JAIL SUICIDE/MENTAL HEALTH UPDATE

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SUICIDE PREVENTION AND MANIPULATIVE BEHAVIOR

On the morning of November 14, 1999, Cheryl Gorman sat on the bathroom floor with a kitchen knife in her hand.[1] Recently charged with killing her young child, Ms. Gorman had been released on bond the previous day. When family friend Susan Ryan found the young woman in the bathroom, Ms. Gorman appeared distraught, shaking, crying, fearful of returning to jail, and "at the end of her rope." Hoping to get her friend civilly committed for mental health treatment, Ms. Ryan drove Cheryl Gorman to the local Community Mental Health Center (CMHC). Upon arrival at the CMHC, Dr. Donna Wilson was informed that Ms. Gorman had been drinking and was suicidal. Ms. Gorman met privately with the psychiatrist and denied any suicidal ideation, although admitted she did not feel very strong, was depressed, and fearful of her legal situation. Based upon Ms. Gorman's denial of suicidal ideation, Dr. Wilson did not think that inpatient commitment was appropriate. The psychiatrist wrote in Ms. Gorman's chart that "Patient does not have a treatable form of depression. I do not believe medication or counseling would be helpful at this point. Possibly manipulative or malingering. I would expect any suicidal behavior to stop once her legal situation is resolved."

Although Ms. Gorman appeared relieved, Susan Ryan was frustrated that the psychiatrist had decided not to pursue civil commitment. Ms. Ryan then took her friend to South Shore Hospital in an effort to convince those staff that Ms. Gorman required inpatient emergency room treatment. They met with emergency room nurse Gerry Clark, and Ms. Ryan again stated that Cheryl Gorman was suicidal and had been drinking. Ms. Gorman conversed with Ms. Clark and denied any suicidal intent or need for emergency room services. She appeared moderately intoxicated to Ms. Clark and complained of being lonely.

A short while later, and outside the presence of her friend and Nurse Clark, Cheryl Gorman left the hospital. She walked into the yard of a residence close to the hospital and asked to use the telephone. Betsy Wood, baby-sitter at the home, described Ms. Gorman as distraught, crying, and had difficulty walking. Ms. Gorman called ex-boyfriend Manny Solarz for assistance, but he rejected her plea for help and informed her that their relationship was over. She left the residence and walked into the yard of Lenny Simmons. According to Mr. Simmons, Ms. Gorman was acting very strange and he offered to drive her to a women's shelter. While en route, he flagged down Officer Andy Klein of the Harrison Police Department, and the young woman was placed under arrest.

Cheryl Gorman was transported to the Harrison City Jail, arriving at approximately 4:30 p.m. on November 14. She was booked by Jailer Willie Clemmey, who knew the young women because she had been confined in the facility for several days following her initial arrest. Cheryl Gorman was placed in a cell designated for intoxicated inmates at approximately 5:00 p.m. A short time later, Jailer Clemmey allowed her to make two telephone calls - one to Mr. Solarz and the other to Nurse Clark at South Shore Hospital. In the conversation with her ex-boyfriend, she was overheard by several police personnel as feeling alone and concerned about whether Mr. Solarz would support and visit her in jail. In her conversation with Nurse Clark, she asked for mental health assistance. Ms. Gorman sounded distraught and told the nurse that "she couldn't take it anymore." When Nurse Clark asked to speak with Mr. Clemmey, she was informed by the jailer that Ms. Gorman "likes to manipulate people" and could not see anyone from the CMHC because she was scheduled to be transported to the county jail later that evening. According to Jailer Clemmey, "Cheryl likes to manipulate people and will do anything, basically, to get out of jail, and her usual technique is to request medical care for various reasons. We've taken her up to the mental health center on the past occasions, and it's usually comes down to nothing. There's been no organic problems. I think the last one it just said basically stress."

[1]In order to ensure confidentiality, individual and agency names have been changed.

INSIDE. . .

Cheryl Gorman was returned to her cell and provided a meal which she did not eat. At approximately 6:30 p.m., Jailer Clemmey checked on the young woman and found her banging her head against the bunk rail four or five times. Despite this behavior, the jailer later stated that he did not consider Ms. Gorman to be suicidal because "she'd been evaluated and found to be non-committable earlier today, which to me indicates that the person is not a suicide risk." Mr. Clemmey then left the facility and the sole responsibility for supervising Cheryl Gorman and three other inmates was given to Dispatcher Glenn McCullough.

Sometime between 6:30 and 7:00 p.m., Dispatcher McCullough left the dispatch area and went downstairs to prepare and eat his dinner. At approximately 7:35 p.m., he finished his dinner and proceeded to the cell area to check the inmates and deliver a letter to Ms. Gorman that her friend Susan Ryan had delivered earlier. Upon arrival at the cell, Dispatcher McCullough opened the food slot window in the door and observed Ms. Gorman hanging from the door hinge by a pair of knee socks. He immediately called out for assistance to Officer Mark Rivers, who was in the squad room. McCullough and Rivers entered the cell together and cut Ms. Gorman free from the noose. Paramedics were called to the scene and Cheryl Gorman was transported to South Shore Hospital where she was subsequently pronounced dead.

Few issues challenge jail officials and staff more than the management of perceived manipulative behavior. Although it is not unusual for inmates to call attention to themselves by threatening suicide or even feigning an attempt in order to avoid a court appearance, be relocated to a different housing unit, be transferred to the facility's infirmary or local hospital, receive preferential staff treatment, or seek compassion from a previously unsympathetic parent or other family member, the literature is replete with evidence to suggest that all threats or acts of self-injury should be treated as potentially suicidal behavior by correctional staff.

In addition, although the prevailing theory is that any inmate who would go to the extreme of threatening suicide or even engaging in self-injurious behavior is suffering from at least an emotional imbalance that requires special attention, too often correctional personnel (with the support of mental health and/or medical staff) conclude that the inmate is not dangerous and simply attempting to manipulative his or her environment. It is often suggested that such behavior be ignored and not reinforced through intervention. In fact, it is not unusual for mental health professionals to resort to labeling, with the inmate engaging in "deliberate self-harm" termed "manipulative" or "attention seeking;" and "truly suicidal" patients seen as "serious" and "crying for help." As demonstrated by Dr. Wilson in Cheryl Gorman's case, clinicians routinely differentiate behavior they regard as genuine suicide attempts from other self-injurious behavior labeled as self-mutilation, suicidal gestures, parasuicide, manipulation or malingering. Such labeling, however, may reflect more upon the clinician's reaction to self-injurious behavior or the inmate rather than the inmate's risk of suicide (Thienhaus & Piasecki, 1997).

In addressing the problem of perceived manipulative behavior by inmates, one observer has suggested that all (correctional, medical and mental health) staff relinquish the tendency to view threats of self-injury by inmates according to expressed or presumed intent:

> There are no reliable bases upon which we can differentiate 'manipulative' suicide attempts posing no threat to the inmate's life from those 'true, non-manipulative' attempts which may end in death. The term 'manipulative' is simply useless in understanding, and destructive in attempting to manage, the suicidal behavior of inmates (or of anybody else) (Haycock, 1992).

Other clinicians would disagree and argue that self-injurious behavior displayed by "truly suicidal" and "manipulative" inmates should result in different interventions. For suicidal inmates, intervention that promotes close supervision, social support, and access to or development of psychosocial resources is crucial. For manipulative inmates, intervention that combines close supervision with behavior management is crucial in preventing or modifying such behavior (Bonner, 1992). Historically, the problem has been that manipulative behavior was ignored or resulted in punitive sanctions, including isolation. Often, manipulative inmates escalate their behavior and die, either by accident or miscalculation of staff's responsiveness. Therefore, the problem is not in how we "label" the behavior, but how we react to it — and the reaction should not include punitive measures such as isolation.

Although there are no perfect solutions for the management of inmates who threaten suicide or engage in self-injurious behavior and are subsequently viewed as manipulative, the following guidelines are offered to correctional officials and staff: 1) utilize preventive steps (e.g., increased supervision) to discourage manipulative behavior; 2) avoid isolation and/or segregation as a response to manipulative behavior — it could escalate the behavior and result in more serious gestures; 3) determining whether an inmate is manipulative or actually suicidal is *not* the correctional officer's responsibility — simply observe and document the behavior; and 4) refer the inmate to mental health/medical personnel for assessment.

In continuing our discussion of suicide prevention and manipulative behavior, we present the following article — "Self-Harm in Prison: Manipulators Can Also Be Suicide Attempters" by Greg E. Dear, Donald M. Thomson, and Adelma M. Hills.

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Self-Harm in Prison: Manipulators Can Also Be Suicide Attempters[1]

by
Greg E. Dear, Donald M. Thomson and Adelma M. Hills

Abstract

This study sought to determine whether self-harm incidents classified as manipulative would also be classified as low suicidal intent and low risk to life. Seventy-four prisoners who had self-harmed were interviewed within three days of the incident. Measures were obtained of the degree of suicidal intent (Suicide Intent Scale), the degree to which the self-harm incident posed a risk to life (assessed by medical staff) and the principal motive for self-harming (open ended question). The data did not support the notion that manipulators and suicide attempters are mutually exclusive groups. Only six of the eighteen participants who reported manipulative motives displayed low suicidal intent, and three of the eighteen enacted self-harm that posed at least a moderate risk to life. Prison staff cannot assume that prisoners who appear manipulative, or who report manipulative motives, were not suicidal at the time of self-harming.

Researchers have noted a desire among prison staff to distinguish between genuine suicide attempts and manipulative acts of self-harm where the goal is to gain attention or force a change in one's circumstances (Harding, 1994; Haycock, 1989; Jones, 1986; Liebling, 1992; Power & Spencer, 1987). The majority of prison staff assume that suicide attempters and manipulators are mutually exclusive groups (Liebling, 1992). The desire to differentiate these two groups is based on the belief that each requires a different management response. While the genuinely suicidal require assistance and support, manipulators should not have their behavior reinforced, that is, they should not obtain attention or a change in their circumstances. Franklin (1988) suggested that failing to manage these two groups along the lines just outlined might "contribute to a pattern of repetitious behavior" (p. 214). Others have argued that attempting to identify manipulators is dangerous in that suicidal prisoners can be mistakenly identified as manipulators and the subsequent management response might precipitate further, and possibly fatal, self-harming behavior (Harding, 1994; Haycock, 1989; Liebling, 1992; Liebling & Krarup, 1993). Cooper (cited in Jones, 1986, p. 293) suggested that prison administrators' aversion to being manipulated is at the core of their difficulty in preventing suicides in prison.

Attempts to determine the proportion of prison self-harm incidents that can be regarded as manipulative have ranged from 28% using self-report data obtained through a semi-structured interview conducted within 48 hours of the self-harm incident (Power & Spencer, 1987) to 50% using data obtained from a review of psychiatric records (Franklin, 1988). Hawton and Catalan (1987) cite data that indicate psychiatrists are more likely than their patients to ascribe manipulative motives to the patient's self-harm behavior. This might explain why Franklin found a higher rate of manipulation than Power and Spencer. Neither study tested the assumption that manipulative motives equate with a lack of suicidal intent.

Studies have consistently found that the majority of self-harm incidents in prison carry little risk to life (Fleming, McDonald, & Biles, 1992; Franklin, 1988; Haycock, 1989; Jones, 1986; Liebling & Krarup, 1993; Power & Spencer, 1987). Such findings have been cited as support for the view that most self-harm in prison is essentially manipulative (Franklin, 1988; Power & Spencer, 1987). There is an apparent belief that low risk to life equates with low suicidal intent which equates with manipulative motives. Others have, on the basis of qualitative data, expressed the view that all self-harming behavior indicates a breakdown in coping and the degree of suicidal intent should not be estimated on the apparent manipulative motives for self-harming (Liebling, 1992; Toch, 1977; Toch, Adams, & Grant, 1989).

We found five studies that examined the association between risk to life and suicidal intent, and these are summarized in Table 1. Studies with psychiatric and other hospital patients have found higher suicidal intent among patients employing more lethal self-harm methods (Pierce, 1977) and have shown a positive relationship between degree of suicidal intent and the medical seriousness of the self-harm incident (Hamdi, Amin, & Mattar, 1991; Pallis & Sainsbury, 1976; Pierce, 1977). Despite this association, some persons enacting self-harm of low medical seriousness evidence high suicidal intent (Hamdi et al., 1991; Hawton, 1989). Power and Spencer (1987) found higher levels of suicidal intent among those prisoners whose self-harm incident carried some risk to life than among those whose self-harm was judged by medical staff to hold no risk to life. Liebling (1992), however, failed to find a significant relationship between risk to life and suicidal intent in her study of young prisoners (16 to 21 years of age).

There have been no attempts to examine the relationship between motives (i.e., manipulative or not) and suicidal intent or medical seriousness. If attention seeking or manipulative motives are always accompanied by low suicidal intent and self-harming that poses little or no risk to life, then it might be appropriate for prison staff to identify manipulative self-harmers and manage them differently from non-manipulative self-harmers (who are more likely to be suicide attempters). This study sought to determine whether self-harm incidents classified as manipulative would also be classified as low suicidal intent and no risk to life.

Method

Participants

Eighty-one prisoners (70 males and 11 females) who self-harmed were interviewed within three days of the incident. Seventy four participants (64 males and 10 females) provided

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data on all three measures (as outlined below). Ages ranged from 18 to 55 years with a mean age of 25.7 (SD = 6.92). Forty seven (63.5%) of the sample were aged 25 years or less. Table 2 displays other demographic details. Unsentenced prisoners and prisoners aged 25 or less were over-represented in the sample compared to the average state prison population for the period of the study. This is consistent with the higher self-harm rate among these groups reported in previous research (Fleming et al., 1992; Jones, 1986; Liebling, 1992; Liebling & Krarup, 1993, Wool & Dooley, 1987). Women were also over-represented in the sample, but this might be an artefact of the small sample size. The sample was representative in terms of race and previous imprisonment.

Procedures

The Information Analysis Unit of the Western Australian Ministry of Justice notified the research team of all self-harm incidents that occurred during the period of data collection. This unit receives daily reports from all prisons across the state regarding any security-related incidents (including self-harm incidents). Following such notification arrangements were made to interview the prisoner who had self-harmed. These interviews were conducted within three days of the incident in a private location nominated by the prison administration.

The prisoner was either sent or escorted to the interview room by Unit staff. The interviewer introduced himself, briefly explained the purpose of the study, informed participants about confidentiality and voluntary participation and answered any questions concerning the interview or the study in general. Prisoners who consented to being interviewed were then asked to sign a written consent form. Six prisoners did not consent to being interviewed and 81 did consent to an interview. This study is part of a wider research project into self-harm in prison and a complete account of the sampling and other procedures is provided by Dear, Thomson, Hall and Howells (1998).

Measures

Participants were assessed on three variables: motive for self-harming, medical seriousness of the self-harm incident and degree of suicidal intent. Motives were assessed on the basis of a single item that required the prisoner to articulate the function of the self-harm, that is, what he or she expected to happen as a result of self-harming. Responses were coded into one of three categories: manipulative motives, psychological relief, or escape. A manipulative motive was defined as either attention seeking (e.g., "wanted staff to take me more seriously") or an attempt to change one's circumstances (e.g., "wanted to get transferred out of this unit"). Responses were coded as psychological relief if the reported motive was to eliminate or minimize particular dysphoric affective states or cognitive experiences. Psychological relief included such motives as "to let out some of my anger and tension" and "to stop all these weird thoughts from spinning round in my head." Responses were coded as escape if the prisoner reported wanting to get away from more global circumstances than specific

TABLE 1
STUDIES THAT EXAMINED THE ASSOCIATION BETWEEN RISK TO LIFE AND DEGREE OF SUICIDAL INTENT

Authors (year)	Sample	Measure of Suicidal Intent	Measure of Risk to Life	Statistical Analysis
Pierce (1977)	N=500; consecutive cases of deliberate self-harm seen at a general hospital	SIS	Rating on 5-point scale by medical staff	Product-moment Correlation, r=.476
Hamdi, Amin & Mattar (1991)	N=61; consecutive admissions for deliberate self-harm at two general hospitals	SIS	Rating on 4-point scale by researchers from information in medical file	ANOVA, IV (Risk to Life), DV (SIS). F=6.87; df=3.58; p<.001. SIS scores increased with each increase in level of risk
Pallis & Sainsbury (1976)	N=81; patients admitted for assessment at general hospital following deliberate self-harm	SIS	3-point scale rated by medical officer who admitted patient and by researcher (only included those cases where both raters agreed)	ANOVA, IV (Rik to Life), DV (SIS) score increased with each increase in level of risk
Power & Spencer (1987)	N=76; consecutive inmates from Scottish Young Offenders' Institution (aged 16-21) placed on Strict Suicide Observation following threatened or actual self-harm	SIS	3-point scale rated by nursing officer on basis of degree of medical attention required	No statistical analysis reported. Compared means, higher SIS score in higher levels of risk to life
Liebling (1992)	N=50; inmates in English and Welsh Young Offender Institutions (aged 16-21 who self-harmed in custody	Single items asking if subject regarded the incident as a suicide attempt; responses coded as "yes," "ambivalent," "no"	4-point scale rated by medical staff	No statistical analysis reported. Stated in discussion "severity of injury did not correlate with...describing one's own action in terms of a suicide attempt" (p. 173)

TABLE 2
DESCRIPTIVE DETAIL OF SELF-HARMERS INTERVIEWED (N=74)

Variable	Category	n	%
Status	Unsentenced[a]	31	41.9
	Sentenced	43	58.1
Race	Caucasian	47	63.5
	Aboriginal	24	32.4
	Asian	3	4.1
Level of Education[b]	Year 9 or Less	43	58.9
	Completed Year 10	18	24.7
	Completed High School	5	6.8
	Trade/Tertiary	7	9.5
Previous Imprisonment	No	14	18.9
	Yes	60	81.1

[a]This includes persons who have been convicted and are awaiting sentence and persons who have been charged but have not yet gone to trial (remanded in custody) and are therefore unconvicted. These prisoners are similar to U.S. jail inmates.
[b]N=73 (1 missing).

affective or cognitive states (e.g., "I just wanted everything to stop, I couldn't take anymore").

Of the 81 participants interviewed, 75 reported motives that could be coded into the above three categories. Four participants indicated that they were not sure what their motive had been. The responses of another two could not be coded into the above categories. One claimed that he likes the sight of blood and likes playing with it, the other stated that he self-harmed to punish himself for things he had done.

Medical seriousness was assessed by nursing staff who rated the incident as either no risk to life, some risk to life (death was possible but unlikely) or high risk to life (death was probable if there had been no intervention). Where possible the nurse who attended the prisoner following the incident provided this rating. Alternatively, a nurse who was involved in subsequent care of the prisoner gave this rating. In either case, notes from the medical file were used to assist the nurse in determining the degree of risk to life. We were unable to obtain a rating of medical seriousness for one participant.

Suicidal intent was assessed using the Suicide Intent Scale (SIS) (Beck, Schuyler, & Herman, 1974). This scale is administered in a structured interview format to persons who have enacted deliberate self-harm. The scale comprises 15 items each of which examine a specific indicator of suicidal intent. Items are equally weighted and scored 0, 1, or 2, with high scores indicating greater intent. There are two sections: items 1 to 8 examine circumstances relating to a self-harm incident (e.g., whether precautions were taken against discovery, the degree of planning, whether a suicide note was written), whereas items 9 to 15 examine introspective data (e.g., whether the person thought death was a possible or probable outcome of his/her actions). Total scale scores can be categorized into three levels of intent (Hamdi et al., 1991; Pierce, 1981): little or no intent (0 to 3); moderate intent (4 to 10); and high intent (11 or higher). Beck et al. reported extremely good interrater reliability (r = .95) and acceptable internal consistency (Spearman-Brown coefficient of .82). Evidence for validity is limited, but acceptable, in that meaningful relationships have been found between SIS scores and a number of relevant factors. SIS scores have shown significant associations with the medical seriousness of suicide attempts (Hamdi et al., 1991; Pallis & Sainsbury, 1976), and with a suicide risk scale comprising empirically derived demographic and clinical risk factors (Pallis & Sainsbury, 1976). SIS scores have also shown a stronger relationship with hopelessness than with overall depressive symptomotology (Beck et al., 1974). Consistent with this, high SIS scores were associated with feelings of hopelessness and isolation while low scores were associated with feelings of anger and frustration (Hamdi et al., 1991). Finally, a modified version of the scale was used in longitudinal research where self-harmers who subsequently committed suicide over a five year follow-up period were found to have higher SIS scores (particularly for their penultimate episode) than those who did not commit suicide (Pierce, 1981). A later reanalysis of these data (Pierce, 1984) found patients who self-harmed on more than one occasion, with rising intent scores across successive episodes, to have a significantly higher suicide rate (10.5%) than other patients (1.95%).

Results

Eighteen (24.3%) of the 74 prisoners reported motives that were coded as manipulation, 32 (43.2%) were coded as psychological relief, and 24 (32.4%) were coded as escape. Only 15 (20.3%) of the 74 incidents were assessed as posing as least some risk to life, whereas 58 (78.4%) were assessed as involving at least a moderate degree of suicidal intent. Twenty-seven (36.5%) prisoners displayed high suicidal intent. The internal consistency of the SIS was adequate; Cronbach's Alpha for the full scale was .852. Cronbach's Alpha for the self-report items was .903, whereas Alpha was only .476 for the circumstance items. Internal consistency is less relevant for the circumstance items as they constitute a checklist of independent indicators of intent rather than a set of related factors.

Tables 3 to 5 show the cross-tabulations between suicidal intent and medical seriousness, motive and medical seriousness, and motive and suicidal intent, respectively. Table 6 shows the 3-way cross-tabulation between motive, medical seriousness, and suicidal intent.

TABLE 3
CROSS-TABULATION OF MEDICAL SERIOUSNESS AND DEGREE OF SUICIDAL INTENT

Medical Seriousness	*Degree of Suicidal Intent*			Total	%
	None/ Low	Moderate	High		
No risk to life	16	28	15	59	79.7
Some risk to life		1	3	4	5.4
High risk to life		2	9	11	14.9
Total	16	31	27	74	100
%	21.6	41.9	36.5	100	

The classification of suicidal intent was weakly associated with the classification of medical seriousness (see Table 3), Lambda = .155, $p < .05$. The main consistency between these measures was that no participant whose self-harm incident held at least some risk to life reported low suicidal intent and the majority (9 out of 11) whose self-harm posed a high risk to life were categorized as high suicidal intent. On the other hand, the majority of participants with moderate or high suicidal intent enacted self-harm that was assessed as posing no risk to life.

There was no association between motive and medical seriousness (see Table 4), Lambda = .07, $p = .24$. Most participants within each category of motive enacted self-harm that posed no risk to life. Only 11 (14.9%) of the 74 incidents were assessed as posing a high risk to life.

Table 4
Cross-Tabulation of Motive and Medical Seriousness

Motive	*Medical Seriousness*			Total	%
	No Risk to Life	Some Risk to Life	High Risk to Life		
Manipulation	15	1	2	18	24.3
Psychological Relief	28	1	3	32	43.2
Escape	16	2	6	24	32.4
Total	59	4	11	74	
%	79.7	5.4	14.9	100	

There was some consistency between reported motive and suicidal intent in that no participant of the 24 who reported a motive of escape reported low suicidal intent and 19 of the 24 (79.2%) reported high suicidal intent. The association between these two measures was moderate, Lambda = .341, $p < .005$, but this was almost entirely due to the commonality between high suicidal intent and a motive of escape. Of the 18 prisoners who reported manipulative motives, only 6 (33.3%) displayed low suicidal intent, while 8 (44.4%) displayed moderate suicidal intent, and 4 (22.2%) displayed high suicidal intent.

Table 5
Cross-Tabulation of Motive and Degree of Suicidal Intent

Motive	*Degree of Suicidal Intent*			Total	%
	None/ Low	Moderate	High		
Manipulation	6	8	4	18	24.3
Psychological Relief	10	18	4	32	43.2
Escape		5	19	24	32.4
Total	16	31	27	74	
%	21.6	41.9	36.5	100	

The three-way cross- tabulation (see Table 6) indicates quite clearly the consistency across the measures for those participants who reported low suicidal intent. None of these 16 participants enacted self-harm that was assessed as posing any risk to life and none reported a motive of escape. Table 6 also indicates that only 6 (33%) of the 18 prisoners who reported manipulative motives were categorised as low suicidal intent and also enacted self-harm that was assessed as no risk to life.

The 4 prisoners who reported a manipulative motive and high suicidal intent were examined in more detail in order to discover possible explanations for this apparently inconsistent combination. Table 6 shows that 3 of these 4 enacted self-harm that posed at least some risk to life. Table 7 shows that each of these 4 participants thought death was at least a possible outcome of their self-harm and that their expectations regarding fatality were mostly in line with the medical assessment of risk to life.

It is possible for a participant to have been classified as moderate suicidal intent while not having had any actual intention of dying from their self-harm behavior. For example, a prisoner might have inflicted minor cuts to his forearm as a means of venting his agitation, and scored 5 on the SIS (moderate suicidal intent) by (a) timing the incident so that intervention was not likely (score of 1 on item 2), (b) taking active precautions to prevent or impede intervention (score of 2 on item 3), (c) having made extensive preparations for the incident (score of 2 on item 6), and (d) scoring zero on all other items. On the other hand, it is unlikely that a participant classified as high suicidal intent (scoring 11 or more on the SIS) had no intention of dying, particularly if they indicated an expectation that the incident could result in death (scoring more than zero on either item 10 or 11).

The 11 participants who reported escape as their motive and displayed high suicidal intent, yet enacted self-harm that held no risk to life, were also examined in more detail. Table 8 indicates that each of these participants also thought death was at least a possible outcome of their self-harming, and that in only 4 of the 11 incidents were staff alerted to the incident by the prisoner who self-harmed.

Discussion

The data did not support the notion that manipulative motives always coincide with low suicidal intent nor that manipulative motives always involve little or no risk to life. In this sample, two out of three prisoners with manipulative motives had at least moderate suicidal intent, and one in six enacted self-harm behavior that posed at least some risk to life.

The data also indicated that a motive of escape coincides with at least moderate suicidal intent and is more likely to involve highly lethal self-harm behavior than are other motives. Of the 24 participants who reported escape as their motive, 16 made some reference to death in their response (e.g., “I wanted to end it all, to get away from everything”; “I wanted out of here and there’s only one way to do that”). In reporting a motive of escape, prisoners were, in the main, also reporting suicidal intent. It is no surprise then that a motive of escape largely coincided with high scores on the SIS.

Motive

It appears that clinicians have some justification for diagnosing genuine suicidal intent in prisoners who, when asked about the function of their act of self-harm, report escapist motives and having wanted to die. However, clinicians do not appear to be justified in assuming an absence of suicidal intent for all prisoners who report a motive of manipulation or attention seeking.

Two groups of participants provided data that were inconsistent across the measures employed. The first group comprised four participants who displayed high suicidal intent despite reporting their main motive as manipulation. Only one of the four enacted self-harm that posed no risk to life. Each indicated that they thought death was a possible (if not likely) outcome of what they were doing, and none reported having tried to do less than what they thought would be lethal. Although they were seeking to improve their circumstances they seemed prepared to die in the process. This appears difficult to explain. However, such mixed motives are said to be relatively common among suicide attempters in the general population (Hawton, 1989; Hawton & Catalan, 1987; Shneidman, 1985; Williams, 1997) so why should they not appear among self-harmers in prison? Shneidman (1985) conceptualized suicidal persons not as committed seekers of death, but as persons unable to tolerate their current life situation, who want desperately for circumstances to improve, but who are not hopeful of success in their efforts to change their circumstances. Hawton (1989) argued that "motives for suicide attempts may be fairly complex, and an attempt may have several reasons - for example, an ambivalent wish to die, a need to show other people how hurt the attempter feels, and a wish for temporary oblivion" (p. 203).

The second group comprised 11 participants who sought to escape from their overall life situation and displayed high suicidal intent yet enacted self-harm that posed no risk to life. Each of these prisoners indicated that they thought death was a possible outcome of what they were doing, and none indicated having tried to do less than what would be lethal. It appears this group might have been naive as to what they needed to do to ensure death. This naivety might explain the apparent inconsistency between the lethality of their self-harm incident and their reported motive and high suicidal intent. Alternatively, their use of non-lethal means might simply be a manifestation of the ambivalence that Shneidman (1985) attributes to all suicidal persons.

Another explanation for inconsistencies across the measures is that one or more of the measures are invalid, unreliable or both. While there is some evidence for the reliability and validity of the SIS, there are no data pertaining to the psychometric properties of the other measures and either could be invalid. In particular, measuring motive by coding responses to one open-ended question might well be problematic. There are obvious semantic overlaps between the categories of psychological relief and escape. While these categories were differentiated on the basis of the specificity of the experience that the prisoner sought to avoid (specific thoughts or emotions versus general life circumstances), this distinction might reflect differences in prisoners' capacity to articulate their motives as much as differences in actual motive. On the other hand, responses that were coded as manipulative did not appear to share any common content with the other categories, and the central concern of this research was with the degree of suicidal intent and risk to life exhibited by prisoners who reported manipulative motives for self-harming. Moreover, our measures of motive and risk to life simulate the type of inquiry that prison health staff typically employ in an assessment interview with a prisoner who has self-harmed, and as such are appropriate for the purpose of this study despite their limited validity.

Whatever explanation one provides for the two groups of participants who provided inconsistent data, it still remains that no prisoner who indicated low suicidal intent reported their main objective as escaping from their overall life situation and none were assessed by nursing staff to have enacted self-harm that posed any risk to life. The Suicide Intent Scale therefore appears to be the most

TABLE 7
PARTICIPANTS REPORTING MANIPULATIVE MOTIVES AND HIGH SUICIDAL INTENT

Method	Who Reported Incident to Staff	Specific Motive	Medical Seriousness	*SIS*	
				Item 10[a]	Item 11[b]
1. Hanging	Staff discovered incident	To change circumstances	High risk to life	2	2
2. Laceration	Another prisoner notified staff	To get someone to listen to me	High risk to life	2	1
3. Laceration	Prisoner who self-harmed	To change circumstances	No risk to life	2	1
4. Laceration	Prisoner who self-harmed	To get someone to listen to me	Some risk to life	1	1

NOTE: SIS = Suicide Intent Scale
[a]Expectation regarding fatality: 0=patient thought death was unlikely; 1=patient thought death was possible but not probable; 2=patient thought death was probable.
[b]Patient's conception of lethality: 0=patient did less than what they thought would be lethal; 1=patient wasn't sure or thought act might be lethal; 2=act equaled or exceeded what the patient thought would be lethal.

defensible measure for classifying self-harm incidents. Moreover, there is some evidence of the reliability and validity of this measure.

Liebling and Krarup's (1993) caution about the perils of trying to identify manipulators is well founded. Eighteen of the 74 participants (24.3%) reported a manipulative motive for their self-harm. When all three measures employed in this study were combined only 6 of 74 incidents (8.1%) were classified as manipulative, low lethality and low suicidal intent. If prison staff were to classify prisoners on the basis of reported motive alone, and manipulators were assumed to be "not suicidal," then an alarming rate of false negatives (prisoners judged to be not suicidal who actually are suicidal) would result. The potential consequence of a false negative (an unexpected death) is far more dire than the potential cost of a false positive (managing a non-suicidal prisoner as though he or she were suicidal). The data from this study indicate that the likelihood of producing a false negative is lower if one were to classify prisoners who have self-harmed on the basis of SIS scores than using either of the other measures.

In conclusion, the data did not support the notion that manipulators and suicide attempters are mutually exclusive groups. Prison staff cannot assume that prisoners who appear manipulative, or who report manipulative motives, were not suicidal at the time of self-harming.

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TABLE 8
PARTICIPANTS WITH HIGH SUICIDAL INTENT AND ESCAPE AS THE MOTIVE BUT WHOSE SELF-HARM POSED NO RISK TO LIFE

Method	Who Reported Incident to Staff	*SIS* Item 10[a]	*SIS* Item 11[b]
1. Laceration	Staff discovered incident	2	1
2. Laceration	Prisoner who self-harmed	2	1
3. Electrocution	Staff discovered incident	2	2
4. Hanging	Prisoner who self-harmed	2	2
5. Hanging	Staff discovered incident	2	2
6. Laceration	Prisoner who self-harmed	1	1
7. Laceration	Another prisoner notified staff	2	1
8. Laceration	Prisoner who self-harmed	1	1
9. Laceration	Staff discovered incident	1	1
10. Laceration	Staff discovered incident	2	1
11. Laceration	Staff discovered incident	2	1

NOTE: SIS = Suicide Intent Scale
[a]Expectation regarding fatality: 0=patient thought death was unlikely; 1=patient thought death was possible but not probable; 2=patient thought death was probable.
[b]Patient's conception of lethality: 0=patient did less than what they thought would be lethal; 1=patient wasn't sure or thought act might be lethal; 2=act equaled or exceeded what the patient thought would be lethal.

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About the Authors

Greg E. Dear, School of Psychology, Edith Cowan University; Donald M. Thomson, Professor of Psychology, Charles Sturt University; Adelma M. Hills, Psychology Department, University of Western Sydney, Macarthur. This research was supported by a grant from the Australian Research Council with further funding from the Western Australian Ministry of Justice. Correspondence concerning this article should be addressed to Greg Dear, School of Psychology, Edith Cowan University, 100 Joondalup Drive, Joondalup, Western Australia, Australia. 6027, E-Mail: g.dear@cowan.edu.au ❑

LETTER TO THE EDITOR

Dear Editor:

The history of litigation intended to improve mental health care in departments of correction regrettably has promoted a revival of the obsolete, but cherished, legal fiction that contrasts helpless victims who suffer from mental illness from those bad actors who are presumed to make conscious antisocial choices. The summer 2000 edition of the ***Jail Suicide/Mental Health Update*** (Volume 9, Number 4) appears to reinforce this distortion when it suggests that the developmentally disabled and inmates with a mental disorder are "at greater risk of being victimized" and "less likely to understand and comply with institutional rules." Risk of victimization and noncompliance with rules, of course, are separate phenomena from the spectrum of mental disorders. To focus on a judicial definition of mental illness is to miss the forest for the trees. While demographics of inmates who complete suicide can be instructive, the psychological literature consistently finds that impulsivity, hopelessness, anger and/or fear are common determinates of self-injury or suicide. Any of these mental states can exist within the full spectrum of inmate behaviors, and are not confined to a narrow definition of mental illness promoted in class-action litigation. When correctional mental health services become focused on narrow definitions, those inmates whose mental states may place them at highest risk may end up being ignored.

Drs. Couturier and Maue notably report on expanded services for the mentally ill inmate as part of their suicide prevention effort. They separate "inmates with mental illness" from "drug and alcohol abusers" and "sex offenders," and yet paradoxically recognize the impact of social policy, i.e., the restriction of parole release which adversely impacts the entire inmate population. Although they advocate for expanded service to the mentally ill, they unwittingly polarize those deserving of treatment (the mentally ill) from those who do not (drug and alcohol abusers and sex offenders). The ***Update*** appears to accept this judicial proscription and, in our view, contributes to narrow and poorly conceived operational service guidelines. It would be better that Correctional Mental Health Services be allocated to any and all inmates, as is the general thrust of civilian mental health services in our communities.

We urge the Editorial Board of the ***Update*** to advocate for the broadest application of mental health services to any and all who might seek support and treatment. We believe that expanded mental health services to the incarcerated, without discriminations based on Axis II pathology, substance abuse disorders, conduct disorders or paraphilias, would further the goals of containing self-destructive behaviors.

Sincerely,
Alan A. Abrams, M.D., J.D.
Chief Psychiatrist, Centinela State Prison, California

Steven J. Davis, M.D.
Staff Psychiatrist, Centinela State Prison, California

Drs. Couturier and Maue Respond:

This is a follow-up to our "Suicide Prevention Initiatives in a Large Statewide Department of Corrections: A Full-Court Press to Save Lives" article and a response to the letter submitted by Drs. Abrams and Davis who complain that we separate inmates with mental illness from drug abusers and sex offenders and "unwittingly polarize those deserving treatment (the mentally ill) from those who do not (drug and alcohol abusers and sex offenders)." From our own experience with class-action lawsuits, we agree that the plaintiffs demonstrate much more concern for treatment rights of the mentally ill than they do for the treatment of the general population inmates. However, we never suggested anywhere in the article, nor do we believe, that there are categories of inmates, such as sex offenders and drug and alcohol abusers, who are not deserving of treatment. Indeed, the Pennsylvania Department of Corrections has a long history of providing treatment services to all persons who are incarcerated in its facilities.

In the article, we identified a number of risk factors for suicides in Pennsylvania prisons (including mental illness, alcohol and other drug abusers, and sex offenders). However, we were careful to emphasize that "obviously these were not discrete categories; in fact, there was considerable overlap, with victims falling into several different risk groups." For example, most of our inmates with mental illness also suffer from substance abuse. Our intent in the suicide prevention "full-court press" is to reduce risk to *all* inmates. The strategies developed are intended to impact upon the welfare of both general population and mentally ill inmates alike, although the mentally ill are at the greatest risk.

There are substantial relationships between suicide, mental illness, and substance abuse. The legitimate concerns expressed by Drs. Abrams and Davis notwithstanding, we need to tell it like it is. Both inside and outside the prison walls, there is a substantial relationship of mental illness, alcoholism, and drug abuse to suicide. In her recent masterpiece on the subject (*Night Falls Fast - Understanding Suicide*), Kay Redfield Jamison writes that:

> The most common element in suicide is psychopathology, or mental illness; of the disparate mental illnesses, a relative few are particularly and powerfully bound to self-inflicted death: the mood disorders (depression and manic depression), schizophrenia, borderline and antisocial personality disorder, alcoholism, and drug abuse...in all of the major investigations to date, 90 to 95 percent of people who committed suicide had a diagnosable psychiatric illness (1999, p. 100).

We stressed in the article that inmates with mental illness compose approximately 13 to 15 percent of the inmate population. However, these individuals accounted for 56 percent of the suicides in 1997 and 64 percent in 1998. If one wishes to reduce suicides in their prison system, one of the first places to begin is with the mental health population. We should remember why Willie Sutton robbed banks.

Sincerely,
Lance Couturier, Ph.D.
Chief of Psychological Services, Pennsylvania Department of Corrections

Fred R. Maue, M.D.
Chief of Clinical Services, Pennsylvania Department of Corrections

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NOVACK V. COUNTY OF WOOD: A DIVIDED DEFENSE VERDICT

On August 7, 2000, a divided panel from the United States Court of Appeals for the 7th Circuit ruled 2-to-1 that Wood County, Wisconsin, did not act with deliberate indifference in the jail suicide of Shannon Novack. The case, Novack v. County of Wood (No. 99-3270), is reprinted below.

Before: FLAUM (Chief Judge), POSNER and WILLIAMS, Circuit Judges.

FLAUM, Chief Judge:

The estate of Shannon Novack and Susan Turbin brought suit against the County of Wood (the "County") under 42 U.S.C. sec. 1983, alleging that the County deprived Novack of his Eighth Amendment rights when it failed to prevent his suicide during his incarceration in the Wood County Jail ("WCJ"). The district court granted summary judgment in favor of the defendant. For the reasons stated herein, we affirm.

I. Background

On December 22, 1997, Shannon Novack was diagnosed by Dr. Edward Root as a paranoid schizophrenic who tended to be impulsive and who was a possible suicide risk. Dr. Root prescribed medication to address Novack's condition. On December 29, 1997, while he was with his mother, Susan Turbin, and grandmother, Gladys Jaehn, Novack became agitated and threatened to kill himself. Turbin convinced Novack to voluntarily commit himself at the Norwood Mental Health Center ("Norwood"). However, when Turbin and Novack arrived at Norwood, Novack changed his mind about being committed and left the facility.

A short time later, Novack was arrested by an officer from the Marshfield Police Department on outstanding warrants and taken to the Marshfield police station. Shortly thereafter, Wood County Deputy Sheriff Rick Kirst transported Novack from the police station to the Wood County Jail. Deputy Kirst talked with Turbin and Kenneth Wahlstrand, an employee at Norwood, regarding

Novack's condition. Deputy Kirst told Turbin and Wahlstrand that he would notify WCJ staff of Novack's potential for suicide and that jail personnel would watch him closely. When Deputy Kirst met with Deputy Raymond Starks to transfer Novack to WCJ, he informed Starks that Novack was a suicide risk and should be watched closely. Neither Kirst nor Starks thought that Novack behaved in an unusual manner during their contact with him.

Novack was booked into WCJ by Officer Denise Ellis, who conducted a medical screening of Novack as part of standard WCJ procedure. The medical screening is intended to identify physical or mental problems that an inmate may possess. In his responses to the medical screening questions, Novack indicated that he had seen mental health professionals in the past, including a visit to Dr. Root earlier in the week, but stated that he was not considering suicide and had never attempted suicide. Deputy Starks then informed Officer Ellis that Novack was a suicide risk and that WCJ staff should watch him accordingly. Deputy Starks also told Officer Ellis that Novack had been at Norwood earlier in the day but had not been admitted. Officer Ellis concluded that Novack had a possible mental illness based on the information provided by Deputy Starks and the medical screening.

Officer Ellis decided to place Novack in an observation cell which is normally used for inmates on suicide watch. The WCJ officer on duty the following day was not informed of the reasons for Novack's placement in the observation cell. Novack remained in the observation cell until about 2:00 p.m. the next day when he was taken to court and it was determined that he would remain in custody because of a probation violation. Upon his return from court, Novack was placed in a two-person cell in the general jail population. Officer King, the supervisor on duty at the time, does not know who made the decision to place Novack in the general population instead of in the observation cell or why that decision was made.

The following day, December 31, 1997, Dr. Root telephoned WCJ to prescribe new medication for Novack. WCJ personnel filled the prescription and administered the medication to Novack during the remainder of his stay at WCJ. During the following two weeks, Annalee Miller, an inmate housed in the cell next to Novack's, heard Novack pounding on the cell walls on a daily basis and periodically giggling uncontrollably. Miller reported Novack's behavior to WCJ officers and expressed concern that Novack might be in need of mental health care. Novack's cell-mate Lewis England also saw Novack regularly pounding on the cell walls and thought he was in need of mental health care. However, WCJ personnel did not observe any unusual behavior by Novack during his stay at WCJ.

At 10:00 p.m. on January 17, 1998, WCJ officers entered Novack's cell to give him his prescribed medication. At 12:05 a.m. on January 18, jail personnel returned to Novack's cell and discovered that Novack had hung himself using a bed sheet. Susan Turbin, Novack's mother, brought suit on behalf of Novack's estate and on her own behalf against Wood County alleging that the County had deprived her son of his Eighth Amendment rights by having inadequate policies and practices for treating mentally ill inmates and by failing to adequately train WCJ personnel to provide necessary mental health care to her son that would have prevented his suicide. The district court granted summary judgment in favor of the County, and the plaintiffs now appeal.

II. Discussion

We review the district court's grant of summary judgment in favor of the County *de novo*. See *Johnson v. University of Wisc. Eau-Claire*, 70 F.3d 469, 477 (7th Cir. 1995). We look at all evidence in the light most favorable to the plaintiffs and draw all reasonable inferences in their favor. See *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 250 (1986).

Prison inmates have an Eighth Amendment right to be confined under conditions that provide "adequate food, clothing, shelter, and medical care." *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) (quoting *Hudson v. Palmer*, 468 U.S. 517, 526-27 (1984)). In addition, prison officials are responsible for taking reasonable steps to guarantee the safety of the inmates in their charge. *Id*. To make out a claim for a violation of an inmate's Eighth Amendment right to adequate conditions of confinement, a plaintiff must make two showings: "First, the danger to the inmate must be objectively serious, posing a substantial risk of serious harm. Second, the prison official must have a sufficiently culpable state of mind—one of 'deliberate indifference' to inmate health or safety." *Haley v. Gross*, 86 F.3d 630, 640-41 (7th Cir. 1996); see *Farmer*, 511 U.S. at 834.

"Deliberate indifference," as it is used in the Eighth Amendment context, comprehends more than mere negligence but less than the purposeful or knowing infliction of harm. See *Farmer*, 511 U.S. at 836; *Estelle v. Gamble*, 429 U.S. 97, 106 (1976); *Haley*, 86 F.3d at 641. Deliberate indifference requires that a prison official know of and disregard a substantial risk of serious harm to inmate health or safety. See *Farmer*, 511 U.S. at 837. The deliberate indifference standard is a subjective one. It is not enough that there was a danger of which a prison official objectively should have been aware. "[T]he 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." *Id*.

Shannon Novack committed suicide while incarcerated in the Wood County Jail. The plaintiffs argue that Novack's suicide was the result of WCJ policies and practices that reflected the County's deliberate indifference to the medical needs of mentally ill inmates. Suicide is a "serious harm" and prison officials must take reasonable preventative steps when they are aware that there is a substantial risk that an inmate may attempt to take his own life. See *Estate of Cole v. Fromm*, 94 F.3d 254, 259 (7th Cir. 1996) (holding that defendant prison officials "may be liable for [an inmate's] suicide if they were deliberately indifferent to a substantial suicide risk"); see also *Collignon v. Milwaukee County*, 163 F.3d 982, 990 (7th Cir. 1998); *Payne v. Churchich*, 161 F.3d 1030, 1041 (7th Cir. 1998). Mere knowledge that an inmate is behaving violently or "acting in a 'freaky' manner" is not sufficient to impute awareness of a substantial risk of suicide. State *Bank of St. Charles v. Camic*, 712 F.2d 1140, 1146 (7th Cir. 1983); see also *Mathis v. Fairman*, 120 F.3d 88, 91 (7th Cir. 1997). In order to be liable under the Eighth Amendment, 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. See *Collignon*, 163 F.3d at 990 (holding that even placing an inmate on suicide watch may not demonstrate a subjective awareness of a substantial risk of imminent suicide); *Camic*, 712 F.3d at 1146 (holding that officers took reasonable measures to prevent an inmate's suicide where they were unaware that the inmate was a high suicide risk but removed the prisoner's belt and shoe laces in order to guard against suicide attempts).

In this case, when Shannon Novack was first brought to the WCJ, jail officials were informed that he had been at a mental health facility earlier in the day and that he was a potential risk for suicide. Novack was then questioned concerning his mental health, and he responded that he was not contemplating suicide and had never attempted suicide. In addition, neither the sheriff's deputies who transported Novack to WCJ nor the jail personnel who initially admitted him were aware of any suicidal behavior exhibited by Novack. Nevertheless, Novack was placed in an observation cell until he was taken to court the next day. Novack did not exhibit any suicidal behavior during this time. When Novack's psychiatrist Dr. Root contacted the jail the next day, he prescribed medication for Novack but did not inform WCJ that Novack was a suicide risk. Other inmates apparently informed jail personnel that Novack was behaving strangely by pounding on the walls of his cell and giggling. However, 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. See *Mathis*, 120 F.3d at 91; *Camic*, 712 F.2d at 1146. Novack did not take his life until more than two weeks after he was incarcerated at WCJ. While he may have exhibited some bizarre behavior during that time, he evidenced no behavior that put jail officials on notice that there was a significant likelihood that he would attempt to harm himself. We cannot conclude on this record that WCJ personnel were subjectively aware that Novack posed a high risk of suicide and were deliberately indifferent to that risk.

The plaintiffs argue, however, that WCJ personnel would have been aware that Novack posed a substantial suicide risk had they been adequately trained to handle mentally ill inmates. Ordinarily, a prison official does not violate the Eighth Amendment when he should have been aware of a risk that harm would befall an inmate but was not actually subjectively aware of that risk. See *Farmer*, 511 U.S. at 838 ("[A]n official's failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be condemned as the infliction of punishment."). However, a municipality, rather than an individual, may violate the Eighth Amendment where a risk of serious harm was so patently obvious that the municipality must have been aware of risk of harm and, by failing to act to rectify it, sanctioned the harmful conduct. See *Jackson v. Marion County*, 66 F.3d 151, 152 (7th Cir. 1995); *Farmer*, 511 U.S. at 841 (noting that allegations that individual officers violated Eighth Amendment rights are examined using a subjective awareness standard while allegations of municipal misconduct receive an objective analysis).

A municipality may be liable for harm to persons incarcerated under its authority "if it maintains a policy that sanctions the maintenance of prison conditions that infringe upon the constitutional rights of the prisoners." *Payne*, 161 F.3d at 1043. This liability is not founded on a theory of vicarious liability or respondeat superior that holds a municipality responsible for the misdeeds of its employees. See *City of Canton v. Harris*, 489 U.S. 378, 385 (1989); *Pembaur v. City of Cincinnati*, 475 U.S. 469, 479 (1986). Rather, a municipal policy or practice must be the "direct cause" or "moving force" behind the constitutional violation. See *City of Oklahoma v. Tuttle*, 471 U.S. 808, 820 (1985); *City of Canton*, 489 U.S. at 385; *Monell v. Department of Soc. Servs*., 436 U.S. 658, 691 (1978). In other words, "it is when execution of a government's policy or custom....inflicts the injury that the government as an entity is responsible under sec. 1983." *Monell*, 436 U.S. at 694. That a constitutional injury was caused by a municipality may be shown directly by demonstrating that the policy itself is unconstitutional. See *id.* at 694-95 (holding that a municipality may be liable under sec. 1983 for a policy that requires pregnant women to take unpaid leave before leave was required for medical reasons because the policy itself is unconstitutional). Municipal liability may also be demonstrated indirectly "by showing a series of bad acts and inviting the court to infer from them that the policymaking level of government was bound to have noticed what was going on and by failing to do anything must have encouraged or at least condoned, thus in either event adopting, the misconduct of subordinate officers." *Jackson*, 66 F.3d at 152.

The plaintiffs argue that the policies in place to train WCJ personnel on the proper treatment of mentally ill inmates were so inadequate that the County was on notice at the time Shannon Novack was incarcerated that there was a substantial risk that he would be deprived of necessary medical care in violation of his Eighth Amendment rights. The plaintiffs allege that because of

inadequate WCJ policies and practices concerning the treatment of mentally ill inmates, WCJ officers were unaware that Novack posed a significant suicide risk and failed to take reasonable steps to prevent him from taking his own life.

As noted above, the plaintiffs may prove their allegation that the County was deliberately indifferent to the constitutional violations WCJ personnel were inflicting on mentally ill inmates by presenting either a series of unconstitutional acts from which it may be inferred that the County knew WCJ officers were violating the constitutional rights of WCJ inmates and did nothing or by direct evidence that the WCJ policies, practices or training methods were unconstitutional. Plaintiffs have not shown that there was a pattern of suicide at WCJ from which we can draw the inference that the County was aware that WCJ policies for treating mentally ill inmates at risk for suicide were inadequate and chose to do nothing in the face of this knowledge. Even if we were to find that Novack's suicide itself was a result of unconstitutional conduct, a single instance of allegedly unconstitutional conduct does not demonstrate a municipality's deliberate indifference to the constitutional rights of its inhabitants. See *Tuttle*, 471 U.S. at 823-24 ("Proof of a single incident of unconstitutional activity is not sufficient to impose liability under Monell, unless proof of the incident includes proof that it was caused by an existing, unconstitutional municipal policy."); *Jackson*, 66 F.3d at 152. In the absence of a series of constitutional violations from which deliberate indifference can be inferred, the plaintiffs must show that the policy itself is unconstitutional.

As evidence that WCJ policies themselves were constitutionally inadequate the plaintiffs first point to several instances where the policies and practice of WCJ differ from the requirements of state statute. While state law violations should be of concern to Wood County and the State of Wisconsin, they do not form the basis for imposing sec. 1983 liability. See *White v. Olig*, 56 F.3d 817, 820 (7th Cir. 1995); *Burgess v. Ryan*, 996 F.2d 180, 184 (7th Cir. 1993); *Martin v. Tyson*, 845 F.2d 1451, 1455 (7th Cir. 1988). It is only when municipal policy fails to meet federal constitutional or statutory standards that sec. 1983 liability may be imposed. See *Tuttle*, 471 U.S. at 816. Section 1983 provides no remedy for failure to meet state law requirements.

Next, the plaintiffs present expert testimony from a psychiatrist who points out numerous flaws in the WCJ policies for treating mentally ill inmates and states the opinion that these deficiencies contributed to Novack's death. While the expert's opinion may demonstrate that WCJ personnel could have done more to become aware of the danger that Novack posed to himself based on the strange behavior that he was exhibiting, that opinion does not indicate that WCJ policies caused jail personnel to be deliberately indifferent in the face of a patently obvious suicide risk. In other words, the evidence presented by the plaintiffs has not shown that but for WCJ policies, WCJ personnel would have been aware that Novack posed a high risk of suicide and would have taken reasonable steps to prevent him from taking his own life. We have found that WCJ officers in this case were not deliberately indifferent to the suicide risk posed by Novack, and we cannot conclude that the officers would have been aware of that risk had it not been for the County policies that caused their deliberate indifference.

III. Conclusion

For the foregoing reasons, the district court's grant of summary judgment to the defendant is Affirmed.

WILLIAMS, Circuit Judge, dissenting:

I generally agree with my colleagues' legal analysis but find that genuine issues of material fact preclude summary judgment. I agree with the majority's determination that the Eighth Amendment is implicated only when prison officials are cognizant of a significant likelihood that an inmate may imminently seek to take his own life. Thus, we have not found prison officials liable for prison suicides without an allegation of suicidal tendencies, evidence of past suicide attempts, or warnings of suicidal conditions. See *Payne v. Churchich*, 161 F.3d 1030, 1042 (7th Cir. 1998), *cert. denied*, 527 U.S. 1004 (1999). Moreover, behaving in a strange or bizarre manner is not enough to put prison officials on notice that an inmate is a substantial suicide risk. See *Mathis v. Fairman*, 120 F.3d 88 (7th Cir. 1997); *State Bank of St. Charles v. Camic*, 712 F.2d 1140 (7th Cir. 1983).

In Novack's case, however, genuine issues of material fact exist for a reasonable jury to find that prison officials were aware of a substantial risk that he may imminently commit suicide. For example, when Novack was booked into the Wood County Jail, Deputy Raymond Starks of the Wood County Sheriff's Department informed Officer Denise Ellis that Novack was a suicide risk and that the jail staff should watch him accordingly. Officer Ellis also knew that Novack had been at Norwood Mental Health Center earlier that day. Furthermore, she wrote "watch" on Novack's medical screening inventory. She was aware that Novack had been diagnosed in the past with a mental illness, and she concluded that Novack had a possible mental illness.

Novack was then placed in an observation cell that is normally used for inmates on suicide watch.(1) However, there is no record that the jail officials paid close attention to Novack while he was in the observation cell. Furthermore, without consulting any mental health experts or insuring that he would be subject to suicide watch scrutiny, the officials inexplicably transferred him to the general jail population.

While in jail, Novack took psychotropic medicine prescribed by his psychiatrist. There is no record of the jail officials insuring that he took his medicine when they handed it to him. Furthermore, his jailers did not make any record of closely observing Novack to watch his reaction to this prescription medicine. During his time in general population, his mental health did not improve. He pounded on his cell walls almost every day and was subject to regular uncontrolled fits of laughing and giggling. He did not eat all of his meals, he lost weight, and his appearance was unkept. However, jail staff never conducted a full medical evaluation of Novack.

The facts at issue here are similar to those in *Hall v. Ryan*, 957 F.2d 402 (7th Cir. 1992), where we ruled that a jury, and not the court, must determine whether jail officials were aware of a substantial suicide risk. In Hall, we affirmed the district court's denial of defendants' summary judgment motion. We agreed that the detainee's estate raised genuine issues of material fact whether

defendants were aware that the detainee was a substantial suicide risk.(2) See *id*. at 405. After his arrest, the detainee became excited and belligerent. He urinated on the floor and swore at the police officers. See *id*. at 403. Moreover, he had threatened to commit suicide when he was arrested by the same police department nine months prior to the incident in question. See *id*. at 403-04. The detainee's prior arrest report states that he has attempted suicide several times. See *id*. at 404. Based on the detainee's behavior on the day of his arrest and his prior encounters with this police department, we found that the plaintiff had raised genuine issues of material fact whether defendants knew that the detainee was a serious suicide risk. See *id*. at 405.(3)

As in Hall, we 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. Finally, the jail staff failed to conduct a full medical evaluation and failed to subject Novack to any suicide watch scrutiny. Consequently, from this evidence, a reasonable factfinder could conclude that there existed a substantial risk that Novack would imminently commit suicide and that jail officials knew of this risk, yet failed to act.

The majority opinion seems to discount this evidence and instead focuses on the fact that Novack told the intake officer that he was not contemplating suicide. Moreover, the majority opinion focuses on the conversation between Dr. Root, Novack's psychiatrist, and jail officials, where Root did not mention that Novack had any suicidal tendencies. These facts do not, however, allow us to draw a legal conclusion that Wood County Jail officials were not deliberately indifferent to a substantial risk that Novack would harm himself.

The County of Wood is the only remaining defendant. Local government liability cannot be based upon the theory of respondeat superior. As the majority opinion indicates, however, municipal liability can be demonstrated indirectly if a court can infer from a series of bad acts that policymakers were condoning subordinates' misconduct. See *Jackson v. Marion County*, 66 F.3d 151, 152 (7th Cir. 1995).

A reasonable jury could find that Wood County's customs and lack of procedures caused the deliberate indifference to Novack's Eighth Amendment rights. First, the jury could find that there was a custom of not following certain procedures as it relates to mentally ill inmates and that this custom caused Novack's suicide. For example, evidence suggests that the following jail policies were routinely ignored: (1) referral of mentally ill inmates to medical staff; (2) segregation of mentally ill from non-mentally ill inmates; (3) suicide watch for at-risk inmates where they are checked and a log completed every 15 minutes; (4) medicine consumed in front of officers; and (5) officers determining and documenting the reason that inmates decline food. By ignoring these policies, a reasonable jury could find that the jail showed deliberate indifference toward inmates who, like Novack, already had a demonstrated risk of suicide. Consequently, a jury could properly infer from these "bad acts" that Wood County Jail condoned this conduct.(4)

Second, a reasonable jury could find that the lack of certain jail procedures demonstrates deliberate indifference toward suicide risk inmates. Arden Geisler, the administrator of the jail since 1978, is responsible for policies and procedures at the Wood County Jail. Wisconsin state law makes the sheriff or other jailkeeper responsible for enacting a policy and procedure manual for the operation of the jail. See *Wis. Stat.* sec. 302.365(1)(a). The following procedures were not in place at Wood County Jail: (1) no health appraisal is conducted by a health care professional, even when initial screening warrants it; (2) a supervisor may remove an inmate from a suicide watch without consulting with a health professional; (3) no mental health professional examines an inmate after he is put on suicide watch; and (4) suicide risk assessments are not performed, even when initial screening warrants it. By failing to implement procedures to involve health care professionals in the care taking of mentally ill inmates who are specific suicide risks, a reasonable jury could find that the Wood County Jail showed deliberate indifference toward inmates who are known suicide risks.

While the district court should review the whole record, it must draw all reasonable inferences in favor of the nonmovant and can neither weigh the evidence nor make any credibility determinations. Cf. *Reeves v. Sanderson Plumbing Prods., Inc*., 120 S. Ct. 2097, 2110 (2000).(5) "Credibility determinations, the weighing of the evidence, and drawing of legitimate inferences from the facts are jury functions, not those of a judge." *Anderson v. Liberty Lobby*, 477 U.S. 242, 255 (1986). Consequently, we must give credence to the numerous facts that support plaintiffs' allegations that Wood County Jail officials were aware of a substantial risk that Novack may imminently commit suicide. The weighing of this evidence is the sole province of the jury — not the district court, or this court. The district court's grant of summary judgment in favor of Wood County Jail should be reversed. Accordingly, I respectfully dissent.

(1) The majority cites *Collignon v. Milwaukee County*, 163 F.3d 982, 990 (7th Cir. 1998), for the proposition that placing an inmate on suicide watch may not demonstrate a subjective awareness of a substantial risk of imminent suicide. *Collignon*, however, concerns an inmate who killed himself after being released to the custody of his parents. The issue in *Collignon* was whether officials had a constitutional obligation to devise a treatment plan for the inmate, not whether they could have prevented his suicide while he was in custody.

(2) Pretrial detainees, who are protected under the Fourteenth Amendment's Due Process Clause for maltreatment while in custody, receive the same protection as inmates. See *Payne*, 161 F.3d at 1041.

(3) Other courts have denied summary judgment motions by defendants in similar situations. See *Greason v. Kemp*, 891 F.2d 829, 831-32, 835 (11th Cir. 1990) (finding that a factfinder could conclude that defendants were deliberately indifferent to decedent's needs because defendants were aware that decedent had contemplated suicide, continued to have suicidal tendencies, and was taking antidepressants); *Cabrales v. County of Los Angeles*, 886 F.2d 235 (9th Cir. 1989) (finding deliberate indifference because the same jailers had rescued decedent from a previous suicide attempt); *Partridge v. Two Unknown Police Officers*, 791 F.2d 1182 (5th Cir. 1986) (finding deliberate indifference because defendants knew that decedent had attempted

suicide in a previous confinement); *Viero v. Bufano*, 925 F. Supp. 1374, 1377-78, 1388 (N.D. Ill. 1996) (finding genuine issue of material fact because defendants knew about decedent's emotional health, his depression, his thoughts of suicide, and his need for medication); *Guglielmoni v. Alexander*, 583 F. Supp. 821 (D. Conn. 1984) (finding genuine issue because inmate hanged himself after previous faked suicide); *Matje v. Leis*, 571 F. Supp. 918 (S.D. Ohio 1983) (finding genuine issue because inmate's counsel had informed jailers of decedent's suicide threats).

(4) Moreover, the jail was arguably under constructive notice that some of its policies were not working. Less than a month before Novack was incarcerated, another prisoner committed suicide while supposedly under continuous surveillance in the observation cell.

(5) While Reeves involved a judgment as a matter of law, the summary judgment analysis is identical. See 120 S. Ct. at 2110 "[T]he standard for granting summary judgment 'mirrors' the standard for judgment as a matter of law, such that 'the inquiry under each is the same.'" (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250-51 [1986]). ❑

News From Around the Country

*Continuing with this issue, the **Update** will periodically present brief stories regarding jail suicide, mental health services, and other related topics that have recently occurred throughout the country.*

California

Los Angeles County supervisors agreed in February to pay $600,000 to the family of a Palmdale man who died after struggling with sheriff's deputies in the county's "Twin Towers" jail facility. Jailed on suspicion of stealing a shopping cart, 33-year-old Kevin Evans, stopped breathing after struggling with deputies trying to place him in a restraining device.

Court documents indicated that Mr. Evans became combative with several officers and was placed in four-point restraints. Shortly thereafter, the inmate was found unconscious and without vital signs. An autopsy found that Mr. Evan's injuries were caused by "neck trauma and exhaustion from restraint against combative behavior." The inmate had also suffered from severe heart disease.

Ironically, Kevin Evans was initially given a citiation by police after absconding with a shopping cart from a local grocery store. He was subsequently sent to jail by a judge after appearing argumentative and disruptive in court.

Maine

According to a recent report, mentally ill prison and jail inmates fare poorly in a correctional system that offers limited mental health services while focusing on security and punishment. Issued in January by the National Alliance for the Mentally Ill of Maine, the report states that new treatment services are needed to help the thousands of inmates in the state with mental health problems.

Two recent incidents pointed to the need for changes, said Carol Carothers, executive director of the National Alliance for the Mentally Ill of Maine. In one, a 19-year-old man was transferred from the Lincoln County jail and committed suicide after being segregated at the state's Supermax prison because he showed signs of depression and possible suicide (see Volume 9, Number 3, Spring 2000 issue of the ***Update***). The second incident involved a 22-year-old man housed at the Supermax, who bit off pieces of his fingers.

Mentally ill people often arrive at jail and prison after running into problems with law enforcement officials because of their illnesses, Ms. Carothers said, and the treatment they receive in jails often makes their illnesses worse. She acknowledged that the report's proposals would be large, complex and expensive. "This will have a huge bill and it will be very controversial," she told the *Associated Press*.

Representative Edward J. Povich, House chairman of the Legislature's Criminal Justice Committee, said he would sponsor legislation derived from Carothers' study. But he made it clear he might alter her group's proposals after consulting with county and state corrections officials. "I said if you want me to hang onto all of them, then I'm the wrong sponsor. But if you want me to lead a discussion, that's what I'll do," Povich said.

Povich and Department of Corrections spokeswoman Denise Lord criticized Carothers' report for superimposing national percentages on Maine statistics. "I think the Maine situation is different," Lord said. "A lot of this criticism, I haven't seen the documentation for. I suspect it is anecdotal."

While acknowledging that any system can be improved, Lord defended the state's actions. "For prisoners with mental health issues, I think we provide comprehensive treatment. I think we can do better, you always can. But we're not a hospital and we're not set up to be a hospital," she said.

In May, after hearing testimony from an array of individuals involved in the issue, the Criminal Justice Committee voted to form a study commission to investigate the treatmnent of mentally ill inmates. The study commission will consider the construction of a new mental health center for inmates, a mental health court modeled on the drug courts, and specialized training for correctional staff. The committee's Senate chair, Michael McAlevey, endorsed the study commission idea because a "band-aid or partial approach" was unacceptable and any effort to fund a serious change was "doomed to death" before the Appropriations Committee. Another committee member, however, went one step further, and called for a "major overhaul of the entire system." Representative Patricia A Blanchette stated that "it would be far cheaper in the long run to treat these inmates than to keep placing them in jail cells. It's time we stood up as a government and offered a solution. I can't think of a more inhumane thing to do than put them into a correctional setting."

Florida

The state's prisons and jails have become treatment centers of last resort for people who are mentally ill or suffering from alcoholism or drug addiction, members of an advocacy coalition said in Februaruy. Florida Partners in Crisis, an eclectic group that includes police, judges, prosecutors, public defenders and doctors, are urging lawmakers to increase funding for mental health and substance abuse programs and create a statewide coordinating council in the governor's office. The group also wants the Legislature to update state laws to conform with advances in science and treatment capabilities. It is seeking revisions to better define the role and priorities of the Department of Children and Families and provide the agency with better management and purchasing abilities.

The organization is supporting a proposal by Governor Jeb Bush to increase spending on mental health and substance abuse programs by $34 million in the next budget year. The money would provide services to an additional 2,200 people. It received a high-level endorsement from House Speaker Tom Feeney, but he warned that the Legislature is facing a tight budget year. "Governor Bush is absolutely committed to making sure we do the best job we can on the front lines," Feeney said. "Having said that, we want to make sure it's the entities that are doing the best job, that have the lowest recidivism rates, the highest rates of success, where we're putting our resources."

People are winding up in jail and prison instead of treatment programs because funding has remained unchanged through years of inflation and the state's population has grown, said David Shern, dean of the University of South Florida's Mental Health Institute and chairman of the Florida Commission on Mental Health and Substance Abuse.

The coalition also announced a planned billboard message that says one of five people suffer from mental illness and a 30-second television public service announcement featuring Linda Gregory and Alice Petree, who met through misfortune. Gregory's husband, Seminole County Sheriff's Deputy Gene Gregory, was fatally shot during a standoff with Petree's brother, Alan Singletary. Singletary, who was mentally ill, also died in the 1998 confrontation. The women urge that the state's mental health system be improved to prevent similar tragedies.

Washington State

In February, the state Department of Corrections agreed to pay $245,000 to the mother of an inmate who died in his cell hours after complaining to prison staff that he was having trouble breathing. Charles Snipes died in July 1998 in the Monroe Correctional Complex's Special Offender Center, which holds severely mentally ill inmates. "The size of the settlement to resolve this is clear recognition of the culpability for having caused his death," said Darrell Cochran, attorney for the victim's family. According to a state official, however, the settlement was approved to save taxpayers the cost of trial and to give Snipes' family some closure. "The Department of Corrections did not, by its actions or inaction, cause the death of Charles Snipes III," said agency risk manager Kathy Gastreich.

In her lawsuit, Sharon Corner alleged that corrections officers and medical staff ignored her son's pleas for help and then spent a half-hour throwing wet socks and shooting paper wads at the motionless man. An internal investigation of the case found problems regarding Mr. Snipes' treatment in the hours surrounding his death.

Charles Snipes was regarded as a difficult prisoner in his nearly four years in prison, according to court documents. He was obese, HIV-positive, and suffered from heart disease and schizophrenia. The department's investigation revealed that some prison staff feared Mr. Snipes' outbursts and his penchant for throwing his own urine and feces at staff, something they interpreted as an effort to infect them with the HIV virus. At approximately 6:00 p.m. on the hot day of July 22, 1998, Mr. Snipes complained to an officer that he was having trouble breathing. A nurse who was told of the complaint recommended he take a cold shower. Approximately 90 minutes later, a volunteer saw the inmate lying naked in his cell and told an officer that he seemed "really out of it tonight," according to one report. At 9:30 p.m., an officer reported seeing Mr. Snipes lying on the floor and asked if he needed medical help. According to the officer, the inmate declined needing any assistance. Over the next three hours, Mr. Snipes did not respond to officers who called his name, banged on his door, or peered into his cell. Several staff members reported hearing him snoring or seeing him breathing. He was declared dead at approximately 1:30 a.m.

New York

New York City must arrange continuing mental health care for inmates who are released from city jails until a lawsuit on the matter is decided, the Appellate Division of State Supreme Court ruled in March. The ruling prevents the city from appealing a preliminary injunction issued in July 2000 that required the city to schedule treatment for mentally ill inmates before they are released from Riker's Island and other city jails. The judge who made the earlier ruling, Justice Richard F. Braun of State Supreme Court in Manhattan, also gave class-action status to a lawsuit filed against the city in 1999 by seven mentally ill inmates of the jail.

The plaintiffs contend that the 25,000 inmates who are treated for mental illness each year while in the New York City jail system on Riker's Island are being released without proper provision for treatment in the community. State law requires that arrangements be made for continuing treatment of mentally ill patients before they are released from psychiatric hospitals and other treatment programs. But the city argued that inmates were not covered by that law. "We think that the law doesn't apply because a jail setting is so very, very different from a hospital setting, where people are discharged," Thomas Crane, a senior lawyer for the corporation counsel's office, told *The New York Times*. "It's almost like apples and oranges."

The initial case is still before the State Supreme Court, and a final ruling is expected within the next few months. Until the February ruling, the city did not have to provide continuing care for the vast majority of mental patients released from jails because it had obtained a stay of Justice Braun's ruling. Independent of the recent decision, Mr. Crane said, the city was "developing a quite comprehensive program of discharge planning that's being phased in" and has been hiring more workers. The plan involved several

city agencies, including the Department of Mental Health, the New York City Health and Hospitals Corporation and an outside mental health provider, he said.

But Heather Barr, a lawyer with the Urban Justice Center, a group that helped file the lawsuit, along with the firm Debevoise & Plimpton and New York Lawyers for the Public Interest, would not declare complete victory. "Based on how hard the city's fought so far, I don't feel confident saying that they're not going to fight anymore," Ms. Barr said. "I hope they won't. We've always wanted to settle this case. We'll be watching to see whether the city is complying with the preliminary injunction."

The lawsuit charged that mentally ill inmates who are released are often treated like other prisoners: dropped off at Queens Plaza in New Yortk City between 2:00 and 6:00 a.m. with little more than $1.50 in cash and a two- fare MetroCard. Inmates who are mentally ill and recently released from jail are often unable to get counseling or medication because they cannot afford it, the lawsuit said. Many are back in jail shortly after they are released.

Oklahoma

A year-old Jail Diversion Plan in Tulsa County to make sure mentally ill offenders are not needlessly jailed is being hailed by the Tulsa Institute of Behavioral Sciences. According to an analysis performed in March, more than 300 inmates successfully went through the Jail Diversion Program during the past 12 months and officials are learning how to more effectively separate non-violent mentally ill offenders from the main Tulsa County Jail population. Program Coordinator Greer Fites said the study found the program has been effective, but does not indicate whether the number of inmates with mental illness has dropped. "We knew there was a need for this program, and these numbers reflect that," she said.

The program mandates mental health screening for any inmate exhibiting behavior that may indicate a mental illness, and that treatment be given if a problem is found. Getting program clients mental health treatment while they await court dates became a smoother process during the past year. The highest percentage of inmates with serious mental illness spent only one to two days in jail before being referred for mental health services, the study found.

Tulsa County Commissioner John Selph said he has been pleased with the progress the program has made in a year. "There's no doubt the program is working, he told the *Associated Press*. "But as with all things, there's always room for improvement.''

Ms. Fites said many mentally ill people are in the Tulsa County Jail on arrests related to substance abuse, citing their tendency to self-medicate their symptoms with street drugs or alcohol. "We had suspected the number of inmates who are jailed on substance-abuse-related charges was high," she said. "This reinforces our belief that such facilities (for treatment) are desperately needed in Tulsa."

The report also found that mentally ill offenders are not likely to post bond, showing that only 33 percent of those in the program did so early on, dropping to 2 percent by the end of the year. Officials said that makes the jail diversion process even more vital, since mentally ill people would likely otherwise remain in jail.

The 12-month old Jail Diversion Program started with a two-year law enforcement grant of $100,000. Fites said she hopes the grant is renewed or that additional funds are made available to keep the program going. "The future of this program depends on how far we want to go with it," she said. "We certainly could expand it, but a lot of it depends on finding additional funding."

Texas

Two years after a highly publicized incident in which city police officers fatally shot a schizophrenic woman after she called paramedics for help, the Houston Police Department is receiving praise from mental-health advocates for implementing a program to compassionately handle people in mental crisis. The one-year-old Crisis Intervention Team (CIT) program is devoted to helping mentally ill people receive treatment. So far, training has been provided to 527 officers.

Without guns, nightsticks or pepper spray, the CIT-trained officers attempt to defuse potentially violent confrontations with mentally imbalanced people. They look for signs of mental illness and persuade the people, without injuring them, to seek treatment at public mental-health facilities. For those times when force is necessary, the officers are trained to first use beanbag shotguns and other less lethal weapons.

The program is already credited by Harris County mental-health professionals with helping hundreds of people receive care. "It's been a wonderful success for the whole mental-health system," Betsy Schwartz, executive director of the Mental Health Association of Greater Houston and the catalyst behind CIT's creation, recently told the *Houston Chronicle*. Police officials concurred. "It's a win for the officers, the mentally impaired and mental-health professionals," said Captain Dwayne Ready, commander of the department's emergency communications division.

The CIT program came too late and may not have been helpful for some mentally ill people killed by police when they appeared to threaten officers. A *Houston Chronicle* study after the fatal shooting in 1999 found that of the 39 people killed by Houston police over a five-year period, at least six were known to be mentally ill. In particular, the fatal shooting by police of a woman with schizophrenia in January 1999 — about six months before the department implemented a pilot CIT program — underscored the potentially tragic consequences of confrontations between police officers and people with mental illness. Police shot and killed Sheryl Seymour, 40, who had called the Fire Department to take her to a psychiatric hospital. She had suffered from schizophrenia for several years and knew when a bad episode was about to overtake her. But when medical workers arrived, they were accompanied by two police officers. When Seymour advanced toward the officers with a knife, one of them shot her. Al Seymour, father of the dead woman, said officers who responded to his daughter's emergency call should have been better trained for the situation. He said he applauds the city's effort to offer training, but he fears some officers might not learn enough to prepare them for confrontations with the mentally ill. "In model form, it sounds like a very important first step," Seymour said. "Execution (of the program) is something else."

The Seymour family's lawsuit against the city and the officer who fired the fatal shot is pending.

Seven months after Sheryl Seymour was killed, Houston police killed another known mentally ill woman. That shooting occurred about a month after the department implemented the pilot CIT program. On Aug. 24, 1999, police fatally shot Colleen Kelly, who suffered from severe depression and migraine headaches, after her psychiatrist called 911 to report that Kelly had told him she was looking for a gun to kill herself. Police found Kelly walking in west Houston and shot her when she approached them with her raised hand inside a fanny pack. Officers reported that they had told the woman to drop the fanny pack, but she did not. Kelly, who suffered from 50 percent hearing loss, had continued to approach their squad car instead. She died on the way to the hospital. Kelly's family also filed a wrongful-death lawsuit against the city in the wake of the fatal shooting. A federal judge in Houston ruled in favor of the city and the officer, but the family is appealing.

Police officials and mental-health professionals claim the shooting deaths did not lead the department to implement a permanent CIT program. Rather, they said, the department and the mental-health community had been working on a plan to best serve the mentally ill as far back as 1995. They said the intervention team grew out of a belief among law enforcement and mental-health professionals that some mentally ill people who had committed minor offenses, such as loitering, or who had been considered a danger to themselves or others were being unnecessarily placed in the criminal justice system.

"They're not criminals," said Geri Konigsberg, spokeswoman for the University of Texas Harris County Psychiatric Center in Houston. "If they are mentally ill, they need to be dealt with differently." At the urging of the Mental Health Association of Greater Houston, Harris County Judge Robert Eckels convened a task force in 1997 to investigate how the city could better care for people in mental crisis. The police department began a pilot CIT program in July 1999 with 62 officers. The program became permanent and was expanded throughout the patrol force in spring 2000.

Based on similar programs in Memphis, Tennessee and Albuquerque, New Mexico, its mission is to teach patrol officers to recognize possible mental illness in people and equip them with communication skills to handle these situations without violence. Officers who once may have misunderstood mental illness now recognize the signs of possible depression, schizophrenia or other complex brain disorders. "They not only have skills to communicate better, they understand mental health, so they know what they're dealing with," said Betsy Schwartz of the Mental Health Association.

Police Officer Mike Lee, an 11-year veteran in the department, said that before his CIT training he saw himself primarily as a crime-fighter. But the training made him understand that some people simply need police help. "There is a lot more compassion on officers' part toward the mentally ill," he said. Lee said he won't soon forget a recent bloody encounter he had when his CIT training helped him persuade a man not to

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/inst/jail-mental.htm

commit suicide. Responding to an emergency call that involved a possibly mentally ill man, Lee watched as the man stabbed himself repeatedly in the stomach with a hunting knife. The man was despondent over apparently unfounded fears that his girlfriend was having an affair. Lee spoke calmly for about 20 minutes, persuading the man to put down his knife and to seek medical and mental-health treatment. Paramedics took him to a local hospital where he was found to have suffered possibly permanent intestinal damage from his wounds. But he survived the episode. "He wanted to die," Lee said. "He had a big hunting knife. He was cutting himself to pieces."

Officer Frank Webb, team coordinator and an instructor at the Houston Police Department's training academy, said officers who volunteer for the CIT program receive 40 hours of training. They also are required to complete an eight-hour refresher course. They also can volunteer for a four-hour training session in which they accompany a psychiatrist meeting with patients at a mental-health facility. Dispatchers also are trained to identify calls that possibly involve mentally ill people and to direct CIT officers to them. In the past four months of last year, dispatchers identified about 2,600 calls involving mentally distressed people, Webb said. The types of CIT calls range from people walking in traffic, to possible suicide attempts, to people displaying generally erratic behavior. Webb said CIT officers are taught to avoid force, even loud voices, when dealing with people in apparent mental crisis. They are taught to speak patiently, to listen to the people and to calm them down by never invading their personal space or making demands by screaming. "Don't try to control them, and you end up in control," Webb said. However, he added, as in all cases where the officers' or other lives are in danger, the police ultimately are authorized to use whatever force is necessary.

CIT officers take people suspected of being in mental crisis to the NeuroPsychiatric Center, an emergency mental-health facility in the Texas Medical Center operated by the Mental Health and Mental Retardation Authority of Harris County. The center evaluates people and refers them to other public mental-health care providers. In the past 12 months, law enforcement agencies brought 2,624 people to the center, approximately 28 percent of its patients during that period, said Barbara Dawson, the center's interim deputy director. Most of those patients were brought in by CIT officers.

Webb said he is designing a data-gathering system to track CIT calls and their dispositions to determine the program's impact. Ideally, approximately 25 percent of a police force's patrol officers should be CIT-trained, Webb said. If too many officers are CIT-ready, few would be able to use their abilities enough to keep them sharp.

The police department's CIT represents approximately 20 percent of the city's patrol officers. Three more 40-hour CIT training courses are planned this year. CIT officers get no extra pay, only a lapel pin and a black windbreaker with "Crisis Intervention Team" stenciled on the back. But, said Webb, "I really truly believe we're saving lives out there." ❑

JUSTICE'S MIDDLEMAN

by
Jan Jonas

Imagine yourself leaving a store in the mall. As you step through the exit, an awful clanging starts and doesn't stop. The noise is deafening. Clerks run toward you shouting. The police show up, you're arrested and you're thrown into jail. You're accused of shoplifting. By tripping an anti-theft device, you've become the newest piece of data in the criminal justice system.

Bad enough. Now imagine that you are a person whose mother drank while she was pregnant with you and that you aren't quite able to understand what all the fuss is about. You saw something shiny, something pretty. You wanted it. You picked it up and carried it away from the store. That's all you know. It's really all that makes sense to you.

If you're lucky, perhaps the most important person to enter your life next is Lucas O'Connell. O'Connell is a bright, articulate and charming man of 27 who conducts justice and advocacy training with The Arc of New Mexico, a nonprofit group specializing in advocacy for people with developmental disabilities and their families. O'Connell talks to the police, your family, your public defender or attorney, the district attorney's representative, members of the crisis intervention team and anyone he can think of who might be able to help you get out of the mess created because you couldn't understand the concept of money in exchange for a bright glittery object.
"Cerebral palsy or cognitive disability often means problems with making day-to-day purchases and getting around the community," O'Connell said. "Our criminal justice system has become the overflow housing for people who are waiting for services or who haven't been identified as needing them. I have seen people who are considered dangerous who, if they receive the appropriate services, they would never have brushes with the law again."

In the course of his work, he carries about 30 active cases at a time. Raised in Southern California and St. Louis, O'Connell says he enjoys, even sometimes thrives on, his job. "My last two years in school, I worked at a secure, locked setting with teens with mental illness and developmental disability," O'Connell said. "What I saw there was their entire future laid out for them in an institution. It occurred to me it didn't have to be that way." Every one of his Arc clients has a developmental disability, usually some level of mental retardation from brain damage caused by trauma or fetal alcohol syndrome.

"Everyone who I'm advocating for had incurred criminal charges," O'Connell said. "They all are victims or have been victims in their life. One troubling statistic is if you meet someone with a disability, chances are better that they've been sexually or physically abused than not. I'm helping people break the cycle."

One part of breaking the cycle is teaching patience to law enforcement personnel who often are called upon to deal with a bad situation. If someone with a developmental disability is a victim or perpetrator, police need special skills to deal with that person. "When I do police trainings, I try to draw a parallel with them. When you are

trying to stabilize a scene, the nature of the person's disability demands patience and full attention for a longer period of time than they would have to take with someone else," O'Connell said.

But first, the law enforcement officials have to recognize that someone has a developmental disability and isn't drunk or under the influence of illegal drugs. Sometimes disability and intoxication are difficult to tell apart for the untrained observer.

Part of O'Connell's job is to go to police academies and corrections departments giving workshops on how to recognize someone with a developmental disability and teaching law enforcement personnel the best way of dealing with developmentally disabled people.

Any such person kept out of the justice system, O'Connell says, is a person with the potential to be a valuable contributing member of the community. "If you can get them appropriate work, the developmentally disabled are the best employees," he said. Unlike former inmates, the developmentally disabled come out of jail and go to work immediately, likely never to be seen in the criminal justice system again. With proper training, people with mental retardation often make good, steady workers because their job is the most important part of their lives, he said.

O'Connell also offers one-stop aid to the developmentally disabled. It includes seeking residential services, behavioral therapy, speech and language therapy, occupational therapy, medical aid and any other type of service the person needs to help them become a contributing member of the community — instead of being repeatedly incarcerated for years.

It's important to identify people with developmental disabilities before they get sentenced, O'Connell says. The pre-trial service and crisis intervention teams do all they can to help fix the problem. "The criminal justice system is dark and dismal," O'Connell said. "Trying to fix a problem can be done in a matter of hours. There is a population of people with developmental disabilities we can remove from the criminal justice system, if we choose this as a society."

What keeps O'Connell going are the Cinderella stories, like the teen with fetal alcohol syndrome. Used as a runner by his gang, he wanted to please the only family he knew, so when told to deliver drugs, he did it with a smile. He was making his friends happy. It wasn't until the teen's most recent arrest that O'Connell met the boy. O'Connell suggested a psychiatric evaluation, which showed the 18-year-old had the intelligence of a 6-year-old child. The teen was moved out of the crack house where he lived, placed into a three-bedroom residential facility with support staff and within six months was working full time in a grocery store.

Such success stories aren't rags-to-riches; they might be more like going from an awful situation to a better situation. O'Connell might not have a magic wand, but his ability to weave Cinderella stories by identifying the right glass slipper for the person with a developmental disability provides the opportunity for that person to step into a different kind of life — one with dignity and self-respect.

*Jan Jonas is a reporter for the **Albuquerque Tribune**. The above article appeared in the January 24, 2001 edition of the newspaper and is reprinted with the permission of the **Albuquerque Tribune**.* ❑

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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Unless otherwise noted, all articles appearing in this newsletter are written by Lindsay M. Hayes, Editor/ Project Director.

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 and 9)

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

Lindsay M. Hayes, Editor/Project Director
National Center on Institutions and Alternatives
40 Lantern Lane
Mansfield, Massachusetts 02048
(508) 337-8806 • (508) 337-3083 (fax)
Web Site:: http://www.igc.org/ncia/suicide.html
E-Mail: Lhayesta@aol.com

or

NIC Information Center
1860 Industrial Circle, Suite A
Longmont, Colorado 80501
(800) 877-1461 • (303) 682-0558 (fax)
Web Site: http://www.nicic.org/inst/jail-mental.htm