, phones, etc., per the PBNDS 2011. Documentation for security checks, retention hearings and disciplinary hearings is completed and thorough.

In reviewing the ICE Confinement Record form that is completed when a detainee is placed in segregation, it is apparent that the form could be improved. While the form requires a general reason for placement be documented,[30] it does not require a documented reasoning for release. It is important to document the reasoning that went into a decision to both place and release a detainee from segregation.[31] While this level of detail in documentation is not an issue of PBNDS compliance, it is a best practice and protects both the detainee and the facility administration.

During our unit inspection, we observed the law library computer, the telephones and the recreation yards, all services provided to detainees in SMU. All activities are documented as they occur for each detainee and safety checks are conducted every 15-30 minutes. It is apparent that every effort is made to provide detainees in segregation for protective custody reasons the same level of program and access to services they would receive in a general population housing unit. The operation of the Segregation Unit at OMDC is in compliance with the PBNDS 2011.

Recommendations:

- CRCL recommends that OMDC consider revising the ICE Confinement Record to provide a space to document both the reasoning for placement and release from segregation. (**Best Practices**)

[29] This is documented on the ICE Confinement Record form 10-1A.
[30] This is a check-the-box designating the reason for placement, e.g., protective custody, disciplinary, etc.
[31] This is especially true in protective custody cases. Documenting the reason protective custody is needed, as well as, the reasoning for determining that a detainee no longer needs the protection of segregation establishes a record that the decisions to place and release were not arbitrary or without appropriate consideration.

3. Sexual Abuse and Assault Prevention and Intervention (SAAPI)

The PBNDS 2011, "…requires that facilities that house ICE/ERO detainees act affirmatively to prevent sexual abuse and assaults on detainees; provide prompt and effective intervention and treatment for victims of sexual abuse and assault; and control, discipline and prosecute the perpetrators of sexual abuse and assault.[32] The PBNDS 2011 SAAPI standards contain a multitude of specific requirements that must be implemented to ensure compliance. The SAAPI program and process were thoroughly evaluated by the CRCL team while on-site at OMDC.

Analysis:

The SAAPI Coordinator was interviewed regarding the Sexual Abuse and Assault Prevention and Intervention process. From all the documents reviewed and the on-site inspection, it is apparent that the OMDC management has posted appropriate notifications throughout the facility and appropriately trained the personnel. The zero tolerance for sexual abuse and assault is clearly communicated and allegations of sexual abuse or assault are appropriately documented, reported, and investigated.[33]

The SAAPI pre-screening requirement of the PBNDS 2011 for all detainees during the intake and classification process is functioning well. The standard intake process includes the risk assessment tool necessary to determine vulnerability and is included in every detainee intake file. The officers managing the intake process are knowledgeable and skilled in administering the prescreening assessment.

When allegations of sexual abuse or assault are made, the involved detainees are separated and medically examined; the crime scene, if identified, is secured and processed; the detainees are interviewed by a mental health clinician and moved to appropriate and safe housing; all required notifications are made; and, local

[32] PBNDS 2011, 2.11, I.

[33] There were fourteen SAAPI complaints at OMDC over the past 12 months.

law enforcement is contacted and responds to take a statement and investigate any criminal allegations.[34] Allegations that, if true would not constitute a crime, are also taken seriously and investigated administratively by the SAAPI Investigator. The quality of the investigations is very good; the proper witnesses are interviewed and the reports are well written.

In reviewing the tracking system utilized to track and coordinate all the activities related to the SAAPI, it was evident that the system currently in place for tracking and ensuring compliance with all requirements and timelines is very well established. The SAAPI Coordinator had an effective tracking mechanism for ensuring compliance with all notifications and timelines and for evaluating and assessing the effectiveness of the SAAPI program with data collection and reporting as required by the PBNDS 2011. The OMDC SAAPI process is in full compliance with the PBNDS 2011.

Recommendations:

- None related to this process.

4. Detainee Grievance System

The PBNDS 2011 standard, Grievance System, 6.2, I, "protects a detainee's rights and ensures that all detainees are treated fairly by providing a procedure for them to file both informal and formal grievances, which shall receive timely responses relating to any aspect of their detention, including medical care." The standard includes specific requirements that must be met for compliance, including the requirement that, "all written materials provided to detainees shall generally be translated into Spanish."

Analysis:

Grievance forms are available to detainees in each housing unit in the English language. The grievance forms were not available in the housing units in the

[34] The Sheriff's Office is notified and responds to take a statement on all allegations of sexual abuse or assault even if the circumstances appear not to be criminal. Following taking the statement, a decision is made as to whether a criminal investigation will be conducted.

Spanish language. When we inquired about the grievance forms in Spanish we determined that the forms in the Spanish language were at the facility but had not been distributed to the housing units. In all the grievances we reviewed, none were written on grievance forms provided in Spanish, however, we did observe grievances written by detainees in Spanish and answered by staff in Spanish on the English language grievance forms.

Receptacles are in the dining rooms, the medical units and the segregation units for detainees to place their initiated grievance forms. The mailroom staff pick up the grievances from the receptacles and delivers them to the Grievance Coordinator.

The Grievance Coordinator assigns a number, logs, makes copies, and assigns the grievances to the appropriate Unit Manager to complete the grievance response.[35] The completed grievances are returned to the Grievance Coordinator who copies, logs, and sends a copy to the detainee's file.[36]

Our review determined that the grievance process at OMDC is functioning well, timeframes for processing the grievances are being met and issues are being resolved appropriately. Grievance findings are determined and expressed in terms of, "inmates' favor" or "not inmate's favor."[37] While this is not contrary to the PBNDS, the process may be better served by developing a finding process that includes more specific language such as, "grievance granted," "grievance granted in part," or, "grievance denied." This type of documentation would provide information to the management team regarding grievance outcomes that could serve to influence operational and program practices.

[35] Medical grievances are forwarded to medical management and religious services grievances are assigned to the Chaplin.

[36] The detainee is given a completed copy of the grievance by the staff person completing the grievance response before it is sent to the Grievance Coordinator.

[37] There were approximately 300 grievances over the past year. Many of the grievances reviewed were resolved in the detainee's favor, which would indicate that the process is balanced and working well for the detainees.

Recommendations:

- CRCL recommends that the grievance forms in Spanish be distributed to the housing units and made available to the LEP population. **(PBNDS 6.2, II.,10., Priority 1)**
- CRCL recommends that OMDC consider revising the grievance process to allow for a clearer description of what is being granted, granted-in-part or denied in a grievance request. (**Best Practices**)

5. Visiting Services

PBNDS 2011, Visitation, 5.7, I, "ensures that detainees shall be able to maintain morale and ties through visitation with their families, the community, legal representatives and consular officials, within the constraints of the safety, security and good order of the facility."

Analysis:

OMDC has visitation for family and friends scheduled and in operation seven (7) days a week. Visitation by video is available 7 days a week and contact visitation at the facility is offered on Saturday and Sunday from 9:00 am to 7:00 pm. Legal visitation also operates seven (7) days per week from 8:30 am – 9:30 pm. Visits are for a one-hour duration and detainees may have one visit per day with up to four visitors per visit.

Attorneys may call ahead to verify that their client is present at the facility, but no appointment is necessary. Attorneys must have a valid bar card number and picture identification to visit. Attorney visitation is conducted in private contact visiting rooms. Attorney visits may be longer than one hour if needed.

There are very few complaints about the general visitation program and detainees who receive visits seem to be satisfied. Some expressed the preference for contact visits rather than video visits, but seem to be appreciative of having both methods available.

Recommendations:

- None related to this process.

6. Recreation

PBNDS 2011, Recreation, 5.4, I, "ensures that each detainee has access to recreational and exercise programs and activities, within the constraints of safety, security and good order."

Analysis:

The recreation program at OMDC is operated 7 days a week. Each housing unit has an adjacent small outdoor recreation area that detainees can access during the out-of-cell program time throughout the day. There is also a single, large outdoor recreation area with an artificial turf soccer field that detainees from each housing unit can access for one hour each day.[38] There is a recreation officer assigned to supervise the large recreation yard and related activities.

In our detainee interviews we heard no complaints, with detainees indicating that the access to outdoor recreation was fully adequate. Our observation is that the recreation program at OMDC is fully compliant with all PBNDS 2011 standards and is a "**best practice**" program.

Recommendation:

- None related to this process

7. Mail Services

PBNDS 2011, Correspondence and Other Mail, 5.1, I, "ensures that detainees shall be able to correspond with their families, the community, legal representatives, government offices and consular officials consistent with the safe and orderly operation of the facility."

[38] The large recreation yard operates on a weekly rotating schedule by housing unit.

Analysis:

We interviewed the mailroom supervisor assigned to coordinate the delivery of mail. She had a good system for processing and delivering mail to detainees. All regular mail is opened in the mailroom and searched for contraband. The mail is then verified for detainee identification and housing assignment and is placed in a designated folder for each housing unit. The assigned housing unit officers reporting in the afternoon for the evening shift, pick up the mail folders and deliver the mail to the housing units where it is distributed to the detainees each day. When money is received in mail, the mail supervisor removes the money, writes a receipt for the detainee and forwards the money to the detainee's trust account.[39]

Detainees may send mail out by placing it in a mail receptacle. The mail receptacles are available in the dining rooms, the law library, the medical unit and the segregation unit. Detainees may purchase postage in the detainee commissary. Indigent detainees receive free postage.

The legal mail is processed in a manner that requires detainees to sign for receipt of legal mail. The mail supervisor logs legal mail in a log book indicating the name or organization sending the correspondence and provides it to the unit manager of the detainee's housing unit. The unit managers are responsible to issue the legal mail to the detainees, opening it and checking it for contraband in the presence of the detainee. The detainee is required to sign for receipt of the legal mail in the log. The mailroom supervisor keeps good records that verify that legal mail has been received.

When detainees send legal mail out of the facility, the mailroom logs the mail in the legal mail log to verify that it was sent and to whom it was sent. The mail delivery at OMDC is organized and efficient.

[39] A copy of the money receipt is placed in the mail to the detainee, a copy is kept in the mailroom and a copy is sent with the money to the detainees' trust account.

Recommendations:

- None related to this process.

8. Religious Services

PBNDS 2011, 5.5 Religious Practices I, Purpose and Scope, provides that, "detainees of different religious beliefs are provided reasonable and equitable opportunities to participate in the practices of their respective faiths, constrained only by concerns about safety, security and the orderly operation of the facility."

Analysis:

We interviewed the OMDC Chaplin who coordinates all religious services. Detainees identify religious preference at initial intake and are approved to participate in the religion of their choice. All accepted religious activities and observances, services, special diets and headwear are accommodated. Requests for special religious diets are reviewed and approved by the Chaplin.[40]

Religious Services are offered on a regular schedule for all religious affiliations.[41] The services are coordinated by the Chaplin and provided by 13 active volunteers who come to the facility on a regularly scheduled basis or by fellow detainees who lead services as lay clergymen. Services are held in the facility chapel and in the multipurpose rooms in each of the housing units. The services are provided in Spanish, English and Chinese.

The Religious Services Program at OMDC is one of the best organized and most active programs we have observed. The schedule of services and diversity of services is outstanding. In our interviews with detainees no complaints were expressed when queried about religious services and accommodations. The Chaplin is to be commended for his service at OMDC.

[40] Religious diets offered include Halal, Vegetarian and Kosher.
[41] Catholic, Protestant, Muslim and Jewish services are offered on the weekly schedule. The Muslim prayer services are conducted by detainees because volunteer clergy are not available in the community to provide services to the detainee population.

Recommendations:

- None related to this process.

9. Telephone Access

PBNDS 2011, 5.6, Telephone Access, I, Purpose and Scope, "ensures that detainees may maintain ties with their families and others in the community, legal representatives, consulates, courts and government agencies by providing them reasonable and equitable access to telephone services."

Analysis:

Telephones are located in the housing units at OMDC. Detainees have unfettered access to make phone calls. The detainees have a PIN number to use when making calls and the system has a voice recognition component to ensure detainees cannot use PIN numbers belonging to another detainee. The phones are available all day up until bedtime each evening. We observed detainees using the telephones in the housing units throughout our inspection. All detainees interviewed indicated that access to phones was fully adequate.

Recommendations:

- None related to this process

10. Law Library Services

PBNDS 2011, 6.3, Law Libraries and Legal Material, I., Purpose and Scope, "protects detainees' rights by ensuring their access to courts, counsel and comprehensive legal materials."

Analysis:

We visited the law library, the satellite libraries and reviewed the logs kept to document law library usage. The logs confirmed that detainees who wish to use the law library have adequate opportunity and access to do so. There is a main

law library and satellite law libraries in each housing unit including the Segregated Housing Unit.

Detainees submit requests to use the law library to the unit officers who schedules detainees for access to the satellite law libraries. The main library is offered on a weekly schedule by housing unit.

The library materials are kept current by ICE officials and detainees are available to assist other detainees if they need assistance with using the law library.[42] Copies are provided to detainees upon request. All detainees interviewed indicated that law library access, availability and legal materials are fully adequate.

Recommendations:

- None related to this process

General Observations:

The personnel at OMDC are knowledgeable and professional. The facility is very new, has abundant space for programs and services and is well maintained. The tenor and tone of the facility was good and the interaction between detainees and officers appeared to be healthy. Supplies, such as, hygiene items and grievance/request forms were in abundance in the housing units.

While Food Services operations are normally addressed in the CRCL inspections by an Environmental Health Specialist, our specialist(s) was not available on this inspection. So, we toured and inspected the main kitchen where the food is stored and prepared. The freezer and storage areas were clean, food was properly stored off the floor, boxes were labeled and dated and temperature logs were kept.

The food preparation was properly organized and workers wore the proper hair nets. Meals are served to the general population in the main dining rooms. Trays

[42] Law library material on Lexus Nexus is available in several languages including Spanish and English. All updated materials are provided by ICE quarterly.

were also assembled in thermal tray containers, properly stacked, delivered and served to detainees in the segregated housing units. Three hot meals are prepared, delivered and served each day. Our interviews with detainees produced no complaints regarding the food and food services is rarely the subject of detainee grievances. We have no recommendations for improvement in Food Services.

Lastly, the leadership at OMDC, starting with the Warden was very impressive. As we toured the facility, it was very evident that the Warden and his management team knew the line staff, were committed to and involved in the program and were familiar and in touch with the detainee population. The healthy communication and staff/detainee relations we observed is a reflection of good leadership.

Summary of Recommendations:

The following is a summary of the recommendations made throughout the body of this report:

- CRCL recommends that OMDC conduct training with officers and supervisors regarding the use of catch-phrase language in force reports. In reviewing the officers force reports, it was determined that some training is needed to ensure that catch-phrases like, "using the minimum force necessary," are not included in the reports. The, "minimum force necessary," does not describe the actual force applied. It is more important to describe the actual actions taken and the level of force exerted to overcome resistance, rather than to leave it to the reader to imagine how much force was the "minimum" amount. (**Best Practices**)
- CRCL recommends that OMDC review and consider revising the definition of use of force in the Use of Force policy. The current definition reads, "Use of Force – Any incident or allegation of a physical assault perpetuated by staff against a detainee. This includes any incident or allegation of facility staff engaging in an act of violence against a detainee, or any intentional attempt to harm that detainee through force or violence, regardless of

whether injury results or a weapon is used." CRCL suggests a simple definition of force such as, "Any action taken by staff to physically overcome resistance in an effort to control or restrain a detainee." (**Best Practices**)

- CRCL recommends that OMDC consider revising the ICE Confinement Record to provide a space to better document the reasoning for placement and release from segregation. While the form requires a general reason for placement be documented,[43] it does not require a documented reasoning for release. It is important to document the reasoning that went into a decision to both place and release a detainee from segregation.[44] While this level of detail in documentation is not an issue of PBNDS compliance, it is a best practice and protects both the detainee and the facility administration. (**Best Practices**)
- CRCL found that grievance forms were not available in the housing units in Spanish. CRCL recommends that the Spanish grievance forms be distributed to the housing units and made available to the LEP population. **(PBNDS 6.2, II.,10., Priority 1)**
- CRCL recommends that OMDC consider revising the grievance process to allow for a clearer description of what is being granted, granted-in-part or denied in a grievance request. Grievance findings are currently determined and expressed in terms of, "inmates' favor" or "not inmate's favor."[45] While this is not contrary to the PBNDS, the process may be better served by developing a finding process that includes more specific language such as, "grievance granted," "grievance granted in part," or, "grievance denied." This type of documentation would provide information to the management team regarding grievance outcomes that could serve to influence operational and program practices. (**Best Practices**)

[43] This is a check-the-box designating the reason for placement, e.g., protective custody, disciplinary, etc.
[44] This is especially true in protective custody cases. Documenting the reason protective custody is needed, as well as, the reasoning for determining that a detainee no longer needs the protection of segregation establishes a record that the decisions to place and release were not arbitrary or without appropriate consideration.
[45] There were approximately 300 grievances over the past year. Many of the grievances reviewed were resolved in the detainee's favor, which would indicate that the process is balanced and working well for the detainees.

Appendix A

Detainee #1: (b) (6)

Detainee #2:

Detainee #3:

Detainee #4:

Detainee #5:

(b) (6), PH.D.
(b) (6)
Atlanta, GA 30319

(b) (6)

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REPORT FOR THE
U.S. DEPARTMENT OF HOMELAND SECURITY
OFFICE FOR CIVIL RIGHTS AND CIVIL LIBERTIES
October 7, 2017

Investigation regarding Otay Mesa Detention Center

Prepared by (b) (6), **Ph.D.**

Table of Contents

I. EXECUTIVE SUMMARY

The assessment regarding the delivery of mental health services at the Otay Mesa Detention Center focused on services provided to ICE detainees, a subset of Otay Mesa's incarcerated population (ICE detainees and inmates from the United States Marshals Service) during the September 25 - 27, 2017 site visit.

In preface to my comments, I'd like to say that facility leadership and staff, especially the medical and mental health staff were gracious and accommodating, spending as much time as needed to help me obtain the information required for the inspection. Additionally, they were professional, knowledgeable and transparent, proudly sharing their processes and programs while simultaneously talking about their challenges. Their morale and cohesiveness were high, and they demonstrated nothing but respect for the detainees.

Overall, the positive aspects of the mental health delivery system far outweigh the problematic aspects. To their credit, they were ACA and NCCHC accredited, and they achieved a 100% compliance score on a PBNDS 2011 Inspection in January 2017. Medical and mental health leadership's behavior reflected their commitment to providing the best health care available. Mental health staff was knowledgeable, skilled, invested and experienced in providing excellent mental health care.

Without getting into the details, which are presented below, the primary finding is that the mental health delivery system is staffed and programmed to provide excellent care for detainees who can adaptively live in general population and be treat as mental health outpatients. Problems arise when they're tasked to provide services to moderate severe mentally ill detainees, and to high acuity mentally ill detainees.

The quality of care provided to the mild mentally ill detainees is good; however, quality begins to deteriorate when services are provided to the more severely and acutely mentally ill because the mental health delivery system is not appropriately staffed and the infrastructure (units, programs, and services) is not in place. This finding is illustrated by the two complainants and by detainee interviews which are discussed below. To the staff's credit, the most severely mentally ill detainees are identified and transferred to facilities that provide a higher level of care; however, there are many detainees who are on the margins of this group, in need of a higher level of care than they're receiving at OMDC. These groups include the males in the Medical Housing Unit (MHU) who receive minimal programming and services, the females who need to be in a MHU but live in general population because a female MHU does not exist, and the detainees who are repeatedly placed in Safety Cells which have minimal to no programming. Recommended solutions include: 1) hiring additional lower level mental health care providers to work in MHUs and Safety Cells; and 2) carving out space for a female MHU.

II. CRCL INVESTIGATION OF OMDC's MH DELIVERY SYSTEM

A) INTRODUCTION

Professional Qualifications

(b) (6)

[redacted]

Referral Issue

The U.S. Department of Homeland Security's (DHS) Office for Civil Rights and Civil Liberties (CRCL) asked me to participate in an investigation of complaints it received that included issues regarding the adequacy of Otay Mesa Detention Center's (HDC) mental health delivery system for ICE detainees. I reviewed the mental health care provided to two complainants. I also reviewed the relevant aspects of Otay Mesa's mental health services to assess compliance with the following national and professional standards.

Standards, Policies and Procedures, and Best Practices

- Performance Based National Detention Standards 2011 (PBNDS 2011),
- IHSC Directives:
    a) IHSC Operations Memorandum, (Abnormal Involuntary Movement Scale), dated 1 Oct 2015
    b) IHSC Behavioral Health Services Guide, dated 26 Mar 2016

c) IHSC Directive 07-02 (Behavioral Health Services Overview), dated 26 Mar 2016
d) IHSC Directive 07-03 (Forensic Mental Health Evaluations), dated 4 Mar 2016
e) IHSC Directive 07-05 (Serious Mental Disorders or Conditions), dated 15 Mar 2016
f) IHSC Directive 03-01 (Sexual or Physical Assault, Abuse and/or Neglect), dated 28 Mar 2016

- American Correctional Association's Standards (ACA),
- National Commission on Correctional Healthcare's Standards (NCCHC),
- Prison Rape Elimination Act (PREA)

Sources of Information

- **Facility Tour**

- **Documents Reviewed**
  - IHSC Intake Screening template, dated 01 Jan 2001
  - Otay Mesa Detention Center, 2016 Suicide Prevention Plan
  - Behavioral Healthcare Records of the two Complainants
  - Behavioral Healthcare Records of 10 ICE Detainees
  - PBNDS 2011 Audit, dated 26 Jan 2017
  - Behavioral Healthcare Record of a detainee receiving medication nonadherence counseling, dated 08/24/2017
  - Behavioral Healthcare Records of detainees receiving a PREA Evaluations, dated 03/27/2017 & 07/21/2017
  - Signed Consent Forms for Psychotropic Medications, dated 9/7/2017 & 9/21/2017
  - Drug Utilization Reports, filled between 8/14/2017 – 9/26/ 2017
  - Weekly Patient Report with names and diagnoses, dated 9/26/2017
  - Initial and Annual Suicide Prevention Training Rosters, dated 01/01/2017 & 02/15/2017
  - IHSC – San Diego: Staff Meeting Minutes, dated 08/30/2017
  - IHSC – San diego: governing Body Meeting Minutes, dated 09/21/2017
  - IHSC QI Meeting Minutes, dated 05/09/2017, 06/27/2017, 07/11/2017
  - Healthcare Failure Modes and Effects Analysis (HFMEA), dated 04/01/2017 – 06/12/2017
  - IHSC QI Audit tools for:
    1. Suicide Watch, dated 3rd quarter FY2017
    2. Hunger Strikes, dated 3rd quarter FY2017
    3. Medication Refusals. Dated 3rd quarter FY 2017
    4. Mental Illness with Psychotropic Medication, 3rd quarter FY2017

- **Interviews Performed**
  - Staff
    1) CAPT (b) (6), (b) (7)(C), IHSC
    2) LCDR (b) (6), Psy.D., IHSC
    3) Dr. (b) (6), Ph.D., IHSC
    4) Dr. (b) (6), M.D.
    5) Dr. (b) (6), Psy.D.
    6) Ms. (b) (6), LCSW

  - Male Detainees, Refer to Appendix I

  - Female Detainees, refer to Appendix I

- **Records Reviewed**
  - Refer to Appendix II

Otay Mesa Detention Center Contextual Information

Otay Mesa Detention Center (OMDC) is a 371,756-square foot facility. It has a bed capacity of 1.492, with an average daily count of approximately 1,200 detainees and inmates. The facility houses male and female immigration detainees and United States Marshal inmates with minimum and medium/high security levels in 13 housing units. Given OMDC's diverse population, the mission and logistics for the provision of medical and mental health services are extremely complicated and challenging since the males and females have to be kept apart, detainees and inmates have to be kept apart, and low and high security residents have to be kept apart.

On September 25, 2017 OMDC had 1,006 detainees and 352 U.S. Marshall inmates for a total count of 1,131. In other words, 89% of the total population was comprised of detainees, while 11% were US Marshall inmates. Breaking it out by gender, 14% of the detainees were female and 25% of the US Marshall inmates were female, resulting in 20% of the total population being female. OMDC has an annual intake of approximately 12,000 detainees and inmates. ICE Health Service Corps, comprised of USPHS officers, operates a total of six negative pressure rooms, 18 Medical Housing Unit beds in two units, 9 beds in each of MHU, and 14 single cell MHU beds for mental health observation. There is one safety cell and one stepdown cell in medical and two safety cells and two stepdown cells in receiving and discharge.

OMDC staff were very accommodating and gave 100% answering the reviewer's questions. The electronic health record, with its built-in capabilities (i.e., referrals, tracking, tickler files, etc.) appeared to have eliminated the need for tracking individual mental health provider's caseloads and the need for aggregate information on the overall mental health caseload. Consequently, providers were unable to print copies of their active caseloads or print a copy of the overall mental health caseload. In response to the caseload question, staff was able to calculate the number of "pending mental health encounters" as of September 26th and discovered that there were 258 pending encounters, with 63 of them being pending psychiatric encounters. Additionally, their average length of stay was unclear, ranging from a few months to two years. These numbers

suggest that approximately 23% of the facility's total population is receiving some type of mental health treatment; however, it's unclear which specific populations (i.e., males vs females, low vs high security, detainees vs inmates), are receiving what type of specific resources/services (i.e., pharmacological vs nonpharmacological, repeat stabilization services vs chronic care in general population). Without this information, it's difficult to perform a systemwide needs assessment and justify staffing patterns.

B) REVIEW OF THE MENTAL HEALTH CARE PROVIDED TO THE COMPLAINANTS

A. Complaint No. 17-07-ICE-0344

1) Sources of Information:

a) Document(s): Detainee 1's behavioral health record was reviewed**.**

b) Interviews: Dr. (b) (6) was interviewed about the delivery of mental health services to Detainee 1. He was familiar with the case, having seen him five times in April and once in May. He stated that Detainee 1's treatment and management were complicated and difficult, consuming a lot of staff resources. He also stated that the detainee was more likely than not to have had both a diagnosis of a psychotic Delusional Disorder, (consistent with his mental status examination on 05/09/2017) and an Antisocial Personality Disorder.

2) Nature of the Complaint:

An April 26, 2017, CRCL received a referral from the DHS OIG regarding Detainee 1, an ICE detainee at OMDC in San Diego, California. In a call to the OIG hotline on April 19, 2017, the detainee alleged that the facility neglected his medical needs. He stated that he should be in segregation due to his medical condition. ICE's response to CRCL's medical referral revealed that the detainee had been on suicide watch three times since his arrival, had been seen by doctors five times, and had been housed in either the medical housing unit or segregation since his arrival at OMDC.

After his case had been reviewed by ICE and CRCL, concerns were expressed about the conditions regarding the housing of detainees with mental health issues.

3) Behavioral Health Record Review:

a) Complainant's Detention History:

Detainee 1 was detained at OMDC for approximately two months from April 4, 2017 until June 1, 2017. He was transferred to OMDC from Adelanto Detention Center where he was reportedly detained for 16 months.

b) Complainant's Personal History:

Detainee 1 was a 25-year-old male who originated from Iran. He described himself as a Muslim who was never married. He was raised predominantly by his mother. He entered the United States in 2008 when he was 18 years old. Prior to coming to the U.S., he reported having been sexually molested at 3 to

4 years of age by a family member and at seven years of age by a neighbor. He denied ever reporting these incidents. He was reportedly taken to a psychologist by his mother as a child because of aggressive behavior toward his peers. He said that he graduated from high school and completed three years of college, studying to be a mechanical engineer. When questioned about his employment history, he said that he worked as a cashier in a grocery store. His drug and alcohol history consisted of occasionally drinking beer and using methamphetamine approximately five times between December 2013 and November 2015. He reported a criminal justice history of having been incarcerated and placed on probation between 2013 and 2015, charged with multiple counts of burglary, driving under the influence, rape, aggravated assault, and probation violation. He denied ever attending a drug and alcohol treatment program; however, he said that he attended "some Alcoholics Anonymous meetings that were mandated by the court following his DUIs."

c) Complainant's Mental Health History:

Detainee 1 reported having an extensive mental health history at Adelanto Detention Center where he was reportedly placed on suicide watch in a Safety Cell between 20 and 30 times over his 16-month detention. During that time, he also stated that he was psychiatrically hospitalized at Alvarado Parkway Institute (API), where he said, "the staff know me well."

d) Complaint's Chief Complaint:

The complainant denied having any current mental health problem. His chief complaint was that he had unspecified medical problems which were not being treated, (i.e., "when he eats any food and/or drinks water, his vision goes blurry, his vocal chords swell up, and he feels pain and fatigue throughout his body"). He stated that he believed his medical problems will and can only be resolved if he's "released from custody and seen by his own doctor in the community." He denied ever having had any mental health problems; however, he reported a family history of mental health problems, saying that his father was an "alcoholic".

e) Complaint's OMDC MH Treatment History:

(1) At OMDC, Detainee 1 received mental health services from the day he arrived (April 7, 2017) to the day he left (June 1, 2017).

(2) Upon arrival at OMDC, detainee 1 was placed in the single cell Medical Housing Unit where he stayed from April 7 through April 12. During that time, he "did not participate in recreational activities because he just arrived nor was he able to socialize in the dayroom." On April 13, he was moved to a general population unit, where he stayed for less than 24 hours before expressing suicidal ideation and being placed in segregation and then in a Safety Cell where he spent 12 of the next 15 days. Being locked down in the "single cell" medical housing unit, in segregation, and in the extreme conditions of a Safety Cell for extended periods of time is problematic.

(3) Detainee 1 was seen by mental health on 43 of the 56 days he was at OMDC.

(4) Detainee 1 was seen by five mental health providers. One of the five providers saw him on 24 occasions while the other four providers saw him on 28 occasions. (Note, he was occasionally seen more than once a day.)

(5) Detainee 1 was placed on suicide watch in a safety cell seven times. Out of his 56 days at OMDC, he was on suicide watch in a Safety Cell for 26 days, which was 46% of his time at OMDC.

(6) The hours spent in Safety Cells during each admission ranged from 48 to 96 hours, with an average length of stay being at least 72 hours. (Note, the Safety Cell serves a critical function; namely, the provision of a safe place when the suicide risk assessment indicates that a detainee's risk for suicide is high. Consequently, the precautions are extreme. The safety cell order in the progress note reads, "the detainee will be housed in the safety cell with one to one continuous direct supervision of a custody officer, nursing will complete eight-hour checks, and a mental health provider will see the detainee every 24 hours. The detainee will be given a suicide gown, suicide blanket, mattress, and a sack lunch. The detainee will not be given utensils, saran wrap, or personal property." The safety cell is suicide resistant. It's rubberized and it has a hole in the floor serving as a toilet.)

(7) Detainee 1 was diagnosed with an Antisocial Personality Disorder and three "rule-in / rule-out" diagnoses; namely, a Somatic Symptom Disorder, a Delusional Disorder, and Malingering. A review of the record also revealed that the detainee's diagnosis was never clarified nor did the providers document how they were attempting to make this differential diagnosis.

(8) There was no documentation indicating that detainee 1 was ever seen by a psychiatrist.

(9) Treatment goals were: **a.** Not to harm himself or others; **b.** To take all his medications as prescribed; **c.** To experience mood management at least 70% of the time; **d**. To experience appropriate reality testing at least 70% of the time; and **e**. To follow facility mandates and comply with the treatment plan. It was unclear how goals **c.** and **d.** were operationalized and measured.

(10) Treatment strategies were: **a.** To teach coping skills; **b.** To do reality testing as needed; **c.** To do behavior modification as needed; **d**. To teach cognitive control; and **e.** To teach stress/mood management. In the narrative section of the progress notes, there was little evidence that these interventions were being used.

(11) The strategies and goals of the treatment plan never changed, even though the strategies didn't appear to be effective and the goals weren't achieved.

f) Findings: The progress notes in Detainee 1's behavioral health record were reviewed and Dr. (b) (6) was interviewed. The notes indicated that Detainee 1 was receiving mental health services almost daily while at OMDC. These notes were informative, containing all required elements: evaluations; suicide risk assessments; mental status examinations; diagnoses; and a plan for treatment. When they were read as a "stand-alone note", the evaluations, diagnoses, and overall treatment looked good; however, problems emerged

when they were read together to review the course of treatment. **First**, Detainee 1 was seen 52 times by five mental health providers within two months. Based on reading these progress notes, the providers appeared to be interchangeable. After reading the notes which included the "treatment plan", I had difficulty identifying the detainee's primary mental health provider. Hopefully, the detainee and the providers knew which provider was the primary provider, responsible for modifying the treatment plan and overseeing the course of treatment. Having a primary provider in the mental health arena is required to establishing a therapeutic relationship, to maintaining rapport, and to ensuring continuity of care. **Second,** the detainee's mental health record from Adelanto Detention Center was only partially reviewed "because it was large" and there was no documentation that any of the information from the detainee's old record or his hospitalization at API was reviewed. The information from these records could have helped clarify the diagnosis and develop a roadmap, identifying effective/ineffective interventions. **Third,** a psychotic "delusional disorder" was never "ruled in" or "ruled out". **Fourth,** the "treatment plan" section of the progress notes appeared to be generic, "cut and paste plans". Instead of directing treatment, they appeared to be unrelated to the interventions noted in the narrative section of the progress notes. **Fifth,** treatment did not appear to be effective, as evidenced by the detainee's number of Safety Cell admissions. Despite these treatment failures, the treatment plan was never changed, (i.e., goals and strategies). There was no evidence that the primary mental health care provider or the treatment team ever attempted to understand why the detainee repeatedly threatened to harm himself. The treatment plan strategies of "education" and "encouragement" were ineffective. Rather than getting into an apparent power struggle and doing "more of the same", staff's time could have been better spent attempting to understand the "antecedents to" and "consequences of" the detainee's maladaptive behavior. **Sixth**, given the severity of this case, it's unclear why there was no evidence that psychiatry was ever consulted. It appears as if staff either didn't have time to discuss and better understand the underlying dynamics of the case or they accepted the belief that the detainee's behavior was manipulative and didn't deserve a psychiatric consultation.

4) **Summary of Findings:**
The complaint wasn't substantiated; however, the detainee's overall health care was insufficient because his primary health problem, which appeared to have been psychiatric, was not properly diagnosed or treated. More specifically, a differential psychiatric diagnosis was never clarified, an adequate treatment plan was never developed or implemented, a psychiatric referral was never made, and a psychiatric hospital referral was never even considered after repeated Safety Cell placements for extended periods of time.

B. Reference No. Contact-DHS-17-1665

1) **Sources of Information:**

~~*Protected by the Deliberative Process Privilege*~~

a) **Documents Reviewed:** Detainee 2's OMDC behavioral health record was reviewed.

b) **Staff Interviews:** Dr. (b) (6) was briefly interviewed about the delivery of mental health services to detainee 2. He was very familiar with the detainee, having had and continuing to have counseling sessions with him. He acknowledged that Detainee 2 was complex and unpredictable. He noted that Detainee 2 had a lot of difficulty adjusting to OMDC during his first few months in the facility. He also noted that he has been more cooperative and less irritable over the past four months, ingesting foreign objects and being placed in the Safety Cell only once since May. He stated that Detainee 2 appeared to have adjusted fairly well to OMDC; however, he acknowledged that the detainee remained unpredictable.

Dr. (b) (6) was also questioned about Detainee 2. He talked about the detainee's psychiatric hospitalization, saying that psychiatric hospitals often over-patologize patients, giving them major psychiatric diagnoses. He stated that he believed detainee AA did not have a major mental health disorder.

c) **Detainee Interview:** Detainee 2 was interviewed for approximately 30 minutes. He spoke English well. He was alert, oriented and cooperative. His hygiene was good. There was no evidence of distress. Rapport was quickly established. Eye contact was good. There were no unusual behaviors. He occasionally initiated conversation and responded to questions appropriately. The rate and volume of his speech were unremarkable. His articulation was good. There was no evidence of disorganized or delusional thinking. His mood was euthymic and his affect was congruent with the situation. There was no evidence of suicidal/homicidal ideation or auditory/visual hallucinations.

He began talking about the "injustices of his case"; however, he was able to be redirected. When questioned about ingesting foreign objects, he immediately denied having a mental illness and stated that he never intended to kill himself. He attributed his behavior to being locked down. He talked about segregation, calling it a "death pod" and said that he'd "rather be beaten than placed in segregation." He said, "The days are very long in segregation. I can't describe it. It's the most inhumane thing you can do to a person. Even dogs don't live like that. My mind goes crazy in there. I just stare at the wall. There's no one to talk to and nothing to do."

After talking about segregation, he began talking about the safety and stepdown cells, saying "They can be used as tools of punishment." He illustrated this comment by talking about a mental health provider whom he "doesn't like and doesn't trust". He said, "I was in the stepdown cell and I refused to talk with her, so she moved me back into the Safety Cell to teach me a lesson. It's all about power."

When asked to compare being in segregation to being in a Safety Cell, he said "Segregation is much worse. There's no one to talk to in segregation. In the Safety

Cell, you can at least talk to the observer. But the Safety Cell is a problem too because it's degrading to use the toilet which is a hole in the floor with a grill over it. You can't flush it and my feces are too big to go through the grill. The stink is real bad. It's mental torture. Thank God, I really wasn't suicidal because that place would have made me kill myself. Sometimes I'd have to smear the feces from the grill on myself and on the walls because then they'd let me take a shower and someone would clean my cell, making it smell good again."

He ended the interview, talking about his case, hopeful that it would have a good outcome.

2) Nature of the Referral:

On June 9, 2017, the DHS OIG was contacted by Detainee 2 who said that he was unfairly detained by San Diego police and then by ICE. He stated that he was a victim of a customer scam in Denver, resulting in "me cashing three $500 checks that bounced."

Detainee 2 was charged with fraud in 2010. He fought the charges and lost, resulting in a Class 5 Felony and a five-year probation sentence. He was reportedly detained by ICE because he violated his refugee status by receiving a felony for writing bad checks in Denver.

He moved to San Diego and stated that he was targeted by the San Diego police because of verbal arguments he had with them. He said that he had a right to tell the San Diego police whatever he wanted because of his freedom of speech. He stated that he has never committed a crime and would like to be released because he is a citizen.

After ICE and CRCL reviewed his case, concerns were expressed about the conditions regarding the housing of detainees with mental health issues.

3) Behavioral Health Record Review:

a) Complaint's Detention Review:

Detainee 2 has been detained at OMDC for approximately seven months, from February 16, 2017 to the present. He was previously detained by San Diego police and then by ICE because he violated his refugee status, having a Class 5 Felony on his record.

b) Complainant's Personal History:

Detainee 2 was a 32-year-old male who originated from Somalia. He said that he was born and raised in Somalia, and came to the United States as a refugee in 2005 when he was 20/21 years old. He said that he completed school in Somalia and worked as a taxi driver for eight months in San Diego prior to be detained. He said that he was married and didn't have any children. His father reportedly worked as a mechanic and his mother was a homemaker. He has two brothers and two sisters. He denied using drugs or alcohol; however, he reported a history of cannabis use.

c) Complainant's Mental Health History:
Detainee 2 denied having a mental health history. He also said that there was no family history of mental health problems or treatment.

d) Complainant's Chief Complaint:
The complainant denied having any mental health problems, and complained about receiving mental health services. He was repeatedly referred to mental health for being agitated and depressed, for threating to harm himself, for making comments about death/suicide, and for ingesting foreign objects such as soap, batteries, and pencils.

e) Complainant's OMDC MH Treatment History:

(1) Detainee 2 arrived at OMDC on February 15, 2017. The next day, mental health received an "urgent referral" from custody because Detainee 2 was unusually agitated after being placed in a negative pressure room. He claimed that he was being unlawfully detained and started talking about Officer Cobain who detained him because he was "speaking out against the Jews." He began receiving mental health services on his second day at OMDC and continued to receive them up to the date of this investigation, September 26, 2017.

(2) Detainee 2 was seen 40 times within his first 15 weeks at OMDC, with four Safety Cell admissions and one psychiatric hospital admission. His Safety Cell admissions and hospital admission occurred after he swallowed foreign objects, (soap, batteries, pencils).

(3) Over the last 18 weeks, Detainee 2 was seen by mental health 14 times and placed in a Safety Cell once after returning from a hospital where he was treated for swallowing pencils.

(4) Detainee 2 was seen by five mental health providers (two psychologists and three social workers whose duties are reportedly the same) and by a psychiatrist. One social worker saw him 19 times and the other providers saw him 35 times.

(5) At OMDC, Detainee 2 was diagnosed with an Adjustment Disorder with Mixed Disturbances in Emotion and Conduct and with an Antisocial Personality Disorder. At Alvarado Parkway Institute (API), Detainee 2 was given a primary discharge diagnosis of Major Depressive Disorder, Recurrent, Severe, without Psychosis and secondary diagnoses of an Antisocial Personality Disorder and Malingering. His Global Assessment of Functioning Score (GAF) was 45 which indicated "serious symptoms and serious impairment in social, occupational and/or school functioning. He was psychiatrically treated at API with Paxil and Remeron.

(6) The first time he was seen by a psychiatrist at OMDC was on May 22, 2017 which was one month after his psychiatric hospital discharge on April 21, 2017. During that session, Dr. (b) (6) identified agitation and sleep as problems and discussed with the detainee the benefits and side effects of being treated with Paxil and Remeron. By the end of the session, they agreed to use Remeron.

(7) Between February 16, 2017 and July 24, 2017, the detainee was only seen by a psychiatrist twice, both times via telepsychiatry on May 22nd and June 19th.

(8) Detainee 2 spent an unusually large amount of time on lockdown status, especially during his first 15 weeks. More specifically, he was in a negative

pressure room for approximately one week with little recreation or socialization. Afterwards he was briefly placed in segregation on protective custody status, and then admitted to a Safety Cell. After being released from the Safety Cell, he was moved back to segregation and then to general population. After being denied bond in court, he began talking about death and was moved back to segregation. Within the next two weeks, he was placed back in a Safety Cell, then back to segregation, then to a Safety Cell, and finally to a psychiatric hospital. When he was released from the hospital, he was placed in a Safety Cell for a couple days, then to segregation for five days, and then to the Medical Housing Unit. Since being placed in general population on May 23, 2017, he has only been admitted to a Safety Cell once from July 7, 2017 to July 11, 2017.

(9) The hours he spent in the safety cell during each admission ranged from 48 to 96, with an average length of stay being approximately 72 hours.

(10) Treatment plan goals tended to be generic and not clearly operationalized or measured.

(11) Treatment strategies were also generic and poorly documented in the narrative.

4) Summary of Findings:

The progress notes in Detainee 2's behavioral health record were reviewed and staff were interviewed. The notes indicated that Detainee 2 was receiving mental health services at least twice a week in February and March, almost daily in April, twice a week May, once a week in June, at least once a week in July, and on an "as needed basis" in August and September. Once again, the progress notes looked good as "standalone notes"; however, when they were read together and informed by staff and detainee interviews, problems emerged. **First**, Detainee 2 was seen 37 times by five mental health providers within his first four months at OMDC. Based on his progress notes, the providers appeared to be interchangeable. Once again, the detainee's primary mental healthcare provider was unclear. Hopefully, the detainee and the providers knew which provider was the primary provider, responsible for modifying the treatment plan and overseeing the course of treatment. Having a primary provider in the mental health arena is required in order to establish a therapeutic relationship, to maintain rapport, and to ensure continuity of care. **Second,** treatment plan goals were: "not to harm himself or other people; to take all medications as prescribed; to experience mood management at least 80% of the time; and to follow facility mandates and comply with the treatment plan". The strategies consisted of providing support and education, teaching him coping skills, cognitive controls, and stress/mood management skills. Unfortunately, these strategies were ineffective in reducing the detainee's distress. In fact, the detainee's distress appeared to be exacerbated and his maladaptive behavior (ingesting foreign objects) appeared to be inadvertently reinforced, resulting in increased self-injurious behavior and a psychiatric hospitalization. **Third,** there was no evidence in the detainee's behavioral health record that any information from his psychiatric hospitalization was used to improve the treatment plan. The hospital's impression of the detainee's psychiatric condition was that he had a serious mental

illness, illustrated by: his diagnosis of a Major Depressive Disorder, Recurrent, Severe; by his GAF score of 45; and by his prescribed psychotropic medication. OMDC did not acknowledge the changed diagnosis or the severe GAF score. They also did not acknowledge or continue the psychotropic medication which was used to stabilize him at API. The detainee's treatment plan was not modified after his hospitalization, nor was there any documented explanation which justified maintaining the same treatment plan. This finding suggests that his continuity of care was inadequate and his treatment plan was generic, not guiding treatment. **Fourth,** Detainee 2 refused to see the tele-psychiatrist in June because he was concerned that the information discussed with the psychiatrist would not be confidential and could be used to possibly harm his case. There was no evidence that any mental health care provider addressed this issue of confidentiality with the detainee. **Fifth,** the number of admissions to a Safety Cell decreased significantly during the detainee's past four months at OMDC. Staff were unable to explain this change in behavior. Given the significance of this change, the primary mental health care provider and possibly the treatment team should perform a CQI study in order to understand the reasons for the change and to possibly use this knowledge to treat other detainees. **Sixth,** based on the detainee's interview and the progress notes in his behavioral health record, it appears as if he continues to be hypervigilant, hypersensitive and suspicious, concerned that others might be out to harm him. He tends to feel vulnerable and when he feels threatened, he withdraws and ingests foreign objects in order to be placed in a safe environment. This information along with the information noted above should be used to update his treatment plan. **Seventh,** from the detainee's perspective, it became clear that he felt as if he was in a power struggle with staff and he felt as if the Safety Cell was used to punish him rather than protect him. It's critical that staff be sensitive to his perception and address any misperception, (reality therapy). Mental health staff are reminded that power struggles and malignant alienation are significant suicide risk factors which are often inadvertently increased by staff.

C. Summary of the Two Complainant's Reviews

Both complainants were complex and difficult diagnostic, treatment and management cases. Detainee 1 was diagnosed with an Antisocial Personality Disorder and a rule-out diagnosis of a Delusional Disorder. Detainee 2 was also diagnosed with an Antisocial Personality Disorder and an Adjustment Disorder. Detainees with these diagnoses, are not uncommon, especially in detention centers where staff are trained to treat and manage them. A problem arises when these diagnoses are used as default diagnoses, not seriously trying to "rule-in" or "rule-out" alternative diagnoses. When this occurs, staff seldom use collateral documents or upper level providers (i.e., psychiatric hospital records, mental health records from previous detention centers, and available psychiatry resources) because they're convinced that they've correctly diagnosed these individuals and are effectively treating them.

From an outside reviewer's perspective, Detainee 1's progress notes revealed a lot of information supporting a Somatic Delusional Disorder and Detainee 2's progress notes revealed a lot of information supporting a severe personality disorder with possible

transient psychotic episodes. These diagnoses are very difficult to make, especially when time is limited and when psychological testing is not available. Additionally, these diagnoses are extremely difficult to treat and manage, especially when structured programming is limited. They're extremely challenging because they're high intensity cases (they're resource intensive, time intensive, and emotionally intensive). They're high risk cases, which can't be treated with traditional approaches. They also produce a lot of pressure/stress, and often result in power struggles, polarization and splitting. Staff need to be sensitive to the detainee's perception of their behavior, (i.e., Is it perceived as punitive?) and to malignant alienation which increases the struggle for control and the lethality of suicide attempts. When staff identify power struggles and the malignant alienation, they should step back to prevent the detainee from thinking, "You can't take away all my control. I can still control over my feces, my ability to injure myself, and my ability to kill myself."

C) A REVIEW OF OMDC's MENTAL HEALTH SYSTEM'S COMPLIANCE WITH PBNDS 2011

- **PBNDS 2011: 4.3 MEDICAL CARE**

A. General

- **Finding(s):**

1) Initial prescreening and intake screening were taking place in a timely manner.

2) Mental health care was available to all detainees and provided to those in need of such services. With few exceptions, appropriate care was provided to those with a mild mental illness who adaptively lived in General Population. (Note, the "few exceptions" were monthly psychiatric follow-up appointments which occasional occurred outside the 30-day window.) Detainees with serious acute mental health problems also received appropriate care, being sent to facilities that provided a higher level of care than OMDC provided. Additionally, detainees in Segregation received appropriate mental health care, being seen weekly.

   In contrast to detainees with mild and severe mental health problems, those with moderate mental health problems in the MHU and those with acute mental health problems in a Safety Cell received less than adequate mental health care. Personal observation and record reviews revealed those living in the MHUs, which provided an intermediate (residential) level of care for moderate mentally ill detainees, received only two mental health provider visits a month "to assess (their) mental status and functional capacity." Actual treatment appeared to be limited to placement in a "medical unit with less stimulation than in the General Population units" and to psychotropic medication for some detainees.

   The same can be said for high risk detainees who were placed in a Safety Cells. They were seen by a mental health provider once a day for a "follow-up suicide

risk assessment". Actual treatment appeared limited to placement in a "suicide resistant rubberized cell" with a suicide resistant mattress, blanket and gown, with one-on-one continuous observation, 8-hour nursing checks, and a 24-hour mental health follow-up to assess suicide risk. In summary, neither the Medical Housing Units or Safety Cells had individualized treatment programs that addressed each detainee's specific mental health needs with evidence-based or best-practices interventions.

3) Comprehensive mental health care was provided in that psychiatry, psychology and social workers treated detainees as-long-as needed and they worked collaboratively with both medical and custody staff.

4) Emergency mental health care was being provided.

5) Female detainees continue to be classified as a special population which requires specialty healthcare. That said, there's clearly a gap in OMDC's mental health delivery system. Unlike the levels of care provided to male detainees, (i.e., treatment for mild mental illness in General Population, treatment for moderate mental illness in Medical Housing Units, and treatment for acute mental illness in a Safety Cell), the female detainees only have services for mild and acute mental illness. A review of the need for a female MHU revealed a significant number of detainees in A-Unit with moderate to severe mental illness, (i.e., 47 females had significant diagnoses to include schizophrenia, schizo-affective disorders, delusional disorders, and bipolar disorders). While interviewing a number of these detainees, it became apparent that many were significantly distressed with an unstable mental status and intrusive memories and feelings related to their histories of abuse. Given the severity of their conditions, a Medical Housing Unit with structured and individualized programming was indicted.

6) Timely responses were not a problem because the electronic health record acted as a tickler, reminding providers of appointments.

7) Detainees were generally sent to a hospital when they needed a higher level of care than could be provided at OMDC. That said, it was unclear when and how staff decided a detainee needed to be sent to a facility which provided a higher level of care. A record review of the two "mental health complainants" revealed that they were repeatedly held in Safety Cells for over 48 and 72 hours without being sent to a facility that provided a higher level of care.

8) There was no evidence of any problems with staff or professional language services which were necessary for detainees with limited language proficiency.

- **Recommendation (1):**
  Analysis of the levels of care revealed service gaps in the Medical Housing Units (MHUs) and in the Safety Cells. OMDC merely places detainees in these specialized units and provides periodic mental health assessments of detainee's functional capacity and suicidality. This does not constitute appropriate mental health treatment. Structured and individualized treatment programs and interventions are needed for detainees who have been placed in these intermediate and acute care units. **(PBNDS-2011 4.3 II. 1 and V. A, Priority 1)**

- **Recommendation (2):**
  The continuum of mental health care for female detainees has gaps in services with the most obvious being no mental health unit(s) for females who are moderately mentally ill, in contrast to moderate mentally ill male detainees who have two nine-bed MHUs and a 14 cell MHU for detainees who need individual cells. A review of the diagnoses of females in just one general population unit revealed 47 with a serious mental illness. Furthermore, interviews with a few of those detainees revealed their fragility and tenuous mental status. The creation of a female MHU with appropriate programming/services is indicated; however, given the relatively small number of female detainees, it might be more appropriate to create a Day Treatment Program because it both fills the gap in services and it maintains an economy of scale. This program would provide increased mental health services/activities in the Day Rooms of their current units. These services could be facilitated by low-level mental health care providers (mental health technicians and/or activity therapists) who could be clinically supervised by a mid-level or upper-level mental healthcare provider (social worker, psychologist, psychiatric nurse practitioner, or psychiatrist). **(PBNDS-2011 4.3 II. 1 and V. A, Priority 1)**

- **Recommendation #3:**
  Required monthly psychiatric follow-up sessions with detainees being treated with psychotropic medication were occurring sporadically. Follow-up sessions need to occur "at least once a month to ensure proper treatment and dosage". CRCL suggests that QI studies are utilized to determine the scope and etiology of this problem (i.e., the use of telepsychiatry due to a psychiatry vacancy and/or a new a relatively new psychiatrist learning the procedures) and to develop strategies to solve it. **(PBNDS-2011 4.3 V. A; 4.3 V.M; and 4.3 V. N4, Priority 1)**

PBNDS-2011 4.3 V. A; 4.3 V.M; and 4.3 V. N4, Priority 1)

B. Designation of Authority

All facilities shall provide medical staff and sufficient support personnel to meet these standards. A staffing plan will be reviewed at least annually which identifies the positions needed to perform the required services.

- **Finding(s):**
  The current mental health staffing pattern (one MH Director who is a psychologist, one staff psychologist, one psychiatrist, and three licensed clinical social workers)

would generally be adequate for an overall population of 1,200 detainees with approximately 23% receiving mental health services. However, given the complexities of the population (i.e., transience, cultures and languages) and the complexities of the facility's logistics (i.e., multiple missions, limited space and movement challenges), mental health clinicians stayed extremely busy seeing detainees in a timely manner and documenting their sessions without actually providing appropriate nonpharmacological (evidence-based) treatment to those placed in Medical Housing Units and Safety Cells. The "missing treatment" could be provided by lower level providers (i.e., mental health technicians and/or activity therapists) rather than upper level or mid-level providers (i.e., psychiatrists, psychologist, and/or social workers)

- **Recommendation (4):**
  OMDC's mental health delivery system is inadequately staffed with six positions (these positions are identified above in the Findings section for the Designation of Authority under PBNDS 2011 Compliance), and thus limited in its ability to provide quality nonpharmacological (evidence-based) treatment to mentally ill detainees in the Medical Housing Units and in the Safety Cells. To provide this treatment, CRCL recommends OMDC hire two additional lower-level staff (i.e., mental health technicians and/or activity therapists) whose services often result in cost avoidances (i.e., a reduction in medical services, crisis services, psychotropic medication, and disruptive behavior) that outweigh costs incurred by hiring them. **(PBNDS 2011 4.3 II. 21 and V. B, Priority 1)**

C. Communicable Disease and Infection Control

- **Finding(s):**
  Not Applicable
- **Recommendation(s):**
  None

D. Notifying Detainees about Health Care Services

Informed consent shall be obtained prior to providing treatment (absent medical emergencies). Consent forms and refusals shall be documented and placed in the detainees medical file.

- **Finding(s):**
  The behavioral health records of detainees who were treated with psychotropic medication, contained signed psychiatric informed consents; however, the potential side-effects of the medication were not always described in the informed consent.

- **Recommendation (5):**
  The behavioral health records of all detainees being treated with psychotropic medication should contain a signed and dated informed consent which describes the medication side effects. CRCL recommends that OMDC review behavioral health records to ensure this information is included and instruct mental health staff to include this information in the future. **(PBNDS-2011 4.3 II. 24 and V. D, Priority1)**

E. **Translation and Language Access for Detainees with Limited English Proficiency**

- **Finding(s):**
  There was no evidence of any problems with translation and language access for detainees with limited English proficiency who were seeking mental health services.
- **Recommendation(s):**
  None

F. Facilities

1. Examination and Treatment Area
2. Medical Records
3. Medical Housing
   a) Care
   b) Wash Basins, Bathing Facilities and Toilets

- **Finding(s):**
  Privacy between providers and patients and confidentiality of information/records were valued at OMDC. I did not observe or hear from staff/detainees of any problems with privacy and confidentiality.

  There was a 24 hour on-call mental healthcare provider, either Dr. (b) (6), the newly hired psychiatrist, or Dr. (b) (6) form Krome via tele-psychiatry. Upper level and/or midlevel medical providers acted as backup to the two psychiatrists.

  It should be noted that the psychiatry position was vacant for approximately six months. Dr. (b) (6) was hired over the summer, went through orientation and began working as a full-time on-site psychiatrist at OMDC in the end of July/beginning of August. From January through June, Dr. (b) (6) from the Krome facility in Florida provided scheduled psychiatric services two days a week, two hours each day. He also reportedly made himself available on an as-needed basis.

  Detainees reported that they were able to submit sick call requests for mental health services seven days a week. Most detainees denied having any delays in

being seen by a mental healthcare provider; however, a few reported having to wait up to a week to see a mental health provider.

- **Recommendation(s):**
  None

G. Pharmacological Management

Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals to include:……documentation of accountability for administering or distributing medications in a timely manner, and according to licensed provider orders.

- **Finding(s):**
  After talking with staff and detainees, and after reviewing behavioral health records, no problems were identified with the availability of psychotropic medication. Administration was performed by properly licensed, credentialed, and trained personnel.

  The administration of medication per a licensed provider orders is problematic because HS at approximately 1600 hrs. has been taking place because of logistical problems in the buildings that include serving the evening meal. Due to this early administration of HS medications, (which is Hora Somni – at the hour of sleep), 2 detainees who were interviewed stated that they occasionally "miss their evening medicine because it makes them tired."

- **Recommendation (6):**
  Psychiatric medication orders were not followed when HS medication (Hora Somni – at the hour of sleep) was being administered at 1600 hours. HS medications should be administered after 1600 hours, in the evening or at bed time rather than late afternoon. When it's administered early, nonadherence increases. The logistical problems preventing evening administration should be investigated and solutions explored. **(PBNDS-2011 4.3 II. 20 and V. G, Priority 1)**

H. **Medical Personnel**

All healthcare staff must be verifiably licensed, certified, credentialed, and or registered in compliance with applicable state and federal requirements. Copies of the documents must be maintained on site and readily available for review. A restricted license does not meet this requirement.

- **Finding(s):**
  Mental health status credentialing files were reviewed. All of them contained the current license, CPR certification, and a peer review.
- **Recommendation(s):**
  None

I. Medical and Mental Health Screening of New Arrivals

- **Finding(s):**
  All intake screens and evaluations were performed by credentialed and supervised staff. Thanks to the electronic health record, (E-Clinical Works), all appropriate inquiries were made. Referrals were made via ECW and were scheduled the same day. All screens and evaluations were performed in a space that ensures safety and privacy.
- **Recommendation(s):**
  None

J. Substance Dependence and Detoxification

- **Finding(s)**:
  All detainees were evaluated during the initial screen for substance use problems. Medical in collaboration with mental health work with detainees diagnosed with a co-occurring disorder.
- **Recommendation(s):**
  None

K. Comprehensive Health Assessment

- **Finding(s):**
  Mental health evaluations were performed in a timely manner and in settings that respected detainees' privacy.

- **Recommendation(s):**
  None

L. Medical/Psychiatric Alerts and Holds

- **Finding(s):**
  Psychiatric alerts were completed on all seriously mentally ill detainees who required ongoing mental health therapy. These alerts were placed in the electronic health record as soon as the detainee's needs were identified.
- **Recommendation(s):**
  None

M. Mental Health Program

1) Mental Health Services Required

2) Mental Health Provider

3) Mental Health Evaluation

4) Referrals and Treatment

5) Medical Isolation

6) Involuntary Administration of Psychotropic Medication

- **Finding(s):**
  a) **Mental Health Services Required:** Per observation of either the following services or of the relevant documentation, I was confident that all required mental health services were being provided, namely: intake screening; mental health referrals; crisis intervention and management; transferring detainees who needed a higher level of care; and implementation of the suicide prevention program.

  b) **Mental Health Provider:** The term mental health provider included psychiatrists, psychologists, and clinical social workers.

  c) **Mental Health Evaluation:** Detainees referred for mental health treatment received an evaluation by a qualified licensed mental health professional in a timely manner.

     All evaluations and screens included: the reason for referral; mental health history of treatment; a history of illicit drug/alcohol use; a history of suicide attempts; the identification of current suicidal/homicidal ideation; the current use of any medication; an estimate of the detainee's current intellectual functioning; the identification of a physical, sexual, or emotional abuse history; identification of a history of head trauma; recommended appropriate treatment; and the implementation of the treatment plan which included housing program participation.

  d) **Referrals and Treatment:** Referrals were made through the electronic health record and see in a timely manner.

     A plan of treatment was included in each progress note. There was no separate treatment plan which was collaboratively developed by an interdisciplinary team and the detainee.

     Detainee's mental health treatment/management plans were inadequate. They consisted of brief generic "orders" at the bottom of each progress note, in the section entitled "Treatment". They listed any restrictions, potential providers, broad goals, and vague treatment strategies. Neither the detainee nor multidisciplinary treatment team members participated in the development and review of the treatment plan. In fact, the goals and treatment strategies never changed, even as the detainee's mental status changed.

     When the detainee's mental health needs/developmental disabilities exceeded the treatment capability of OMDC, the detainee was usually

transferred to a facility that provided a higher level of care. In fact,49 detainees were transferred to such facilities in 2016 and 45 detainees have been transferred to such facilities from January 1, 2017 to September 26, 2017.

A review of records revealed a that a number of detainees who were treated with psychotropic medication did not meet with a psychiatrist on a monthly basis over the past six months. (Refer to Medical Care, A. General, recommendation #2.)

e) **Medical Isolation:** Not Observed

f) **Involuntary Administration of Psychotropic Medication:** Not done at OMDC.

- **Recommendation (7):**
  Mental health "treatment plans" were inadequate. They were generic, generally not individualized, and minimally related to any mental health treatment provided to the detainee. Treatment plans should be meaningful "plans of action" developed by a multidisciplinary treatment team which includes the detainee. They should direct treatment and change as the detainee's mental status changes. Training is recommended on "how to develop useful treatment plans." The specific treatment plans may be in any format, as-long-as they contain all required elements, (i.e., 1. **signatures** from a multidisciplinary team; 2. a **diagnosis**; and 3. a **list** of a) **strengths**, b) **weaknesses**, c) **problems**, d) **objectives** which are targets used to measure progress of the treatment, e) **behavioral and measurable goals** which are tied to the problems, and f) **coordinated interventions** which answer the question, "Who does what, when?"). Specific stand-alone treatment plan forms are preferable to SOAP notes since they facilitate the development of a comprehensive plan which is easily identifiable, enhancing the likelihood of a "continuity of care." To facilitate the development and utilization of meaningful treatment plans, it's recommended that the Mental Health Director/designee construct an audit tool, which could be used to annually audit a sample of treatment plans. **(PBNDS-2011 4.3 II. 8 and V. N-4, Priority 1)**

N. Annual Health Examinations

Any detainee in ICE custody for more than one year continuously shall receive health examinations on an annual basis.

- **Finding(s):**
  The Mental Health Director stated that occasionally a detainee who was receiving mental health services stayed at OMDC for an extended period of time because of the Franko Decision. In those cases, he stated that the detainees were evaluated at least annually.
- **Recommendation(s):**
  None

O. Sick Call

- **Finding(s):**
  The sick call procedure was observed in two units and the detainees whom I interviewed were aware of the procedures. The only concern expressed by one detainee was that she'd "like to have sick call more than once a day."
- **Recommendation(s):**
  None

P. Emergency Medical Services and First-Aid

- **Finding(s):**
  Mental health emergencies services are provided 24-hours a day by a mental health professional or credentialed designee.
- **Recommendation(s):**
  None

Q. Delivery of Medication

- **Finding(s):**
  As stated above in "G. Pharmaceutical Management", HS orders were being administered at approximately 1600 hours, which resulted in some detainees not taking their evening medication because it made them "tired too early".
- **Recommendation(s):**
  Refer to Recommendation #6 above.

R. Health Education and Wellness Information

Qualified healthcare personnel shall provide detainees health education and wellness information.

- **Finding(s):**
  Mental healthcare providers regularly educated detainees on stress management, coping strategies, etc.
- **Recommendation(s):**
  None

S. Special Needs and Close Medical Supervision

- **Finding(s):** All transgender detainees are identified and evaluated by mental health. All of them had access to mental health treatment.
- **Recommendation(s):**
  None

T. Restraints

- **Finding(s):**
  Restraints for mental health purposes were not used at this facility.
- **Recommendation(s):**

~~*Protected by the Deliberative Process Privilege*~~

None

U. Continuity of Care

The facility HSA must ensure that a plan is developed that provides for continuity of medical care in the event of a change in detention placement or status.

- **Finding(s):**
  Mental health staff said that they receive little to no notice when a detainee was being transferred, released, or removed; consequently, they said that a continuity of treatment care plan was rarely developed and provided to the detainee prior to removal.
- **Recommendation (8):**
  The development of a continuity of care treatment plan was rare, reportedly because staff received little to no notice that a detainee was being released, transferred or removed. Keeping an "updated meaningful care plan" in the detainee's electronic health record would be a solution that could facilitate continuity of care. **(PBNDS-2011 4.3 II. 5 and V. W, Priority 1)**

V. Informed Consent and Involuntary Treatment

Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication's side effects, shall be obtained.

- **Finding(s):**
  The signed informed consents and refusals were always present; however, some consent forms lacked the descriptions of the medication's side effects. These cases appeared to be attributable to limited psychiatry resources during the first six months of 2017 year.
- **Recommendation(s):**
  Refer to Recommendation #5 above.

W. Medical Records

- **Findings):** All detainees receiving mental health services had an electronic behavioral health record which was part of that detainee's electronic medical record. Access was clearly limited and confidentiality was protected by passwords.
- **Recommendation(s):**
  None

X. Terminal Illness or Death of a Detainee

- **Findings**
  Not Applicable
- **Recommendation(s):**
  ~~*Protected by the Deliberative Process Privilege*~~

None

Y. Medical Experimentation

Detainees shall not participate in medical, pharmacological or cosmetic research while under the care of ICE.

- **Findings:**
  Staff and detainees stated that detainees were not participating in medical research.
- **Recommendation(s):**
  None

Z. Administration of the Medical Department

1. Quarterly Administrative Meetings

- **Finding(s):** The most recent IHSC-San Diego Administrative Staff Meeting Minutes from 08/30/2017 were provided along with the most recent IHSC-San Diego Governing Body Meeting Minutes from 09/21/2017. The minutes from both meetings were detailed, meeting the agenda requirements.

- **Recommendation(s):** None

2. Healthcare internal review and quality assurance

- **Finding(s):**
  IHSC QI Meeting Minutes were reviewed from 05/29/17, 06/27/17, and from 07/11/17. The minutes were comprehensive and informative. They included all of the required agenda items. A review of their minutes revealed that they clearly hold themselves accountable. The mental health QI screens for Suicide Watch, Medication Refusal, Psychotropic Medication Administration were reviewed. Additionally, a Healthcare Failure Modes and Effects Analysis (HFMEA) from the second quarter of 2017 was reviewed. It assessed failure in the initial suicide risk assessment and in using the special-needs form to alert safety cell observing officers of the suicide risk level of the detainee. Actions were presented to redesign the process and to develop outcome measures.
- **Recommendation(s):**
  None

3. Peer review

The HSA shall implement an intra-organizational, external peer review program for all independently licensed medical professionals. Reviews shall be conducted at least annually.

- **Finding(s):** While reviewing the staff's credentialing files, the HSA provided proof of the peer reviews for each staff member, except for the

newly hired psychiatrist and social worker. These peer reviews were done by IHSC staff from other facilities.

- **Recommendation(s):** None

- **PBNDS 2011: 4.6 Significant Self-Harm and Suicide Prevention and Intervention**

A. **Training**

- **Finding(s):** The suicide training curriculums for IHSC staff and for CCA's custody staff were reviewed. Training rosters were also reviewed for IHSC staff and for custody, to include "new hire training" and the "annual renewal training". The curriculum and frequency of training was in compliance with the Standard.
- **Recommendation(s):**
  None

B. Identification

- **Finding(s):**
  A review of referrals, primarily from custody, revealed that detainees who were at risk for self-injurious behavior were identified throughout the day and throughout the facility, resulting in an "urgent referral" which was responded to in a timely manner.
- **Recommendation(s):**
  None

C. Referral

- **Finding(s):**
  As stated above, detainees "at-risk for suicide" were identified, referred and evaluated in a timely manner.
- **Recommendation(s):**
  None

D. Evaluation

- **Finding(s):**
  Many suicide risk assessments were reviewed in the electronic health records. They contained the above information which was used to make responsible clinical decisions, (i.e., whether to continue a safety cell or step the detainee down to an observation cell).
- **Recommendation(s):**
  None

E. Treatment

- **Finding(s):**

Treatment plans were loosely developed in the progress notes which were written each day; however, they did not change as the level of acuity changed and they did not specifically address the environmental, historical and psychological factors that contributed to the detainee's suicidal ideation. They also did not specifically identify the strategies and interventions to be followed if suicidal ideation reoccurs.

- **Recommendation (9):**
  Safety cell treatment plans, which were found in the "plan" section of progress notes, were inadequate. They did not change as the level of acuity changed and they did not specifically address the "environmental, historical and psychological factors" that contributed to the detainee's suicidal ideation. Stabilization "safety cell" treatment plans should be meaningful, living documents which are based on a good risk assessment and which both direct treatment and change as a detainee's mental status changes. These treatment plans are especially significant for detainees who are placed in safety cells for long periods of time. Each detainee's safety cell treatment plan should be reviewed and updated daily during rounds. Training on "How to Write and Implement Meaningful Safety Cell Treatment Plans" should be provided for all clinical staff who admit and treat detainees in Safety Cells and for all officers who provide continuous observation. During this training, attendees should be given a tool which they should use to audit both the meaningfulness and their implementation of safety cell treatment plans. The Mental Health Director / designee should periodically audit these safety cell treatment plans as part of a larger Continuous Quality Improvement Program. **(PBNDS-2011 4.6 V. E, Priority 1)**

F. Housing and Monitoring

A suicidal detainee requires close supervision in a setting that minimizes opportunities for self-harm. If a staff member identifies someone who is at risk of significant self-harm or suicide, the detainee is placed on suicide precautions and is immediately referred to a qualified mental health professional.

The qualified mental health professional may place the detainee in a special isolation room designed for evaluation and treatment with continuous monitoring that must be documented every 15 minutes or more frequently if necessary. Detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring, checks at least every eight hours by clinical staff, and daily mental health treatment by a qualified clinician.

1. No Excessive Deprivations

Deprivations and restrictions placed on suicidal detainees need to be kept at a minimum. Suicidal detainees may be discouraged from expressing their intentions if the consequences of reporting those intentions are unpleasant or understood to result in punitive treatment or punishment. Placing suicidal detainees in conditions of confinement that are worse than those experienced by the general population detainees can result in the detainees not discussing his or her suicidal intentions and falsely showing an appearance of getting well fast.

- **Finding(s):**
  OMDC's mental health staff closely followed and documented: the schedule of observations by custody, nursing and mental health; the clothing standard; the transfer standard; and the post-discharge from suicide watch. Detainees were identified who stayed in highly restrictive Safety Cells for periods of time exceeding 48 hours. Given the harsh and restrictive conditions of these cells, detainees talked about feeling punished and degraded.

➢ **Recommendation (10):**
Because of the deprivations and restrictions placed on detainees in Safety Cells, (i.e., no hot meals, no personal property, no toilette aside from a hole in the floor, no clothing aside from a suicide resistant garment, and no privacy) and because of high re-admission rates, lengthy stays and a perception that detainees are being punished and humiliated when admitted to a Safety Cell, an enhanced oversight procedure is recommended. This procedure should consist of developing and maintaining logs to determine: the number of detainees who have multiple readmissions; the time intervals between admissions; the names of the providers placing detainees in safety cells; the range and average number of readmissions; the average length of stay; and the clinical characteristics of outliers. The information obtained from these logs should be used to improve OMDC's crisis stabilization services. Additionally, clinicians should be instructed to use the treatment plan to document their understanding of why a detainee is not improving, what new strategies might be used for stabilization, and when a detainee needs to be sent to a facility that can provide a higher level of care. Without such documentation, Safety Cells can be perceived as tools of punishment and retribution rather than as methods of treatment. **(PBNDS 2011 4.6 V. F and CCA 2016 Suicide Prevention Guide, Priority 1)**

- **PREA: Medical and Mental Health Care**
  - **A. 115.82 Access to emergency medical and mental health services**
    Inmate victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.
    - ➢ **Finding(s):**
      After two PREA allegations were made, mental health performs a PREA psychological evaluation. Two of these evaluations were reviewed. Both evaluations performed a mental status examination and assessed for trauma. The evaluations were clinically focused, not involved the security investigations. Based on the results of the evaluations, appropriate recommendations were made.
    - ➢ **Recommendation(s):**
      None

D) COMPARISON OF 01/2017 PBNDS-2011 AUDIT & 09/2017 CRCL INVESTIGATION

DHS conducted a PBNDS 2011 Audit of the Otay Mesa Detention Center in January 2017. The Medial Department which includes both Dental and Mental Health achieved a compliance score of 100% on: Standard 4.3 Medical Care; Standard 4.4 Medical Care (Women); and Standard 4.6 Significant Self-Harm and Suicide Prevention and Intervention.

In September 2017, the DHS Office of Civil Rights and Civil Liberties conducted an investigation that was generated by complaints filed with the Office of the Inspector General. Part of that investigative team focused on concerns with Otay Mesa Detention Center's mental health delivery system. The investigation used the same PBNDS 2011 Standards along with relevant standards from the American Correctional Association, the National Commission of Correctional Health Care, the Prison Rape Elimination Act, and Best Practices. The results of this investigation are briefly compared to the results of the January 2017 Audit.

Standard 4.3 Medical Care: The findings from the investigation of Standard 4.3 tended to be consistent with the PBNDS 2011 audit on January 2017. OMDC's mental health delivery system was found in compliance with Standard 4.3; however, isolated violations were found primarily due to staff vacancies and to a new hire who was in the process of being trained. Along with the isolated standard violations, there were also larger systemic clinical concerns generated by the quality and/or amount of care/services provided to seriously mentally ill male detainees in the Medical Housing Unit. The quality and usefulness of the "overall treatment plan," the "stabilization treatment plan" and the "continuity of care treatment plan" were also matters of concern.

Standard 4.4 Medical Care (Women): The overall findings on Standard 4.4 were similar to those of the audit. The largest concern was that women who were diagnosed with a serious mental illness and who were quite unstable did not have access to an intermediate level of care, between receiving services in the General Population and receiving services in a Safety Cell, unlike the males who had access to the Medical Housing Unit.

Standard 4.6 Significant Self-Harm and Suicide Prevention and Intervention: Once again, the overall findings on Standard 4.6 were similar to those of the audit. The largest concern was that some high acuity severely mentally ill detainees were being kept in a safety cell for excessive periods of

time, throwing compliance into question of the "No Excessive Deprivations" section of PBNDS Standard 4.6 F2.

None

E) DETAINEE INTERVIEWS

Ten detainees were interviewed, five males and five females. All of the males were interviewed individually, with the assistance of a professional translator. All of the males were from the Medical Housing Unit (MHU), four of them living in a nine-bed dorm and one from a single cell. All of the females were from A-Unit. One was interviewed individually and the other four were interviewed in a small group with the help of a professional translator.

All of the detainees were asked if they had problems scheduling an appointment via a sick call request with a mental health provider. Three females said they "often wait up to a week to see a provider"; however, one of the three said that when she's upset, a mental health provider will meet with her quickly. Another one said that she has a weekly scheduled appointment, and the fifth one said that she just started receiving mental health services last week. When the males were asked about scheduling an appointment via a sick call request with a mental health care provider, they said that they've only asked to see a Doctor when they need medication. Only one male and one female knew the name of their mental health provider.

No one reported having problems communicating with mental health care providers. Two females and one male reported that they don't like specific mental health care providers; consequently, they seldom talk with them.

When asked a question about the length of their sessions, they gave a range from 10 to 20 minutes. The males didn't have a problem with the length of their sessions, while the females said that they were too short. Only one detainee reported having a problem with a lack of privacy and confidentiality.

When asked why they're seeing a mental health care provider, most of the females talked about depression and anxiety, while the males talked about suicidal behavior. Those detainees being treated with medication, knew the names of their medication.

In general, the females tended to be highly emotional, becoming tearful and talking about their history of abuse. In contrast, the males tended to be withdrawn and wanted to talk about their "case".

One detainee talked about refusing his HS psychotropic medication at 1400 hours because it made him "fall asleep too early."

Two detainees talked about having "struggled with distress" when they were in segregation and three talked about the "humiliation" of being placed in the Safety Cell.

In summary, there were no problems with communication. There were also no problems with being uninformed. Everyone understood their mental health problems and they knew the names of their psychotropic medications. There appeared to be room for improvement in the timeliness of mental health services and in the length of time spent with detainees. In all cases, placement in either safety cells or segregation was a problem for both males and females, exacerbating distress.

F) BEVIORAL HEALTH RECORD REVIEW

Ten behavioral records were reviewed. One of the records was from a complainant. All of the records were electronic, (E-Clinical Works, ECW), and relatively easy to navigate. Access to the records was based on a "need to know." There didn't appear to be any problems with confidentiality.

All of the records contained an intake screen. Psychiatric evaluations were present when a detainee was being treated with medication. Signed medication informed consents were present; however, a number of them lacked a description of the side effects. Thanks to the electronic health record, all progress notes contained the required elements (i.e., reason for the appointment, use of a translator, a narrative of the session, a mental status examination, a diagnosis, and a plan). The screens, comprehensive evaluations, and suicide risk assessments also contained all of the essential elements. Referrals were made using the electronic health record which also scheduled detainees. "Rule out" diagnoses were often made without an explanation for considering each diagnosis. Additionally, when there were rule out diagnoses, diagnostic clarification was seldom achieved. The plans at the end of each progress note functioned as that detainee's treatment plan, containing goals and strategies. Unfortunately, the goals and strategies did not appear to be related to whatever treatment was taking place. In fact, the goals and strategies seldom changed over time or between detainees. The electronic record has tremendous potential in enhancing continuity of care: however, it will not be achieved if brief boilerplate phrases are used in the treatment plan.

III. REPORT SUMMARY

A) POSITIVE ASPECTS OF THE MH DELIVERY SYSTEM

1. The mental health treatment team is comprised of a MH Director who is a psychologist, a psychiatrist, a staff psychologist, and three licensed clinical social workers. These clinicians form a cohesive team which both supports and is supported by medical and custody staff.
2. Mental health staff are onsite seven days a week and medical is on-call 24 hours a day, seven days a week.
3. The rates of suicides and self-injurious behaviors are low, with no one in medical able to recall a suicide in the past seven years.

4. Detainees who have been placed on suicide watch are housed in a safety cell and continuously observed through a window in the door, until the order is discontinued by a mental health provider after a suicide risk assessment is performed.
5. The suicide watch camera-cells and the stepdown cells are rubberized/suicide resistant.
6. The Suicide Risk Assessment Form is comprehensive and standardized on the electronic health record.
7. The electronic health record (E-Clinical Works, ECW) is user friendly and it's used to facilitate compliance with PBNDS 2011 by tracking referrals and acting as a scheduler with oversite by the MH Director.
8. The ICE Health Service Corps Quality Improvement Committee meets monthly with an Agenda that includes Status Updates of QI Studies, Incident Reports, Quarterly QI Audit Tool, and Grievances. Additionally, an excellent Healthcare Failure Modes and Effects Analysis (HFMEA) was recently performed on preventing future self-harm in safety cells.
9. Detainees requiring a higher level of mental health care than what is available at Otay Mesa are transferred to an appropriate facility (i.e., Krome Transitional Unit or Alvarado Parkway Institute, an inpatient psychiatric hospital) which offer a higher level of care.
10. External audits on medical and mental health have been performed, yielding both ACA Accreditation and NCCHC Certification. Additionally, medical and mental health achieved a 100% compliance score on a Performance Based National Detention Standards 2011 Audit performed in January 2017.

B) PROBLEMATIC ASPECTS OF THE MH DELIVERY SYSTEM

- **Recommendation #1.**

- **Finding and Recommendation:** Analysis of the levels of care revealed service gaps in the Medical Housing Units (MHUs) and in the Safety Cells. OMDC merely places detainees in these specialized units and provides periodic mental health assessments of detainee's functional capacity and suicidality. This does not constitute appropriate mental health treatment. Structured and individualized treatment programs and interventions are needed for detainees who have been placed in these intermediate and acute care units. **(PBNDS-2011 4.3 II. 1 and V. A, Priority 1)**

- **Recommendation #2.**

- **Finding and Recommendation:** The continuum of mental health care for female detainees has gaps in services with the most obvious being no mental health unit(s) for females who are moderately mentally ill, in contrast to moderate mentally ill male detainees who have two nine-bed MHUs and a 14 cell MHU for detainees who need individual cells. A review of the diagnoses of females in just one general population unit revealed 47 with a serious mental illness. Furthermore, interviews with a few of those detainees revealed their fragility and tenuous mental status. The creation of a female MHU with appropriate programming/services is indicated;

however, given the relatively small number of female detainees, it might be more appropriate to create a Day Treatment Program because it both fills the gap in services and it maintains an economy of scale. This program would provide increased mental health services/activities in the Day Rooms of their current units. These services could be facilitated by low-level mental health care providers (mental health technicians and/or activity therapists) who could be clinically supervised by a mid-level or upper-level mental healthcare provider (social worker, psychologist, psychiatric nurse practitioner, or psychiatrist). **(PBNDS-2011 4.3 II. 1 and V. A, Priority 1)**

- **Recommendation #3.**

- **Finding and Recommendation:** Required monthly psychiatric follow-up sessions with detainees being treated with psychotropic medication were occurring sporadically. Follow-up sessions need to occur "at least once a month to ensure proper treatment and dosage". CRCL suggests that QI studies are utilized to determine the scope and etiology of this problem (i.e., the use of telepsychiatry due to a psychiatry vacancy and/or a new a relatively new psychiatrist learning the procedures) and to develop strategies to solve it. **(PBNDS-2011 4.3 V. A; 4.3 V.M; and 4.3 V. N4, Priority 1)**

- **Recommendation #4.**

- **Finding and Recommendation:** OMDC's mental health delivery system is inadequately staffed with six positions (these positions are identified above in the Findings section for the Designation of Authority under PBNDS 2011 Compliance), and thus limited in its ability to provide quality nonpharmacological (evidence-based) treatment to mentally ill detainees in the Medical Housing Units and in the Safety Cells. To provide this treatment, CRCL recommends OMDC hire two additional lower-level staff (i.e., mental health technicians and/or activity therapists) whose services often result in cost avoidances (i.e., a reduction in medical services, crisis services, psychotropic medication, and disruptive behavior) that outweigh costs incurred by hiring them. **(PBNDS 2011 4.3 II. 21 and V. B, Priority 1)**

- **Recommendation #5**

- **Finding and Recommendation:** The behavioral health records of all detainees being treated with psychotropic medication should contain a signed and dated informed consent which describes the medication side effects. CRCL recommends that OMDC review behavioral health records to ensure this information is included and instruct mental health staff to include this information in the future. **(PBNDS-2011 4.3 II. 24 and V. D, Priority1)**

- **Recommendation #6.**

- **Finding and Recommendation:** Psychiatric medication orders were not followed when HS medication (Hora Somni – at the hour of sleep) was being administered at 1600 hours. HS medications should be administered after 1600 hours, in the evening or at bed time

rather than late afternoon. When it's administered early, nonadherence increases. The logistical problems preventing evening administration should be investigated and solutions explored. **(PBNDS-2011 4.3 II. 20 and V. G, Priority 1)**

- **Recommendation #7.**

- **Finding and Recommendation:** Mental health "treatment plans" were inadequate. They were generic, generally not individualized, and minimally related to any mental health treatment provided to the detainee. Treatment plans should be meaningful "plans of action" developed by a multidisciplinary treatment team which includes the detainee. They should direct treatment and change as the detainee's mental status changes. Training is recommended on "how to develop useful treatment plans." The specific treatment plans may be in any format, as-long-as they contain all required elements, (i.e., 1. **signatures** from a multidisciplinary team; 2. a **diagnosis**; and 3. a **list** of a) **strengths**, b) **weaknesses**, c) **problems**, d) **objectives** which are targets used to measure progress of the treatment, e) **behavioral and measurable goals** which are tied to the problems, and f) **coordinated interventions** which answer the question, "Who does what, when?"). Specific stand-alone treatment plan forms are preferable to SOAP notes since they facilitate the development of a comprehensive plan which is easily identifiable, enhancing the likelihood of a "continuity of care." To facilitate the development and utilization of meaningful treatment plans, it's recommended that the Mental Health Director/designee construct an audit tool, which could be used to annually audit a sample of treatment plans. **(PBNDS-2011 4.3 II. 8 and V. N-4, Priority 1)**

- **Recommendation #8.**

- **Finding and Recommendation:** The development of a continuity of care treatment plan was rare, reportedly because staff received little to no notice that a detainee was being released, transferred or removed. Keeping an "updated meaningful care plan" in the detainee's electronic health record would be a solution that could facilitate continuity of care. **(PBNDS-2011 4.3 II. 5 and V. W, Priority 1)**

- **Recommendation #9.**

- **Finding and Recommendation:** Safety cell treatment plans, which were found in the "plan" section of progress notes, were inadequate. They did not change as the level of acuity changed and they did not specifically address the "environmental, historical and psychological factors" that contributed to the detainee's suicidal ideation. Stabilization "safety cell" treatment plans should be meaningful, living documents which are based on a good risk assessment and which both direct treatment and change as a detainee's mental status changes. These treatment plans are especially significant for detainees who are placed in safety cells for long periods of time. Each detainee's safety cell treatment plan should be reviewed and updated daily during rounds. Training on "How to Write and Implement Meaningful Safety Cell Treatment Plans" should be provided for all clinical staff who admit and treat detainees in Safety

Cells and for all officers who provide continuous observation. During this training, attendees should be given a tool which they should use to audit both the meaningfulness and their implementation of safety cell treatment plans. The Mental Health Director / designee should periodically audit these safety cell treatment plans as part of a larger Continuous Quality Improvement Program. **(PBNDS-2011 4.6 V. E, Priority 1)**

- **Recommendation #10.**

- **Finding and Recommendation:** Because of the deprivations and restrictions placed on detainees in Safety Cells, (i.e., no hot meals, no personal property, no toilette aside from a hole in the floor, no clothing aside from a suicide resistant garment, and no privacy) and because of high re-admission rates, lengthy stays and a perception that detainees are being punished and humiliated when admitted to a Safety Cell, an enhanced oversight procedure is recommended. This procedure should consist of developing and maintaining logs to determine: the number of detainees who have multiple readmissions; the time intervals between admissions; the names of the providers placing detainees in safety cells; the range and average number of readmissions; the average length of stay; and the clinical characteristics of outliers. The information obtained from these logs should be used to improve OMDC's crisis stabilization services. Additionally, clinicians should be instructed to use the treatment plan to document their understanding of why a detainee is not improving, what new strategies might be used for stabilization, and when a detainee needs to be sent to a facility that can provide a higher level of care. Without such documentation, Safety Cells can be perceived as tools of punishment and retribution rather than as methods of treatment. **(PBNDS 2011 4.6 V. F and CCA 2016 Suicide Prevention Guide, Priority 1)**

C) CONCLUSIONS

A DHS CRCL investigation of the mental health delivery system at Otay Mesa Detention Center was generated by six complaints filed with the Office of the Inspector General, one of which was related to medical services.

The investigation reviewed the mental health care provided to the complainant whose complaint was related to medical services along with the care provided to all detainees, including those entering and leaving OMDC by interviewing staff, interviewing detainees, and reviewing records. The care provided to these detainees was measured against PBNDS 2011 standards along with other professional standards and best practices.

Overall, OMDC's mental health delivery system was staffed by one psychiatrist, two psychologists, and three licensed clinical social workers. Additionally, the mental health program received excellent administrative, technical and clinical support from other Departments in the

facility and from the Krome Facility in Florida. Most of the mental health staff were interviewed and their credentialing files were reviewed. They were knowledgeable and skilled clinicians, with years of experience. They were committed and motivated to providing the best mental health care possible to an extremely diverse population, many of whom had a traumatic and/or criminal background. Additionally, many of these detainees were overwhelmed with the possibility of being removed from the United States. To add to the difficulty of providing mental health services to a challenging population, the providers seldom knew if the detainees were going to be removed within two months or two years; consequently, it was very difficult to set realistic treatment goals and to select effective treatment interventions. In fact, the facility population turnover was approximately 250 detainees a week. In other words, mental health's patient population was fluid. Other obstacles to treatment included movement and space challenges. Movement was a challenge because males and females were separated, ICE detainees and Marshall inmates were separated, and low and high security residents were separated. Space was also a challenge because mental health was competing with other facility programs to use the same space.

OMDC's six clinicians should have been able to provide excellent mental health services to between 250 and 300 detainees, especially with an electronic health record; however, their efficiency and effectiveness was compromised by the volume of transient detainees, the obstacles listed above, and the multiple missions assigned to mental health, (i.e., treating mild, moderate, and severe mentally ill detainees; treating chronically mentally ill detainees; and treating acute mentally ill detainees).

Mental health staff were providing good mental health care to mild mentally ill detainees who lived in the general population. They were also doing a good job triaging the most seriously mentally ill and the most acutely mentally ill, transferring them to other facilities which provided higher levels of care. Problems arose when they were faced with providing services to the moderate mentally ill detainees who needed a higher level of care than what was being offered in the facility's general population and a lower level of care than what was offered in psychiatric hospitals. These moderate mentally ill detainees needed a "closed supportive living unit" with structured programs that could be run by lower-level mental health technicians and/or activity therapists. At the time of the investigation, the moderate mentally ill male detainees were placed in the Medical Housing Unit which functioned as an intermediate level of care; however, it was far from ideal because it was shared with detainees who needed an intermediate level of medical care and there was little to no mental health programming taking place. The female detainees didn't even have an intermediate level of care. Without effective intermediate care units, moderate mentally ill detainees bounced back and forth, between the general population units where they were overwhelmed, and the safety cells where they were stabilized, as illustrated by the two complainants who were investigated in this review. Both fell into this intermediate grey level, bouncing back and forth between general population and safety cells.

OMDC's mental health resources were spread thin; consequently, clinical care was compromised because staff took "shortcuts" (i.e., using a progress note's "plan" as the treatment plan, not reviewing collateral documents, and seldom referring unstable detainees to a psychiatrist) and they didn't meet the mental health needs of many detainees (i.e., by not providing trauma groups for female detainees in general population). Clinical care was especially compromised for the moderate mentally ill detainees; consequently, they bounced back and forth between general

population units and safety cells. A possible solution would be to hire lower level mental health care providers (i.e., mental health technicians and activity therapists) who could provide the programming and services that were needed but not being provided.

Thanks for the opportunity to perform these investigations. If you have any questions, please don't hesitate to call me.

(b) (6)

(b) (6), Ph.D.
Clinical Director, MHM
Georgia Department of Corrections

IV. APPENDIX I

- **Detainee's Interviewed**
  - Male Detainees
    1) (b) (6)
    2)
    3)
    4)
    5)
  - Female Detainees
    1) (b) (6)
    2)
    3)
    4)
    5)

V. APPENDIX II

- **Behavioral Records Reviewed Records Reviewed**
  - (b) (6)
  - [redacted]

Otay Mesa Detention Center
Complaint No. 17-08-ICE-0377
Complaint No. 16-10-ICE-0582
Complaint No. 17-09-ICE-0330
Complaint No. 17-07-ICE-0344
Complaint No. 17-06-ICE-0378
Complaint No. 17-09-ICE-0379

APPENDIX A
NON-PRIORITY RECOMMENDATIONS

Medical

1. There is a full time radiology technician employed at the facility and an x-ray machine. However, only chest x-rays can be currently performed as the table necessary to perform the spectrum of radiographs is not installed at the facility. A table should be installed that allows a broad range of x-rays to be obtained. This would obviate the need to send patients outside of the institution for x-rays.

2. CRCL finds that while both the Health Services Administrator (HSA) and the physician (the Clinical Medical Authority) are dedicated to the wellbeing of the patients, only the physician is scheduled for clinical shifts. CRCL believes that scheduling the HSA for clinical shifts would improve morale and communication between the InGenesis contractors, the physician, and IHSC administration.

3. The electronic medical record system eClinicalWorks is cumbersome, slow and encountered glitches. CRCL recommends that OMDC searches for a different system or upgrades the current one.

4. The Correctional Pharmacy Software (CIPS) software program used in the pharmacy is not integrated with the eCW electronic medical record. This causes the pharmacy operations to be hindered by having to coordinate medications in two different electronic systems. There should be computer software technician be assigned to review the electronic pharmacy and medical records and provide a fix for this problem.

5. The office space adjacent to the medical unit should be enlarged to include more space for practitioners and meetings. Currently, most meetings are conducted in a small lounge, which does not provide enough space.

Mental Health

6. Because of the deprivations and restrictions placed on detainees in Safety Cells, (i.e., no hot meals, no personal property, no toilette aside from a hole in the floor, and no privacy) and because of apparent high re-admission rates, long lengthy stays and a perception that detainees are being punished and humiliated when admitted to a Safety Cell, QI studies

are recommended to determine: the number of detainees who have multiple readmissions; the range and average number of readmissions; the average length of stay, and the characteristics of outliers. The results of these QI studies can be used to improve OMDC's crisis stabilization services. Additionally, clinicians should be sensitive to such issues and document their speculations as to why a detainee is not improving, what new strategies will be used for stabilization, and when a detainee might be sent to a facility that provides a higher level of care. Without such documentation, Safety Cells can be perceived as tools of punishment and retribution rather than as methods of treatment. (PBNDS-2011 4.6 V. F and CCA 2016 Suicide Prevention Guide).

Corrections

7. CRCL recommends that OMDC conduct training with officers and supervisors regarding the use of catch-phrase language in force reports. In reviewing the officers force reports, it was determined that some training is needed to ensure that catch-phrases like, "using the minimum force necessary," are not included in the reports. The, "minimum force necessary," does not describe the actual force applied. It is more important to describe the actual actions taken and the level of force exerted to overcome resistance, rather than to leave it to the reader to imagine how much force was the "minimum" amount. (Best Practices)

8. CRCL recommends that OMDC review and consider revising the definition of use of force in the Use of Force policy. The current definition reads, "Use of Force – Any incident or allegation of a physical assault perpetuated by staff against a detainee. This includes any incident or allegation of facility staff engaging in an act of violence against a detainee, or any intentional attempt to harm that detainee through force or violence, regardless of whether injury results or a weapon is used." CRCL suggests a simple definition of force such as, "Any action taken by staff to physically overcome resistance in an effort to control or restrain a detainee." (Best Practices)

9. CRCL recommends that OMDC consider revising the ICE Confinement Record to provide a space to better document the reasoning for placement and release from segregation. While the form requires a general reason for placement be documented,[1] it does not require a documented reasoning for release. It is important to document the reasoning that went into a decision to both place and release a detainee from segregation.[2] While this level of detail in documentation is not an issue of PBNDS compliance, it is a best practice and protects both the detainee and the facility administration. (Best Practices)

10. CRCL recommends that OMDC consider revising the grievance process to allow for a clearer description of what is being granted, granted-in-part or denied in a grievance request. Grievance findings are currently determined and expressed in terms of, "inmates'

[1] This is a check-the-box designating the reason for placement, e.g., protective custody, disciplinary, etc.
[2] This is especially true in protective custody cases. Documenting the reason protective custody is needed, as well as, the reasoning for determining that a detainee no longer needs the protection of segregation establishes a record that the decisions to place and release were not arbitrary or without appropriate consideration.

favor" or "not inmate's favor." While this is not contrary to the PBNDS, the process may be better served by developing a finding process that includes more specific language such as, "grievance granted," "grievance granted in part," or, "grievance denied." This type of documentation would provide information to the management team regarding grievance outcomes that could serve to influence operational and program practices. (Best Practices)