

JAIL SUICIDE/MENTAL HEALTH UPDATE

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FACTORS IN PRISON SUICIDE: ONE YEAR STUDY IN TEXAS*

by

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The rate of suicide in jail facilities is substantially higher than that in the general population. Although the number of studies on suicide in county jails has increased in recent decades, the issue of prison suicide has not received comparable attention. Among the previous studies of suicide in state prisons, much of the focus was on suicide rates and victim profiles relying on demographic data, with little or no consideration of precipitating factors, mental illness of suicide victims, and the differences between the prison and jail suicides. This dearth of information on prison suicides undoubtedly limits our appreciation of risk factors for prison suicide. This study, therefore, is intended to examine variables associated with prison suicide and to establish a better understanding of the phenomenon of suicide in prison populations, which we expect will, in turn, assist in the development of improved preventive measures for incarcerated populations.

Methods

We reviewed all 25 cases of inmate suicide, committed within 20 of the 107 Institutional Division prison units of the Texas Department of Criminal Justice Prison System (TDCJ), during the period from June 1996 through June 1997 (13 months). The

cases consisted of 24 males and 1 female, aged 21 to 56 years. There were then Caucasian Americans, eight African Americans, and seven Hispanic Americans. The sample was comprised entirely of prisoners serving different lengths of sentences (ranging from five years to life imprisonment) for a wide variety of crimes against person and/or property as well as drug related crimes.

Data on the suicide victims were obtained from the record department of the Texas Department of Criminal Justice. The victims' medical charts, confinement records, psychiatric evaluation, treatment records, and autopsy reports were reviewed. Data were gathered on the following sets of variables: 1) demographics, 2) mental disorders, 3) characteristics of suicide victims, 4) circumstances of suicide, and 5) autopsy reports.

Results

Demographic Characteristics of Suicides

Age—Ages in this study ranged from 23 to 56 years, with an average age of 33, which is similar to the average age of 34 of the TDCJ prison population.

Gender—Males constituted 96% (N=24) of the suicides compared to only 4% (N=1) females. This was not surprising, since the vast majority of inmates (94%) in the Texas Prison System were males.

Ethnicity—The White inmates consist of 28.6%, Black inmates consist of 46.0%, and Hispanic inmates consist of 26.0% of the total inmate population in the Texas Prison System. Inmates from other ethnic background consist of 0.4% of the inmate population. The inmates who committed suicide were 40% (N=10) White,

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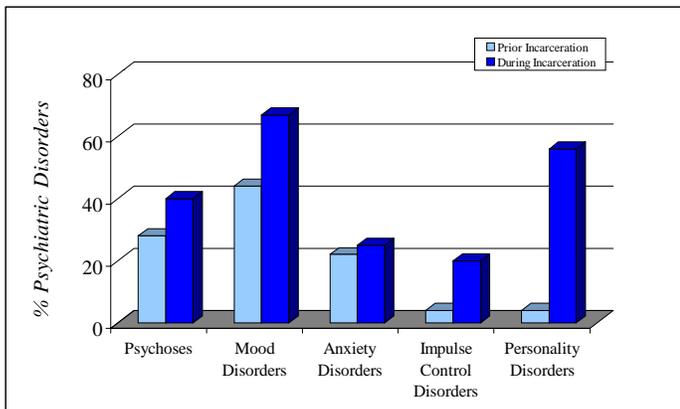
32% (N=8) Black, and 28% (N=7) Hispanic. The suicide victims' ethnic background is slightly over-represented by White inmates and under-represented by Black inmates.

Mental Disorders Among the Suicides

Rates of Mental Illness—Results of this research suggest a high rate of mental disorders among prisoners who committed suicide. Of all 25 cases reviewed, mental disorders excluding personality and substance abuse disorders had been identified at intake screen for 60% (N=15). Psychiatric diagnoses were identified at some time during incarceration for 76% (N=19). Onset of mental disorders occurred before 18 years of age for 67% (N=10). Eleven of these suicide victims had at least one or more prior admissions to a psychiatric hospital.

A wide spectrum of diagnoses emerged across the sample, with high rates of several psychiatric disorders during incarceration. Figure 1 shows all of the psychiatric disorders recorded prior to and during incarceration. The disorders were categorized into five groups: 1) psychoses including: schizophrenia, schizoaffective disorder, and psychosis, not otherwise specified; 2) mood disorders including: major depression, bipolar disorder, adjustment disorder with depressed mood, and dysthymic disorder; 3) anxiety disorders including: acute stress disorder and anxiety disorder with panic attacks; 4) impulse control disorders including: intermittent explosive disorder; 5) personality disorders including: antisocial and borderline personality disorders. We found that mood disorders

Figure 1 — Psychiatric Disorders Among Suicide Victims



were the most frequent among all psychiatric diagnoses recorded prior to incarceration (44%), and remained the highest (64%) during incarceration. Psychoses were noted prior to incarceration in 28% of the suicides, and 44% were diagnosed as psychotic at some time during their last incarceration. Personality disorders were recorded in only 4% of the suicides at admission, but the diagnosis was identified in 56% of the suicides during the current incarceration, with all personality disorders being borderline and/or antisocial. Diagnoses documented in current prison records were higher than at admission. The diagnoses increased 14 times for antisocial and/or borderline personality together, increased 1.5 times for mood disorders, 5 times for impulse control disorders, and increased 1.4 times for psychoses.

Family History of Mental Disorders, Substance Abuse, and Incarceration—Thirty-six percent of inmates who committed suicide had family histories of mental illness, substance abuse, or incarceration. Twenty percent had family members with mental illness, 12% had family members with alcohol or drug abuse, and 8% had family members who had been incarcerated. Additionally, 8% had family members who had committed suicide, 16% had been subject to physical or sexual abuse, and 8% had been raised in foster homes.

History of Suicide Attempt—History of a prior suicide attempt was found to be associated with the completion of suicide. Table 1 lists prior suicide attempts and suicide expressions

Table 1 — History of Suicide Attempt

	Prior to Incarceration	During Incarceration
Suicide Attempt		
No attempt	12/25* (48%)	9/25 (36%)
With attempt	13/25 (52%)	16/25 (64%)
With multiple attempt (>3)	10/13 (77%)	9/16 (56%)
Suicide Ideation		
Voiced suicidal ideation	N/A	18/25 (72%)
Denied suicidal ideation	N/A	5/25 (20%)
No data on suicidal ideation	N/A	2/25 (8%)

*Number of suicide victims.

made by the inmates. Over half of the inmates reported at least one attempt prior to incarceration, and over two thirds of these who had attempted suicide prior to incarceration had made multiple attempts. The percentage of suicide attempts in prison was also quite high. Sixty-four percent of those who committed suicide had made at least one prior suicide attempt in prison, and 56% of those who had attempted suicide made more than three attempts to kill themselves in prison. Sixty-three percent of those who had previously attempted suicide in prison used lethal methods including hanging, burning, swallowing a razor blade, strangulation, and neck cutting during their unsuccessful attempts, all of which resulted in psychiatric hospitalization. Thirty-seven percent of those who had attempted suicide used less serious methods including cutting their wrists, overdosing on small amounts of medications, and refusing food and water. It is possible that these inmates chose less serious methods to inflict pain, cause self-injury, or gain entry into a hospital without intention of death.

History of Substance Abuse—Our study found that 68% of the inmates who committed suicide had a history of alcohol abuse or dependence, and 68% had illicit drug abuse or dependence. Among the drugs abused by the inmates were: 48% marijuana, 32% cocaine, 28% heroin, 24% barbiturates, 24% methadone, 24% LSD, 24% inhalants, 20% amphetamine, and 12% benzodiazepines. Forty-eight percent of the suicides had a history of both alcohol and drug abuse or dependence, and 34% had multiple drug abuse or dependence. There was no information available in the records on alcohol or drug abuse during incarceration, which is prohibited in the prison. As noted in the autopsy reports below, one suicide victim was tested positive for a drug at the time of actual suicide.

Characteristics of Suicide Victims

Comorbidity of Psychiatric Illness and Substances Abuse—Of the suicide victims, 68% had two or more psychiatric diagnoses prior to incarceration; the rate increased to 88% during incarceration. Examination of comorbidity of mental disorders and substance abuse in this sample population revealed that 68% of the suicide victims who suffered from psychiatric disorders also had presentencing substance abuse. Seventy-five percent of the suicidal victims with mood disorders and 91% with psychotic disorders had abused alcohol and/or drugs. Other psychiatric disorders had lower correlated substance abuse.

Stressors—Various subjective comments suggesting stressful circumstances made by the suicide victims were noted in their records. These comments gave some clue as to what stressors these victims might have experienced before they committed suicide. We grouped these comments into four types of stressors in Table 2.

Conflicts with the Institutional Environment—Undesired unit placement, work assignment, and disciplinary confinement were the most commonly mentioned institutional stressors. Some offenders could not bond with other inmates in their units; they experienced complete psychological isolation; some found their work assignment unfavorable and had absolutely no influence on decisions imposed on them; some had frequent fights with other inmates and received disciplinary confinement.

Interpersonal Conflicts—The most common stressors mentioned by suicide victims were disrupted relationships with their families and relatives. After an offender's twin brother passed away, the thought of his own death seemed to be bearable. An offender expressed extreme sadness over the separation from his one-year-

old son. Another offender received a letter from a murder victim's mother. Tremendous guilt and shame were expressed in a counseling session about the crime for which the offender was convicted. Several offenders who committed suicide alleged physical and sexual assault by other inmates. Some had frequent arguments with staff and fights with other inmates.

Legal Processes—Alleged sexual assault of a female guard was found in one offender's record. The offender received an additional charge and disciplinary confinement. A suicide victim was found to be very anxious in his cell prior to a court hearing for alleged physical assault to a guard. An offender committed suicide three days after his entry to the prison for a long sentence.

Medical Conditions—Several offenders who committed suicide had long-standing frequent seizure episodes; one offender had severe insomnia for several days; two offenders might have had delirium from unknown conditions recorded prior to their suicides. Other findings of medical conditions included end-stage diabetes, AIDS with central nervous system involvement, hypertension, and heart disease.

Stressors that the victims experienced within six months of their suicide were defined as acute stressors; stressors that lasted more than six months, chronic stressors. Forty-eight percent of the victims experienced acute stressors. Seventy-six percent suffered from chronic stressors. Of the acute stressors, institutional conflict seemed to be the most common, while interpersonal conflict and medical condition appeared to be high among the chronic stressors.

Criminality versus Psychiatric Disorders and Substance Abuse—Forty-four percent of the suicide victims were charged with violent offenses against a person; 36% with property offense; 12% with

Table 2 — Stressors Associated with Suicide

	Institutional (no.)	Interpersonal (no.)	Legal (no.)	Medical (no.)
Acute Stressor (within 6 months)	Undesired Placement (7) Discipline Confinement (2)	Disrupted Relation (2) Fight with Inmates (1) *Physically Beaten by Other Inmates (2) Sexually Assaulted by Other Inmates (3)	Pre-Hearing (1) Charge with Assault Guard (1) Recently Received a Long Sentence (1)	Delirium (2) Insomnia (1) Seizure (2)
Sub-Total	9	8	3	5
Chronic Stressor (>6 months)	Undesired Placement (5)	Disrupted Relations (6) Fight with Inmates (4) *Physically Beaten by Other Inmates (1) *Sexually Assaulted by Other Inmates (1)	N/A	Medical Conditions (8)
Sub-Total	5	12	---	8

*Physical and sexual assaults were noted from inmates' comments in their clinical records, not adjudicated.

drug offense; and 8% with public-offender offense (Table 3). The victims in this study were more frequently charged with violent offenses against a person. Suicide victims were sentenced to an average of 153 months for all offenses.

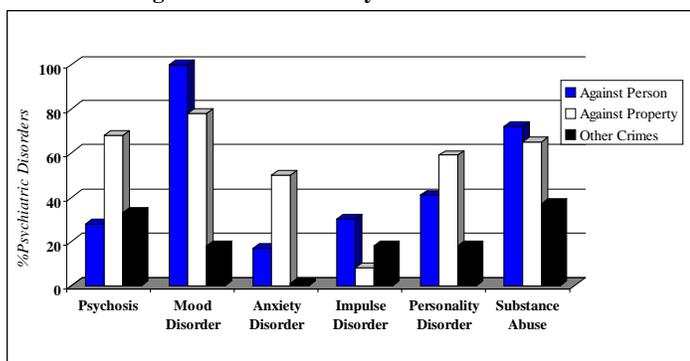
Offense and Sentence—Forty-four percent of the suicide victims were charged with violent offenses against a person; 36% with property offenses; 12% with drug offenses; and 8% with public-order offenses (Table 3). The victims in this study were more frequently charged with violent offenses against a person. Suicide victims were sentenced to an average of 153 months for all offenses.

From the time of admission to prison until the time of their death, the victims served an average 25 months, only 18.4% of their total sentenced time. Twenty percent of the victims completed suicide within three months of their confinement to the prisons.

Table 3 — Offenses

Offense	TDCJ Suicides
Violent Offenses	44%
Murder	16
Sexual Assault	8
Robbery	16
Aggravated Assault	4
Property Offenses	36%
Burglary	28
Larceny/Theft	8
Fraud	0
Drug Offenses	12%
Possession	8
Trafficking	4
Public-Order Offenses	8%

Figure 2 — Criminology in Suicide Victims



Circumstances Related to the Suicides

Method of Suicide—Nineteen of all the suicides were committed by hanging. Of the remaining six suicides, three victims overdoses on tricyclic antidepressants, one jumped from a third floor that was 30 feet above the ground inside of the prison unit, one slashed his left arm and bled to unconsciousness, and one died of strangulation.

Material Used—A variety of materials were used for committing suicide. Bed linen was the most commonly used material for hanging. Other materials included socks, an elastic strip from underpants, a shoelace, and a bandage from wound dressing. The hanging ligatures were found to be attached to an air vent duct (N=10), a handrail on the wall (N=1), a bed rail (N=4), a cell bar (N=2), and a lock box (N=1), and unknown attachment (N=1). Tricyclic antidepressants were the next most common material used for suicide. One victim obtained the medication from unknown sources; two others obtained the antidepressant by prescriptions from psychiatrists. Other materials were also used for suicide, but much less often.

Time and Location of Suicide—There was no obvious pattern to the time of day when the suicide occurred. Suicides occurred throughout a 24 hour period, with 64% of victims dying between 7:00 p.m. and 7:00 a.m. and 36% between 7:00 a.m. and 7:00 p.m. Seventy-six percent of suicides were committed in single-person cells, while much fewer occurred in shared cells (20%), and on an elevated floor outside the prison cells (4%).

Interventions—Twenty-two of the suicide inmates reported a history of mental illness at intake screen, all of them received follow-up psychiatric evaluation and treatment during incarceration. Fifty-six percent had psychiatric hospital admissions for suicide attempt or threat, or acute psychotic episode. Fifty-two percent had regular psychotropic medication follow-up visits; 32% received individual counseling; and 12% participated in group therapy. Mental health professionals in the prison system provided psychiatric medication management, group therapy for anger control, and substance abuse. All the suicide victims who attempted suicide before their death (N=16) had received crisis intervention including suicidal precautions, protective custody, or hospitalization at the time they expressed their thoughts or threats of suicide, or attempted suicide. Sixteen of the inmates had at least one admission to the prison psychiatric hospital, seven of them had three or more admissions during incarceration. Of those with at least one admission, 93% had been admitted within six months of the successful attempt.

Autopsy Report

Mechanism of Death—All of the inmates who hanged themselves and the one who strangled himself died of anoxia due to vascular and airway compression. Of the three inmates who overdosed on tricyclics, two died of heart failure, and one died of sepsis secondary to peritonitis due to colon perforation. One inmate died of exsanguination secondary to a severed medial cubital vein. One inmate died of cerebral hemorrhage secondary to brain injury from jumping from a 30-ft height from third floor.

Evidence of Previous Suicide Attempt—Thirteen inmates had a history of a prior suicide attempt based on self-report at intake screen. The postmortem autopsy found that a total of 18 inmates made a previous suicide attempt as evidenced by healed scars from skin lacerations and gunshot wounds.

Postmortem Toxicology—Seventeen inmates had toxicology tests of urine, blood, and body vitreous humor. Thirteen of them had negative findings of alcohol and other drugs, three had toxic level of tricyclics, and one was positive for propoxyphen that had been obtained by the inmate from an unknown source.

Discussion

Some of the findings in this study were consistent with literature. For example, the majority of suicide inmates were male (96%), had attempted suicide during the current incarceration (64%), committed suicide by means of hanging (76%), chose bed linen as the suicide instrument (60%), and committed suicide in a single cell (72%). In contrast to jail suicides, however, 24% used other lethal means including overdosing on tricyclic antidepressant, jumping, cutting, and strangulation. The time of the suicide was widely distributed and not clustered around entry to the prison.

The characteristics of this study that differ from other studies are the following:

Psychiatric Disorders Among the Suicides—A strong correlate indicator for suicide in the general population is the presence of mental illness.¹ Rich and Runeson² found that more than 90% of all persons who commit suicide have a diagnosable psychiatric illness, with depression and alcohol use the most common diagnoses. Other persons at risk for suicide include those diagnosed with schizophrenia, borderline or antisocial personality disorders, manic-depressive disease, dysthymia, and anxiety disorder.^{3,4,5} The limited research available on prison suicide indicates a history of psychiatric illness can be a factor associated with an increased risk for suicide.^{6,7,8}

Suicide inmates in this study were reviewed with special focus on their history of psychiatric illness and current psychiatric diagnoses. We found that 60% (N=15 of 25) of the victims had a history of psychiatric illness prior to incarceration, which was similar to the percentage of prison suicide victims with mental illness reported by Anno of 68%.⁷ and higher than that reported by White of 49%.⁸ The percentage of the victims who suffered psychiatric illness while incarcerated increased substantially to 76%. One reason for the high rates of psychiatric illness among TDCJ suicide victims is that the screening, diagnostic, and subsequent evaluation procedures are rather thorough. All inmates are carefully evaluated; mentally ill inmates who otherwise would be missed are selected and receive appropriate treatment. Another reason for such high rates of psychiatric illness among the suicide victims is that TDCJ had provided mental health training for all security, medical, and mental health staff to recognize mental illness. This training enabled staff to make prompt referral to mental health professionals for appropriate diagnostic evaluation and treatment of the mentally ill inmates.

Studies on jail suicides usually provide little information about previous psychiatric hospitalizations or treatment of suicide victims. The New York State Commission of Corrections⁹ found that 55% of all inmates who committed suicide during 1979 had been psychiatrically hospitalized on at least one prior occasion. Farmer et al.¹⁰ found that 53.8% of the inmates in a county jail who had self-inflicted medically serious injury had previous inpatient psychiatric diagnoses and treatment while incarcerated. However, such studies provide no information on psychiatric diagnoses and treatment. The few studies available on prison suicide usually provided percentages of mentally ill suicide victims^{7,8,11} but no detailed report on pretrial psychopathology, or psychiatric illness suffered by suicide victims while incarcerated.

To our knowledge, this is the first study to report the rates of psychiatric disorders in prison suicide victims. We report a wide variety of postsentenced disorders. The most frequently recorded psychiatric disorders among the Texas prison suicide victims are psychotic disorders (44%), mood disorders (64%), and personality disorders (56%). In comparison with presentencing population histories, the postsentenced psychiatric disorders were 14 times higher for antisocial and/or borderline personality together, 1.5 times for mood disorders, 5 times for impulse control disorders, and 1.4 times for psychoses. The results of this study provide data on both pretrial psychopathology and postsentenced psychiatric disorders before the victims committed suicide. The increases in the rates of postsentenced psychiatric disorders may be associated with possible exacerbation of the psychiatric illness in the prison, as well as the preventive measures employed by TDCJ system, and especially the comprehensive, concurrent diagnostic evaluations provided all newly admitted prisoners.

The substantial increase in the rate of personality disorders in post-sentenced suicides may be associated with a number of factors. The prison intake screen may focus more on axis I than on axis II psychiatric disorders in the Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM-IV). The suicide inmates with personality disorders may have remembered major diagnosis for which they receive treatment or hospitalization; personality disorders may not have been the focus of their earlier treatment or their memory of treatment. Therefore, inmates' reports at the prison intake screen may not include their previously diagnosed personality disorders. If diagnosed, the suicide inmates' personality disorders may be exacerbated in the crowded, strictly structured prison environment. Personality disorders certainly present a challenge to the prison mental health staff. Development of effective treatment strategies will help in the management of inmates with personality disorders.

Since accurate data on the percentage of the psychiatric disorders among inmates in the general population of the Texas Prison System is not available, it is difficult to compare psychiatric disorders, or draw conclusions based on this report alone. Further research is needed to study the prevalence of psychiatric disorders in all inmates.

Substance Abuse and Comorbidity of Psychiatric Disorders—In his nationwide jail suicide study, Hayes¹² found that inmates who were charged with alcohol or drug related crimes are more suicide-prone, and committed suicide during the first hours and days after arrest, suggesting withdrawal from alcohol or drugs may have been an important factor in their suicidal acts. Physical withdrawal may not be a factor in triggering suicide among inmates in state prison, but abstinence from alcohol and drugs might have deprived the suicidal inmates of their primary means of coping with stressful situations in prison. The high rates of alcohol abuse (68%) and drug abuse (68%) among the Texas prison suicide victims indicate that inmates who have been substance abusers are at significant risk of suicide while imprisoned, even though they are not presently under alcohol or drug influence. Except the three victims who died from overdose on tricyclic antidepressant and the one who had positive propoxyphen in urine, all the Texas prison suicide victims had a negative postmortem toxicology test. It is unknown whether or not this one particular victim took suicidal action while under the influence of propoxyphen.

People who abuse alcohol and drugs are prone to develop substance induced psychotic disorders, mood disorders, or anxiety disorders.¹³ People who suffer from major psychiatric disorders such as psychotic disorders, mood disorders, and anxiety disorders often use alcohol or drugs as a means of calming themselves or easing their anxiety. As expected, the comorbidity of presentencing substance abuse and psychiatric disorders are common (68%) among the Texas prison suicide victims. While it has been recognized that alcohol and/or drug intoxication is a contributing factor in the etiology of suicide attempt in jail studies, it has not been recognized in prison suicide studies; comorbidity has been much less recognized as an important factor in prison suicide.

Stressors—In jail suicide studies, Hayes¹⁴ reported certain features that promote suicide behavior: fear, distrust, lack of control, isolation, and shame. Although prison suicide victims share some of these stressful conditions, the stressors that could be precipitating factors in prison suicide are not identical. Among the acute stressors experienced by the Texas prison suicide victims, an acute trauma, disrupted relationship, sentence hearing, and/or acute medical condition appeared to be the most commonly recorded and might have played important roles in the victims' decision to commit suicide. The chronic stressors experienced by the suicide victims are undesired placement and assignment, loss of contact with family, a fight with other inmates, and chronic medical conditions. The suicide victims with psychiatric disorders in particular may have weakened mental strength and coping ability to handle the common stresses in the prison. When stressors increase or a crisis emerges, they have far fewer inner resources to create solutions to the crisis; they may become hopeless and choose to take their lives.

These stressors are not inconsistent with several models of suicide.¹⁵ The stressors should be viewed as life events that offenders may not be able to handle. Therefore, recognizing these stressors and providing support and intervention should be an important part of education and training for not only mental health professionals, but for other prison staff members as well. However, even all the appropriate procedures for suicide prevention provide no guarantee that inmates will not attempt suicide.

Criminality and Sentence—Most jail studies indicated that suicide victims had been charged with “nonviolent” crime.¹⁶ However, a recent jail study by DuRand¹⁷ indicated that inmates charged with murder or manslaughter were 19 times more likely to commit suicide than were inmates with other charges, and 39% of suicides were committed by individuals charged with murder. He concluded that the charge of murder or manslaughter is an important risk factor in jail suicide.

Anno et al.¹⁸ noted, “It is difficult to come to any conclusions regarding potential suicide risk on the basis of offense alone.” She found that nearly 58% of 38 suicide victims were charged with violent crimes including murder, manslaughter, sexual assault, robbery, and aggravated assault, and 42% were charged with nonviolent crimes. Our findings are in contrast with results of jail suicide and some of the prison suicide studies. Forty-four percent of Texas prison suicide victims were charged with violent crimes, but 56% were charged with nonviolent crimes. The charges of murder or other violent crimes do not appear to be a

contributing factor to the suicides. Clinicians should take all relevant factors into account when assessing an inmate's suicide risk, including psychiatric disorders and comorbid substance abuse, as well as chronic and acute stressors, not based on the criminal offense alone.

Important factors that appear to be associated with increased risk of prison suicide include: 1) previous and current psychiatric disorders, especially psychotic disorders, mood disorders, and antisocial or borderline personality disorders; 2) presentencing and/or comorbid substance abuse; 3) a history of suicide attempt; and 4) chronic and acute stressors.

Our study provides findings that go beyond the demographics or history of mental illness of suicide victims. Beyond reporting presentencing psychopathology in suicide victims, this study also details presuicide psychiatric illness. This approach may eventually improve the ability of prison mental health professionals and prison staff to successfully discriminate those at highest risk from the general incarcerated population. Hopefully these findings contribute to a better understanding of prison suicide and to assist in the development of effective suicide prevention programs in prison.

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References

- ¹Hirschfeld RMA, Davidson L. Risk factors for suicide. *Rev Psychiatry* 1988;7:307-33.
- ²Rich CL, Runeson BS. Similarities and diagnostic comorbidity between suicide among young people in Sweden and the United States. *Acta Psychiatrica Scand* 1992;86:335-9.
- ³Stevenson JM. Suicide. In: Talbot JA, Hales RE, Yudofsky SC, editors. *The American Psychiatry Press text book of psychiatry*. Washington, DC:American Psychiatry Press, Inc. 1988;1021-35.
- ⁴Robin LN. Epidemiological studies in suicide. *Psychiatric Annals* 1988;18:619-27.
- ⁵Weissman M. The epidemiology of suicide attempts. *Arch Gen Psychiatry* 1974;30:737-46.
- ⁶Copeland A. Fatal suicide hanging among prisoners in jail. *Med Sci Law* 1989;29:351-5.
- ⁷Anno BJ. Patterns of suicide in the Texas Department of Corrections 1980-1985. *J Prison Jail Health* 1985;5(2): 82-93.
- ⁸White TW, Schimmel DJ. Suicide prevention in federal prisons: a successful five-step program. In: Hayes LM, editor, *Prison suicide: an overview and guide to prevention*. Washington, D.C.: United States Department of Justice, 1994.
- ⁹New York State Commission of Correction. *Suicide in state and local correctional facilities*
- ¹⁰Farmer KA, Felthous AL, Holzer CE. Medically serious suicide attempts in a jail with suicide-prevention program. *J Forensic Sci* 1996; 41(2): 240-6.
- ¹¹Green C, Kendall K, Andre G, Looman T, Polvi N. A Study of 133 suicides among Canadian federal prisoners. *Med, Sci & Law* 1993;33(2):121-7.
- ¹²Hayes, LM. And Darkness closes in...: a national study of jail suicides. *Crim Jus Behav* 1983;10:461-84.

- ¹³ Kaplan HI, Sadock BJ. Substance-related disorders. In: Cancro R, Edmondson J, editors. *Synopsis of psychiatry*. Baltimore: Williams & Wilkins, 1988;391-5.
- ¹⁴ Hayes LM. Prison suicide: an overview and guide to prevention. *Crisis* 1994;5(4):155-8.
- ¹⁵ Bonner RL. Isolation, seclusion, and psychological vulnerability as risk factors for suicide behind bars. *Assessment and prediction of suicide*: New York, NY: Guilford Press, 1992;398-419.
- ¹⁶ Hayes LM. National study of jail suicides: seven years later. *Psychiatric Quarterly* 1989;60(1):7-28.
- ¹⁷ DuRand CJ. A quarter century of suicide in a major urban jail: implication for community psychiatry. *Am J Psychiatry* 1995;152:1077-80.
- ¹⁸ Anno BJ, Harrison BP, Rowan JR. *Recognizing and responding to medical emergencies and potential suicides*. Chicago: National Commission on Correctional Health Care, 1983. □

RETHINKING SUICIDE PREVENTION AND MANIPULATIVE BEHAVIOR IN CORRECTIONS

by
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The Spring (2001) issue of *Jail Suicide/Mental Health Update* takes a fresh look at the ongoing debate of suicide prevention and manipulative behavior in jails and prisons. Hayes (2001) poignantly captures the tragic risk associated with classifying self-harming behavior as manipulative and responding with inattention. Dear, Thompson, and Hills' study (2001) demonstrates further empirical evidence that suicide intention and risk to life do not always differentiate self-harming inmates with manipulative motives from those who want to escape or die. The authors suggest the better and safer approach may be to manage a non-suicidal (or "manipulative") prisoner as if he was suicidal. This "ideal" suggestion of course presents major challenges to overburdened clinicians in the field who encounter countless inmates who act out or threaten self-harm for a variety of reasons other than wanting to die. Deciding when and where to best utilize staff and program resources and for which inmates is an ongoing struggle for the correctional mental health professional. In addition, from a behavioral management perspective, different self-harm motives and behaviors suggest different interventions are necessary for effective behavior control and change.

A major problem in the current debate is the use of classification and labeling with the term manipulative behavior. One definition of manipulation according to Webster is to control or play upon others by artful, unfair, or insidious means to one's own advantage. When self-harm is viewed in this manner, people involved with the "manipulator" feel used and taken advantage of, and often react defensively with attacks at worst and avoidance at best. Various forms of self-harm behavior may indirectly take advantage of others (in terms of time, energy, work, attention; etc.). However, in reality, these self-harm behaviors are designed to bring some solution or relief to a problem, no matter how poor of a solution it might be. If the reaction to the behavior by others is avoidance or retaliation, this response may escalate the self-harm behavior in an effort to draw further attention to the problem or as an attempt to punish others for their unresponsiveness.

Reconceptualizing self-harm behaviors within a problem-solving framework would seem to offer advantages over the suicidal/manipulation dichotomy, both in terms of management solutions as well as minimizing destructive interpersonal reactions. It is well established that self-harm and suicidal acts are multifactorial events and different categories of suicidal behavior have different etiology, pathogenesis, and expression (Silverman & Maris, 1995). It also is well established that various levels of self-harm and suicidal behavior are behavioral outcomes from the complex interplay of specific stressors and problems of living and person vulnerabilities (Dieserod, Roysamb, Ekeberg, & Kraft, 2001). Self-harm behavior, therefore, must be examined as a problem-solving process which varies in nature and intensity according to the specific problem, a person's coping and problem-solving ability, developmental/learning history, and the degree of hopelessness and wish to die, all of which may be moderated by a host of available social and cognitive resources (Rich & Bonner, in preparation). All acts of self-harm should be evaluated within such a problem-solving framework, in order to understand the motives, intentions, risk, and solutions for a particular case.

In terms of common problem-solving dynamics, correctional clinicians frequently encounter three overlapping self-harm populations. The first group might be described as free of major emotional distress, antisocial in demeanor, and who generally threaten or act out with self-harm when they encounter an undesirable problem (often which is a consequence of their own antisocial behaviors, such as disciplinary sanctions or legal sanctions). Usually the self-harm behavior is done to produce a certain solution, has been reinforced by the correctional system, and temporarily extinguishes when the individual gets the solution he or she wants. The second group might be described as chronic self-harmers, who often display borderline personality traits in which they experience overwhelming, unregulated emotion which is often triggered by a relationship crisis. Self-harm behavior is produced to relieve emotional pressure and exert self-control. The third group is typically thought of as a suicidal "proper" population. These individuals are seriously depressed, overwhelmed with life stressors, and problems in living, often come to view their life and future as hopeless, and struggle with a wish to die for relief. It must be emphasized that each of these groups overlap, are not mutually exclusive, are not all inclusive, and any individual may advance from one group to another, depending upon problem-solving success and emotional reactions.

In conceptualizing and determining the problem-solving aspects of self-harm behaviors, clinicians must likewise complete a comprehensive suicide risk assessment of the individual in question. Having had a recent opportunity to review the literature (Bonner, 2001), risk assessment technology has greatly advanced. The mind state for wanting to kill oneself and die in reaction to a constellation of problems in living is at the core of risk assessment. The idea of suicide should be examined in terms of degree of suicide ideation, the ability to control suicidal wishes, the purpose of a contemplated plan, the strength of the person's wish to die (vs. live), the access and lethality of the contemplated plan of attempt, hopeless expectations, and attitudes toward living or dying. The actual self-harm behavior should be examined in terms of intention for death, lethality of behavior, purpose of the attempt, and opportunities for rescue. The next level of assessment targets

primary proximate risk factors which include psychological risk factors (psychache, depression, mental illness) and physiological risk factors (neurotransmitter dysfunction, heredity, drug and alcohol abuse). The third level of risk assessment focuses on primary distal risk factors, including demographics, cultural influences, and life stress/problems in living. A problem-solving approach integrates these levels by examining the individual's mind state of self-harm intention as influenced by specific problems, emotional distress reactions, inability to find solutions and relief, and motivation toward various forms of self-harm with varying degrees of intention to suicide and die.

With this in mind, once a thorough problem-solving and suicide risk assessment of threats or self-harm behavior has been conducted, the management or intervention plan should logically follow. In the case of someone who meets many of the criteria for the third or suicide proper group, it goes without saying the individual is in need of intense staff monitoring, psychological counseling, and likely psychiatric treatment. The particular treatment plan would evolve from the content and specifics of the problem-solving and mind state assessment. In the case of someone who meets the criteria of the second group, with a low-moderate intention to die, or past low lethality to harm behaviors, the intervention plan might include less intense but close staff monitoring (until crisis resolved), property restriction for items used in self harm (such as razor blades), support for the relationship crisis, and structured psychotherapy to teach mood modulation skills. Finally, for someone who demonstrates many of the characteristics of the first group, where the problem is limited and situational, the intention of the self-harm behavior is to get a certain desired solution (e.g., transfer, cellmate change, avoidance of disciplinary sanctions), correctional counseling can be most useful. Counseling should address the negative consequences of such actions, as well as a clear examination of alternative behaviors which might provide relief or more effective solutions. The individual needs to learn that there are certain options which can improve if not resolve the current problem, while at the same time understanding that self-harm behavior will not solve the problem, may create additional problems, and if it persists, it will be controlled by staff through increased staff monitoring, property and privilege restriction, and if necessary the use of correctional restraints.

Unfortunately, much of the self-harm behavior from individuals with these Group 1 characteristics has been reinforced by the correctional system by being managed with the same protocol as the suicide proper group, including full suicide precautions, often placement in a unit for "easier" time such as a hospital watch room, more privileges, reduction of disciplinary sanctions, and sometimes even the exact solution he or she wants (contrary to policy and fairness). While such individuals are in need of staff attention and monitoring especially in terms of responsible problem-solving, positive attention and reinforcement simply given to the self-harm threats or behavior are apt to increase the frequency of such behavior every time the individual encounters similar situational problems. At worst, the increase runs the risk of growing frustration for the inmate, eventual resentment and disregard by staff, greater suicide intention, and perhaps more serious self-harm or accidental death. The bottom line is that these individuals need to be taken seriously, taught and be given the opportunity to problem-solve appropriately

and maturely (and rewarded accordingly), and understand self-harm threats or behaviors will not solve the problem-at hand, will only create further problems, and if necessary will be externally controlled by staff.

One cannot discuss various self-harm behavior and various problem-solving motives in prison without recognizing that aversive environmental conditions is a primary risk factor (Bonner, 1992). By and large, most self-harm behavior in prison is exhibited by individuals who are confined in conditions of segregation, social isolation, and/or psychosocial deprivation. These conditions have been well studied and are realized empirically and legally as contributing to emotional frustration, depression, and despair. As echoed previously (Bonner, 2000):

The future of corrections must not only reevaluate the use of such archaic practices if it is serious about mental health care and suicide prevention but develop alternative housing and behavior management programs to deal with a variety of special need inmates (p.375).

In sum, inmates display a variety of self-harm behaviors for different reasons in response to varying problems in living behind bars. Motives may range from actually wanting to die to wanting specific solutions to problems or emotional relief. The term manipulation serves little useful purpose in understanding self-harm behavior and often hinders objective problem-solving and risk assessment. Each case must be evaluated in its own right and managed based on the unique problem-solving motives and intention for suicide. There is a well-elaborated literature to guide the clinician in this process. While clinicians are right to not want to reinforce self-harm behavior, it is equally important to still provide serious attention to the individual and develop contingencies which reinforce problem-solving and responsible, non self-harming behavior. Social and environmental isolation is never an appropriate consequence as it undoubtedly worsens emotional state, hinders problem-solving and can increase the risk for life-threatening behavior. Future work and research would better serve correctional suicide prevention by addressing what strategies work best for different problem-solving motives of inmates who self-harm.

References

- Bonner, R. L. (1992). Isolation, seclusion, and psychosocial vulnerability as risk factors for suicide behind bars. In R. Maris, A.L. Berman, J.T. Maltzberger, & R.I. Yufit (Eds.), *Assessment and Prediction of Suicide* (pp. 398-419). New York, NY: Guilford Press.
- Bonner, R. L. (2000). Correctional suicide prevention in the year 2000 and beyond. *Suicide and Life-Threatening Behavior*, 30 (4): 370-376.
- Bonner, R.L. (2001). Moving suicide risk assessment into the next millennium: Lessons from our past. In D. Lester (Ed.), *Suicide Prevention: Resources for the Millennium* (pp. 83-101). Philadelphia, PA: Taylor and Francis (Brunner-Routledge).
- Dear, G.E., Thompson, D.M., & Hills, A.M. (2001). Self-harm in prison: Manipulators can also be suicide attempters. *Jail Suicide/Mental Health Update*, 10(2): 3-9.
- Dieserud, G., Roysamb, E., Ekeberg, O., & Kraft, P. (2001). Toward an integrative model of suicide attempt: A cognitive psychological approach. *Suicide and Life-Threatening Behavior*, 31(2): 153-168
- Hayes, L.M. (2001). Suicide prevention and manipulative behavior. *Jail Suicide/Mental Health Update*, 10(2): 1-2.

Rich, A.R., & Bonner, R.L. (2003). Moderators, mediators, and social problem solving. In E.C. Chang, T.J. D’Zurilla, & L.J. Sanna (Eds.), *Social Problem Solving: Theory, Research, and Training*. Washington, DC: American Psychological Association Press, in preparation.

Silverman, M.M., & Maris, R.W. (1995). The prevention of suicidal behavior: An overview. *Suicide and Life-Threatening Behavior*, 25 (10): 10-21.

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**SANVILLE v. McCAUGHTRY ET AL.:
A PLAINTIFF VERDICT**

On September 21, 2001, the United States Court of Appeals for the 7th Circuit ruled that several correctional officers failed to take “reasonable steps to prevent the inmate (Matthew A. Sanville) from committing suicide,” thereby reversing a lower court opinion that had previously dismissed the case in favor of both health care and correctional personnel. The case *Sanville v. McCaughtry et. al.* (No. 00-2933), is reprinted below.

Before: MANION, KANNE, and EVANS, Circuit Judges.

KANNE, Circuit Judge:

Matt Sanville, a mentally ill inmate incarcerated at the Waupun Correctional Institution in Wisconsin, committed suicide when he was left unsupervised for approximately five hours. His mother, Martha Sanville, filed this lawsuit in federal district court, alleging that a number of prison officials violated Matt’s Eighth Amendment rights through their deliberate indifference to Matt’s serious medical needs (1). While we affirm the district court’s dismissal of plaintiff’s claims against the prison wardens and the medical professionals who treated Matt, we find that Mrs. Sanville has pleaded sufficient facts to survive a motion to dismiss her complaint against several prison guards. We thus affirm in part and reverse in part, and remand the remaining claims for further proceedings.

I. History

Matt Sanville suffered, as do a significant number of prison inmates, from a serious mental health problem. At various times in his life, doctors diagnosed Matt with major depressive disorder, aggressive conduct disorder, bipolar disorder, dysthymic disorder, adjustment disorder, mixed personality disorder, and manic depression. While they might have disagreed as to Matt’s

precise medical condition, the doctors unanimously agreed that Matt needed to be medicated to control his illness. His adult life was characterized by a history of suicide attempts, hospitalizations, and drug treatments directed towards managing his multiple mental disorders.

Matt did not agree that he needed to be medicated and, during an unmedicated period in July 1997, he was arrested for assaulting his mother. When prosecutors charged Matt with assault, his court-appointed attorney moved for a competency evaluation, which the state judge ordered. The medical professional who examined Matt, Harlan R. Heinz, Ph.D., concluded that he was “significantly depressed and acutely psychotic, rendering him incompetent to stand trial.” He also found that Matt 1) “showed significant lack of insight by reporting his thinking was fine,” 2) “was not able to make his needs known,” and 3) was “not competent to refuse medication or treatment for his mental condition.” Matt’s attorney agreed with this assessment and prepared an incompetency defense.

Matt, however, would not admit his incompetency, and his first attorney withdrew as a result. Matt’s second attorney acceded to Matt’s assessment of his own competency and Matt was allowed to plead no contest to the battery charge. His presentence investigation report noted that Matt had received thirty conduct reports during his confinement—for such infractions as covering his cell light, plugging toilets, and throwing feces and urine on staff—all of which occurred while he was not medicated. At sentencing on January 5, 1998, Matt’s mother pleaded with the court not to send Matt to prison, asserting that he was not a danger as long as he was medicated. The prosecutor concurred, stating that he disagreed with the PSI’s recommendation that Matt should go to prison—he even went so far as to note that “I do not believe that sending a person to the Wisconsin State Prison system is the best place to deal with a person’s mental illness.” Although the Judge noted that Matt was probably mentally ill, he sentenced him to the maximum term in prison. Matt began serving his sentence at the Dodge Correctional Institute (hereinafter “Dodge”) on January 7, 1998.

Mrs. Sanville wrote a letter to the evaluator at Dodge explaining that Matt’s conduct was the result of mental illness and relaying the opinions conveyed about Matt’s mental health during the court proceedings. On Matt’s second day at Dodge, Dr. Carl L. Cihlar, the first of the doctor-defendants, performed an intake screening of Matt and incorrectly reported that Matt did not have a mental illness. While noting Matt’s history of suicide attempts, the report also stated that Matt had never taken any medication to help with “anxiety, depression, mood swings, thinking problems, hearing voices or seeing things, or controlling [his] behavior.” Plaintiff alleges that Dr. Cihlar was aware of Matt’s troubled history, including the conclusions of Dr. Heinz’s pretrial competency evaluation. Towards the end of the month, Matt was again evaluated, this time by a classification specialist at Dodge, and she determined that Matt was presently medicated with psychotropic drugs. Her report also noted Matt’s numerous behavioral problems during his unmedicated stay in the county jail.

Matt arrived at Waupun Correctional Institution (WCI) on February 26, 1998. A week after his admission, Matt was seen

for a psychiatric follow-up by Dr. Yogesh Pareek, the second of the doctor-defendants. Because Matt was having problems with nausea and vomiting, Dr. Pareek advised him to go off his psychotropic medication until the problems subsided. As it turned out, Matt had an inflamed appendix, which required an emergency appendectomy on March 6, 1998.

While in the hospital, Matt remained off his medication. On March 10, his mother contacted the hospital to express concern that Matt had been taken off his medication. After the prison was contacted, the staff physician assured her that Matt's anti-psychotic medication had been reordered.

On March 26, 1998, about a week after his release from the hospital, Matt saw Dr. Pareek for the second time. Dr. Pareek noted that Matt had a "history of psychotic disorder, but he [was] refusing to take medication" and that Matt denied "ever hearing voices or ever seeing things [or] ever being paranoid." The doctor decided to discontinue psychotropic medication "at the patient's request." His notes indicated that he would "see [Matt] again in eight weeks. The patient is competent and he knows what is right and wrong." A week later, however, Matt and Dr. Pareek had another session. Matt had not taken any medication since the date of the appendicitis incident, March 5, and indicated that he no longer wanted medication or psychiatric services. Dr. Pareek's treatment plan stated "I will not schedule him as he is not taking any medication and he does not want to."

While he was unmedicated, Matt's behavior became increasingly bizarre. In April, he defied an order to return to his cell, for which he was sent to solitary confinement. In early May, he scrawled venomous, nonsensical threats on his bed sheets ("kill the rapist [sic] and snitches" and "go to hell"). On June 9, he flushed his socks and underwear down the toilet. Yet he also displayed some

evidence of competence (perhaps consistent with his diagnosis that he exhibited "very paranoid behavior with sense of reality"). The day prior to the sock flushing incident he requested that he be placed in an anger management class (he was placed on a waiting list). He also filed a lawsuit based upon the failure of one correctional officer to respond to his requests for medical attention during the appendicitis incident.

In late June, Matt asked to see a psychiatrist. When Dr. Pareek arrived, Matt reported no mental health concerns and persisted in his decision to remain off his medication. Dr. Pareek provided neither treatment nor medication to Matt. At this point, Matt had lost seventeen pounds since his admission to WCI.

On July 11, 1998, Matt assaulted another inmate and was placed in segregation. Just prior to being placed there, Matt drafted a document that he entitled his last will and testament. This document — collected by correctional staff at an undetermined time — was addressed to Matt's mother and contemplated Matt's imminent death.

While in segregation, Matt's bizarre behavior continued. After receiving conduct reports for refusing to return his meal tray and bag lunch, Matt was served "nutri-loaf" — a meal ground up into a loaf that could be eaten without utensils. He did not eat these loaves and thus began to lose weight rapidly. His subsequent autopsy confirmed that he lost about forty-five pounds during his five months at WCI, nearly twenty-five of which were in the final month of his life (after his placement in segregation). Matt wrote to his mother and complained about the nutri-loaf (2); upon receipt of the letter, she called the manager of the Health Services Unit at WCI and relayed her concern that Matt was paranoid, suicidal, and in serious trouble.

On July 24, 1998, Dr. Stephen Fleck, the third doctor-defendant, visited Matt in his cell in response to Mrs. Sanville's phone call. Dr. Fleck was, however, satisfied with Matt's insistence that he had no plans to harm himself. Matt again refused clinical and psychiatric services. Dr. Fleck's report did not make any reference to Matt's weight.

Matt repeatedly asked the guards to bring him a regular meal but his requests were ignored. He reported to many prison employees that he was unable to eat the nutri-loaf. His failure to eat and his corresponding weight loss was allegedly known to, at a minimum, the prison guards who fed him (including defendant Ivy Scaburdine).

Matt mailed a letter to his mother on July 27, 1998, which prison officials read. The letter conveyed that Matt thought he was being retaliated against because of the lawsuit that he had filed, asked for help in finding an attorney, requested clinical services, and again told Mrs. Sanville that he was not eating the nutri-loaf. That same day Matt requested to see someone from clinical services, and Dr. Fleck visited him at his cell. Dr. Fleck's report indicated that Matt said his mood was not good but that "[h]e denied any thoughts and plans to harm himself . . ." The notes continued:

I again recommended a face-to-face. He again refused, stating 'I can take care of myself.' I again suggested he put in an interview request to see Y. Pareek, M.D., Psychiatry, to discuss the option of medication. He stated,

UPDATE ON THE INTERNET

Recent issues of the *Jail Suicide/Mental Health Update* are now available on the Internet at:

<http://www.igc.org/ncia/suicide.html>

Check us out on the Web!
<http://www.igc.org/ncia/suicide.html>

Other jail suicide prevention and jail mental health resources, including several recent articles by Lindsay M. Hayes, can be found at the following web sites:

<http://www.hpub.com/journals/crisis/1997>
<http://www.nicic.org/pubs/jails.htm>
<http://www.nicic.org/pubs/prisons.htm>
http://www.ncjrs.org/html/ojjdp/jjnl_2000_4/sui.html
<http://www.performance-standards.org/resguides.htm>
<http://www.gainsctr.com>

‘I don’t need any drugs, I’m handling it myself.’ . . . I will follow up in four to six weeks to monitor his status.

Later the same day, Matt again requested to see someone from clinical services. Dr. Fleck received this request on July 28, and scheduled an appointment for July 30, 1998, three days after the request. Matt told prison guards sometime during these two days that he was going to kill himself, but no action was taken.

On July 29, 1998, the day of Matt’s suicide, correctional officer Ivy Scaburdine, one of the guard-defendants, made her morning rounds to pass out breakfast. Matt had covered all of the openings in his cell with paper — the vents, the call box, and the window — so that it was nearly impossible to see inside. This was in violation of prison policy. Scaburdine did not serve Matt breakfast, instead skipping his cell and continuing on her rounds. When she made the rounds to serve lunch, Matt’s window was still covered, thus she did not serve him at that time either. All of the defendant guards observed Matt’s covered cell window at some point during the day, but none took any action.

While his cell window was covered, Matt ripped his pillowcase into strips, wet the strips in his sink, and then tied the strips together, thus fashioning a noose. He slid the noose around his neck and tied it to the handicap railing along the west wall of his cell. He managed to position himself so that his weight would pull the noose tighter until he gradually lost consciousness and died.

At approximately 2:48 p.m., correctional officer Eric Schroeder, one of the guard-defendants, was making his rounds. When he passed Matt’s cell he noticed that “inmate Sanville was sitting on his floor in his cell up against the left wall of his cell with the left side of his body against the wall.” He further noted that “[Matt] had his window partially covered with toilet paper making it somewhat difficult to see into his cell.” Schroeder, who was not regularly assigned to the segregation unit, decided not to take any action. He had been instructed that he should assume inmates who ignored him were simply refusing supplies.

Schroeder claims that he returned to Matt’s cell at 2:57 p.m. with officer Glenn Gilgenbach, another guard-defendant. Gilgenbach offered Matt his dinner several times and Matt did not respond. Schroeder wrote in his report that “I then went to the window and observed that he hadn’t moved since supplies were offered, nine minutes [sic] ago.” Schroeder then attempted to call the sergeant for the segregation block, Ann Ingolia, but was unable to reach her because the battery in his radio was dead.

At approximately 3:00 p.m., Schroeder left to retrieve Ingolia. Ingolia followed Schroeder to the door of the cell, peered inside, and noticed that Matt had a sheet around his neck. She instructed Gilgenbach and Schroeder to continue feeding the other inmates while she called Captain Don Strahota to alert him to a possible suicide. Ingolia then returned to the cell to wait for the first responders. Upon arrival, they attempted unsuccessfully to revive Matt. At 3:10 p.m., rescue efforts ceased and Matt was pronounced dead. Matt was last seen alive by the defendants at 10:00 a.m.

The prison file provided to the doctor who performed the autopsy indicated “a past history of suicide attempt” and further disclosed

that, as of February 7, 1998, Matt was “psychotic but in remission with a Navane treatment.” Matt’s weight was estimated at 110-120 pounds. The autopsy concluded that “[a] diagnosis of suicide is reasonable but it sure would have been nice to have him more persuaded to take medication and seek psychiatric help.”

Mrs. Sanville filed this lawsuit in the United States District Court for the Eastern District of Wisconsin on July 25, 1999, raising federal claims under 42 U.S.C. sec. 1983 — alleging that the various defendants violated Matt’s Eighth Amendment rights — and pendent state law negligence and medical malpractice claims. The defendants moved to dismiss the action pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure and filed a corresponding motion for a protective order prohibiting discovery until the court ruled on the motion to dismiss. On June 29, 2000, the court granted defendants’ motion to dismiss the federal claims on qualified immunity grounds and declined to retain jurisdiction of the ancillary state law negligence claims. See *Sanville v. McCaughtry*, No. 99-C-715, slip op. (W.D. Wis. June 28, 2000). Plaintiff appeals this judgment.

II. Analysis

A. Standard of Review

We review dismissals under Rule 12(b)(6) of the Federal Rules of Civil Procedure *de novo*, examining a plaintiff’s factual allegations and any inferences reasonably drawn therefrom in the light most favorable to the plaintiff. See *Marshall-Mosby v. Corporate Receivables, Inc.*, 205 F.3d 323, 326 (7th Cir. 2000). Dismissal under Rule 12(b)(6) is proper only if the plaintiff could prove no set of facts in support of her claims that would entitle her to relief. See *Conley v. Gibson*, 355 U.S. 41, 45-46, 78 S. Ct. 99, 2 L. Ed. 2d 80 (1957); *Veazey v. Communications & Cable of Chi., Inc.*, 194 F.3d 850, 854 (7th Cir. 1999). “[I]f it is possible to hypothesize a set of facts, consistent with the complaint, that would entitle the plaintiff to relief, dismissal under Rule 12(b)(6) is inappropriate.” *Veazey*, 194 F.3d at 854 (citing *Graehling v. Village of Lombard, Ill.*, 58 F.3d. 295, 297 (7th Cir. 1995)).

The district court ruled that the defendants were entitled to qualified immunity. See *Sanville*, slip op at 31. “Qualified immunity shields government officials performing discretionary functions from liability for civil damages unless their conduct violates clearly established statutory or constitutional rights of which a reasonable person would have known.” See *Campbell v. Peters*, 256 F.3d 695, 699 (7th Cir. 2001) (citing *Anderson v. Creighton*, 483 U.S. 635, 640, 107 S. Ct. 3034, 97 L. Ed. 2d 523 (1987)). We review a district court’s grant of qualified immunity *de novo*. See *id.*

Before we reach the merits of Mrs. Sanville’s claims, there are two important issues which we must address, neither of which were discussed by the district court or raised by the parties. Plaintiff alleges that the defendants are liable under 42 U.S.C. sec. 1983, which “requires proof that the defendants were acting under color of state law and that the defendants’ conduct violated the plaintiff’s rights, privileges, or immunities secured by the Constitution or laws of the United States.” *Chavez v. Ill. State Police*, 251 F.3d 612, 651 (7th Cir. 2001) (quotation omitted). Mrs. Sanville sued each of the defendants in their official and

individual capacities, and the district court dismissed all of these claims based upon the doctrine of qualified immunity. *Sanville*, slip op. at 31. The dismissal of the official capacity claims was not proper, as “it is well established that the qualified immunity doctrine does not apply to official capacity claims.” *Ruffino v. Sheahan*, 218 F.3d 697, 700 (7th Cir. 2000).

Yet there is another twist. Official capacity suits are actions against the government entity of which the official is a part. See *Wolf-Lillie v. Sonquist*, 699 F.2d 864, 870 (7th Cir. 1983). To sue the defendants in their official capacities means that Mrs. Sanville is really suing the state entities: the Waupun Correctional Institution and the Dodge Correctional Institution (3). As we have recognized previously, however, “section 1983 does not authorize suits against states.” *Power v. Summers*, 226 F.3d 815, 818 (7th Cir. 2000). We conclude, therefore, that the official capacity claims seeking money damages from the defendants should have been dismissed on the basis that they may not be sustained under sec. 1983.

We thus turn to the remaining claims — the individual capacity claims to which the defendants asserted qualified immunity as a defense. The court must first decide whether the plaintiff’s factual allegations would, if proven, “show the state actor’s conduct violated a constitutional right.” *Billings v. Madison Metro. Sch. Dist.*, 259 F.3d 807, 816 (7th Cir. 2001) (citing *Saucier v. Katz*, 121 S. Ct. 2151, 2156 (2001)). If so, then we proceed to the second step of the analysis, which is to determine “whether the right was clearly established.” *Id.* In line with this framework, we begin by reviewing plaintiff’s substantive claim that the defendants violated Matt’s Eighth Amendment rights; where necessary, we will proceed to consider whether those rights were clearly established at the time of the violation.

B. Did the Defendants’ Conduct Violate Matt’s Eighth Amendment Rights?

Prison officials have a duty, in light of the Eighth Amendment’s prohibition against cruel and unusual punishment, to “ensure that inmates receive adequate food, clothing, shelter, and medical care.” *Farmer v. Brennan*, 511 U.S. 825, 832, 114 S. Ct. 1970, 128 L. Ed. 2d 811 (1994). To determine whether an inmate’s Eighth Amendment rights were violated by a deprivation, we examine the alleged violation both objectively and subjectively. See *id.* at 834. “First, the deprivation alleged must be, objectively, sufficiently serious.” *Id.* (quotation omitted). Second, the mental state of the prison official must have been “one of deliberate indifference to inmate health or safety.” *Id.* (quotation omitted).

Plaintiff alleges, essentially, that the conditions of Matt’s incarceration were such that there was a substantial risk that Matt would commit suicide and that the defendants were deliberately indifferent to this risk. When a claim is based upon the failure to prevent harm, in order to satisfy the first element the plaintiff must show that the inmate was “incarcerated under conditions posing a substantial risk of serious harm.” *Id.* It goes without saying that “[s]uicide is a serious harm.” *Estate of Cole by Pardue v. Fromm*, 94 F.3d 254, 261 (7th Cir. 1996) (quotation omitted); see also *Estate of Novack ex rel. Turbin v. County of Wood*, 226 F.3d 525, 529 (7th Cir. 2000); *Hall v. Ryan*, 957 F.2d 402, 406 (7th Cir. 1992) (recognizing that prisoners have a constitutional

right “to be protected from self-destructive tendencies,” including suicide) (citing *Joseph v. Brierton*, 739 F.2d 1244 (7th Cir. 1984)). In this case, not only was there a risk of serious harm but that harm actually materialized — Matt committed suicide. It would be difficult to think of a more serious deprivation than to be deprived of life, and thus plaintiff’s claim clearly satisfies the first element. Cf. *Reed v. McBride*, 178 F.3d 849, 852 (7th Cir. 1999) (“A condition is objectively serious if failure to treat it could result in further significant injury or unnecessary and wanton infliction of pain.”) (internal quotation omitted) (collecting cases).

We should note that the injury could be framed in a more particularized fashion with respect to the various groups of defendants. The need for a mental illness to be treated could certainly be considered a serious medical need. See *id.* at 853 (citing *Hudson v. McHugh*, 148 F.3d 859, 863 (7th Cir. 1998), for the proposition that unmedicated epilepsy “posed a ‘serious threat’ to a prisoner’s health”). Further, there is the additional possibility that Matt was physically unable to eat the nutri-loaf that he was being served (the complaint states both that he refused his food and that he was unable to eat it). We have held that withholding food from an inmate can, in some circumstances, satisfy the first *Farmer* prong. See *id.* (recognizing that “the amount and duration of the deprivation” would be relevant to whether the deprivation amounted to an objective violation of the Eighth Amendment). Whether these facts would support a finding that Matt was denied food is not something we need to resolve, as we have already concluded that Matt demonstrated a serious medical need.

We therefore turn to the second element of the *Farmer* framework: whether the defendants were deliberately indifferent to the risk that Matt would commit suicide. See *Pardue*, 94 F.3d at 261. The meaning of the “deliberate indifference” prong has recently been clarified by the Supreme Court: “a prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.” *Farmer*, 511 U.S. at 837. With this framework in mind, we consider Mrs. Sanville’s claims against the various defendants.

1. The Medical Defendants: Cihlar, Pareek, Fleck (4)

Plaintiff alleges that the doctors knew that Matt’s refusal to accept care was a symptom of his mental illness and that by deferring to his stated wishes, they deliberately disregarded the substantial risk that he would commit suicide. Thus, because they allowed him to remain unmedicated without taking further precautions to ensure his safety, plaintiff alleges that the doctors were deliberately indifferent to Matt’s serious medical need.

This situation is undeniably tragic. Yet “a complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment.” *Estelle v. Gamble*, 429 U.S. 97, 106, 97 S. Ct. 285, 50 L. Ed. 2d 251 (1976). To avoid dismissal, Mrs. Sanville must plead sufficient facts to demonstrate that a fact-finder could infer deliberate indifference from the doctors’

treatment decisions. “[D]eliberate indifference may be inferred . . . when the medical professional’s decision is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment.” *Pardue*, 94 F.3d at 261-62. We examine Mrs. Sanville’s claims against each of the doctor-defendants in turn.

Plaintiff asserts that Dr. Cihlar, during the screening interview at Dodge, incorrectly found that Matt did not have a mental health illness and that he was not medicated with anti-psychotics. While Dr. Cihlar’s conclusions about Matt’s mental health may have been negligently drawn, stating that Matt did not have a mental illness does not establish deliberate indifference to Matt’s condition. To violate the Eighth Amendment the official must knowingly disregard a substantial risk to inmate health or safety, see *Farmer*, 511 U.S. at 837. Not noticing that an inmate exhibits a serious medical need does not violate the Constitution because not noticing that a need exists is not considered “punishment” under relevant Supreme Court precedent. See *id.* at 837-38.(5) Further, we note that his failure to recognize Matt’s condition did not prevent Matt from getting subsequent treatment for his mental illness.

Mrs. Sanville accuses Dr. Pareek and Dr. Fleck of failing to provide treatment and medication to Matt even though they were aware of Matt’s history of mental illness, which was well-documented in his base file at WCI. She also claimed that they knew that Matt was incapable of making his own decisions regarding medication and that he had a history of asking for help and then denying any need for it. Dr. Pareek advised Matt to discontinue taking his medication — based upon his professional judgment that the medicine was causing Matt’s stomach aches — and later determined that Matt was competent and did not need to be medicated. While plaintiff takes issue with the correctness of these decisions, a complaint that a physician negligently treated Matt’s mental illness does not state a valid Eighth Amendment medical mistreatment claim. See *Estelle*, 429 U.S. at 107. Plaintiff thus asserts that advising Matt to stop taking his medication was such a substantial departure from accepted professional judgment that a jury could infer deliberate indifference. To determine whether this is the case, we ask whether a minimally competent doctor in Dr. Pareek’s shoes would have been aware of a substantial risk that allowing Matt to remain unmedicated would result in serious harm. See *Pardue*, 94 F.3d at 262- 63. Here, we cannot find that the risk was such that Dr. Pareek’s actions were deliberately indifferent. Matt saw Dr. Pareek on March 5, March 26, April 2, and in late June of 1998. The last of these dates was over a month before Matt committed suicide. In April, Matt stated that he no longer wanted medication or psychiatric services, and Dr. Pareek deferred to those wishes. At the time of Dr. Pareek’s June visit, Matt had been off his medication for three months (since March 5) and there is no indication that Matt was, at that time, suicidal or in danger of harming himself. Recognizing that “a medical professional must consider [an inmate’s] conflicting rights,” Dr. Pareek seemingly determined that Matt’s desire to be free from medication outweighed his right (or need) to receive psychotropic drugs for his mental illness. See *Pardue*, 94 F.3d at 262 (noting that an inmate had both an Eighth Amendment right to be restrained so that he would not injure himself and a Fourteenth Amendment right to be free from restraint).

Although we wish Dr. Pareek could have prevented Matt’s suicide, physicians do not practice with a crystal ball in hand. We thus

conclude that plaintiff has not presented evidence from which a trier of fact could find that Dr. Pareek was deliberately indifferent to the substantial risk that Matt would commit suicide. See *Farmer*, 511 U.S. at 837.

Finally, we turn to Dr. Fleck. Dr. Fleck saw Matt two times in the days immediately preceding Matt’s suicide, and his notes indicate that he was concerned about Matt’s welfare. He recommended that Matt come in for a face-to-face visit and that he see Dr. Pareek to discuss the option of medication. Matt responded by stating: “I don’t need any drugs, I’m handling it myself.” Mrs. Sanville points out that Matt was dangerously underweight at the time of Dr. Fleck’s June 27, 1998 visit. She alleges that, by deferring to the opinion of a mentally ill and suicidal inmate, Dr. Fleck abdicated his professional judgment and that, at the least, he should have taken extra precautions with regard to Matt’s health and well-being. These claims are undeniably emotionally appealing. That a doctor would defer to the discretion of a mentally ill inmate may be troubling to a layperson, particularly when the doctor appeared to recognize that Matt needed to be medicated. And we would hope that additional precautions would have been taken if they were thought to be necessary. Plaintiff has not provided us with any reason, however, to find that Dr. Fleck’s choices were not made in the exercise of his professional judgment. While Mrs. Sanville would have preferred the doctor to be less deferential to Matt’s requests and more forceful in pursuing the option of medicating him, we agree with the district court that Dr. Fleck’s actions and medical notes counsel against a finding of deliberate indifference. *Sanville*, slip op. at 21.

In sum, the evidence does not support a finding that the medical professionals at WCI were deliberately indifferent to Matt’s serious medical needs. He was seen by medical professionals eleven times over the five months that he was incarcerated and most of these visits took place shortly after they were requested. Plaintiff points to Dr. Flick’s failure to see Matt promptly after his July 27th request, yet Dr. Flick had already seen Matt once that day. There is no indication that the doctor was aware that Matt was suicidal or in serious harm at that time (if, in fact, Matt was suicidal at that time). Further, Dr. Flick did not even receive the request until July 28th, at which time he scheduled Matt for an appointment on July 30th. Under the circumstances, this delay cannot be considered deliberately indifferent. See *Gutierrez v. Peters*, 111 F.3d 1364, 1374 (7th Cir. 1997) (finding no deliberate indifference where the inmate “repeatedly received treatment over [a] ten-month period and that at most he experienced an isolated occasion or two where he did not receive prompt treatment”); cf. *Reed*, 178 F.3d at 855-56 (distinguishing prior Seventh Circuit cases where “the totality of the [inmate’s] medical care” counseled against a finding of deliberate indifference, and holding that the court was faced with one of those instances in which “mistreatment for a short time would be evidence of a culpable state of mind”) (quotation omitted).

It is troubling that this young man’s suicide might have been prevented had he been taking his prescribed psychotropic medication. The ultimate problem seems to be that none of the doctors ever noted that Matt might be a suicide risk, an observation that would not have seemed too obscure considering his mental illness and history of suicide attempts. Yet the doctors’ failure to correctly diagnose and treat Matt is not, in this instance, evidence of anything more than medical malpractice. Though we find that plaintiff’s claims against

the doctor-defendants were properly dismissed by the district court, we note that plaintiff is certainly free to pursue her state law medical malpractice claims in state court(6).

2. The Guards: Scaburdine, Schroeder, Gilgenbach, John Does Nos. 1-5 (7)

Mrs. Sanville accuses several correctional officers at WCI of knowing that Matt was likely to commit suicide but failing to reasonably respond to this risk. To be liable under the Eighth Amendment for an inmate's suicide, "a prison official must be cognizant of the significant likelihood that an inmate may imminently seek to take his own life and must fail to take reasonable steps to prevent the inmate from performing this act." *Turbin*, 226 F.3d at 529 (citations omitted). However, "an Eighth Amendment claimant need not show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm." *Farmer*, 511 U.S. at 842. Whether a prison official had the requisite knowledge is a question of fact. See *id.* If "the circumstances suggest that the defendant-official being sued had been exposed to information concerning the risk and thus 'must have known' about it, then such evidence could be sufficient to permit a trier of fact to find that the defendant-official had actual knowledge of the risk." *Id.* 842-43. Prison officials can still show that they were unaware of the risk — this is a subjective inquiry — or that they were aware of the risk but that they responded reasonably to it, "even if the harm ultimately was not averted." *Id.* at 844-45. Thus we ask 1) were the prison officials aware of the substantial risk that Matt might take his own life and, if so, 2) did they "take reasonable steps to prevent the inmate from performing this act." *Turbin*, 226 F.3d at 529.

a. Awareness of the Substantial Risk

Plaintiff claims that, once Matt covered his cell openings with toilet paper, the guards were aware of the substantial risk that Matt would commit suicide. She asserts that the guards already knew: 1) that Matt had written a last will and testament contemplating his imminent death and telling his mother how to carry on his affairs after he died; 2) that Matt told certain guards that he planned to commit suicide; 3) that he had attempted suicide in the past; 4) that he had a long history of mental illness; 5) that he was not eating and was dangerously thin; and 6) that his mother had called the prison to alert them that he was paranoid, suicidal, and in trouble.

It seems quite possible that, under the facts as alleged by the plaintiff, the guards could have been aware of the risk that Matt would commit suicide. Particularly if Matt told them that he was suicidal, that alone should have been enough to "impute awareness of a substantial risk of suicide." *Turbin*, 226 F.3d at 529. It is true that "strange behavior alone, without indications that that behavior has a substantial likelihood of taking a suicidal turn, is not sufficient to impute subjective knowledge of a high suicide risk to jail personnel." *Id.* at 530. Thus, if the inmate was a normally functioning individual with no history of mental illness or suicide attempts, who had not recently lost nearly one-third of his body weight or written letters to his mother contemplating his death, then maybe papering up his cell would not be enough to put the guards on notice

that something was wrong. Matt was not a normally functioning individual, however, and it would not be inconsistent with the alleged facts to find that he did "put jail officials on notice that there was a significant likelihood that he would attempt to harm himself." *Id.* The Eighth Amendment does not allow officials to turn a blind eye to the activities of an inmate, particularly one who is suicidal. We thus find that plaintiff's complaint should not have been dismissed because she has alleged sufficient facts that, if proven, would entitle her to relief against the WCI guards. See *Hall*, 957 F.2d at 405 (finding that plaintiff raised a genuine issue of material fact regarding the defendants' knowledge of Howard's suicidal tendencies); cf. *Turbin*, 226 F.3d at 534 (Williams, J., dissenting) ("[W]e have more than Novack's strange and bizarre behavior. We also have evidence that jail officials knew that Novack was a suicide risk and had a possible mental illness.").

Defendants contend that they were not aware of any risk that Matt would harm himself, and assert that plaintiff cannot survive the first *Farmer* prong. We find their arguments unconvincing. First, defendants contend that the only way the guards would have known many of these facts is if they had read Matt's prison file, which they characterize as an unreasonable endeavor. While we do not need to address whether the guards should be familiar with the mental health histories of the prison's inmates, it seems contrary to defendants' assertions that the guards could have been aware of many of the facts alleged by plaintiff without reading Matt's file (for example: that Mrs. Sanville had called the prison to express concern over Matt's condition, and that Matt had written a last will and testament, lost a significant amount of weight, and said that he planned to commit suicide). Second, defendants allege that the fact that Matt was requesting food other than the nutri-loaf and that he had filed a complaint the week before his suicide indicates that the guards would not have thought that Matt was a substantial suicide risk. What the guards thought, however, is not an issue for us to resolve — it is an issue for a trier of fact. See *Farmer*, 511 U.S. at 842. Third, the defendants criticize the plaintiff for doing nothing more than alleging facts. Yet, under the requirements of notice pleading, Mrs. Sanville does not have to prove her factual and legal allegations at this stage, she need only show that relief is possible. See *Conley*, 355 U.S. at 45-46; *Bartholet v. Reishauer A.G. (Zurich)*, 953 F.2d 1073, 1078 (7th Cir. 1992). Plaintiff has certainly met this standard. Of course, this is not the end of the inquiry. During discovery, the parties will undoubtedly explore in greater detail whether the "prison official[s] had the requisite knowledge of a substantial risk" to Matt's health. *Farmer*, 511 U.S. at 842.

b. Whether the Defendants Took Reasonable Steps

While it remains to be seen whether the defendants were actually aware of the substantial risk to Matt's health, there seems to be no evidence that the defendants "[took] reasonable steps to prevent the inmate from [committing suicide]" as is required by our case law. *Turbin*, 226 F.3d at 529. Matt was last seen alive by the defendants at 10:00 a.m. In the five hours during which Matt's cell window was covered with toilet paper, there was no apparent attempt to discern whether he was stable. The guards did not use the video camera to check on Matt, nor did anyone take any action until approximately 3:00 p.m. If the defendants were aware of the alleged risk, failing to determine

what was going on in Matt’s cell could easily be considered egregious enough to rise to the level of deliberate indifference. The evidence here clearly supports an inference that at least some of the guards, if not all of them, were aware of Matt’s serious medical need and demonstrated deliberate indifference to that need.

There are a number of reasons why defendants assert that the guards cannot be found liable, none of which we find meritorious. Contrary to defendants’ allegations, the fact that we have already found that the doctors cannot be held liable does not erect a legal bar that prevents anyone else in the prison from being held liable. See *Estelle*, 429 U.S. at 107-08 (finding that the claims against the doctor defendants amounted, at most, to medical malpractice, but remanded to the Court of Appeals for consideration of “whether a cause of action has been stated against the other prison officials” including the prison warden). Defendants further assert that the guards cannot be held liable because they relied upon the doctors’ determination that Matt was not a suicide risk. The record, however, at least as currently developed, does not support this assertion. There is no evidence indicating that any of the doctors actually determined that Matt was not suicidal, much less that they then informed the guards that Matt was not suicidal and that the guards then decided not to act based on that information. Our review is intended to determine whether the plaintiff could prevail under any set of facts, not whether the defendant could win under any set of facts. Likewise, the fact that Matt was seen by mental health professionals eleven times during his incarceration does not prevent us from finding that someone — whether a guard or a warden or otherwise — was deliberately indifferent to his serious medical needs. The guards’ liability is not premised upon the acts or omissions of the medical professionals, it is premised upon their own deliberate indifference to Matt’s condition.

We will thus consider, subsequently, whether this was a clearly established law at the time of defendants’ actions to determine whether this claim should be reinstated. We first turn to consider plaintiff’s claims against the final group of defendants — the wardens.

3. The Wardens: Warden Gary McCaughtry, Deputy Warden Jane Gamble

Mrs. Sanville alleges that the wardens failed to adopt and enforce adequate suicide prevention policies and that they also failed to train and supervise the guards and doctors (8). Because we have already determined that plaintiff’s official capacity claims against McCaughtry and Gamble should have been dismissed, we need only consider the claims against the wardens in their individual capacities. The plaintiff faces a substantial challenge because failure to train claims are usually maintained against municipalities, not against individuals, see, e.g., *Williams v. Heavener*, 217 F.3d 529, 532 (7th Cir. 2000); *Kitzman-Kelley v. Warner*, 203 F.3d 454, 459 (7th Cir. 2000), and, in the Eighth Amendment context, such claims may only be maintained against a municipality. See *Farmer*, 511 U.S. at 841 (noting that the standard applied in *City of Canton v. Harris*, 489 U.S. 378, 109 S. Ct. 1197, 103 L. Ed. 2d 412 (1989), was not “an appropriate test for determining the liability of prison officials under the Eighth Amendment as interpreted in our cases”).

The doctrine of *respondeat superior* does not apply to sec. 1983 actions; thus to be held individually liable, a defendant must be “personally responsible for the deprivation of a constitutional right.” *Chavez*, 251 F.3d at 651 (quotation omitted); see also *Wolf-Lillie*, 699 F.2d at 869 (“Section 1983 creates a cause of action based upon personal liability and predicated upon fault.”). A defendant “will be deemed to have sufficient personal responsibility if he directed the conduct causing the constitutional violation, or if it occurred with his knowledge or consent.” *Chavez*, 251 F.3d at 652. This definition recognizes that the individual does not have to have participated directly in the deprivation. See *McPhaul v. Board of Comm’rs of Madison Co.*, 226 F.3d 558, 566 (7th Cir. 2000) (quotation omitted). Thus, a supervisor may be liable for “deliberate, reckless indifference” to the misconduct of subordinates. See *Chavez*, 251 F.3d at 651. (“The supervisors must know about the conduct and facilitate it, approve it, condone it, or turn a blind eye for fear of what they might see.”) (quotations omitted).

Mrs. Sanville accuses defendants of tolerating a number of transgressions which she contends rose to the level of systematic failure: 1) on four separate occasions, three guards ignored the paper on Matt’s cell; 2) the camera in his cell was not active the entire three weeks he was in segregation; 3) Matt lost nearly one-third of his body weight while in segregation; and 4) the guards allegedly received no suicide prevention training. None of these allegations, however, suggest that the wardens were personally responsible for any deprivation. Nor does plaintiff allege that they “turned a blind eye” to any particular conduct of the remaining defendants. We thus agree with the district court that plaintiff has alleged no facts that would support a finding of liability with respect to the wardens.

C. Was the Right Clearly Established at the Time of the Violation?

We must now consider whether the guards may be held liable under sec. 1983, or whether they are entitled to qualified immunity. We have recently set forth the framework for making this determination: Qualified immunity protects government officials from individual liability under Section 1983 for actions taken while performing discretionary functions, unless their conduct violates clearly established statutory or constitutional rights of which a reasonable person would have known. Thus, before liability will attach, the contours of the right must be sufficiently clear that a reasonable official would understand that what he is doing violates that right. *Brokaw v. Mercer County*, 235 F.3d 1000, 1022 (7th Cir. 2000) (internal quotation and citations omitted). There can be little debate that it was clearly established, long before 1998, “that prison officials will be liable under Section 1983 for a pretrial detainee’s suicide if they were deliberately indifferent to a substantial suicide risk.” *Hall*, 957 F.2d at 406. Further, “[i]t was clearly established in 1986 that police officers could not be deliberately indifferent to a detainee who is in need of medical attention because of a mental illness or who is a substantial suicide risk. Deliberate indifference to a prisoner’s medical needs constitutes cruel and unusual punishment in violation of the Eighth Amendment.” *Id.* at 404-05. Thus, we find that the guards are not immune from individual liability in this case (9).

III. Conclusion

In light of the foregoing analysis, we AFFIRM the district court's dismissal of Mrs. Sanville's Eighth Amendment claims against the doctor-defendants and the wardens, and REVERSE the district court's dismissal of her claims against the guards.

Footnotes

- ¹For the sake of clarity, we will refer to Matt Sanville as "Matt," and to Martha Sanville as "Mrs. Sanville."
- ²He wrote a letter to his mom, dated July 23, 1998, stating: "the guards are trying to feed me gag loaf (nasty) — I can't eat it."
- ³We take judicial notice of the fact that both these entities are state prisons: the Waupun Correctional Institution is a state penitentiary and the Dodge Correctional Institution is the correctional treatment center at Waupun. See Wis. Stat. sec. 302.01.
- ⁴Plaintiff's complaint also challenged the actions of Narinder Saini, Ph.D., and Gary Ankarlo, Ph.D. On appeal, plaintiff did not present analysis with respect to these doctors, thus we do not address them here.
- ⁵The Supreme Court has rejected the argument that, under the subjective test for deliberate indifference, "prison officials will be free to ignore obvious dangers to inmates." *Farmer*, 511 U.S. at 842. However, even if a risk is obvious — i.e., even if it was well-documented in Matt's file that he had a mental illness that, if left untreated, would pose substantial risk to his health — the prison official is not liable under the Eighth Amendment if "the obvious escaped him." *Id.* at 843 n.8
- ⁶The district court's denial to exercise supplemental jurisdiction over these claims is still appropriate given the disposition of those claims here.
- ⁷Plaintiff's complaint also challenged the actions of Curtis Bender and Jodine Deppisch. On appeal, plaintiff did not present analysis with respect to these defendants, thus we do not address them here.
- ⁸The defendants contend that these allegations were not in plaintiff's district court complaint. We found otherwise: both were included in Count I (alleging violations of Matt's Eighth Amendment rights), paragraph 139.
- ⁹The district court relied upon *State Bank of St. Charles v. Camic*, 712 F.2d 1140 (7th Cir. 1983), to support its conclusion that the defendants were entitled to qualified immunity. See *Sanville v. McCaughtry*, No. 99-C-715, slip op. at 14 (W.D. Wis. June 28, 2000). *Camic* did not address qualified immunity; rather, that case found that the district court's grant of summary judgment was proper because the plaintiff did not raise "a question of material fact as to whether the defendants had knowledge of . . . suicidal tendencies on the part of [the inmate]." *Camic*, 712 F.2d at 1146. □

NEWS FROM AROUND THE COUNTRY

Offered below are brief stories regarding jail suicide, mentally ill offenders, and other related topics that have recently occurred and/or been reported throughout the country.

Tennessee

Tammy Evans believes she might not be alive today without help from Davidson County's Mental Health Court in Nashville. Ms. Evans was facing 18 months in jail on trespassing and drug charges when she was referred to the court last May.

JAIL MENTAL HEALTH SERVICES INITIATIVE FROM THE NATIONAL INSTITUTE OF CORRECTIONS (JAILS DIVISION)

Nearly 6 to 8 percent of the more than 10 million annual commitments to jails are individuals with severe mental illnesses. Many sheriffs and jail administrators view the challenge of responding to the needs of this population as one of the major issues in jail management. In response, the National Institute of Corrections (NIC) has worked collaboratively with the National Institute of Mental Health for the past several years, and more recently, with the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services to increase and improve these services. As a result of these collaborations, the NIC Jails Division has developed a mental health initiative for jails.

An important component of the initiative is the offering of regional workshops conducted in collaboration with state, regional, and local jurisdictions. The 21-hour regional workshops will be provided upon request to help small and medium-sized jails enhance mental health services and service delivery for inmates. Several jurisdictions in a region can each send a three-person team consisting of a jail administrator, a representative of the jail's community mental health provider, and the person who coordinates mental health services for inmates. Each workshop will include: overview of the problem, planning principles, contract development, leadership and managing change, implementation strategies, staffing and cross-training, and coalition building. The workshops are conducted at the request of a host agency, which is responsible for furnishing the training rooms and equipment. The NIC Jails Division provides two trainers, the curriculum and training materials. Participants are responsible for their own expenses.

In addition to the workshops, the NIC Jails Division's mental health initiative includes the following services:

- ◆ **On-site Technical Assistance:** This assistance usually consists of an assessment of a jail system's mental health needs, *but also can be targeted at suicide prevention issues in the jail;*
- ◆ **Newsletter:** The NIC Jails Division funds the *Jail Suicide/Mental Health Update*, a newsletter which is distributed free of charge on a quarterly basis;
- ◆ **Information Resources:** The NIC Information Center has compiled a jail mental health information resource order form that contains 22 items. The form is available at the mental health workshops held in Longmont, Colorado and at regional sites. It can also be obtained by calling the Information Center at (800) 877-1461.

For more information on the NIC Jails Division's mental health initiative, on-site technical assistance, and the mental health workshops, contact the agency at (800) 995-6429, or visit their website at: www.nicic.org

She has since undergone treatment for her drug addiction and is earning enough money at a printing company to rent a house. “I had an \$800-a-day crack habit, I was eating out of dumpsters and I was sleeping in drainage ditches,” Ms. Evans told the *Associated Press* in December 2001. “I was ready to just go lie down in jail and forget it all.”

The Mental Health Court, a special division of Davidson County’s General Sessions Court, was created a year ago for defendants suffering from mental illness. According to Rick Curran, mental health specialist for the program, “It’s extremely inappropriate, if not immoral, to have someone in jail for no other reason than the fact that they suffer from mental illness. When someone’s mentally ill, you can’t just throw medication at them and hope for the best.”

Ms. Evans was transferred to Mental Health Court because her charges were not serious and her mental illness (manic depression and anxiety disorder) was diagnosed. She appeared before a judge every other week for the first two months and then once a month thereafter. “I had to agree to go into a halfway house and intensive out-patient treatment and get back on my medication,” she said. “They gave me my life back. They let me see that there was hope.” Ms. Evans was one of 240 defendants that have been transferred to the court during the past year — only 15 individuals have been sent back to jail because of an arrest on new charges or a probation violation. The Davidson County’s Mental Health Court, among the growing number of specialty or “boutique” courts cropping up across the country, is funded primarily by a federal grant.

Oregon

Overcrowding at Oregon State Hospital in Salem is causing mentally ill patients to wait almost five times longer than the law allows to receive court-ordered treatment. In fact, mentally ill people facing minor charges sometimes wait longer in jail for a state hospital bed than they would serve in prison if convicted. “The situation at the state hospital has reached a crisis level,” Multnomah County Chief Criminal Judge Julie E. Frantz told the *Associated Press* in November 2001. “We’re all anxious. No one wants to have someone with mental illness issues languishing in jail rather than receiving treatment.”

The wait for a bed in the state hospital’s forensics unit is now approximately 34 days, and one Multnomah County (Portland) Jail inmate recently waited 111 days. State law requires no more than a seven-day delay. And the wait is almost four months to be seen by the state hospital to determine whether a defendant is able to aid in their defense. The forensics unit was over capacity by more than 20 patients in November despite the recent addition of 35 beds. Plans to build a 400-bed unit in January 2003 may be scrapped because of budget cuts. That may spare the state balance sheet, but not necessarily the taxpayers. Earlier this year, Multnomah County paid more than \$500,000 in a legal settlement to a mentally ill man whose condition deteriorated as he waited in a jail cell for a state hospital bed. The 20-year-old gouged out his eyes with his fingernails during a psychotic episode.

Patients found unable to aid and assist in their legal process may be ordered by a judge to undergo treatment until they are deemed capable. The law says they must be transported to the state hospital

“within seven days after the court’s determination unless doing so would jeopardize the health or safety of the defendant or others.” John Keogh, director of forensic evaluation and treatment, said the hospital cannot obey the first part of the law without breaking the second. An overcrowded hospital, he argues, is unsafe. In addition, the hospital has an understaffing problem with vacancies for a psychiatrist and two psychologists.

“The problem is not our willingness to get help for these people,” Multnomah County Sheriff Dan Noelle told the *Associated Press*. “It’s not the state hospital being jerks. It’s the state’s inability to properly fund the state hospital to make the space available to take these people.” Sheriff Noelle said he receives backlogs of inmates who should be getting treatment in the hospital, such as the man who gouged out his eyes. “We didn’t get him moved down to the state hospital because they had no beds.” The situation has not improved. As a result, Sheriff Noelle now orders his deputies to transport inmates to the state hospital even if he knows they might have to turn around and drive right back. It costs the county an estimated \$200 per trip. “I make the hospital refuse us at the door,” he said. “It may seem like a stupid thing to do after they tell us they don’t have room, but it’s the only way to protect (county) taxpayers in terms of litigation.”

Arkansas

The state of Oregon is certainly not alone in experiencing significant delays in the provision of state hospital-based psychiatric examinations for criminal defendants. In November 2001, a federal judge in Little Rock called state hospital delays in providing mental health treatment and examination for county jail inmates a “nightmare.” U.S. District Judge Stephen Reasoner granted class-action status to a lawsuit against the state of Arkansas, in part, because he believed that inmates with mentally illness had little political clout to get state officials to correct the problem. “The mentally ill are pushed aside,” Bettina Brownstein, a lawyer for the American Civil Liberties Union in Arkansas, told the court. “I don’t think people really understand.” Judge Reasoner responded: “I understand exactly what you are saying. It’s not a constituency with a lot of power.”

Ms. Brownstein and her colleagues filed the suit in August 2000 on behalf of a former Sebastian County (Fort Smith) Jail inmate, saying that James M. Terry was held for months without getting treatment for a psychotic disorder. Mr. Terry was eventually transferred to the State Hospital. The suit was filed against Sebastian County Sheriff Frank Atkinson and Richard Hill, deputy director of the state Division of Mental Health.

In granting class-action status, Judge Reasoner noted that state attorneys had no objection to the request and also seemed to agree that a statewide problem exists. The ruling means that all county jail inmates ordered for treatment or evaluation at the State Hospital will be included in the suit. (That number is currently estimated to be 65 inmates.)

Jay Wills, an attorney for the state Human Services Department, said the state agrees there is a problem but will argue at trial that the hospital delays do not amount to cruel and unusual punishment in violation of the U.S. Constitution. “I don’t think there is a lot of argument over the facts,” Mr. Wills told the *Associated Press*. He said the State Hospital has 64 beds for criminal defendants, but needs

approximately 130 beds to carry out the court-ordered psychiatric evaluations. Mr. Wills suggested that the problem might be better addressed by state officials and legislators.

The State Hospital also has beds for mentally ill people who are not criminal defendants. Those patients are not part of the current lawsuit, but Ms. Brownstein said there has been discussion about the possibility of moving them to private hospitals that offer mental health care and using the State Hospital for criminal defendants only. "Of course, there is a funding problem" with that option, she admitted. Mr. Wills said the change also would require legislation. "What can the court do about that?" Judge Reasoner asked. "I can't write the laws for the state of Arkansas." Ms. Brownstein said that the court could declare the current conditions unconstitutional and that the ruling would set in motion changes at the state and local levels. "No one wants to take care of them (mentally ill inmates) more than the sheriffs," Ms. Brownstein said. "People are suffering."

Arizona

Two parents who watched their suicidal son die when a Pima County Sheriff's Department deputy shot him last year are bringing a crisis intervention training program to Tucson. The program, based on a 40-hour program used in Memphis, Tennessee, will train city police and Pima County Sheriff's Department personnel on how to safely handle individuals who are mentally ill and/or emotionally distraught. "If the training program had been in place, I strongly believe that my son would be alive today," Joe Mucenski, whose son was shot in September 2000, told the *Associated Press*.

The shooting of Joseph Mucenski, Jr., was indeed tragic. The suicidal young man telephoned his parents one night to say good-bye and would not tell them where he was. They immediately called the sheriff's department. Two deputies, accompanied by the parents, eventually found Joseph, Jr. back in his apartment, but he would not answer the door. One of the deputies began banging on the door and ordering the young man to open up. Joseph, Jr. eventually responded from behind the closed door, urging the deputy to shoot him, his parents said. The situation continued to escalate with friends trying to break into the apartment to help him and his parents begging deputies to let them talk to him. "I told them that the way they were handling it, they were going to end up killing him," Joe Mucenski said. Finally, Joseph, Jr. talked to friends on the balcony of his apartment with a knife in one hand and a telephone in the other. He later returned inside, and his friends heard sheriff deputies yelling at him to drop a knife. Then there were gunshots. The deputies later claimed that Joseph, Jr. lunged at them with the knife which resulted in the fatal shots being fired.

"The sad reality is that the reason the police are in this position is because there are such holes in the mental health system," said Ron Honberg, legal director for the National Alliance for the Mentally Ill.

A tragedy similar to Joseph Mucenski's sparked the changes in Memphis. The results have been dramatic. Since the training program began in 1988, the city has had only two "suicides by

cop" after previously averaging approximately five such deaths per year. The Memphis Police Department's Crisis Intervention Team (CIT) program has been adopted by more than 20 police departments throughout the country (see, for example, the *Jail Suicide/Mental Health Update*, 10 (2): 17-19). For more information on the Memphis CIT program, contact Major Sam Cochran, Memphis Police Department, Criminal Justice Complex, 201 Poplar Avenue, Memphis, TN 38103, (901/545-5700), or on the Internet at <http://www.memphispolice.org>

California

The Los Angeles County Sheriff's Department negligently allowed a mentally ill man to die in its custody after deputies tried to subdue him, then performed an internal investigation so flawed that it undermined the agency's credibility, according to a strongly worded report by the county supervisors' special monitor of the agency. The report, issued by attorney Merrick Bobb, was requested by county supervisors after spending \$600,000 to settle a wrongful-death lawsuit by the family of Kevin Evans.

Mr. Bobb reported that Kevin Evans had never acted violently yet was placed in restraints, that sheriff's deputies held the inmate down for minutes even after he began gagging, and that after he stopped breathing, no one initiated cardiopulmonary resuscitation (CPR) for 15 minutes. One nurse involved in the case has been forced to leave the department. But even though the report cited a host of oversights and questionable actions, no deputy has been disciplined to date.

The sheriff department's review of the incident found that its deputies acted appropriately. Mr. Bobb sharply disagreed. He criticized the internal investigation as "careless to the point of slipshod, self-justifying and rationalizing to the point where their credibility vanished, and insensitive and defensive to the point where reason and good judgment flew out the window."

While saying that he does not believe the deputies who restrained Mr. Evans intended to harm the inmate, Mr. Bobb recommended that some personnel be disciplined and that the agency undertake wide-ranging reforms in its jail health care system, including immediately trying to contract with local medical schools for better service. He noted that for years he has urged improvements in health care for the nation's largest jail system, which is also being monitored by the U.S. Department of Justice.

Taylor Moorehead, head of the department's custody division, told the *Los Angeles Times* that the agency considered Mr. Evans' death a "tragedy" and blamed the state's failing mental health system. Cutbacks in that network have left mentally ill people with nowhere to go but jail, he said, and deputies are not trained to counsel some of the most disturbed inmates. "Nobody punched him, nobody kicked him, nobody was brutal to him," Chief Moorehead stated. "They did the best they could to calm him down.....They did it exactly textbook, by policy.....The deputies did not have homicide in their minds. They feel awful. I mean, my god, a man died." Chief Moorehead has since promised a new, more thorough investigation of the incident.

Supervisor Gloria Molina, whose viewing of a videotape of the incident sparked the external probe, said she was not reassured

by the agency's promise of a new investigation. "I'm supposed to trust what they tell me?" she told the *Los Angeles Times*. Comparing Mr. Evans' death to the beating of Rodney G. King, Supervisor Molina said she was especially concerned that top sheriff's officials found that their deputies behaved properly. "When you have the top brass looking at this and saying there is not a problem," she said, "you have to worry about the top brass."

Kevin Evans had been arrested for stealing a shopping cart in Palmdale on the evening of October 20, 1999. He was held in a minimum-security cell in the sheriff department's jail and classified as "aggressive" for no apparent reason, according to the Bobb report. Mr. Evans spoke erratically in the holding cell and during a court appearance the next day. One deputy, not identified in the report, filled out a "keep away" card after the inmate made a gesture that she interpreted as threatening. The report found some of her justification for classifying Mr. Evans in that manner to be "exaggerations."

When Mr. Evans was processed into Twin Towers Jail in downtown Los Angeles that night, that "keep away" card led him to be classified as "dangerous," according to the report. Because the department did not have computerized records of inmates, deputies could not know that Mr. Evans had several prior stays in the Los Angeles County Jail system, during which he spoke erratically but was never violent.

A physician examined Mr. Evans, diagnosed him with cerebral palsy and ordered him into three-point restraints without writing his justification on the report. Two hours later, Mr. Evans was still waiting to be restrained. As he sat handcuffed on a bench, a nurse noticed him mumbling and called a jail psychiatrist at home. Without coming to the jail to examine the inmate, the psychiatrist increased the order to four-point restraints.

An hour later, Mr. Evans was moved to a room in the jail's Medical Services Building to be restrained. He was still calm, clutching a baloney sandwich. A videotape recorded his restraint by four deputies. Mr. Evans remained calm when laid down on the bed, but when a deputy, without explanation, grabbed the sandwich from his hand, the inmate began kicking and struggling. As the deputies shouted for him to calm down, other officers ran into the room to help hold Mr. Evans down.

Although a sergeant was present, Mr. Bobb wrote, "no one coordinated the use of force. Instead, the officers improvised." One deputy leaned on Mr. Evans chest. Two other deputies pressed against his throat area with their hands and knees. When the inmate began gasping and groaning, the sergeant, believing Mr. Evans was about to spit on deputies, called for a mask to block his spittle. (The coroner's office later theorized that the mask could have contributed to the Mr. Evans' asphyxiation. The autopsy report concluded that the inmate died from a combination of asphyxiation and the strain against his enlarged and scarred heart.)

After more than six minutes, Mr. Evans drew quiet. The sergeant ordered everyone but two deputies out of the area. Mr. Bobb said the videotape showed that one deputy who had been leaning on Mr. Evans' chest let his full weight come down on the inmate while hopping off. A sheet had apparently been placed over the

inmate's head. Several seconds later, deputies checked for a pulse. "Someone want to get a nurse in here?" one deputy asked. "Kill the camera," the sergeant ordered. The videotape then ended.

The staff in the medical ward called paramedics, but it reportedly took 15 minutes before a jail physician realized that no one had attempted CPR and began doing so. Jail records, however, were falsified to obscure the time of death, according to Mr. Bobb's report. The supervising nurse that night was forced to resign for violating department policy by not ensuring that medical staff were present during the restraint. The nurse also pleaded no contest to a misdemeanor charge of falsifying a report.

Merrick Bobb said that sheriff department's investigators performed a poor follow-up investigation. His report listed two pages of witnesses who were not interviewed, including the deputy who filled out the inmate's "keep away" card, the doctors who ordered him into restraints and one of the deputies who restrained Mr. Evans. In addition, the Bobb report also stated that department investigators never questioned why deputies placed a sheet over Mr. Evans' face, or held his neck or his diaphragm even after he was restrained. "Instead," the report stated, "the investigators sailed quickly through their interviews, spending roughly 10 minutes to question each officer."

(Reprinted, in part, from the *Los Angeles Times*, October 14, 2001, "County Called Negligent in Inmate's Death," by Nicholas Riccardi, Staff Writer.)

Arkansas

A 15-year-old youngster committed suicide in the Alexander Youth Services Center on September 15, 2001 marking the second suicide in the facility during a five-month period of time. The youth, who had a history of suicidal behavior, had been left unobserved in his room for over an hour. On May 13, 2001, a 16-year-old boy committed suicide in the very same room in the facility. As a result of the first death, one staff member was fired for falsifying records and three other employees were disciplined were not reporting that a video surveillance system was inoperative.

The most recent death came only two weeks after the state relinquished control of the facility to a private contractor. On September 1, 2001, the Division of Youth Services (a branch of the Department of Human Services) contracted with Cornell Companies, Inc., a private corrections provider based in Houston, Texas, to assume operational and programmatic responsibility for the Alexander Youth Services Center. Yet according to a Department of Human Services (DHS) probe of the facility following the most recent death, at-risk youth were still not being properly observed, nor were housing units being adequately staffed during a two-hour staff training session. "There were several children on suicide and close observation," investigator Barbara Ausbrooks wrote in the report. "It was clear (from reviewing video surveillance tapes) that mandatory 15-minute checks were not being done. The children on suicide precaution were not in constant line of sight."

"We are tremendously frustrated that we are once again discussing an issue like this with Cornell," Joe Quinn, a DHS spokesman

told the *Associated Press* in late October 2001. "There is no excuse at all for juveniles not being checked in an appropriate time frame."

A separate investigation by Cornell concerning the September suicide was equally troubling. The investigation found that the youth had threatened suicide and was taunted by other residents with calls of "Do it, do it," and "Kill yourself, kill yourself," prior to his death. The youth subsequently covered the window in the door of his room with paper and was left unobserved by staff who allegedly were tending to another incident in the facility. A Cornell investigator also found that staff had falsified logbooks, failed to make mandatory headcounts and left the housing unit to take smoke breaks. Two line staff were subsequently fired and a supervisor resigned. Another investigation found that the youth had previously been on suicide precautions in the facility, but that Cornell officials were apparently unaware of his history because they failed to review medical files of any of the residents when they assumed responsibility for the Alexander Youth Services Center.

Thomas Jenkins, chief operating officer for Cornell Companies, acknowledged that Alexander Youth Services Center was troubled and that it will take time to correct all the problems. "There will be mistakes and difficulties encountered along the way; however, these mistakes do not mean that positive changes at the facility and in the lives of our clients are not occurring," he told a joint Senate Interim Committee on Children and Youth and the House Interim Committee on Aging and Legislative Affairs in October 2001. Since the most recent suicide, efforts have been undertaken to improve intake screening, provide suicide prevention training to staff, and improve security. But Mr. Jenkins also stated that the company had warned the Division of Youth Services prior to assuming control that there were various physical plant deficiencies that needed correction, including exposed piping in the room where both suicides occurred. One of the victims utilized the exposed pipes as an anchoring device in the suicide.

The company received mixed reviews from committee members. "I'm just totally surprised that someone who is supposedly in this business and has been for many years and is a national concern would make such basic mistakes," stated Representative Jay Bradford. Yet Representative Jan Judy argued that Cornell was making improvements in the short time that it assumed responsibility for the facility. "They are working very hard," she stated. "It wasn't that they didn't have staff on premises. They were doing an important training session and trying to better their program."

Doyle Herndon, the seventh director of the Division of Youth Services since 1997, acknowledged that his agency historically had problems in safely managing juveniles in its facilities, but asked the joint legislative committee for patience since he had only been appointed to the position in August 2001 and Cornell was hired to run the facility the following month. "You've got two new players here," Mr. Herndon testified. Senator Mike Beebe quickly replied: "Well, we get frustrated because there's always two new players." □

JAIL SUICIDE/MENTAL HEALTH UPDATE

This technical update, published quarterly, is part of the National Center on Institutions and Alternatives (NCIA)'s continuing efforts to keep state and local officials, individual correctional staff, mental health/medical personnel, and interested others aware of developments in the field of jail suicide prevention and jail mental health services. Please contact us if you are not on our mailing list. Readers are encouraged to offer opinions and/or submit pertinent materials for inclusion into future issues.

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AVAILABLE JAIL/PRISON SUICIDE PREVENTION MATERIALS

And Darkness Closes In...National Study of Jail Suicides (1981)
National Study of Jail Suicides: Seven Years Later (1988)
Training Curriculum on Suicide Detection and Prevention in Jails and Lockups—Second Edition (1995)
Curriculum Transparencies—Second Edition (1995)
Prison Suicide: An Overview and Guide to Prevention (1995)
Jail Suicide/Mental Health Update (Volumes 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10)

For more information regarding the availability and cost of the above publications, contact either:

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