JAIL SUICIDE/MENTAL HEALTH UPDATE

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SPECIAL ISSUE: PREVENTING SUICIDES THROUGH PROMPT INTERVENTION

Two days before Matthew Mancl committed suicide in the Pepin County Jail in Durand, Wisconsin on October 20, 1999, a patrol sergeant from the local police department overheard a jail deputy tell a colleague: "There's a problem in the jail. Mancl thinks he wants to kill himself. If the f..... wants to kill himself, make sure he's dead before you cut him down." The deputy was not only sued as a result of Mr. Mancl suicide, but was criminally charged with obstruction of justice when he subsequently admitted to falsifying a jail log to reflect cell checks that never occurred.

As repugnant as this case may appear, it is not necessarily an aberration. Take the case of Tina Hatch. On the morning of August 22, 2000, Ms. Hatch was arrested for violation of probation and transported to the Teton County Jail in Driggs, Idaho. She was checked by jail staff periodically throughout the morning and early afternoon, with the last observation recorded at 1:50 pm. An officer found Ms. Hatch hanging from a television support shelf by a bedsheet at approximately 3:00 pm. Correctional staff did not immediately cut the victim down nor remove the noose, instead, one officer checked for vital signs while another ran for a camera and photographed the victim. Cardiopulmonary resuscitation (CPR) was never initiated nor considered. Emergency medical services (EMS) personnel arrived approximately 10 minutes later, vital signs were taken again, and then Ms. Hatch's body was cut down. She was pronounced dead. The sheet was eventually removed from Tina Hatch's neck several hours later during the autopsy.

Chaos Within A County Detention Center

Although staff training and identification of suicide risk are critical areas of suicide prevention, following a suicide attempt, the degree and promptness of the staff's *intervention* often foretells whether the victim will survive. Perhaps few cases symbolize the systemic ineptitude regarding proper intervention following a suicide attempt than that of Quincy Rice, as well as eight other recent suicides in the County Detention Center.[1] Arrested for a violent offense, Mr. Rice was placed in administrative segregation shortly after his arrival. He suffered from depression and spent long hours sleeping or inactive in his cell. Mr. Rice's intake screening form had indicated prior suicide attempts by hanging, wrist cutting, and drug overdose. He was seen frequently by the jail's mental health staff, later assessed as suffering from a "psychiatric disorder," and prescribed medication for depression. Mr. Rice was eventually placed on suicide watch in the forensic unit for verbalizing suicidal ideation, and released from the watch five days later after a psychiatrist determined that he was stable.

Mr. Rice approached a mental health worker the following day and requested protective custody because he had been threatened by another inmate. The request was granted and Mr. Rice was locked in his cell. He was found hanging by a sheet from the door of his cell by an officer 15 minutes later. Mr. Rice was taken down and placed on the floor. No effort was made to initiate CPR by any of the correctional staff. Instead, the jail's medical staff were summoned and arrived more than 10 minutes later, apparently because they had not heard the first page over the intercom system. Upon arrival, medical staff initiated CPR and continued resuscitation efforts until EMS personnel arrived more than 45 minutes after Mr. Rice was found hanging. Due to the prolonged delay in initiating CPR, medical personnel were never able to obtain a pulse or breathing on the victim. Records also indicated that the oxygen tank did not function properly and a device to monitor cardiac rhythm was missing from the crash cart.

The death of Quincy Rice was the last of *nine* suicides to occur in the County Detention Center (CDC) during a recent catastrophic

[1]In order to ensure complete confidentiality, certain identifying information regarding the facility and all suicide victims have been removed. No other modifications have been made.

INSIDE. . .

24-month period. Situated in a large metropolitan area, the CDC has approximately 1,700 inmates. On an average day, 80 to 90 inmates are processed through the jail, or approximately 30,000 inmates per year. Although the facility predominantly houses pretrial inmates, there are a significant number of sentenced prisoners convicted of both misdemeanor and felony offenses. On-site medical personnel are available 24 hours a day, with mental health services available on-site five days a week and on-call around the clock. The facility has 18 housing blocks, including a forensic unit with 75 beds. Detailed below are summaries of the remaining eight inmate suicide cases, all of which involved grossly inadequate delays in intervention.

Month 1

Larry Stearns was committed to the CDC as a pretrial inmate charged with a minor offense. Due to certain information that was self-reported during the intake process, Mr. Stearns was placed in protective custody and housed in general population. However, his jail records did not accompany him to the housing unit and many correctional staff were apparently unaware of Mr. Stearns' protective custody status. In early evening two days later, several inmates found Mr. Stearns hanging by a sheet from the light fixture in his cell. Although the last recorded security check was an hour earlier and a meal delivery was completed 30 minutes earlier, it was not known when he was last physically observed by staff because, contrary to jail policy, a blanket had been covering his cell door and obstructing visibility. The inmates who found Mr. Stearns yelled out for correctional staff who arrived at the cell and had difficulty opening the door. Only after medical staff arrived five minutes later was the cell door opened and the victim removed from the light fixture. Although medical staff promptly responded to the emergency, they initially failed to arrive with any emergency equipment. After several additional minutes of delay, the equipment arrived and CPR was initiated. Mr. Stearns was subsequently transported to the hospital where he died three days later.

Month 2

John Turner was committed to the CDC as a pretrial inmate charged with a violent offense. He was processed, housed in general population and, for reasons that were unknown, placed in protective custody. Mr. Turner attended a court hearing five months later in which he was found guilty. The following night an inmate delivering meals on the housing unit observed him hanging by a sheet from the air vent in his cell. (Although the last recorded security check was an hour earlier, it is not known when Mr. Turner was last physically observed by staff because a towel was covering his door.) The inmate who found Mr. Turner yelled for assistance and an officer responded to the cell and attempted to remove the sheet from the victim's neck. However, although the officer was able to remove the victim from the air vent, he was unable to remove the sheet from around his neck. When medical staff arrived more than five minutes later, Mr. Turner was lying on his bunk with the sheet still tightly wrapped around his neck. The sheet was eventually removed and CPR was initiated, although medical staff reported that the victim's body appeared "cold." After a short time, first aid efforts were discontinued and Mr. Turner was pronounced dead at the scene by a jail physician.

Month 4

Edward Booth was committed to the CDC as a pretrial inmate charged with a minor property offense. He was processed and housed in general population. On the morning of his third day of confinement, an inmate found Mr. Booth hanging by a sheet from the light fixture in his cell. (He had last been seen alive by staff approximately 30 minutes earlier while returning from the infirmary.) When correctional staff were alerted to the emergency, officers arrived at the cell and removed Mr. Booth from the light fixture, placed him in a chair and moved him into the corridor. Despite the presence of at least three correctional officers, CPR was not initiated until medical staff arrived approximately five minutes later. Mr. Booth was subsequently transported to the hospital where he died two days later.

Month 6

Fred Payton was committed to the CDC as a pretrial inmate charged with various property offenses. He requested and was approved for protective custody based upon a concern for his personal safety. Mr. Payton was assigned to the facility's forensic unit because of an extensive psychiatric history which included a diagnosis of chronic schizophrenia and depression. He also had a history of multiple suicide attempts and/or gestures that resulted in his placement on suicide watch in the CDC the previous year. During his most recent stay on the forensic unit, Mr. Payton was seen regularly by mental health staff, including a unit psychiatrist who prescribed psychotropic medication to control his depression and auditory hallucinations. The inmate's weekly progress notes by the psychiatrist often included the impression that Mr. Payton was calm and denied suicide ideation.

Mr. Payton was sentenced four months later and had a release date listed as the following month. However, one day prior to his release, Mr. Payton was informed that a parole board warrant had been issued that would continue his incarceration pending a revocation hearing. Shortly thereafter, a mental health worker passed Mr. Payton's cell and noticed that a blanket hanging on his door was obstructing visibility into the cell. She called out to the inmate who responded that he was using the toilet. She departed without further inquiry. Less than 30 minutes later an inmate walking down the corridor found Mr. Payton hanging by a sheet from the cell door. Correctional officers responded, removed the victim from the door, and placed him on the floor. Several mental heath staff responded to the scene and initiated CPR with the assistance of a correctional officer. Medical staff were notified, arrived five minutes later and continued resuscitative efforts until EMS personnel arrived more than 35 minutes after the incident was first discovered. In addition to the delayed medical response, there were again problems with the facility's medical equipment.

Month 9

Raymond Middleton was committed to the CDC as a sentenced inmate awaiting transfer to the state prison system to serve a term for a property offense. Due to an extensive psychiatric history, which included extended stays at a psychiatric hospital, Mr. Middleton was housed in the facility's forensic unit. He was considered a quiet inmate who preferred to be alone, and was in protective custody

because he feared being housed in general population. Mr. Middleton was not considered suicidal. His medical file revealed that, although considered schizophrenic and delusional, a recent psychiatric consultation showed that his psychosis was in remission.

Following several months of uneventful confinement, Mr. Middleton was found hanging by a sheet from the air vent in his cell by an inmate picking up meal trays very early one morning. (Although the last recorded security check was 45 minutes earlier and the meal delivery to his cell was completed 15 minutes earlier, it is not known when Mr. Middleton was last physically observed by staff because the meal tray was still undisturbed at the cell opening and a blanket was covering his door.) The inmate who found Mr. Middleton yelled for assistance, and two correctional officers responded to the cell. Although officers cut the sheet off the victim's neck, CPR was not initiated until medical staff arrived approximately five minutes later. Medical staff later reported that Mr. Middleton's body appeared "cold" when they arrived, and had apparently been hanging for a prolonged period of time. Medical staff also had difficulty utilizing the oxygen tank, either because of faulty equipment or lack of oxygen in the tank. Mr. Middleton was subsequently transported to the hospital where he was pronounced dead.

Month 12

Darryl Dawson was committed to the CDC as a pretrial inmate charged with a violent offense. He was processed and housed in the forensic unit due to a psychiatric history that included at least three prior suicide attempts by hanging several years earlier and a threat of self-injury during his most recent prior incarceration. For reasons that are unknown, Mr. Dawson was placed in protective custody. Although he could not attend his initial appointment with the jail psychiatrist because he was at a court hearing, Mr. Dawson's mental health records nonetheless noted that he was "stable" on that day and a follow-up assessment was recommended in four weeks. During the morning hours a few weeks later, several inmates found Mr. Dawson hanging by a sheet from the door of his cell. (He had last been seen by a nurse approximately 30 minutes earlier.) Several correctional staff responded to the cell and, with the assistance from other inmates, removed the victim from the door. After several minutes of waiting for medical staff to arrive, one officer and an inmate initiated CPR on the victim. The officer later stated that she only initiated CPR because medical staff took so long in responding to the emergency. Following two separate calls from the facility's Central Control station, medical staff arrived 15 minutes later and Mr. Dawson was pronounced dead.

Month 15

Johnny Whitley was committed to the CDC as a pretrial inmate charged with a violent offense. Although he was recommended for a psychiatric evaluation by the committing judge after the defendant stated his life was in danger, CDC mental health staff were not notified of this referral and the inmate was cleared for general population housing. Mr. Whitley was placed under protective custody and transferred to another housing unit two days later after notifying correctional staff that: "I fear for my safety." In fact, Mr. Whitley was verbally harassed by other inmates during the transfer and correctional staff admitted that he was "genuinely scared." Several hours later an inmate found Mr. Whitley hanging by a sheet from the bunk in his cell. Correctional officers responded, removed the victim from the bunk, and placed him on the floor of the cell. However, no effort was made to remove the tightly wrapped noose from his neck, nor was CPR initiated by any of the officers. Instead, medical staff arrived approximately five minutes later and determined that CPR would be fruitless because Mr. Whitley had been dead for a prolonged period of time.

Month 18

Wayne Scott was committed to the CDC as a pretrial inmate charged with a minor offense. Due to an extensive psychiatric history, which included two threats at self-injury while in the facility the previous year, Mr. Scott was housed in the forensic unit. While in the unit, the inmate asked to be placed under "protective custody" because he wanted "to be alone." Mr. Scott was initially diagnosed by a unit psychiatrist as suffering from an organic mental disorder. A progress note written by a psychiatric nurse during a screening clinic stated that the psychiatrist found him having trouble adjusting to incarceration, suffering from insomnia, situational depression, visual hallucinations, and recent paranoia. A progress note written a week later by a mental health worker indicated that Mr. Scott requested a cell change and removal from protective custody. A similar progress note was written two months later.

During the morning of the following day a correctional officer observed Mr. Scott crying, complaining that he was depressed and tired of being locked down. Approximately 30 minutes later, he asked to speak with a mental health worker regarding his protective custody status, but the worker refused to talk with him. A few minutes later Mr. Scott asked to speak to a physician's assistant who was on the unit conducting sick call, but was informed that he would have to wait until sick call was completed. Mr. Scott returned to his cell and several inmates observed him hanging by a sheet from the cell door 20 minutes later. Correctional staff rushed to the cell but had difficulty opening the door and removing the sheet. They eventually were able to remove the sheet and open the door, but not before Mr. Scott's body fell to the floor. The victim was placed on his bed and CPR was initiated by the physician's assistant who had been on the unit at the time. Additional medical staff arrived shortly thereafter, but had difficulty using the oxygen equipment (the tank was either empty or the value and/or tubing were non-functional). Mr. Scott was subsequently transported to the hospital where he was pronounced dead.

From Chaos to Calm

Aside from the above described features common in many of these suicides, it will appear obvious to our readers that there were several systemic deficiencies within the County Detention Center that resulted in these nine deaths. First, staff supervision of these inmates was grossly inadequate. With one exception, all of the victims were discovered hanging, not by correctional staff, but by other inmates. The victims were either found during the delivery of meals or by inmates simply walking by their cells. In three of the cases, it was not known when the victims were last

WHAT THE STANDARDS REQUIRE

Detailed below is a listing of the applicable national standards relating to emergency response within correctional facilities. Unless otherwise indicated, these standards apply to all types of correctional facilities, including city/county jails, prisons, juvenile facilities, and police department lockups/holding facilities.

AMERICAN CORRECTIONAL ASSOCIATION

Standards for Adult Local Detention Facilities, Third Edition, March 1991
Standards for Adult Correctional Institutions, Third Edition, January 1990

Emergency Care

Written policy, procedure, and practice provide that correctional and other personnel are trained to respond to health-related situations *within a four-minute response time* (emphasize added). The training program is established by the responsible health authority in cooperation with the facility administrator and includes the following:

- recognition of signs and symptoms and knowledge of action required in potential emergency situations
- administration of first aid and cardiopulmonary resuscitation (CPR)
- methods of obtaining assistance
- signs and symptoms of mental illness, retardation, and chemical dependency
- procedures for patient transfers to appropriate medical facilities or health care providers

Comment: The required CPR certification must be current at the time of the audit, consistent with jurisdictional statutes for certification. The preferred CPR course covers mouth-to-mouth breathing, one- and two-rescuer CPR care for conscious or unconscious choking victims, and respiratory emergencies.

NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

Standards for Health Services in Jails, 1996
Standards for Health Services in Prisons, 1997

Training for Correctional Officers

Written policy and defined procedures require, and actual practice evidences, that a training program, established or approved by the responsible health authority in cooperation with the prison administrator, guides the health-related training of all correctional officers who work with inmates. Training is ongoing (i.e., each officer is trained at least every two years), documented, and includes at least the following areas:

- the administration of first aid;
- recognizing the need for emergency care in life-threatening situations (e.g., heart attack, asthma);
- recognizing acute manifestations of certain chronic illnesses (e.g., seizures, intoxication and withdrawal, and adverse reaction to medication);
- recognizing signs and symptoms of mental illness;
- suicide prevention;
- procedures for appropriate referral for health complaints;

- precautions and procedures with respect to infectious and communicable diseases; and
- cardiopulmonary resuscitation.

Discussion: Correctional personnel should be aware of the potential for emergencies that may arise, know the proper response to life-threatening situations, and understand their part in the early detection of illness and injury.

It is recognized that at a given time, 100 percent of the correctional staff may not be trained in all of these areas, although that is the goal. Compliance with the standard requires that a substantial portion of the staff present on each shift (i.e., 75% or more) has been trained, that the training is current, and that the facility has an ongoing training program.

Emergency Services

Written policy and defined procedures require, and actual practices evidences, that the jail provides 24-hour emergency health care that includes arrangements for the following:

- emergency evacuation of the inmate from the facility when required;
- use of an emergency medical vehicle;
- use of one or more designated hospital emergency departments or other appropriate facilities;
- emergency on-call physician and dentist services when the emergency health care facility is not located nearby; and
- security procedures for the immediate transfer of inmates when it is necessary.

Discussion: Emergency health care is care for an acute illness or an unexpected health need that cannot be deferred until the next scheduled sick call nor clinic. All members of the staff on all shifts (both health care and correctional) should be familiar with the procedures for obtaining emergency medical care and responding to emergencies. The names, addresses, and telephone numbers of people to be notified and/or services (such as ambulance and hospital) to be used should be readily accessible to all personnel.

Additionally, emergency drugs and medical equipment should be maintained regularly so they are accessible in the event of an emergency. It is desirable that health care personnel be trained in advanced cardiac life support services or the use of a defibrillator. If neither is available at the facility, the nearest health care facility equipped to handle such emergencies should be identified and listed in the procedures.

Suicide Prevention: Intervention

The plan should address how to handle a suicide in progress, including appropriate first-aid measures.

Commission on Accreditation for Law Enforcement Agencies

Standards for Law Enforcement Agencies, Fourth Edition, 1999

Medical and Health Care Services

A written directive, approved by a licensed physician, identifies the policies and procedures to be followed when a detainee is in need of medical assistance.

Commentary: Arrangements for detainee emergency health care should be made with a local medical facility. If possible, a licensed health care professional should be identified as the emergency health care contact person. At least one on-duty person should be certified in first-aid. The intent of this standard is to ensure that staff recognize, take immediate action on, and report all detainee medical emergencies.

Emergency Rescue Tools

Approximately 95 percent of all suicides occur by hanging. Prompt emergency response is often interrupted when correctional staff have difficulty loosening or removing the ligature from the victim's neck. More time is lost trying to locate a knife or other sharp object that can be utilized to cut the victim down without causing further injury. But conventional, straight-edge knives, as well as medical shears or scissors, are often unable to cut through blankets or heavy cloth. There is also the obvious concern for safety and safely storing a knife or scissors within a correctional facility.

In recent years, specially designed knives (often referred to as 911 rescue tools) have become available as safe and efficient devices in cutting a variety of fibrous materials found in correctional facilities. With its hooked shape, the rescue tool allows for rapid insertion between the ligature and the skin, with no risk of cutting the victim. (In fact, paramedics and fire fighters have historically utilized these knives to cut seatbelts away from automobile accident victims, while mountain climbers utilize the knives for clearing lines and outdoorsmen use them for cleaning fish and deer.) Several models, such as the Addis Wonder Knife shown above, are preferable because they contain a replaceable stainless steel blade that can quickly cut through all fibrous material found in a cell — including blankets, clothing, belts, and shoelaces. And because the blade is located inside the frame of the tool, it cannot be utilized as a life-threatening weapon in the hands of an inmate.

Emergency rescue tools have become a standard piece of the equipment for responding to a hanging attempt. The tools are commonly utilized in all types of correctional facilities, including city/county jails, prisons, juvenile facilities, and police department lockups/holding facilities. Because a suicide attempt can occur within any inmate housing unit, it is strongly recommended that one rescue tool should be securely placed with other emergency response equipment in an easily accessible location in each housing unit of the facility.

physically observed by staff because either blankets or towels obstructed a view of the cell interior. In addition, the majority (five of nine) of the suicides occurred during daytime hours, ironically when staffing levels were the highest. In fact, five suicides occurred in the forensic unit, a housing location that boasted the highest staff complement. In addition, although the jail policy in effect at the time required that each inmate housed in the forensic unit be observed at intervals that did not exceed every 15 minutes, these cell checks were not consistently made or not made at all.

Second, despite the fact that the infirmary was in close proximity to all housing units, medical staff arrived five minutes or more from the time that eight of nine victims were discovered (10 minutes or more in two cases). In seven cases, medical personnel either failed to initially bring emergency rescue equipment or the equipment they brought was faulty. More importantly, with the exception of two cases, correctional staff failed to initiate CPR anytime during the critical period prior to the arrival of medical staff.

To correct the glaring deficiencies associated with intervention following these suicide attempts, the County Detention Center (with assistance from a suicide prevention consultant and federal court monitor) embarked upon the development of comprehensive intervention procedures that would be incorporated into their suicide prevention policy. CDC officials first looked to national correctional standards for guidance. As shown on pages 4 and 5, however, although both American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC) standards address the issue of intervention, neither are elaborative in offering specific protocols. The ACA standards require that "personnel are trained to respond to health-related situations within a four-minute response time. The training program...includes the following: recognition of signs and symptoms, and knowledge of action required in potential emergency situations; administration of first aid and cardiopulmonary resuscitation (CPR)...," while NCCHC standards require that the "intervention" section of a facility's suicide prevention policy address "how to handle a suicide in progress, including appropriate first-aid measures."

CDC's intervention procedures were ultimately framed within three guiding principles: 1) All staff who come into contact with inmates will be trained in standard first aid and cardiopulmonary resuscitation (CPR); 2) Any staff member who discovers an inmate attempting suicide will immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin standard first aid and/or CPR; and 3) Staff will never presume that the inmate is dead, but rather initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. With this framework, the following procedures were developed:

Model Suicide Intervention Procedures

1) All staff who come into contact with inmates will be trained in standard first aid and cardiopulmonary resuscitation (CPR). All staff who come into contact with inmates will participate in annual "mock drill" training to ensure a prompt emergency response to all suicide attempts.

2) All housing units will contain an emergency response bag that includes a first aid kit, pocket mask, microshield or face shield, latex gloves, and emergency rescue tool. All staff who come into regular contact with inmates will know the location of this emergency response bag and be trained in its use. The emergency response bag will be inspected by correctional staff each shift to ensure all equipment is accounted for and in proper working order.

3) Any staff member who discovers an inmate attempting suicide will immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for CDC's medical personnel, and bring the emergency response bag to the cell. If the suicide attempt is life-threatening, Central Control personnel will be instructed to immediately notify outside ("911") Emergency Medical Services (EMS). The exact nature (e.g., " hanging attempt") and location of the emergency will be communicated to both CDC medical staff and EMS personnel.

4) The first responding officer will use their professional judgment in regard to entering the cell without waiting for backup staff to arrive. With no exceptions, if cell entry is not immediate, it will occur no later than four minutes from initial notification of the emergency. (Should the emergency take place within the Special Housing Unit and require use of the Cell Entry Team, the Team will be assembled, equipped and enter the cell as soon as possible, and no later than four minutes from initial notification of the emergency.) Correctional staff will *never* wait for medical personnel to arrive before entering a cell or before initiating appropriate life-saving measures (e.g., first aid and CPR).

5) Upon entering the cell, correctional staff will *never* presume that the victim is dead, rather life-saving measures will be initiated immediately. In hanging attempts, the victim will first be released from the ligature (using the emergency rescue tool if necessary). Staff will assume a neck/spinal cord injury and carefully place the victim on the floor. Should the victim lack vital signs, CPR will be initiated immediately. All life-saving measures will be continued by correctional staff until relieved by medical personnel.

6) The shift supervisor will ensure that both arriving CDC medical staff and EMS personnel have unimpeded access to the scene in order to provide prompt medical services to, and evacuation of, the victim.

7) Although the scene of the emergency will be preserved as much as possible, the first priority will always be to provide immediate life-saving measures to the victim. Scene preservation will receive secondary priority.

8) An Automated External Defibrillator (AED) is located in the Special Housing Unit. All medical staff, as well as designated correctional personnel, will be trained (both initial and annual instruction) in its use. The facility medical director will provide direct oversight of AED use and maintenance. (See also policy on "Automated External Defibrillator Use.")

9) The facility medical director will ensure that all equipment utilized in responding to medical emergencies (e.g., crash cart, oxygen tank, AED, etc.) is inspected and in proper working order on a daily basis.

10) All staff and inmates involved in the emergency will be offered critical incident stress debriefing. (See CDC Policy on "Critical Incident Stress Debriefing.")

Conclusion

Many correctional officials cling to the misguided belief that suicide prevention and the collateral issues of liability begin and end at the point of intake when the detainee is initially assessed for the risk of self-harm. It has become well established, however, that suicide prevention is a multidimensional issue and includes prompt intervention following self-injury. And as shown in the following article, as well as a related article in page 15, federal courts have ruled that correctional officials and their staff can be held liable for delaying and/or failing to provide prompt emergency medical services to inmates.

In conclusion, any inmate death that results from unclear or confusing procedures, inadequately trained, callous or simply unwilling participants, and faulty (or non-existent) equipment is inexcusable. As reflected by both their written policy and actions, correctional facilities that fail to adequately address the issue of prompt intervention following a suicide attempt will substantial increase the likelihood of preventable deaths and subsequent litigation. ❑

PROMPT INTERVENTION AND THE COURTS: *TLAMKA V. SERRELL ET. AL*

Inmate Frank J. Tlamka collapsed to the ground from a heart attack in the prison yard at the Nebraska State Penitentiary in Lincoln on July 1, 1995. Several fellow inmates rushed to his side and initiated cardiopulmonary resuscitation (CPR). Three correctional officers arrived shortly thereafter and ordered that the inmates stop CPR and leave the area. The officers did not resume CPR, rather they waited for a nurse to arrive several minutes later. CPR was initiated by the nurse, but Mr. Tlamka never regained consciousness and later died at a local hospital.

The family of Frank Tlamka filed a federal lawsuit against the three officers and several prison officials alleging that the defendants were deliberately indifferent to the victim by refusing and delaying the initiation of CPR during his heart attack. Consistent with a similar case involving a jail suicide [*Heflin v.*

Stewart County, 958 F.2d 709 (6th Cir. 1992)] the United States Court of Appeals for the 8th Circuit ruled unanimously in favor of the Tlamka family on March 23, 2001, and stated, in part, that: "An inmate's right to medical care is violated if a prison official's conduct amounts to a deliberate indifference to the prisoner's serious medical needs. We conclude that under the facts we are presented...any reasonable officer would have known that delaying Tlamka's emergency medical treatment for 10 minutes, with no good explanation for the delay, would have risen to an Eighth Amendment violation." The case, *Tlamka v. Serrell et al* (No. 00-1648), is reprinted below.

Before McMILLIAN, ROSS, and HANSEN, Circuit Judges.

HANSEN, Circuit Judge:

Plaintiff, Gerald R. Tlamka, brings this action pursuant to 42 U.S.C. § 1983 on behalf of his father's estate. Plaintiff's father, Frank J. Tlamka (Tlamka), was incarcerated at the Nebraska State Penitentiary (NSP) from December 2, 1994, through July 1, 1995, the date on which he suffered a heart attack and later died. Plaintiff alleges that corrections officers Otha Serrell, Michael Lichtenfeld, and Michelle Williams violated Tlamka's Eighth Amendment rights by deliberately refusing and delaying emergency medical treatment during his heart attack. Plaintiff further claims Frank Hopkins, NSP Warden, and Harold Clarke, Director of the Nebraska Department of Correctional Services, failed to train the corrections officers, thus causing a deprivation of Tlamka's constitutional rights. The district court granted summary judgment in favor of all defendants, concluding they were entitled to qualified immunity, and plaintiff now appeals. We affirm the district court's decision as to Hopkins and Clarke but reverse and remand as to the claims against the corrections officers.

I.

The record upon which the district court based its summary judgment ruling is comprised almost entirely of affidavits by prisoners and corrections officers present at the time Tlamka collapsed in the prison yard. From these accounts, we discern the following facts relevant to whether defendants are entitled to summary judgment based on qualified immunity. At approximately 1:00 p.m. on July 1, 1995, Tlamka suffered a heart attack and collapsed in the NSP prison yard. A nearby inmate ran to notify a corrections officer that he thought Tlamka was having a heart attack. Two other inmates rushed to the unconscious Tlamka and attempted to locate his pulse. Unable to find one and noting that Tlamka was turning bluish in color, the inmates immediately began cardiopulmonary resuscitation (CPR). One of the inmates had previously received CPR training, while a third inmate who was knowledgeable in proper CPR techniques provided instruction. The inmates continued CPR for approximately one to five minutes and began to see positive results — Tlamka regained a more normal color, his eyes opened, and his chest began to heave as if he was struggling to catch his breath on his own.

The affidavit accounts of what next transpired substantially conflict and differ. According to the inmates, corrections officers Lichtenfeld, Williams, and Serrell arrived on the scene, at which time Officer Serrell immediately ordered the inmates to cease administering CPR[1] Despite the order, the inmates continued to perform CPR but were again ordered by Serrell to cease and to clear the area. Upon the second order, the inmates desisted reluctantly and with objection, both from the inmates performing the CPR and from other inmates who had gathered at the scene. The inmate providing the CPR instruction argued with the corrections officers that it was imperative that CPR be continued.

Tlamka's condition deteriorated immediately after the inmates ceased CPR — as one inmate describes, Tlamka again turned blue, and his chest began "hitching." According to the inmates' sworn accounts, although Tlamka was in dire distress, none of the corrections officers approached him to check his pulse nor did they continue the CPR begun by the inmates. Sometime later, other corrections officers arrived with a gurney to transport Tlamka to the turnkey area, located approximately 50 feet from where he had collapsed, where a prison nurse was waiting to render aid. By the time the gurney arrived, Tlamka had turned a darker shade of blue and purple. As he was transported to the turnkey area, the officers walked at a normal pace and did not provide Tlamka with any medical attention. Upon his arrival, the awaiting nurse initiated CPR, which was continued until an ambulance arrived and transported Tlamka to the local hospital. Tlamka never regained consciousness and later died at the hospital.

The inmates offer a range of estimates as to how long Tlamka went without CPR after Serrell issued the order to the inmates to cease CPR. The consensus, as the district court noted, is that a two- to five-minute delay occurred between issuance of the order and the time when Tlamka reached the turnkey area where the nurse resumed CPR. Inmate Rodney Porter contended in his affidavit that there was a ten-minute delay during the same period. He also stated, as did the other inmates, that none of the corrections officers performed CPR nor attempted to a administer any other type of medical attention to Tlamka prior to his arrival in the turnkey area.

Defendants offer affidavits from Serrell, Williams, and another corrections officer in support of summary judgment. None denied in the affidavits that an order was issued directing the inmates to cease CPR. Serrell contended, however, that Lichtenfeld relieved one of the inmates who was performing CPR immediately after he arrived on the scene. He also contended that CPR was continued as Tlamka was transported to the turnkey area. In addition, the corrections officers' accounts of the incident do not support inmate Porter's claim that 10 minutes passed before Tlamka arrived in the turnkey area. Serrell, in particular, stated that approximately three minutes passed from the time he arrived on the scene to the time Tlamka arrived in the turnkey area.

Consequently, there are two important areas of factual dispute raised by the dueling affidavits. Was the administration of CPR to Tlamka stopped by the officers, and, if so, how much time did it take to get Tlamka to where the prison nurse could tend to the emergency?

II.

The district court concluded in ruling on defendants' motion for summary judgment that it was not clearly established at

the time of Tlamka's heart attack that a corrections officer may violate an inmate's Eighth Amendment rights by temporarily halting CPR. The court therefore granted summary judgment on qualified immunity grounds. Plaintiff argues on appeal that the district court failed to view the record in his favor and that the court's qualified immunity determination was erroneous. We review *de novo* a district court's grant of qualified immunity on summary judgment. *Lambert v. City of Dumas*, 187 F.3d 931, 935 (8th Cir. 1999). Summary judgment is proper when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). In deciding whether defendants are entitled to summary judgment, we view the summary judgment record in a light most favorable to the plaintiff, the nonmoving party, affording him the benefit of all reasonable inferences. *Lambert*, 187 F.3d at 934.

A.

Qualified immunity protects a governmental official from suit when his "conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known." *Sexton v. Martin*, 210 F.3d 905, 909 (8th Cir. 2000) (quoting *Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982)). "What this means in practice is that whether an official protected by qualified immunity may be held personally liable for an allegedly unlawful official action generally turns on the objective legal reasonableness of the action, assessed in light of the legal rules that were clearly established at the time it was taken." *Wilson v. Layne*, 526 U.S. 603, 614 (1999) (internal quotations omitted). To determine whether an official is entitled to qualified immunity, we apply a two-part inquiry: "whether the plaintiff has alleged the deprivation of an actual constitutional right at all, and if so, . . . whether that right was clearly established at the time of the alleged violation." *Id*. at 609 (quoting *Conn v. Gabbert*, 526 U.S. 286, 290 (1999)); see also *Sexton*, 210 F.3d at 909. When applying this inquiry at the summary judgment stage, the official's conduct must be viewed through the prism of Rule 56 — that is, we must take as true those facts asserted by plaintiff that are properly supported in the record. See *Behrens v. Pelletier*, 516 U.S. 299, 309 (1996); see also *Gregoire v. Class*, No. 00-1255, 2000 WL 1880249, (8th Cir. Dec. 29, 2000) ("[I]f there is a genuine dispute concerning predicate facts material to the qualified immunity issue, there can be no summary judgment." (brackets in original) (quoting *Lambert*, 187 F.3d at 935)). Once the predicate facts are established, the reasonableness of the official's conduct under the circumstances is a question of law. *Pace v. City of Des Moines*, 201 F.3d 1050, 1056 (8th Cir. 2000).

B.

We turn first to plaintiff's claims against Officers Serrell, Williams, and Lichtenfeld. Before reaching the question of whether the district court correctly determined that the law was not clearly established, we determine whether plaintiff has set forth sufficient evidence to support a finding that the corrections officers violated Tlamka's constitutional rights at all. The Eighth Amendment prohibits prison officials' cruel and unusual punishment of inmates, and it has been interpreted as obligating prison officials to provide medical care to inmates in their custody. See *Estelle v. Gamble*, 429 U.S. 97, 102-03 (1976). An inmate's right to medical care is violated if a prison official's conduct amounts to a "deliberate indifference to [the prisoner's] serious medical needs." *Dulany v. Carnahan*, 132 F.3d 1234, 1237-38 (8th Cir. 1997) (brackets in original) (quoting *Estelle*, 429 U.S. at 104). There is both an objective and subjective component to a claim of deliberate indifference. A plaintiff must demonstrate "(1) that [he] suffered objectively serious medical needs and (2) that the prison officials actually knew of but deliberately disregarded those needs." *Id*. at 1239.

With this standard in mind, we conclude that plaintiff has presented sufficient facts, viewing the record in the light we must, to establish an underlying violation of Tlamka's Eighth Amendment rights. "It is well settled that an intentional delay in obtaining medical care for a prisoner who needs it may be a violation of the eighth amendment." *Ruark v. Drury*, 21 F.3d 213, 216 (8th Cir.), *cert. denied*, 513 U.S. 813 (1994). For delay to rise to an actionable Eighth Amendment violation, however, the information available to the prison official must be such that a reasonable person would know that the inmate requires medical attention, or the prison official's actions (or inaction) must be so dangerous to the health or safety of the inmate that the official can be presumed to have knowledge of a risk to the inmate. *Id*.

Based on the obvious and serious nature of Tlamka's condition, the corrections officers' alleged failure to even approach Tlamka during the maximum 10-minute period would rise to a showing of deliberate indifference. None of the parties dispute that Tlamka's medical condition was objectively serious nor that it was obvious to those present at the scene that his condition was life threatening. Nevertheless, according to the plaintiff's witnesses, the corrections officers failed to provide CPR or approach Tlamka for a period of 10 minutes (albeit that time estimate is provided by only one inmate) even though all three officers were trained to provide CPR.[2] The officers' alleged inaction occurred even though they were presumably aware that Tlamka had been responding favorably to the CPR provided by the inmates, and an inmate told them that it was essential that CPR be continued under the circumstances. This alleged failure to act given the patent nature of Tlamka's condition, considering the corrections officers' ability to provide CPR, is conduct sufficiently severe to evidence an Eighth Amendment violation.[3] See *Jolly v. Knudsen*, 205 F.3d 1094, 1096 (8th Cir. 2000) (observing that sufficiently harmful omissions in medical care are sufficient to evidence deliberate indifference). The record contains no explanation for the purported delay in CPR, and thus, under the facts as presented on summary judgment, we cannot say that as a matter of law the officers were not deliberately indifferent in responding to Tlamka's heart attack.[4] *Cf. Curry v. Crist*, 226 F.3d 974, 977 (8th Cir. 2000) (recognizing that a prison official is entitled to qualified immunity if he knew of a substantial risk of harm to inmate health or safety but responded reasonably to the risk, even though harm was not ultimately averted).

We are somewhat wary of inmate Porter's allegation that the delay was 10 minutes long and of the almost unthinkable suggestion that the officers were doing nothing to assist Tlamka during that time. At this stage of the litigation, however, we must accept the facts as recited in the affidavits filed by the prisoners as true. See *Grossman v. Dillard Dep't Stores, Inc*., 47 F.3d 969, 971 (8th Cir. 1995) ("We may neither weigh evidence nor make credibility determinations at the summary judgment stage.") We therefore

conclude that plaintiff has met his burden of establishing a genuine issue of material fact as to whether the corrections officers knew of and were deliberately indifferent to Tlamka's medical needs. See *Yellow Horse v. Pennington County*, 225 F.3d 923, 927 (8th Cir. 2000) (stating that when qualified immunity is claimed, it is a plaintiff's burden to show that a question of fact precludes summary judgment).

Having concluded that plaintiff's complaint and his untested evidence states and supports a valid Eighth Amendment violation against the corrections officers, we address whether it was one of clearly established law. To be clearly established the "contours of the right [allegedly violated] must be sufficiently clear that a reasonable official would understand that what he is doing violates that right." *Buckley v. Rogerson*, 133 F.3d 1125, 1128 (8th Cir. 1998) (quoting *Anderson v. Creighton*, 483 U.S. 635, 640 (1987)). "The official is not required to guess the direction of future legal decisions, *Mitchell v. Forsyth*, 472 U.S. 511, 535, 105 S. Ct. 2806, 2820, 86 L. Ed. 2d 411 (1985), but may rely on preexisting case law for guidance." *Buckley*, 133 F.3d at 1128. Our circuit subscribes to a "broad view" of what constitutes clearly established law; "[i]n the absence of binding precedent, a court should look to all available decisional law, including decisions of state courts, other circuits and district courts." *Id*. at 1129 (quoting *Norfleet v. Ark. Dep't of Human Servs*., 989 F.2d 289, 291 (8th Cir. 1993)).

We are unaware of any decisions involving facts similar to those presented in this case, but that is not dispositive of our inquiry. At the time of Tlamka's heart attack, as we discussed previously, the law in this circuit was settled that an intentional delay in obtaining medical care for an inmate could give rise to a violation. See *Ruark*, 21 F.3d at 216;[5] *cf. Lancaster v. Monroe County*, 116 F.3d 1419, 1425 (11th Cir. 1997) ("The case law also had clearly established before this case arose that an official acts with deliberate indifference when he intentionally delays providing an inmate with access to medical treatment, knowing that the inmate has a life-threatening condition or an urgent medical condition that would be exacerbated by delay." (citing cases from 1994 or earlier)). While the determination of whether that delay is constitutionally actionable depends on the seriousness of an inmate's medical condition and on the reason for the delay, *Harris v. Coweta County*, 21 F.3d 388, 393-94 (11th Cir. 1994), we conclude that under the facts we are presented with in this summary judgment appeal, any reasonable officer would have known that delaying Tlamka's emergency medical treatment for 10 minutes, with no good or apparent explanation for the delay, would have risen to an Eighth Amendment violation. Plaintiff's factual assertions, in our view, if proven to be true, would constitute a quintessential case of deliberate indifference to serious medical needs.

C.

Plaintiff also seeks to hold Hopkins and Clarke liable for the alleged deprivation of Tlamka's medical care on a failure-to-train theory. The district court granted summary judgment on the claim, concluding as a matter of law that the two could not be held liable absent an underlying violation of clearly established law by the corrections officers. Although we reverse as to the corrections officers, Hopkins and Clarke are entitled to summary judgment on their assertion of qualified immunity.

A supervisor may not be held liable under §1983 for the constitutional violations of a subordinate on a respondeat superior theory. *Boyd v. Knox*, 47 F.3d 966, 968 (8th Cir. 1995). Rather, a supervisor's liability arises if:

> he directly participates in a constitutional violation or if a failure to properly supervise and train the offending employee caused a deprivation of constitutional rights. The plaintiff must demonstrate that the supervisor was deliberately indifferent to or tacitly authorized the offending acts. This requires a showing that the supervisor had notice that the training procedures and supervision were inadequate and likely to result in a constitutional violation.

Andrews v. Fowler, 98 F.3d 1069, 1078 (8th Cir. 1996) (citations omitted). In this case, plaintiff alleges the officers were inadequately trained to respond to Tlamka's emergency, but the record is void of any facts which would have alerted Hopkins and Clarke that the officers were inadequately trained. In fact, it is uncontroverted that all NSP new hires are trained in CPR and that the training is updated as necessary. Based on the record, no reasonable fact finder could conclude that Hopkins and Clarke violated Tlamka's constitutional rights by failing to properly train the corrections officers. See *Davis v. Fulton County*, 90 F.3d 1346, 1350 (8th Cir. 1996) ("The non-moving party . . . may not rest upon mere denials or allegations in the pleadings, but must set forth specific facts sufficient to raise a genuine issue for trial.").

III.

For these reasons, we affirm the district court's judgment as to Hopkins and Clarke but reverse and remand the deliberate indifference claim against Serrell, Lichtenfeld, and Williams for further proceedings consistent with this opinion.

Footnotes

[1]The inmate accounts are not entirely consistent or clear on the sequence in which Serrell, Lichtenfeld, and Williams arrived. In fact, inmate Rodney Porter contends that Officer Lichtenfeld arrived first and issued the order to discontinue CPR; the complaint alleges it was Serrell. Based on the inmate accounts, we find a reasonable fact finder could infer that all three officers arrived on the scene either together or shortly after the order was issued.

[2]Defendants' counsel conceded at oral argument that the three officers received CPR instruction, and Warden Hopkins stated in his affidavit that all corrections officers receive CPR instruction as part of their initial training. The training is updated as necessary by an NSP training specialist. In addition, NSP regulations specifically provided at the time of Tlamka's heart attack that at least one on-duty corrections officer was to be trained in basic life-support measures and was to respond to the scene of any medical emergency immediately. (J.A. at 67.) Williams was the designated responding officer on the day of Tlamka's heart attack.

[3]The district court concluded that, at most, there was a five-minute delay in CPR and that "[i]t [was] undisputed that these five crucial minutes were not idle time." (Appellant's Add. at 8.)

We respectfully disagree with the district court's view of the record because it appears to overlook the affidavit of inmate Rodney Porter and the reasonable inferences to be drawn from it, and the affidavits of other inmates who claimed the officers provided no assistance during the period when CPR was interrupted.

[4]One of the corrections officers stated in his affidavit that a decision was made to transport Tlamka to the turnkey area because inmates were crowding the yard area, creating a security risk. Even so, there is no explanation for why the officers present offered no aid prior to transporting Tlamka.

[5]Defendants argue the district court correctly concluded that the officers' conduct did not violate clearly established law based on this circuit's decision in *Ruark*. In *Ruark*, the court affirmed the trial court's holding that a 20-minute delay in calling an ambulance, without more, was insufficient to give rise to a claim of deliberate indifference. 21 F.3d at 217-18. This case is distinguishable from *Ruark* because there is no explanation for the officers' alleged failure to render aid to Tlamka during the delay. There was evidence in *Ruark*, in contrast, establishing that the jailers were unaware of the serious nature of the inmate's condition and that they had no knowledge their delay risked harm to the inmate. *Id*. at 216. ❑

Use of Automated External Defibrillators in Correctional Settings

A Position Statement of the National Commission on Correctional Health Care[1]

Background

Approximately 360,000 Americans experience sudden cardiac arrest annually. Ventricular fibrillation (VF) is the most common cause of sudden cardiac arrest, with pulseless ventricular tachycardia (VT) as another leading cause. The standard therapeutic response to ventricular fibrillation and pulseless ventricular tachycardia is defibrillation. Sudden cardiac arrest is survivable. The sooner defibrillation is provided after onset, the greater the likelihood that the patient will survive a VF or VT event. It has been demonstrated that within the first ten minutes of a sudden cardiac arrest, a patient's survival rate improves 10 per cent for every minute that is saved by getting the defibrillator to the patient (Eisenberg, Horwood & Cummins, 1990). Technological innovations in Automated External Defibrillators (AEDs) have made early defibrillation programs possible in many public places, such as airplanes, restaurants, and sport facilities. The American Heart Association (AHA) has recommended that all communities implement a principle of early defibrillation with use of AEDs, strengthen their access to the emergency dispatch system, promote cardiopulmonary training and response, and coordinate first response units with advanced life support units.

An AED is an electronic device, first introduced in 1979, that interprets cardiac rhythms, makes a "shock" or "no shock" decision, and, if appropriate, delivers an electrical shock to the patient. An AED can be applied by non-physician medical personnel and lay persons with minimal training. The simplicity of an AED makes training and application easy. Studies have shown that volunteer first responders can remain effective past six months of a brief two-hour training in applying an AED (Walters, Glucksman & Evans, 1994).

AEDs have been found to be very effective. Studies on AED use have shown they can be instrumental in successful out-of-hospital cardiac resuscitation in adults (Stapczynski, Burklow, Calhoun & Svenson, 1995). Children and young adolescents have also benefited by the early application of AEDs (Atkins, Hartley & York, 1998). Typically, AED units cost a few thousand dollars, have few maintenance costs, and are lightweight and durable. Studies have found AEDs to be reliable, and experts have called for increased federal and state support for AED utilization (Smith & Hamburg, 1998). Safeguards in the equipment prevent accidental defibrillating shocks.

AEDs have become the standard of care for sudden cardiac arrest (Cummins, 1993). Training in the application and use of AEDs has become standardized in the AHA's Advanced Cardiac Life Support (ACLS) curriculum. The success of AEDs in improving cardiac survival from a sudden arrest, its ease of use, and a fail safe technology has led the AHA to call for its use even by non-medical, minimally trained personnel (e.g., security guards and spouses of cardiac patients). The American College of Emergency Physicians (ACEP) endorses the use of AEDs when integrated into the emergency medical system (American College of Emergency Physicians, 1991 and 1993). The question facing correctional facilities is, should they incorporate AEDs into their medical systems, and if so, how?

Most correctional facilities are not practically able to maintain ACLS capability in the institution on a 24-hour a day (or even part-time) basis. Most rely on the local EMS system to bring ACLS into the institution when it is required. AEDs used in the institution can provide the early defibrillation needed prior to ACLS arrival.

The implementation of an early defibrillation program requires careful study and analysis. Correctional administrators and medical directors considering the use of AEDs, should identify when AEDs should be used, who should be trained in their use, and where AEDs should be kept.

Position Statement

Institutions considering the implementation of an early defibrillation program and the use of AEDs should do so only after a thorough needs analysis with input from physicians who are experienced in implementing such programs. Correctional institutions should refer to the Commission's Standards for Health Services in Prisons, the Standards for Health Services in Jails, and

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Standards for Health Services in Juvenile Detention and Confinement Facilities for further guidance. The standards on Emergency Plan, Communication on Special Needs Patients, Continuing Education for Qualified Health Care Professionals, Training for Correctional Officers, Position Descriptions, Assessment Protocols, and Emergency Services may be of assistance to correctional administrators.

Correctional institutions differ in size, type, population, and staffing. The decision as to who should be trained in the use of AEDs in a correctional facility should be made by the medical director in collaboration with the correctional authority. Correctional officers are generally the first responders to any situation in a jail, prison, or juvenile facility, and as such should be given appropriate training and permitted to use AEDs. When a facility is staffed 24 hours with health care staff, it may not be necessary to train correctional officers in the application of AEDs. In prisons, jails, and juvenile detention and confinement facilities that do not have health staff on a 24-hour basis, correctional officers are an essential element of an early defibrillation program and should be trained accordingly.

AEDs should be located where there will be quick and easy access by individuals who are trained in their use. The decision of where to place an AED in a correctional facility must be determined by the medical director working in conjunction with the facility administrator, taking into account the staffing and facility design. The following recommendations provide guidelines for instituting AEDs in a correctional setting:

1. The use of AEDs should be approved, planned, and implemented under the direction of the responsible physician in collaboration with the facility authority.

2. An early defibrillation program includes a training program to designated staff who would be authorized to use AEDs. This includes both initial and periodic in-services as appropriate.
3. The location of AEDs should be approved by facility administrators and the responsible physician, taking into account the staffing and design of the facility.

Adopted by the National Commission on Correctional Health Care, Board of Directors: November 1, 1998.

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First Installment of a National Strategy for Suicide Prevention Unveiled

In May 2001, United States Surgeon General David Satcher, M.D., joined a coalition of public and private groups to unveil a national blueprint of goals and objectives to prevent suicide, the eighth leading cause of death in the United States. The Surgeon General released a document (*National Strategy for Suicide Prevention: Goals and Objectives for Action*) that establishes 11 goals and 68 measurable objectives for public and private sector involvement to prevent suicides and attempts,

UPDATE
ON THE INTERNET

Recent issues of the ***Jail Suicide/Mental Health Update*** are now available on the Internet at http://www.igc.org/ncia/suicide.html

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

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

http://www.hhpub.com/journals/crisis/1997
http://www.nicic.org/inst/jail-mental.htm
http://www.nicic.org/pubs/jails.htm
http://www.nicic.org/pubs/prisons.htm
http://www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
http://www.performance-standards.org/resguide.htm
http://www.prainc.com/gains/webpub.htm

as well as reduce the harmful after-effects they have on families and communities.

Suicide takes the lives of more than 30,000 Americans a year — which amounts to more than three suicides for every two homicides committed — while more than 650,000 Americans attempt suicide annually. "Suicide has stolen lives and contributed to the disability and suffering of hundreds of thousands of Americans each year," Dr. Satcher said. "There are few who escape being touched by the tragedy of suicide in their lifetimes....Only recently have the knowledge and tools become available to approach suicide as a preventable problem with realistic opportunities to save many lives."

The *National Strategy for Suicide Prevention: Goals and Objectives for Action* provides a framework for action and guide development of an array of services and programs yet to be set in motion. It strives to provide direction to efforts to modify the social infrastructure in ways that will affect the most basic attitudes about suicide and that will also change judicial, educational, social service and health care systems. The 68 objectives contained in the report include:

- Implementing integrated community-based suicide prevention programs that build life skills, beliefs and values, and connections to family and community support known to reduce the risk of suicide;
- Incorporating suicide-risk screening at the primary health care level;
- Increasing the number of states that require health insurance plans to cover mental health and substance abuse care on a par with coverage for physical health care;
- Providing treatment for more suicidal persons with mental health problems;
- Developing technical support centers to increase the capacity of states to implement and evaluate prevention programs;
- Increasing availability of comprehensive support programs for survivors of suicide;
- Increasing the number of professional and volunteer groups as well as faith-based communities that integrate suicide prevention into their ongoing activities;
- Improving suicide prevention education and training for health care professionals, counselors, clergy, teachers and other key "community gatekeepers;"
- Increasing the number of television programs and movies that accurately and safely depict suicide and mental illness; and
- Implementing a national violent death reporting system that includes suicide.

Finally, there are three objectives that specifically address suicide prevention within both adult and juvenile correctional facilities:

- *Increasing the proportion of correctional institutions with evidence-based suicide prevention programs*;
- *Increasing the proportion of correctional staff who have received training on identifying and responding to persons at risk for suicide*; and
- *Defining and implementing national guidelines for mental health screening, assessment and treatment of suicidal adult and juvenile incarcerated populations.*

Copies of the *National Strategy for Suicide Prevention: Goals and Objectives for Action* can be obtained from the Center for Mental Health Services' Knowledge Exchange Network at 800/789-2647, reference document number SMA-3517, or on the Internet at http://www. mentalhealth.org/suicideprevention ❑

News From Around the Country

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

Colorado

The El Paso County Sheriff's office announced in April that it settled a lawsuit brought by the family of a man who died in the county jail almost three years ago. The sheriff's office, which still denies responsibility for the death of Michael Lewis, agreed to a $116,000 settlement with the victim's family. On May 7, 1998, the 54-year-old Lewis was strapped face-down to a restraining board used to subdue unruly inmates. His mother, Aylett Lewis, filed the lawsuit in December 2000 alleging that her son's civil rights were violated and that medical personnel failed to care for him properly.

The El Paso County Coroner determined that Mr. Lewis likely died from a combination of a pre-existing heart condition, drugs given to calm him, and the more than two hours he was strapped to the board. Although the district attorney's office concluded that jail staff were not negligent in Mr. Lewis' death, jail officials suspended use of the restraint board in July 1999 and now use a restraint chair.

Washington (State)

Standard training for officers of the Seattle Police Department includes approximately half a day of instruction on dealing with the mentally ill. Many say that is not enough. Since 1998,

the department also has offered a week-long crisis intervention training program on mental illness and mental health training. Approximately 200 officers have volunteered for the program, one of a handful of its kind nationwide. Officials say calls for hostage negotiators to deal with people who are mentally ill have declined significantly since the program began. A shorter, 8-hour version of the program was made mandatory for all patrol officers after last year's fatal shooting of a mental ill man. "I felt we had so little training with the mentally ill population that we needed to fine-tune our approach," Sergeant Liz Eddy, who leads the training program and the hostage negotiation team, told *The Seattle Times* in September.

The Seattle Police Department responds to approximately 10,000 incidents a year involving someone who is mentally ill. The program is intended to enable dispatchers to send an officer trained in crisis intervention within minutes after a trouble call. Police say the training will not be enough to resolve every situation. The goal is to teach officers how to gain control in dealing with the mentally ill and to understand that seemingly random actions are often symptoms of a disease. "The potential for violence is greatest when you don't know what will happen next," instructor Ellis Amdur said. "I try and make the behavior understandable and somewhat predictable." Training also can reassure relatives of the mentally ill that officers are prepared to help.

"By default, the police are brought into situations that could best be handled in the treatment system," said Eleanor Owen, executive director of Washington Advocates for the Mentally Ill. "I think the Crisis Intervention Team program is a reflection of the humane and compassionate component of police." Officers without training often call King County Crisis and Commitment Services to say someone is "acting crazy," coordinator Amnon Shoenfeld said. Trained officers can better describe the behavior and determine whether there is a danger of violence.

Texas

In Corpus Christi, Nueces County's insurance company settled a wrongful death lawsuit over a jail inmate's death in 1999 for $1 million, according to federal court documents filed in August. A federal judge approved an agreement between Nueces County and the family of Bobby Stuart.

The lawsuit had contended that Mr. Stuart died after he was beaten and put in a restraining chair following his arrest on suspicion of criminal mischief and public intoxication. According to court records, he fought with police officers and jail officers. At one point, correctional staff realized that Mr. Stuart was not breathing in his cell. "If they would have taken him to the hospital when he first had problems, he would not have died, regardless of what the reason was," Plaintiff Attorney James Ragan told the *Caller-Times*. The county's attorney, Phillip McKinney, offered only a brief comment on the case saying that the county chose to settle because of "the facts and circumstances of the case."

Oregon

In June, Jackson County agreed to pay $1.8 million to settle the case of a jail inmate who died after being placed in a restraint chair. The county agreed to pay the family of Jeffrey Stuart Anderson $1.7 million, as well as an additional $100,000 in legal fees. Mr. Anderson turned himself in to the Jackson County Jail in Medford in April 1996 on a probation violation. After a few days, he started to suffer from alcohol withdrawal, was given only sporadic medication, and issued a medical identification bracelet. Allegedly unaware of his medical condition, deputies placed the thrashing, hallucinating inmate in the jail's restraint chair for over 10 hours. When he was removed, Mr. Anderson was bruised from his feet to his head. He was taken to the hospital a few days later, but a baseball-sized blood clot had formed in his brain. He died on May 2, 1996.

The family sued the county for excessive use of force, inadequate medical care and wrongful death. Following an eight-day trial, a jury found deputies negligent and awarded the family $3.1 million. But the judge did not immediately accept the verdict and the settlement agreement was reached the following day.

In a press release, the county emphasized that it did not admit any liability in the case. "It is the county's firm stance that all employees in this matter acted appropriately," the release said. "Jackson County's policies and procedures dealing with inmates are appropriate, strong and followed by all county employees." The Anderson family was pleased with the agreement. "I can't explain it really, but it's been five years of hell losing Stuart and then wanting to bring this out," Helen Anderson, the victim's mother, told the *Associated Press*. "This should never happen to anyone else." The bulk of the money will go into trust funds for Mr. Anderson's two teenage sons.

Oklahoma

A state jail inspector warned jail officials in April that the Garfield County Jail in Enid could be forced to close unless a better place for mentally ill inmates is found. Don Garrison, director of the state Health Department jail inspection division, told members of the Garfield County Jail Research Committee that chaining mentally ill inmates under the stairs in the jail as a form of segregation must stop. As reported by the *Associated Press*, Mr. Garrison told the jail committee that "if I come up here again and see someone (chained under the stairs), I'm going directly to the state attorney general and recommend that he shut you down."

Sheriff Bill Winchester admitted that his staff had chained inmates to the stairs in the booking area of the office whenever jailers cannot find a place to segregate mentally ill or problem inmates from others in the jail. The sheriff said that segregation was one of his biggest problems and, if staff needed to put an inmate in a cell alone, they had to find somewhere else to put inmates other than the standard four-man cell. That sometimes meant putting inmates under the stairs. According to the sheriff, because the inmates were handcuffed near jail staff, they could tell his employees when they needed water or requested a rest room.

Florida

Robert Marshal Ferris had spent three decades battling mental illness. The battle ended in July when he choked to death on a piece of his blanket in the Brevard County Detention Center in Sharpes. Although the autopsy report listed the cause of death as

asphyxia by a foreign body, his mother and the advocates for the mentally ill said Mr. Ferris died because the county mental health system was not able to help him when he needed it the most.

"People need to know that we are in a crisis because we don't have enough funds to take care of the people who are ill," Freda Schildroth, president of the Space Coast chapter of the National Alliance for the Mentally Ill, told *Florida Today*. Although Brevard County has recently requested funds from the state Department of Children and Families for expanded community services for youth suffering from substance abuse, Ms. Schildroth would also like to see the county establish a crisis prevention program to divert the mentally ill from the county jail.

According to Mike Brown, jail commander at the facility, approximately 100 inmates (or 10 percent) of the population are on psychotropic medication. "What I support is the county having some kind of secure mental health facility where we might be able to divert some of the people we incarcerate with mental illness to those types of facilities as opposed to them spending time in jail."

Mr. Ferris was diagnosed with paranoid schizophrenia when he was in his 20s, but stopped seeing his psychiatrist and taking his medication. His mother tried to help her 54-year-old son by obtaining a court-ordered emergency psychiatric commitment for evaluation. But on the morning that the court order was to be served, local police arrested Mr. Ferris for threatening to kill his neighbor with a knife. Soon after arriving at the Brevard County Detention Center in June, Mr. Ferris flooded his cell, refused a shower, and threatened jail staff. He also refused to eat, wear clothes or take any medication. Finally, on July 21, Mr. Ferris started chewing on his blanket until a piece caught in his throat and he died.

Yet according to Ms. Schildroth, blame for Robert Ferris' death should not be directed solely at the jail system. "When Rob stopped seeing his psychiatrist or picking up his drugs there wasn't a case worker to supervise him. He was compromised," she said. "We didn't grab this guy and put him in the safety net before it was too late."

Oklahoma

Criticizing the "reckless way" the family of Kenneth Michael Trentadue was treated, a federal judge ordered the federal government to pay $1.1 million to the dead inmate's family in May. U.S. District Judge Tim Leonard ruled the Trentadue family "suffered severe emotional distress" because of the insensitive actions of Federal Bureau of Prison officials. Mr. Trentadue was found hanging in his cell August. 21, 1995, at the Federal Transfer Center in Oklahoma City.

Federal and state investigators called his death a suicide, but the victim's family alleged he was murdered by prison staff or another inmate. His body had numerous injuries, unusual for a self-inflicted hanging. Those injuries caused family and others to suspect Mr. Trentadue was beaten. State Medical Examiner Fred Jordan initially ruled the cause of death as unknown. Federal and state investigations subsequently determined the injuries were self-inflicted, caused by a botched attempt to hang himself before succeeding on the second try. The medical examiner then amended the cause of death to suicide.

In 1997, the Trentadue family filed a lawsuit against the Federal Bureau of Prisons. In December 2000, a federal jury found that Lieutenant Stuart A. Lee, a former officer at the Federal Transfer Center, was "deliberately indifferent" to Mr. Trentadue's medical needs. When the inmate was found hanging in his cell, the supervisor failed to order his officers to cut Mr. Trentadue down and initiate CPR. Lieutenant Lee had claimed it was obvious the victim was already dead. The jury awarded $20,000 in compensatory damages to the family. Jurors decided only the case against the lieutenant, the broader allegations against the federal government were decided by the judge.

Judge Leonard ruled the federal government was liable for the "intentional infliction of emotional distress" caused to Mr. Trentadue's wife and family. The judge scolded prison officials for not informing the family of the victim's injuries or that an autopsy had been performed. The family had to learn of those injuries when his body was shipped to them in California, he said. As reported by *The Oklahoman*, Judge Leonard stated that "despite the numerous, unusual and obvious extensive injuries to Trentadue's body, the family had not been told in advance of these injuries and were thus also forced to discover these on their own, much to their horror." Prison officials did not initially answer the family's "valid and understandable questions" about the unexpected death of their loved one, and their silence and mishandling of potential evidence from the cell helped fuel conspiracy theories that the inmate was murdered, the judge said. Judge Leonard did find that Mr. Trentadue had committed suicide, and that allegations of a conspiracy by prison officials to cover up a murder were mere speculation. The judge also specifically criticized the testimony of three officials at the Federal Transfer Center, stating that "from the time of Trentadue's death up to and including the trial, these witnesses seemed unable to comprehend the importance of a truthful answer."

Plaintiff attorney Scott Adams said he was pleased the judge punished the prison officials for their actions. "They stonewalled us from day one," Mr. Adams told *The Oklahoman*. "They treated the family very horribly. You cannot treat people the way the government treated the Trentadue family." He also believes that Judge Leonard was sending a message with his award of $1.1 million. "He's telling the government don't ever do this to anyone else," the attorney stated. Mr. Adams said he and the family have reluctantly accepted the facts that Mr. Trentadue committed suicide, but will always have questions about his death. "I will never fully understand what happened to Kenneth Trentadue," he said.

South Carolina

Law enforcement officials worry that reduced services from the state Mental Health Department will lead to jailers handling more inmates diagnosed with mental illness. The state agency expects to cut $40 million by reducing available services. "There are people in jails who do not need to be there, they need to be getting treatment," said Dave Almeida of the stated chapter of the National Alliance for the Mentally Ill. He told the *Associated Press*

in June that "this not only taxes the jail system, it continues to stigmatize people with mental illness."

Officials at the Greenville County Detention Center in Greenville believe that at least 15 percent of their approximately 1,000 inmates are mentally ill. State prison officials say they care for approximately 2,200 mentally ill inmates, or about 10 percent of all prisoners in the system. "We are constantly having inmates brought in exhibiting some kind of bizarre behavior that our officers are trying to watch...(and) about half a dozen suicide attempts a week," said James M. Dorriety, assistant Greenville County administrator. "So we end up jailing sick people and that's what we're seeing increasingly."

In April 2000, the county spent $8,000 a month, or 35 percent of its monthly pharmacy budget, on psychotropic drugs for 95 of 807 inmates. One year later on April 2001, the amount rose to $20,000 (or 46 percent) for 146 of 978 inmates, said Kristi McCraw, director of nursing at the jail.

Geoff Mason, the state Mental Health Department's acting deputy director of budget, planning and administration, said his agency wants to cut approximately 200 beds through the system the next year. He said the state's goal is to provide more community care options. "There will always be provisions for those folks that do need long term care," Mr. Mason said.

But Dr. Stephen McLeod-Bryant, public affairs representative with the South Carolina Psychiatric Association and vice chairman of clinical affairs at the Institute of Psychiatry at the Medical University of South Carolina, said if the mental health department cuts back, the already crowded jails will be affected. "We're like a bathtub," he said. "We're responsible for the water, but we have no control over the drain or the faucet." Some inmates can never stand trial because of their illness. "They end up waiting and waiting...We've got one now who's been here for over two years," said Dr. McLeod-Bryant.

Kristi McCraw said that many inmates are caught in a revolving door of incarceration and rarely receive that services they need. "We need more community-based placements, more outreach, more communication with resources, more education," she said. "It's not appropriate to place these people in jail. We have gone from one inhumane solution to another."

New York

In June, a state court judge ordered the release of medical records of mentally ill inmates held in the New York City jail system at Rikers Island so their lawyers could proceed with contempt of court motions against the city. State Supreme Court Justice Richard F. Braun ruled that the plaintiffs had shown that the city was probably in contempt of his July 2000 order to provide every mentally ill inmate with a discharge plan before their release. Lawyers for the plaintiffs charged that the city was dumping mentally ill inmates at subway stops in the middle of the night with a $3 MetroCard, $1.50 in cash and no plans for medication or counseling. In July 2000, Judge Braun issued an injunction against that alleged practice. He also gave class-action status to a suit that had been filed against the city in August 1999 by seven mentally ill inmates at the Rikers Island facilities. The city appealed and, in March 2000, the State Supreme Court's Appellate Division upheld Judge Braun's ruling (see ***Jail Suicide/Mental Health Update***, 10 (2): 16-17).

Heather Barr, a lawyer with the Urban Justice Center who represents the inmates, told the *Associated Press* that the class includes approximately 30,000 inmates a year. She stated that the plaintiffs need the medical records so they can determine who the members of the class are, find and communicate with them, and learn to what extent the city has failed to provide discharge planning for them.. Her agency had waited about two months for the city to comply with the judge's order before filing the contempt motion.

The city had argued against the motion for disclosure of the inmates' medical records, saying that state law makes them confidential. Judge Braun disagreed. He said that section of the law on which the city relies "is applicable only to facilities licensed or operated by the office of mental health or the office of mental retardation and developmental disabilities, which the city jails are not." Judge Braun also said that even if the section that the city cites were applicable, he would still grant the plaintiffs' motion "in the interests of justice." The disclosure would "enable them to try to demonstrate plaintiffs' need for discharge planning and defendants' apparent continuing failure to provide it other than to a small percentage of the class," he said.

Thomas Crane, a senior attorney for the corporation counsel's office, told the *Associated Press* that most of the inmates whose records are being sought do not even know they are part of a class action, and the city could be liable if it released their medical records. He also said the city has begun a discharge planning program for inmates receiving mental health treatment. Some parts of the program are in effect, and some are still being developed. One aspect of the program includes borough offices run by a non-profit agency where the former inmates will be able to get assistance. Those offices should be operating within a couple of months, Mr. Crane said.

California

Recent estimates indicate that there are 50,000 homeless severely mentally ill citizens in the state, including 10,000 to 20,000 homeless mentally ill veterans. In the 1999, the state legislature appropriated $10 million for the establishment of pilot programs providing integrated services to persons who are homeless mentally ill, at risk of homelessness and/or at imminent risk of being incarcerated. The Community Mental Health Treatment Program was started in three counties — Los Angeles, Sacramento and Stanislaus — and has enrolled more than 1,100 people. The program offers less debilitating medications, aggressive outreach, and the promise of housing and job training to enroll patients. It also provides intensive counseling and medical attention, group therapy and even a money manager who will hold their government benefit checks and help them pay their bills (see also ***Jail Suicide/Mental Health Update***, 10 (1): 12-13.).

The initial success of the pilot programs served as an impetus for the strong support from Governor Gray Davis and the state legislature to provide continued funding for this program and the target population In November 2000, the state Department of Mental Health (DMH) awarded grants totaling almost $55 million

annually over three years to support programs in 24 counties and 2 cities. "These funds will allow us to carry out our commitment to providing the kinds of comprehensive services that these individuals need to get their lives back on track," said DMH Director Stephen W. Mayberg, Ph.D. "The early program results proved that persons with mental illness and who are homeless can be helped by providing services that reduce the symptoms that impair their abilities to work, live independently, participate in their families, remain healthy and avoid crime."

In May 2001, the DMH released its annual report to the legislature regarding the program. Entitled "Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness," the report found, in part, that: 1) hospitalizations for participants dropped 78 percent from the previous year, the number of days spent in jail declined 85 percent, and the number of days spent homeless fell 69 percent; 2) money spent from reduced hospitalizations and jail time exceeded $7.3 million; and 3) among the more than 800 participants in Los Angeles County, homelessness declined 55 percent, jail time decreased 82 percent, and full-time employment increased by 155 percent. Commented Assemblyman Darrell Steinberg, who wrote the legislation that created the program, "What we're doing is beginning to fulfill a promise of a generation ago to actually build a community-based mental health care system."

To learn more about the Integrated Services for Homeless Mentally Ill Program and/or to obtain a copy of "Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness," contact the California Department of Mental Health, 1600 9th Street, Sacramento, California 95814, (916/654-2309) or http://www.dmh.cahwnet.gov ❑

Creating Integrated Service Systems for People with Co-Occurring Disorders Diverted from the Criminal Justice System: The King County (Seattle) Experience

Finding a Common Ground for Promoting Systems Integration

The need to divert people with co-occurring mental health and substance use disorders from the criminal justice system to treatment is increasingly apparent. Many offenders — both youth and adult — whose misdemeanor offenses are related more to the symptoms of mental illness and substance use than to truly criminal behavior are poorly served in a criminal justice system that offers little in the way of structured treatment. Jailing these individuals only perpetuates the cycle of offense and incarceration. Diverting these individuals from the criminal justice system and providing intensive community-based treatment and support offers far more hope to improving the lives of individual offenders and the welfare of the larger community.

In King County, Seattle, Washington, the data supporting the need for effective diversion alternatives for persons in the justice system

Key Tactics

- **Use the momentum that builds behind powerful, multi–system stakeholder consensus for systems change.** When multiple stakeholders agree on the same vision and carry that vision to the funders and decision-makers within a local jurisdiction, the impact of this consensus is difficult to ignore. In a democracy, policies and funding follow the public will.

- **Identify "one-time" resources that exist in every system that can be redirected to collective diversion efforts.** Because of the way human service and criminal justice systems build and defend their operating budgets, one-time funds exist in almost every system. Stakeholders can be encouraged to identify these funds and blend these resources in shared activities related to the system's integration vision.

- **Mobilize "pilot projects" that give all systems more than any one could afford.** Any single system will balk at having to pay the full cost of a multi-system, integrated jail diversion program. Additionally, in most cases, the "one-time" funds of a single system alone will be insufficient to support the operations of such a program. Yet when these resources are pooled, each system will get more for its money than it could have purchased on its own.

- **Promote multi-system ownership of pilot efforts.** Just as each system contributes some of the resources needed to mobilize diversion efforts, each system should be encouraged to claim ownership of the diversion projects. Shared ownership contributes to the synergy that results from shared funding and instills in all stakeholders a desire to see collective efforts succeed.

- **Carefully monitor and evaluate all diversion efforts.** Outcome-based evaluation of diversion efforts based on performance measures that have emerged from cross-system discussion is essential. Demonstrating the success of diversion efforts that generate positive treatment outcomes while reducing costs in the criminal justice system setting are critical to making the case for institutionalizing pilot efforts and creating more permanent programming rooted in secure, ongoing funding streams.

is compelling. For adults within the King County correctional system, active substance use is reported among 60 percent to 80 percent of those admitted to jail. Up to 15 percent of the locally incarcerated population suffer from a major mental illness, and a recent study of a random stratified King County Jail sample revealed that 23 percent of "high impact" (i.e., repeated recycling through the criminal justice, mental health and chemical dependency systems) jail inmates are diagnosed with co-occurring substance use and mental disorders.

The provision of an integrated approach to the multiple problems these populations present when they are diverted to community-based treatment and support is essential. Diversion itself helps little; diversion to appropriate services is key.

What is an Integrated System?

Systems integration occurs when there is the sharing of clients' information, planning, and resources.

- **Sharing Clients:** Multi-problem clients that traditionally receive services in only one system or receive uncoordinated care in multiple systems are shared by appropriate treatment systems and treated in a coordinated fashion (e.g. single treatment plans, multi-disciplinary teams, etc.).

- **Sharing Information:** Information about programs, services, treatment models, and clients move across the traditional lines of service delivery systems.

- **Sharing Planning:** Multiple systems engage in joint processes to plan integrated services to multi-problem clients.

- **Sharing Resources:** The resources available to multiple systems are blended and/or shared to ensure that services are configured in a way that meets the individualized needs of clients rather than the needs of the systems or providers offering care.

Finding Support for Integrated Diversion Services

The current political environment is not conducive to funding expensive projects that promote jail diversion and systems integration. In fact, the opposite is usually the case. Increasingly, taxpayer sentiment has supported increased expenditures of limited public resources to build and fill more jails rather than to provide community–based treatment and supports. In King County, 67 percent of regular county tax revenues are spent to support criminal justice system costs. To further complicate the situation, the emergence of managed care in the public sector of behavioral health care presents a unique set of challenges to the mobilization of flexible diversion programs.

The strength of the coalitions built during the strategic planning phases of diversion efforts is critical. To make diversion occur, the fourth (and perhaps most threatening) principle of integration must be brought into play: sharing resources. Although in King County no single system could afford the up-front costs of effective

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

jail diversion programming, all the systems that could potentially reap the long-term benefits of jail diversion *collectively* identified the resources required to mobilize initial projects. Each system was asked to bring to the table the resources it had available for the shared effort. "Resources" in this discussion were not limited to funds, but also included staff time, space, and the commitment to change policies and practices. A few examples illustrate the sharing of resources in the King County diversion efforts:

The Seattle Police Department: Without new staff or resources, the Seattle Police Department undertook a commitment to mobilize a Crisis Intervention Team (CIT) modeled on the Memphis, Tennessee program. A group of more than 100 volunteers from the existing ranks of the police force agreed to receive 40 hours of specialized training on dealing with persons with mental illness, drug/alcohol problems, and developmental disabilities. Training provided voluntarily by representatives of the treatment systems, consumers, and family members offered officers new skills to recognize different types of illnesses and to intervene to de-escalate potentially dangerous situations without using force or making arrests. CIT officers are now regularly dispatched to calls involving persons with mental illness with a primary goal being jail diversion. (See related story on pages 13-14.)

The County Hospital: Working with the active support of the local mental health and drug/alcohol systems, the county hospital provided the space and part of the staffing required to reconfigure an existing psychiatric emergency room into a Crisis Triage Unit capable of managing pre-booking diversion referrals made by police officers. This meant moving away from the traditional emergency room model of "treat and release" toward a strategy of "assess, intervene, and link to needed services." Staffing of the psychiatric emergency unit was increased and diversified. "Back-door" staff were added from the mental health and drug/alcohol systems to ensure the effectiveness of referral linkages for persons leaving the Crisis Triage Unit.

The King County District Court: The District Court for King County committed time and resources to mobilize a mental health court. Representatives from the court, prosecuting attorney, public defender, probation, and mental health systems all agreed to provide dedicated staffing to the mental health court. Resources from the mental health system fund balance were provided to secure treatment capacity for non-Medicaid eligible referrals from the court. Mental health system liaison staffing was provided to ensure that linkages from the court to treatment were effective.

The Mental Health and Substance Abuse Systems: Participation of these systems required a reconceptualization of the managed care paradigm from the "enemy" to that of an active partner in systems integration. The managed care system, when held accountable to its stated goal of promoting increased client choice and individualized and tailored care, can support jail diversion efforts. Systems integration advocates argued that a portion of the systems savings ("fund balance") generated by the managed care model could be reinvested in services targeting those for whom the managed care paradigm worked least well — including persons with co-occurring disorders involved in the justice system. This meant that fund balance dollars produced by the managed care process could be applied to supplementing the staffing needed to create the hospital's Crisis Triage Unit and the Mental Health Court. Additionally, clear and precise policies were embedded in the managed care system contracts requiring providers of care in the community to accept referrals from the Crisis Triage Unit and the Mental Health Court. Finally, expectations related to these initiatives were embedded in outcomes and performance indicators that stressed integration and diversion from the criminal justice system.

Importance of Disclosing "Up-Front" Investments

As systems and stakeholders initiate the process of developing and promoting integrated jail diversion programming, there are a variety of "up-front" investments that will help to ensure positive outcomes. Most of these up-front investments require minimal fiscal allocations. As these up-front investments are identified, it is important to disclose them to stakeholders. These investments include:

- *Effective placement and use of "boundary-spanner" staff at the systems and service levels.* The systems integration literature describes the potential roles and uses of boundary-spanner staff at both the systems and service levels. Such staff are critical to the success of diversion initiatives. First, staff assigned to boundary-spanning roles at the system level can help identify and bring together the stakeholders required to build consensus around a vision and momentum behind implementing action steps. Second, boundary-spanning staff at the service level provide the essential "glue" that joins the different systems for each diverted individual. These staff are central to ensuring that referrals from the police, jails, and courts actually make it to the treatment systems that will offer the greatest benefit.

- *Time commitment from key stakeholders.* Mobilizing diversion projects requires that individuals from all levels of the multiple systems involved be available for and invested in the planning process. Funders must be willing to identify "one-time" resources available for systems integration pilot projects. Policymakers must commit to reviewing and altering policies that perpetuate gaps and barriers in the system. Service providers must help identify the nuts-and-bolts issues of what will and will not work in the field. The willingness on the part of all these stakeholders to attend many meetings and remain connected to the process goes a long way to promoting success.

- *Agreement to step outside of traditional service and business paradigms:* In order to plan across multiple systems and blend local resources from different, often categorical, funding streams, all involved stakeholders must be willing to challenge the underlying

assumptions about how business is transacted and develop new and creative approaches to funding, policies and procedures.

- *Willingness to take risks:* Some pilot efforts to promote diversion will fail to produce the desired results for a variety of reasons. Failures must be re-framed as opportunities to determine how to be more effective the next time. Although not the familiar turf of most bureaucrats, risk-taking becomes easier when risks are shared across multiple systems and finger-pointing is discouraged when things do not happen exactly as planned.

- *Measurement and analysis of results:* Resources must be set aside to evaluate the results of the efforts undertaken. Without this evaluation process, the long-term security of even the most effective diversion efforts will be jeopardized. Whether these evaluation resources are identified in existing evaluation staff units or funded independently as part of the initial pilot efforts, they are a critical component of any integration activity and must not be overlooked.

- *Dissemination of findings and results:* Systems integration and diversion efforts cannot shrink from public and media relations. Letting the stakeholders and community know what you are doing and the outcomes of these efforts will help to solidify consensus around vision, goals, objectives, and programming. Negative incidents involving offenders with co-occurring disorders that receive extensive media exposure should be considered opportunities to make the case for more effective integration of services, rather than examples of yet one more time that the system has demonstrated its ineffectiveness.

Conclusion

The King County experience demonstrates when there is political will, creative vision, and invested people, significant progress can be made in creating integrated systems of care to divert individuals with co-occurring mental health and substance use disorders from the criminal justice system. Further, these experiences demonstrate that the infusion of large amounts of new money is not the key. Rather, it is a matter of joint planning, pooling resources, and more effectively managing existing resources toward new goals.

For more information about the King County program, contact David Wertheimer, Systems Integration Administrator for the King County Department of Community and Human Services, at (206) 205-1354 or e-mail: David.Wertheimer@metrokc.gov

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Jail Suicide/Mental Health Update

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

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Available Jail/Prison Suicide Prevention Materials

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

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

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