

JAIL SUICIDE/MENTAL HEALTH UPDATE

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CHARACTERISTICS OF SUICIDE ATTEMPTS IN A LARGE URBAN JAIL SYSTEM WITH AN ESTABLISHED SUICIDE PREVENTION PROGRAM*

by

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Abstract

Objective: The King County Department of Adult and Juvenile Detention in Washington State, like many jail systems across the nation, implemented a suicide prevention program in response to high suicide rates. A review committee was formed to prospectively study the patterns of suicide attempts that occurred in the system after the program was implemented and to make recommendations for improvements. **Methods:** All first suicide attempts per jail booking over a 33-month period in two of the department's jails were studied. For each attempt, characteristics of the individual and the attempt were abstracted by trained staff. **Results:** A total of 132 first suicide attempts were made by 124 individual inmates during the study period. The prevalence of mental illness among inmates who attempted suicide was 77 percent, compared with 15 percent in the general jail population. Seventy-five percent of the inmates who attempted suicide had received a mental health evaluation from jail personnel before the attempt. Suicide attempts that were made in observation units for suicidal inmates (42 percent of all attempts), particularly those made in group observation units, necessitated fewer visits to an emergency department than those that occurred in general areas of the jail. **Conclusions:** On the basis of these findings, the jails implemented interventions such as more suicide screening and treatment for inmates who have active substance abuse, greater consensus building in decisions about housing, and structural changes such as greater use of group-housing units and the use of barriers to prevent the inmates from jumping from balconies.

Introduction

Suicide is the leading cause of death in U.S. jails (1). Although the precise rate of suicide in jails is controversial, estimates range from 47 to 114 per 100,000, which is 9 to 14

times higher than the rate in the general population (2). Factors that make jails a particularly high-risk environment include the large proportion of inmates who have mental illness, the high rate of enforced withdrawal from alcohol and drugs, and the traumatic effect that criminal conviction and incarceration have on an inmate's personal life. Furthermore, the transient nature of the jail population adds complexity to the identification of high-risk individuals (2-6).

Over the past decade, growing attention has been paid to the effectiveness of suicide prevention programs in jails. Studies have documented reductions in the number of suicide attempts and deaths in systems in which prevention programs have been implemented (1, 2, 4). The King County Department of Adult and Juvenile Detention in Washington State adopted a suicide surveillance and prevention program in 1991. The prevention program, consistent with other programs described in the literature, includes training for correctional officers and health professionals, intake screening, psychiatric evaluation for at-risk inmates, communication among staff, special safe-housing units, observation of inmates by officers, medical intervention procedures, and a review of completed suicides (3, 6, 4). These efforts have helped reduce the number of suicide deaths in this jail system.

However, suicide attempts continue to occur. Such attempts, especially among individuals who were not prospectively identified as being at risk, pose a formidable challenge for jails, which are charged not only with keeping inmates safe but also with minimizing liability. As part of an effort to further improve the suicide prevention program, a quality improvement committee was

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formed in the Department of Adult and Juvenile Detention to examine the characteristics of inmates who attempted suicide in the county jail system and to make recommendations for actions to be taken. This article summarizes the major findings from that process.

Methods

Setting: The King County Department of Adult and Juvenile Detention manages several correctional facilities in King County, Washington, the two largest of which are the King County Correctional Facility in downtown Seattle and the Regional Justice Center in the city of Kent in south King County, which was opened in April 1997. Both facilities are accredited by the National Commission on Correctional Health Care. About 60,000 individuals are booked into the two jails each year. The average daily population increased from 1,875 in 1996 to 2,266 in 1999. Most of the inmates housed in these facilities have been charged and are awaiting or undergoing trial, have been convicted and are awaiting sentencing, or are serving sentences of up to a year. A small proportion of inmates are held while awaiting transfer to other facilities.

Medical staff are available 24 hours a day at both jails. Although most direct patient care occurs at on-site clinics, the jails have special units for inmates who are mentally ill, who are under suicide observation, or who need acute medical services, including treatment for problematic alcohol or drug withdrawal. Inmates who experience life-threatening emergencies or who need specialized medical services are referred to one of two local hospitals.

As each inmate is booked into jail, health-trained correctional staff members use an intake screening form to obtain medical, psychiatric, substance abuse, and pregnancy histories. Any inmate who is found to have a psychiatric history or psychiatric symptoms, who is found to have significant health complaints, or who appears to be disoriented, agitated, or obtunded is referred immediately to medical personnel. On the basis of this initial screening procedure, about 15 percent of all inmates are referred to the jail's psychiatric staff for a mental health evaluation.

Master's - or doctoral-level psychiatric evaluation specialists or trained psychiatric nurses are available 24 hours a day for the immediate evaluation of inmates who are identified as having mental health problems or who are exhibiting suicidal warning signs. The purpose of the evaluation is to assess the inmate's symptoms and to generate an accurate diagnostic impression that will guide therapeutic decisions.

Central to the evaluation is the completion of a standard form that includes detailed questions about psychiatric history and hospitalizations, questions about medications, and a thorough assessment of current and past suicidal behavior. The form also includes questions about drug and alcohol abuse, a detailed social history, and whether the inmate has a case manager. Finally, a mental status examination is performed. On the basis of these findings and a review of the inmate's medical record (if one exists), a diagnosis is made and a therapeutic plan implemented. The principal decisions made at this juncture are whether the

inmate requires housing in a special psychiatric unit for mental health reasons or because of suicidality or whether the inmate is a suitable candidate for placement in a general area of the jail. About half of inmates who are initially evaluated are housed in one of several mental health units, and the other half are considered fit to be housed in the general areas. Inmates who are housed in general areas are considered to have stable mental health conditions that are manageable through the jail's psychiatric clinic, and their risk of suicide is considered comparable to that of the general jail population.

About 27 percent of inmates housed in the psychiatric unit are under suicide observation, either in a group-housing unit or in an individual cell. Those who require housing in individual cells are checked on by a correctional officer at least every 15 minutes. Those who are housed in a group unit are in plain view of a correctional officer who is stationed about 20 feet away. On a regular basis, the mental health team reviews the cases of inmates who are under suicide observation to decide whether they need to continue in special housing or whether it is appropriate to move them to a general area. About half of the inmates who are initially placed under suicide observation are subsequently moved to a general area of the jail.

Data collection and analysis: Psychiatric staff at the two jails collected data on all suicide attempts during the 33-month period from October 1, 1996, to June 30, 1999. "Suicide attempt" was defined as any self-harm incident brought to the attention of medical staff that was linked with an inmate's expressed intent to commit suicide. We did not try to differentiate between "real" suicide attempts and "gestures" (manipulative, attention-getting acts) as defined in a 1984 Special Commission on Detention Suicides in Massachusetts (7), because there is evidence that the characteristics of inmate behavior are similar between lethal and nonlethal attempts (8) and that the presence of a manipulative component does not distinguish life-threatening events from medically insignificant ones, especially among incarcerated persons (7).

After each suicide attempt, psychiatric staff at the two jails collected data from the inmate's medical record and officers' logs. Basic demographic information; medical, psychiatric, and substance abuse history; housing status; characteristics of the suicide attempt; and whether transportation to a local hospital emergency department was required were abstracted and entered into a Microsoft Access database and analyzed with SPSS, version 7.5.1. Only first attempts during a single incarceration episode were included in the analysis to avoid the bias associated with the small number of inmates who made multiple attempts during an incarceration.

The primary analysis consisted of a comparison of the characteristics of inmates and suicide attempts by suicide observation status: inmates who had received a psychiatric evaluation before the attempt and who were under suicide observation at the time of the attempt, inmates who received a psychiatric evaluation before the attempt but who were not under suicide observation at the time of the attempt, and inmates who had not received a psychiatric evaluation before the attempt and who thus were not under suicide observation at the time of the

attempt. Patient identifiers were encoded before analysis. The study was approved by the University of Washington’s institutional review board in December 2000.

Results: Between October 1996 and June 1999, a total of 158 known suicide attempts were made in the King County Correctional Facility and the Regional Justice Center. The rate of suicide attempts in this series was calculated as 22 attempts per 1,000 average daily population per year, which was comparable to a rate calculated for the jails in South Carolina between 1985 and 1989 (9,10). The 158 attempts were made during 132 separate incarcerations by 124 individual inmates. Nineteen inmates (15 percent) accounted for 34 percent of all attempts. The subsequent analysis was restricted to the 132 first attempts made during an incarceration.

During the study period, two suicide deaths occurred. In both cases the inmates were known to be at high risk of suicide and were under suicide observation at the time of the incident. One inmate had made repeated threats over many months but had not made any actual suicide attempts until the one that resulted in death. Because this was a first attempt during the incarceration, it was included in the analysis. The second inmate had made an attempt several days before the completed suicide. Only the first, nonfatal attempt was included in the analysis.

Table 1 summarizes the demographic, clinical, and other characteristics of the inmates who attempted suicide. The average age of inmates who attempted suicide was 31.5 ± 8.7 years. Eighty (61 percent) of the 132 incarcerations involved a felony charge. These characteristics were not significantly different from those of the general jail population, for whom the average age was 29.5 years and of whom 64 percent had been charged with a felony. Women constituted a higher proportion of inmates who attempted

suicide (24 inmates, or 18 percent) than of the general jail population (12 percent).

Inmates who attempted suicide were much more likely to have a chronic psychiatric problem than inmates in the general jail population (102 inmates, or 77 percent, compared with 15 percent.) However, the proportion of inmates with a chronic medical condition (54 inmates who attempted suicide, or 41 percent, compared with 40 percent in the general jail population) or a history of substance abuse (84 inmates, or 64 percent, compared with 60 percent) was similar. Fifty suicide attempts (38 percent) occurred within three days of incarceration, and 37 (28 percent) occurred more than 30 days after incarceration. Only 14 percent of inmates in the general jail population stayed in jail longer than 30 days.

Fifty-five of the 132 suicide attempts (42 percent) were made by inmates who were under formal suicide observation at the time of the attempt. The remaining 77 attempts (58 percent) were made by inmates who were housed in a general area of the jail. No significant differences were noted in age, sex, or type of charge between the three suicide observation categories.

Inmates who had not received a psychiatric evaluation before their suicide attempt and therefore were not candidates for suicide observation tended to have higher rates of substance abuse and opiate withdrawal than those who had received a psychiatric evaluation, although these differences were not significant. Among the inmates who had received no psychiatric evaluation before their suicide attempt, 39 percent had a chronic psychiatric problem, a rate far greater than that found in the general jail population (15 percent). In the course of psychiatric evaluations of these individuals after their suicide attempt, about 21 percent were found to have made a previous attempt.

TABLE 1
Characteristics of Inmates in 132 Suicide Attempts, Categorized by the Inmate’s Suicide Observation Status

Variable	Mental Health Evaluation Previously Conducted				Mental Health Evaluation Not Previously Conducted		X<+>2<P>df
	Under Suicide Observation (N=55)		Not Under Suicide Observation (N=44)		N=33		
	N or Mean	%	N or Mean	%	N or Mean	%	
Age (mean ± SD years)	31.6±8.7		30.8±8.9		32.7±8.7		
Sex, male	43	78	39	89	26	79	
Felony charge ^a	33	61	31	71	16	50	
History of substance abuse	31	56	28	64	25	76	
Opiate withdrawal	9	16	5	11	9	27	
Chronic medical problem	25	46	15	34	14	42	
Chronic psychiatric problem	51	93	38	86	13	39	36.51** 2
Previous suicide attempt							
Yes	31	56	16	36	7	21	
No	8	15	13	30	13	39	
Unknown	16	29	15	34	13	39	12.54* 4

^aData available for 54 inmates under suicide observation and 32 inmates who had not received a mental health evaluation.

*p<.05

**p<.001

TABLE 2
Characteristics of 132 Suicide Attempts, Categorized by the Inmate's Suicide Observation Status

Variable	Mental Health Evaluation Previously Conducted				Mental Health Evaluation Not Previously Conducted		X<+>2<P>df
	Under Suicide Observation (N=55)		Not Under Suicide Observation (N=44)		N=33		
	N	%	N	%	N	%	
Time Since Incarceration							
Less than three days	22	40	8	18	20	61	
Three to 30 days	18	33	19	43	8	24	
More than 30 days	15	27	17	39	5	15	14.84** 4
Suicide Method							
Cutting or head banging	21	38	14	32	4	12	
Overdose	3	6	9	21	8	24	
Hanging	7	13	8	18	8	24	
Jumping	0	---	3	7	2	6	
Strangulation	23	42	9	21	11	33	
Other	1	2	1	2	0	---	20.28* 10
Death	1	2	0	---	0	---	

*p<.05
**p<.001

Table 2 summarizes the characteristics of the 132 suicide attempts. Forty percent of attempts made by inmates who were housed in a suicidal observation unit occurred within the first three days of incarceration. In the case of inmates who received a mental health evaluation before their suicide attempt but who were not under suicide observation, only 18 percent of attempts occurred within the first three days, which suggests that this group of inmates were in fact at lower risk. In contrast, for inmates who had not previously received a mental health evaluation, 61 percent

of the attempts occurred during the first three days. Inmates who were under suicide observation made fewer attempts by overdose, hanging, and jumping from a second-floor balcony than those who were not under observation, which probably reflects differences in the availability of self-harm options.

The suicide method in attempts that led to transportation to a local hospital emergency department, along with statistics

TABLE 3
Suicide Attempts that Necessitated Transportation to an Emergency Department Categorized by the Inmate's Suicide Observation Status

Variable	Mental Health Evaluation Previously Conducted				Mental Health Evaluation Not Previously Conducted		X<+>2<P>df
	Under Suicide Observation (N=55)		Not Under Suicide Observation (N=44)		N=33		
	N	%	N	%	N	%	
Transported to Emergency Department ^a	15	27	25	57	19	59	12.14** 2
Suicide Method ^b							
Cutting or head banging	6	29	4	29	4	100	7.96* 2
Overdose	2	67	8	89	8	100	
Hanging	5	71	6	75	5	71	
Jumping	0	---	2	67	1	50	
Strangulation	2	9	4	44	1	9	6.63* 2
Other	0	0	1	100	0	---	

^aData available for 32 inmates who had not received a mental health evaluation.

^bThe total numbers of attempts involving each method are listed in Table 2.

*p<.05
**p<.001

indicating the relationship between them, are detailed in Table 3 for each suicide observation category. Attempts that were made in an observation unit were associated with a significantly lower rate of transportation to an emergency department than attempts that were made in a general housing area.

To examine the relationship between suicide attempts and isolation units, we restricted the analysis to inmates who were under formal suicide observation at the time of their suicide attempt. During the study period, these inmates were housed in one of two ways. About a third of all suicidal inmates were housed in a group observation unit, and the remaining two-thirds were housed in isolation units where a correctional officer performed a visual check at least every 15 minutes.

Of the 55 attempts made by inmates who were under suicide observation, seven (13 percent) were made by inmates who lived in group housing, and 48 (87 percent) were made by inmates who were in isolation units. Only one (14 percent) of the seven attempts in the group observation unit resulted in transportation to the emergency department, whereas 14 (29 percent) of the 48 attempts that occurred in the isolation cells necessitated transportation to the emergency department.

Discussion

The characteristics of the suicide attempts in this study differed from those in studies that used data collected in the 1980s. These older studies showed that suicidal inmates in jails and lockups tended to be younger white men without psychiatric histories who were intoxicated when they were arrested for minor charges and who committed suicide by hanging within the first 24 hours of incarceration (3, 6, 11). The findings of more recent studies of suicide in urban jails have been consistent with our findings — that is, that chronic mental illness is common among inmates who attempt suicide and that the timing of their attempts ranges from days to months after incarceration (1, 2, 4, 12). These differences may reflect a growing proportion of inmates who are mentally ill (13) or may be the result of suicide prevention programs that are better able to prevent early suicide attempts or the result of differences in the environments (jails versus lockups) that have been documented in the literature (2, 3, 14).

This review of consecutive suicide attempts showed that a majority of at-risk inmates at these urban jails were successfully identified, screened, and triaged. The mortality rate associated with suicide attempts was well below published norms for jails that do not have prevention programs (3) and was comparable to the rate observed in New York State, which has a well-documented suicide prevention program (4). Despite these encouraging findings, this process highlighted the persistence of a high-risk and vulnerable population of individuals entering the jails and identified opportunities for continued improvement.

Of major concern is the finding that 25 percent of the inmates who attempted suicide had not received a mental health evaluation. About 40 percent of these inmates had a psychiatric history, and a disproportionately large number had active

substance abuse. Targeting services for this group of individuals is extremely difficult; by definition, they do not identify themselves as suicidal and generally do not exhibit disturbing behavior before their attempt.

To better identify and manage this group of suicidal inmates, three significant interventions have been put in place. First, there has been a greater effort to conduct mental health screenings for persons who are intoxicated or experiencing withdrawal. Second, efforts have been made to improve communication between local mental health providers and jail health providers, primarily through greater use of telephone- and fax-based notification systems. Finally, new policies that allow the use of methadone maintenance therapy have been promoted in response to the numerous medical, psychiatric, and behavioral consequences of enforced withdrawal from opiates upon entry to the jails.

The use of methadone in the jail system represents a series of policy decisions that have required collaboration between public health and correctional officials, the jail health team, and local methadone maintenance services. Inmates with opiate addictions who elect to receive methadone while they are in jail will, at a minimum, not lose their place on the waiting list for methadone treatment centers, and some will be given priority status for services when they are released. These interventions have led to a heightened awareness among correctional and health staff of the connection between substance use and suicide risk.

We also noted that about a third of the inmates who attempted suicide had received a psychiatric evaluation but were not under suicide observation at the time of the attempt. To address this problem, efforts to improve the accuracy of the screening process have been pursued. These efforts have included a greater degree of team consensus in decisions about housing for inmates whose cases are challenging and an expansion of educational programs focused on suicide prevention in the jails.

In this study we also examined the role of isolation among these suicidal inmates. The literature is replete with observations on the value of housing suicidal inmates together or in proximity to inmate observation aides (1, 3, 15). Such arrangements arguably provide for additional observational capacity and create opportunities for much-needed social association. However, Felthous (14) has urged caution in examining the apparent relationship between isolation and suicides in jail on the grounds that causality cannot be confirmed.

Often isolation is the mechanism of choice for managing an already suicidal and self-destructive inmate. On balance, however, the existing literature and the findings of this study support the value of group-housing units for appropriate candidates. At the time of the study, it was possible to house a maximum of 20 suicidal inmates together. At the time of writing, capacity has been expanded to allow up to 33 inmates (23 men and ten women) to be housed, and further expansion is planned.

Finally, to address the problem of inmates' jumping off second-floor balconies, acrylic barriers have been erected in the areas of the jails in which suicidal inmates are housed or managed. These areas include the psychiatric housing units, the medical infirmary, and the clinic.

This intervention should virtually eliminate the risk that inmates will jump during transportation or when cell doors are opened.

Conclusions

This study has outlined a series of steps taken by two urban jails to identify the characteristics of suicide attempts in a system that has an established suicide prevention program and to make improvements where possible. It is hoped that these interventions will enable the number and severity of suicide attempts to be reduced further. The interventions were achieved through a quality-improvement process involving collaboration between correctional and health care staff.

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GIBSON V. COUNTY OF WASHOE (NV) ET AL: A PLAINTIFF VERDICT WITH A SURPRISING TWIST

Stephen Gibson suffered from manic depressive disorder. On February 3, 1996, he was arrested by police in Reno, Nevada on several charges, including reckless driving and resisting arrest. He was transported to the Washoe County Jail and, because of his combative and uncooperative behavior, Mr. Gibson was not medically screened by the jail nurse. Following the booking process, he was forcibly carried in restraints to a holding cell. During the next several hours, Mr. Gibson continued to exhibit loud and combative behavior. He slipped out of his waist chain and banged it against the cell door window. When deputies entered the cell to again restrain him, Mr. Gibson began fighting with them. He was then pepper-sprayed, restrained and forcibly moved to a special watch cell that contained leather restraints and a helmet. Tragically, during the struggle with deputies, Mr. Gibson lost consciousness and died. The medical examiner later ruled that the cause of Mr. Gibson's death was severe arteriosclerosis or, in essence, he suffered a heart attack during his struggle with deputies.

Mr. Gibson's family filed a lawsuit in federal court against Washoe County and various deputies, and the trial court granted summary judgment in favor of the defendants. However, on May 22, 2002, the United States Court of Appeals for the Ninth District ruled that although the deputies were not individually liable for Mr. Gibson's death, Washoe County was deliberately indifferent because their policy of failing to screen detainees for health risks posed a substantial risk of serious harm to Mr. Gibson. Based on his behavior, a reasonable jury could infer that Washoe County knew he suffered from mental illness and chose to ignore it. The

case, *Gibson v. County of Washoe, Nevada* [290 F.3rd 1175 (9th Cir. 2002)], is reprinted below.

Before: Stephen Reinhardt, A. Wallace Tashima and Marsha S. Berzon, Circuit Judges.

BERZON, Circuit Judge:

On February 3, 1996, Stephen Gibson suffered a heart attack and died while in the custody of the Washoe County, Nevada, Sheriff's Department. Gibson's wife Michelle ("Ms. Gibson") brought this lawsuit under 42 U.S.C. § 1983, on behalf of herself, their two children, and Gibson's estate, against the County, the sheriff, and a number of the sheriff's deputies who were on duty at the Washoe County jail the night Gibson died. Ms. Gibson contended in the district court that the County and the individual defendants violated Gibson's substantive due process rights by the manner in which they treated him on the night he died. She now appeals from the district court's grant of summary judgment for the defendants. We affirm with regard to the individual officers and, in part, with regard to the County. We conclude, however, that summary judgment was improperly granted on the question whether the County was deliberately indifferent to Gibson's mental illness while he was in custody at the county jail.

Because this appeal follows a grant of summary judgment for the defendants, review is de novo. To determine whether there is a genuine issue of material fact, we take into account all the reasonable inferences that favor the non-moving party. *Villiarimo v. Aloha Island Air, Inc.*, 281 F.3d 1054, 1061 (9th Cir. 2002).

I. Background

A. Gibson's Death

1. The "Attempts To Locate"

Stephen Gibson suffered from manic depressive disorder. He had been hospitalized several times for the disorder from 1991 until his death in 1996, and was in the regular care of a psychiatrist, Dr. Tanenbaum, at the time of his death. Dr. Tanenbaum prescribed medications to help Gibson control his illness.

In late January 1996, Gibson was entering a manic phase. Early on the morning of Wednesday, January 31, he was pacing agitatedly through his home, pointing his gun at the walls and twirling a large knife in his hands. Gibson then packed his clothes and left the house, refusing to tell Ms. Gibson where he was going. When she suggested that he take one of the sedatives that he often used during his manic phases, he told her to shut up and said that he would "take her up to the mountains." Interpreting this statement as a threat to her safety, Ms. Gibson packed her things, gathered the children, and went to her in-laws' home. Ms. Gibson also contacted West Hills Hospital to make arrangements for Gibson's admission.

Over the next two days, Ms. Gibson called the police several times — once in the company of Dr. Rich, the psychiatrist on call at West Hills — in an effort to find Gibson and have him taken to the hospital. Four dispatches were broadcast over the Reno and Washoe County police frequencies [1]:

On February 1 at 9:33 pm, a notice was broadcast, providing Gibson's name and description and describing him as missing and endangered. The broadcast stated that Gibson was "a manic depressive on several medications, [reported] to have a loaded 10-32 with him and does not like police officers."

On February 2 at 3:58 pm, an "attempt to locate" ("ATL") dispatch was broadcast, stating that Gibson was manic depressive, had threatened to kill his wife, and might be armed with a gun or knives.

At 5:15 pm that same day, another ATL was broadcast, describing Gibson and stating that, in accord with the directions of his doctor, Dr. Rich, he should be brought to West Hills Hospital for emergency commitment. This ATL was rebroadcast at 10:39 pm.

2. The Arrest

Just after 3:00 am on February 3, Washoe County deputies Anthony Miranda and Richard Hodges encountered Gibson outside a convenience store. Gibson left his truck running with the lights on and the driver's door open while he went into the store. Miranda followed him inside. Gibson bought a beer, a cup of coffee, and a pack of cigarettes, and as he paid for them, flung his change across the counter past the cashier. Miranda thought Gibson might be drunk, but smelled no alcohol on him.

Gibson left the store and continued to behave strangely. He wandered around the parking lot near his truck for about 20 minutes and returned to the store several times. Gibson eventually got into the truck, which did not have license plates, and drove away. The deputies, who believed that Gibson was possibly driving under the influence of alcohol or drugs, observed Gibson attempt to turn out of the parking lot, then back up and try the turn again, this time successfully. Gibson then drove out of the deputies' sight. The deputies left the parking lot and caught up with Gibson, in time to observe him drive straight through an intersection from a left-turn lane. The deputies then radioed dispatch that they were stopping a possible DUI driver and pulled Gibson over. Although Gibson promptly stopped, he refused to turn off the ignition or to leave the truck when the deputies requested him to do so.

Because Gibson refused to get out of the truck, Hodges opened the driver's door, grabbed Gibson's arm, and pulled him from the truck. Although he was shouting obscenities and yelling that the police were going to plant something in his truck, Gibson then became physically cooperative, stepping toward the patrol car with his hands on his head as directed.

Hodges administered a field sobriety test. Gibson was adamant that he had not been drinking, but agreed to the test, peppering the officers with obscenities all the while. Gibson's behavior made administration of the test difficult. Finally, after Gibson told Hodges to "shut the f___ up," the deputies had enough, and placed Gibson under arrest.

Miranda and Hodges had not heard the ATL about Gibson when it was broadcast earlier that evening. During the course of the arrest, the deputies called in to their dispatcher to check Gibson's name

and the truck's registration against various crime databases. Although the dispatcher performed these checks and reported back to the deputies, the dispatcher did not notify the deputies that Gibson was the subject of an outstanding ATL directing that Gibson be taken to West Hills for emergency commitment.

When Hodges searched Gibson's truck after the arrest, he located several prescription medication containers with Gibson's name on the label. Although he did not recognize the names of the drugs, Hodges suspected that they were "psych meds," and that Gibson might not be taking his medication.

During the arrest, Gibson was physically cooperative with the deputies as they handcuffed him, but continued to swear at them. After the deputies put Gibson in the patrol car and headed for the Washoe County jail, however, Gibson became physically combative, kicking the partition between the car's front and back seats. The deputies called ahead to the jail to notify the officers there that they were bringing in a combative suspect.

3. The Jail

When Deputies Miranda and Hodges arrived at the Washoe County Jail with Gibson, he refused to get out of the patrol car. Four deputies pulled Gibson from the car and carried him into the jail's sally port, the vestibule to the jail's booking area where incoming arrestees are searched. There, they placed Gibson face down on the floor. As the officers searched Gibson, he repeatedly called out, "Help me, Jesus." The officers restrained Gibson with a waist chain, wrist chains, and leg irons, and dragged him through the booking area. After Gibson was photographed and booked, the officers placed him, alone, in a holding cell.

Meanwhile, Hodges and Miranda completed their paperwork, and, consistently with County policy, delivered the drug containers Hodges found in Gibson's truck to the nurse on duty. The nurse confirmed to Deputy Miranda that the medications were to stabilize somebody who was suffering from mental illness. As far as the record shows, however, no one else on duty at the jail that night was told about the likelihood that Gibson suffered from a mental illness, and, aside from conclusions that could be drawn from Gibson's behavior, no one else had reason to suspect that Gibson so suffered.

Twice during the night, Gibson slipped out of his waist chain. The first time, the deputies on duty entered Gibson's cell and replaced the chain with little difficulty. Later, around 6:00 in the morning, Gibson slipped out of the chain again, and banged it repeatedly against the window in his cell door. This time, Sgt. John Williams, who was in charge that night, decided that Gibson should be further restrained. As several deputies readied to enter the holding cell, Gibson assumed a fighting stance with his fists up and shouted obscenities at them.

Because Gibson was so difficult to control, Williams then gave the order to transfer him to a special watch cell containing a bench with attached soft restraints and a helmet. Williams opened the cell door as Deputy Robert Bowlin quickly sprayed Gibson in the face with pepper spray. The officers shut the cell door as Gibson fell to his knees, screaming that the spray was burning him.

Deputies Bowlin, Scott Thomas, and Robert Cook entered the holding cell and grabbed Gibson; the three officers held Gibson down, while more deputies came to help take Gibson from the holding cell.

Several deputies dragged Gibson into the special watch cell and shifted him up onto the bench. As Gibson lay face down on the bench, Deputies Michelle Youngs and Mary Jean Cloud climbed onto his back and legs, while the other deputies helped restrain his arms and legs. Gibson continued to struggle. In Deputy Jeremy Wormington's words:

We put him on his stomach. And he was still at this point kicking and screaming and fighting and everything and yelling at us and he was, for being pepper sprayed twice.....this guy had an incredible amount of fight in him. I mean just huge amount of fight....cause here were are, at this time, I don't remember how many deputies were on him, but I was trying to control his head, his left shoulder blade, his left forearm, and I remember Deputy Cloud was right to my right on his back and he like jumped, I mean lifted himself off the bed.....I mean, this guy was fighting. And all of a sudden for some reason I looked at his head and I looked at Cloud and we looked down and Cloud's like, 'Get a pulse.'

An on-site paramedic and several of the deputies immediately administered CPR. Several minutes later, a team of paramedics arrived and took Gibson to St. Mary's Hospital, but Gibson never revived.

According to an autopsy report, the immediate cause of Gibson's death was severe arteriosclerosis, a disease of which neither he nor Ms. Gibson had been aware. The defendants' medical expert testified that the "entire milieu" of Gibson's uncontrolled manic state and the officers' efforts to restrain him "resulted in a physiologically stressful state for Mr. Gibson, which essentially resulted in a heart attack."

B. The County's Policies

Washoe County has numerous detailed, written policies and procedures concerning the intake of detainees at the jail. Most pertinent here are those policies and procedures relating to the medical evaluation of incoming detainees. (Other policies are described later in this opinion.)

First, upon bringing an arrestee into the sally port, a deputy must "visually assess the prisoner...for any obvious signs of sickness or injury requiring medical attention." The jail's nursing staff also evaluates "all inmates, upon arrival, for any obvious signs of sickness or injury requiring immediate medical attention." [2] The medical screening process to be conducted by a medical staff member consists of several steps: a visual assessment of the inmate, filling out a medical questionnaire, completion of a suicide prevention screening form, and completion of a treatment consent form. If the jail is unable to provide the medical care that a prisoner needs, the medical staff may reject the prisoner, and the prisoner will be taken to a hospital. However, this "Medical Screening process will be delayed if the inmate is combative,

uncooperative or unable to effectively answer questions due to intoxication.”

Second, “[i]f the prisoner has prescription medication, the intake nurse will be requested to evaluate the medication and make a determination whether the medication is placed in secured property or in the Infirmary for follow up care.”

In addition, County policy requires that the jail’s medical unit be staffed twenty-four hours a day by licensed medical personnel. The medical staff has sole responsibility for determining if “the prisoner is accepted or refused into the facility due to medical reasons.” Until 1995, the County also had employed, through the state’s institution for the criminally insane, a full-time clinical mental health worker at the jail to perform mental health screenings of inmates. From 1995 until 1999, however, there was no mental health worker at the county jail to perform this function, because of a soured relationship between the jail’s medical staff and the mental hospital. At the time that Gibson died in the County’s custody, consequently, the County did not screen detainees at the jail. The mental health evaluation service resumed in 1999 after, in Sheriff Kirkland’s words, the sheriff’s department “patch[ed] up those bad feelings.”

II. This Litigation

Ms. Gibson, on behalf of herself, her husband’s estate, and her children, filed a complaint under 42 U.S.C. § 1983 against Washoe County, and, in their official and individual capacities, the county sheriff, the chief deputy sheriff, a supervising sergeant, and several deputies who were on duty at the jail the night that Gibson died.[3] She alleged three causes of action: (1) that the individual deputies used excessive force on Gibson in violation of his due process rights; (2) that the individual deputies showed deliberate indifference to Gibson’s serious mental health condition in violation of his substantive due process rights; (3) that the individual deputies’ actions resulted from policies, practices or customs of the Washoe County sheriff’s department, and these policies, practices or customs caused and/or contributed to Gibson’s death, in violation of his due process rights. [4]

In addition to the County policies described above, Ms. Gibson asserted that several other policies contributed to Gibson’s death. She contended that the lack of a system for communicating outstanding ATL’s from one shift to another, and from deputies on patrol to deputies or medical staff at the jail, revealed deliberate indifference to the constitutional rights of the mentally ill. Ms. Gibson also argued that the County failed adequately to train its deputies in recognizing and handling mentally ill individuals whom they encountered in the course of their duties.

The district court referred the disposition of the defendants’ motion for summary judgment to a magistrate judge, who recommended granting the motion as to all of Ms. Gibson’s claims. First, the magistrate judge determined that the inadequacies in communicating ATL’s could not give rise to a constitutional violation because the county lacks any duty to provide competent emergency services to the general public, citing *DeShaney v. Winnebago County Dept. of Soc. Servs.*, 489 U.S. 189 (1989). Second, citing *City of Canton v. Harris*, 489 U.S. 378 (1989), the

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

magistrate judge concluded that Ms. Gibson's allegations that the County failed adequately to train its sheriff's deputies in recognizing and dealing with mentally ill individuals lacked merit. There was no evidence of a pattern of constitutional violations resulting from failure to recognize detainees' mental illnesses, the magistrate judge concluded, nor was the need to train deputies in recognizing and dealing with mentally ill individuals "so obvious" that the failure to do so was likely to result in constitutional violations. Third, characterizing Gibson's serious health condition not as his mental illness but as his severe heart disease, the magistrate concluded that the individual defendants did not show deliberate indifference to his health. Finally, the magistrate judge rejected the contention that the individual defendants had used excessive force in moving Gibson from his holding cell and restraining him in the special watch cell.

After considering and rejecting Ms. Gibson's objections to the magistrate's report and recommendation, the district court granted the defendants' motion for summary judgment. Ms. Gibson appeals.

III. Analysis

County Liability

A municipality may be held liable under a claim brought under § 1983 only when the municipality inflicts an injury, and it may not be held liable under a respondeat superior theory. *Monell v. New York City Dept. of Social Services*, 436 U.S. 658, 694 (1978).

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.hhpublish.com/journals/crisis/1997>

<http://www.nicic.org/pubs/jails.htm>

<http://www.nicic.org/pubs/prisons.htm>

http://www.ncjrs.org/html/ojdp/jjnl_2000_4/sui.html

<http://www.performance-standards.org/resguides.htm>

<http://www.gainsctr.com>

A. Two Paths to County Liability

At least two routes can lead to the conclusion that a municipality has inflicted a constitutional injury. First, a plaintiff can show that a municipality itself violated someone's rights or that it directed its employee to do so. *Board of County Comm'rs of Bryan County v. Brown*, 520 U.S. 397, 404 (1994). Alternatively, in limited situations, a plaintiff can demonstrate that a municipality is responsible for a constitutional tort committed by its employee, even though it did not direct the employee to commit the tort. *Id.*, at 406-7; *Canton*, 489 U.S. at 387.

Under one route to liability, a municipality may be liable under § 1983, just as natural persons are, because when Congress enacted § 1983 it "intend[ed] municipalities and other local government units to be included among those persons to whom § 1983 applies." [5] *Monell*, 436 U.S. at 689. To show that the municipality violated someone's rights or instructed its employees to do so, a plaintiff can prove that the municipality acted with "the state of mind required to prove the underlying violation," just as a plaintiff does when he or she alleges that a natural person has violated his federal rights. *Board of County Comm'rs*, 520 U.S. at 405. Examples of this direct path to municipal liability include: a city's policy of discriminating against pregnant women in violation of the Fourteenth Amendment, *Monell*, 436 U.S. 658; a policymaker's order to its employees to serve capias [6] in violation of the Fourth Amendment, *Pembauer v. City of Cincinnati*, 475 U.S. 469 (1986); and a county policy that policymakers know will place aggressive and passive homosexuals in the same jail cell in violation of the passive homosexual's Fourteenth Amendment right to personal security. *Redman v. County of San Diego*, 942 F.2d 1435 (9th Cir. 1991) (en banc). [7]

Under a second route to municipality liability, a plaintiff need not allege that the municipality itself violated someone's constitutional rights or directed one of its employees to do so. Instead, a plaintiff can allege that through its omissions the municipality is responsible for a constitutional violation committed by one of its employees, even though the municipality's policies were facially constitutional, the municipality did not direct the employee to take the unconstitutional action, and the municipality did not have the state of mind required to prove the underlying violation. *Canton*, 489 U.S. at 387-89. However, because *Monell* held that a municipality may not be held liable under a theory of respondeat superior, a plaintiff must show that the municipality's deliberate indifference led to its omission and that the omission caused the employee to commit the constitutional violation. *Id.* at 387. To prove deliberate indifference, the plaintiff must show that the municipality was on actual or constructive notice that its omission would likely result in a constitutional violation. *Farmer v. Brennan*, 511 U.S. 825, 841 (1994). Compared to the more direct route to municipal liability discussed above, "much more difficult problems of proof" are presented in a case where a city employee acting under a constitutionally valid policy violated someone's rights. *Board of County Comm'rs*, 520 U.S. at 406.

As the record now stands in the case currently before the court, Ms. Gibson may be able to demonstrate municipal liability under either route described above. There is evidence from which a jury could properly conclude that the County itself violated Gibson's rights under

the Constitution. In addition, there is also evidence from which a jury could properly conclude that the County's failures to act caused its employee to violate Gibson's rights, and that those failures amounted to deliberate indifference under *Canton*.

B. The First Route to Municipal Liability

In considering whether a municipality itself violated a person's rights or directed its employee to do so, the focus is on the municipality's "policy statement, ordinance, regulation, or decision officially adopted and promulgated by that body's officers." *City of St. Louis v. Praprotnik*, 485 U.S. 112, 121 (1988) (quoting *Monell*, 436 U.S. at 690). In this case, drawing all reasonable inferences from the record in favor of Ms. Gibson, we conclude that the County's policies and procedures regarding medical evaluations of incoming detainees violated Gibson's constitutionally protected right to receive medical care while in the custody of the County. Before explaining why the policies violated this right, we first describe the right in more detail.

1. The Right to Medical Care While in Custody

Ms. Gibson alleges that the County violated Gibson's right to receive adequate medical care while in the custody of the County. Because Gibson had not been convicted of a crime, but had only been arrested, his rights derive from the due process clause rather than the Eighth Amendment's protection against cruel and unusual punishment. *Bell v. Wolfish*, 441 U.S. 520, 535 (1979); *Frost v. Agnos*, 152 F.3d 1124, 1128 (9th Cir. 1998); *Carnell v. Grimm*, 74 F.3d 977, 979 (9th Cir. 1996).

With regard to medical needs, the due process clause imposes, at a minimum, the same duty the Eighth Amendment imposes: "persons in custody ha[ve] the established right to not have officials remain deliberately indifferent to their serious medical needs." *Carnell*, 74 F.3d at 979. This duty to provide medical care encompasses detainees' psychiatric needs. *Cabrales v. County of Los Angeles*, 864 F.2d 1454, 1461 (9th Cir. 1988), *vac'd*, 490 U.S. 1087 (1989), *opinion reinstated*, 886 F.2d 235 (9th Cir. 1989), *cert. denied*, 494 U.S. 1091 (1990); see also *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983); *Ramos v. Lamm*, 639 F.2d 559, 574 (10th Cir. 1980). In order to comply with their duty not to engage in acts evidencing deliberate indifference to inmates' medical and psychiatric needs, jails must provide medical staff who are "competent to deal with prisoners' problems." *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982).

Under the Eighth Amendment's standard of deliberate indifference, a person is liable for denying a prisoner needed medical care only if the person "knows of and disregards an excessive risk to inmate health and safety." [8] *Farmer*, 511 U.S. at 837. In order to know of the excessive risk, it is not enough that the person merely "be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw that inference." *Id.* If a person should have been aware of the risk, but was not, then the person has not violated the Eighth Amendment, no matter how severe the risk. *Jeffers v. Gomez*, 267 F.3d 895, 914 (9th Cir. 2001). But if a person is aware of a substantial risk of serious harm, a person may be liable

for neglecting a prisoner's serious medical needs on the basis of either his action or his inaction. *Farmer*, 511 U.S. at 842.

2. The Policy

When viewed in the light most favorable to Ms. Gibson, the record demonstrates that the County's failure to respond to Gibson's urgent need for medical attention was a direct result of an affirmative County policy that was deliberately indifferent, under the *Farmer* standard, to this need. [9] To find the County liable under *Farmer*, the County must have (1) had a policy that posed a substantial risk of serious harm to Gibson; and (2) known that its policy posed this risk. [10] *Id.* at 837.

On the present record, a jury could conclude that the County's medical screening policies not only posed a substantial risk of serious harm to Gibson, but in fact caused him serious harm. The County's written "Medical Screening" procedures require its medical staff to "check all inmates, upon arrival to the facility, for any obvious signs of sickness or injury requiring medical attention." If an inmate needs medical attention that only a hospital can provide, the County's policy is to take the prisoner to the hospital. According to Washoe County Undersheriff Raymond Wright, this policy also required the medical staff to screen "incoming folks for.....mental illness." Standing alone, these policies are assuredly constitutional. But there is a critical exception to these procedures: "The Medical Screening process will be delayed if the inmate is combative, uncooperative or unable to effectively answer questions due to intoxication" (emphasis added).

This mandatory exception to the County's normal medical screening procedures poses a substantial risk of serious harm to those with certain mental illnesses. There is evidence in the record that a common symptom of someone in a manic state is that they are combative and uncooperative. Gibson exhibited that symptom when the police brought him to the jail. Because Gibson was combative and uncooperative, no medical evaluation took place, [11] although the police did conduct other booking procedures, such as searching Gibson and photographing him. Stated differently, it was Gibson's urgent medical need that made him combative and uncooperative, and because Gibson was combative and uncooperative County policy directed the jail's medical staff not to evaluate Gibson to determine if he had an urgent medical need. As a result, Gibson's serious medical needs went untreated, Gibson was jailed rather than hospitalized, and the police treated Gibson as if he were either intoxicated or, as Deputy Miranda stated, "just somebody who was angry and pissed off."

This failure to identify Gibson's urgent medical needs was exacerbated by another County policy regarding prescription medication found with incoming detainees. Under this policy, an officer who discovers medication is to turn it over to a medical staff person, who, in turn, is to place the medication either in "secured property" or "in the Infirmary for follow up care." In accordance with this policy, Deputy Hodges, one of the arresting officers, gave the three containers of prescription psychotropic medication bearing Gibson's name that he found in Gibson's truck to a medical staff member, informing her that he believed the medication was psychotropic.[12] Because the County's directives

regarding medication did not include using the medication to determine and alleviate the arrestee's *immediate* medical needs, no one at the jail responded to Gibson's urgent need of medical treatment.

Had the medical staff performed a medical evaluation of Gibson to see if he had a medical condition requiring immediate attention, it could have directed the police to take Gibson to the mental hospital. An evaluation by a trained medical staff member surely would have revealed Gibson's condition. Not only did the medical staff have the clues provided by the psychotropic medication, but Gibson's behavior at the jail was so bizarre that numerous deputies, untrained to diagnose someone in a manic state, took special note of it.[13]

Finally there is evidence in the record to support the inference that if the medical staff had evaluated Gibson, prevented him from entering the jail, and directed him to a mental hospital, Gibson almost certainly would have received the care he needed, rather than face conditions that worsened his outlook. Following Gibson's death the State of Nevada conducted an investigation and interviewed Gibson's psychiatrist, Dr. Tannenbaum, about Gibson and his condition. Dr. Tannenbaum stated that when a person "becomes out of control" due to a manic phase, staff are "always able to manage them in our hospital setting." However, people in a manic state do not do "real well with any type of authority." Because of this vulnerability, people in a manic state are at a particular risk in a penal setting if their situation goes unidentified. "[A] person in the manic state may look like one of the worst...criminal[s] you have, but they're a sick person who we can treat easily and...[who] can easily die in a prison system." As a result, the County's policy of not evaluating incoming detainees who were combative, even when the medical staff had access to medications that would facilitate such an evaluation, posed a particular risk to people — such as Gibson — suffering from a manic state.

The County's liability, however, hinges not only on the existence of a policy that poses a substantial risk of serious harm, but also on whether the County was aware of this risk. *Farmer*, 511 U.S. at 837. Although direct evidence of a person's mental state rarely exists, it is not always necessary to prove a person's subjective awareness, as this inquiry is "subject to demonstration in the usual ways, including inference from circumstantial evidence." *Id.* at 842. In this case, a plethora of circumstantial evidence could lead a reasonable jury to infer that the County was aware of the risk that its policies presented.

First, a jury could conclude that County policymakers knew that inevitably some prisoners arrive at the jail with urgent health problems requiring hospitalization. The fact that County policy requires that detainees be checked for medical conditions requiring immediate attention indicates such knowledge.

Second, the County's policies make it clear that policymakers were keenly aware that mental illness, and manic phases in particular, were within the range of health problems that would sometimes require urgent care. In addition, the policies reveal that the policymakers knew that people in a manic state will sometimes be combative.

Significantly, the County had a detailed policy concerning the administration of psychotropic drugs that, *inter alia*, provides that such drugs must sometimes be forcefully administered on an emergency basis because an imminent danger to the prisoner or others might exist. [14] In addition, County policy requires placing "inmates with mental disorders that become combative [or] violent" in special watch cells. Another policy requires frequent checking of prisoners in medical unit cells "who are violent, mentally disordered, or demonstrating bizarre/unusual behavior." And still another policy requires the presence of a mental health technician to be present at the jail five days a week. Additional testimony by Sheriff Kirkland further indicates that the policymakers knew that they needed to deal safely and effectively with the special challenges posed by the mentally ill: "Certainly it's well-known that the Washoe County jail is the second or third largest houser of people who have mental difficulties in the state, including the Nevada Mental Health Institute."

Third, the record suggests that the County not only knew that it had to treat the mentally ill in order to avoid harm, but that it had made a practice of ignoring this need. Until 1995, the County had a full-time mental health professional on site at the jail to perform mental health screenings of detainees. A reasonable jury could infer that this program existed because the County had recognized that it needed such a program in order to provide adequate mental health care to detainees and to avoid serious harm caused by the lack of such care. In 1995, the County dropped its mental health professional position — and did not fill it for four years — not because jail policymakers concluded it was unnecessary, but, according to the record before us, because of what Sheriff Kirkland described as "a very bad relationship" between state psychiatric hospital officials who supplied the psychiatric personnel, the jail's medical staff, and the sheriff's department. That the County tolerated such a long lapse in this service for such a trivial and arbitrary reason as a personality conflict demonstrates that the County chose to ignore the acknowledged mental health needs of detainees. [15]

We note that the question of whether the County policies violated Gibson's rights does not hinge on whether County policymakers knew that the County's policies would pose a substantial risk of serious harm to *Gibson*, in particular. As long as a jury can infer that the policymakers knew that their policy of not screening certain incoming detainees would pose a risk to someone in Gibson's situation, we must reverse the summary judgment in favor of the County. *Farmer*, 511 U.S. at 843-44 ("it does not matter.....whether a prisoner faces an excessive risk.....for reasons personal to him or because all prisoners in his situation face such a risk" and when prison officials know of rampant inmate rape and do nothing about it, "it would obviously be irrelevant to liability that the officials could not guess beforehand precisely who would attack whom"); *Redman*, 942 F.2d at 1448.

The County emphasizes the facts that Gibson had an unhealthy heart and that his autopsy listed severe coronary arteriosclerosis as the cause of his death. As a result, the County argues that it was not deliberately indifferent to Gibson's serious medical need because "[t]he serious medical need at issue in this case was Mr. Gibson's coronary disease, not his mental health condition."

This argument is, as we understand it, not one about causation — on the summary judgment record a jury easily could conclude that the County caused Gibson’s death. Indeed, the County’s medical expert Dr. Charles Welti recognized that Gibson’s “physiologically stressful state” resulted in Gibson’s fatal heart attack.

Instead, the County’s argument is about foreseeability: Even if the County was deliberately indifferent to Gibson’s mental health condition, this deliberate indifference did not cause Gibson’s death because the County neither knew nor had reason to know that a fatal heart attack would result from ignoring Gibson’s severe mental health condition.

We reject this argument for two reasons. In the first place, there is sufficient evidence in the record on which a jury could find that death *is* a foreseeable result of not treating a manic person and placing him in a penal setting. As noted earlier, in an interview with the Nevada Department of Investigation, Dr. Tannenbaum testified that an untreated person in a manic state “can easily die in a prison system,” [16] and that a rapid pulse and increased blood pressure are commonly associated with manic bouts. Although the precise way in which Gibson died may not have been foreseeable, the extreme stress on Gibson’s system and the possibility that this stress would trigger a fatal reaction of some sort were foreseeable.

Second, even if the County is correct that death was not a foreseeable consequence of its deliberate indifference, this argument does not exonerate the County. Death was not the only injury Gibson suffered at the hands of the County. Instead of attending to Gibson’s serious medical needs, the County reacted to Gibson’s illness by locking him in a cell, pepper spraying him, shackling him for several hours by the hands, feet, and waist, dragging him through the corridor, and having two deputies climb on top of him. The likely result, a jury could find, was severe psychological and physiological distress. A plaintiff may recover from a municipality for far less severe injuries in a suit of this nature. *Cf. Canton*, 489 U.S. at 381 (allowing cause of action for failure to provide medical care action to proceed when municipal officials left a woman with severe emotional ailments lying on a police station floor for an hour).

In addition, these injuries were indisputably foreseeable. Uncontrollable behavior is a foreseeable consequence of not identifying a manic condition, and having to chain, pepper spray and drag someone, with attendant psychological and physiological harm, is a foreseeable consequence of dealing with someone who is out of control.

The “time-honored legal principle that a wrongdoer takes his victim as he finds him” means that if the County is liable for Gibson’s other injuries it also must bear liability for Gibson’s death. *Wakefield v. Nat’ l Labor Relations Bd.*, 779 F.2d 1437, 1438 (9th Cir. 1986). Sometimes referred to as the “eggshell skull” doctrine, this principle renders defendants liable for any physical injury they cause, no matter how unforeseeable, once they inflict harm on a plaintiff’s body. As a leading torts hornbook states:

There is almost universal agreement upon liability beyond the risk, for quite unforeseeable consequences, when they follow an impact upon the person of the

plaintiff. It is as if a magic circle were drawn about the person, and one who breaks it, even by so much as a cut on the finger, becomes liable for all resulting harm to the person, although it may be death....The defendant is held liable for unusual results of personal injuries which are regarded as unforeseeable, such as....heart disease....The defendant of course is liable only for the extent to which the defendant’s conduct has resulted in an aggravation of the pre-existing condition, and not for the condition as it was; but as to the aggravation, foreseeability is not a factor. [W. Page Keeton et al., *Prosser and Keeton on The Law of Torts* § 43 at 291-92.]

Because “§ 1983 creates a species of tort liability” the Supreme Court “has interpreted the statute in light of the background of tort liability.” *Tahoe-Sierra Preservation Council, Inc. v. Tahoe Regional Planning Agency*, 216 F.3d 764, 783 n.34 (9th Cir. 2000) (quoting *City of Monterey v. Del Monte Dunes at Monterey, Ltd.*, 526 U.S. 687, 709 (1999)), *aff’d*, No. 00-1167, 2002 WL 654431, ___ U.S. ___ (Apr. 23, 2002). We see no reason for diverging from the Supreme Court’s general guidance in this situation. Although the deliberate indifference doctrine contains a heightened foreseeability requirement, this requirement differs from the traditional negligence foreseeability requirement only insofar as deliberate indifference requires the defendant to be *subjectively* aware that serious harm is likely to result from a failure to provide medical care. But the deliberate indifference doctrine does not require that a *particular* consequence be more predictable than is required under traditional tort law. Accordingly, the First Circuit has approved of the use of the eggshell skull doctrine in a § 1983 case with similar facts. *Figueroa-Torres v. Toledo-Davila*, 232 F.3d 270, 274-76 (1st Cir. 2000) (police officers may be liable for death of a person with a diseased and enlarged spleen even though the death was not a foreseeable consequence of the police’s hitting and kicking). [17]

For the above reasons, the County’s policies posed a substantial risk of serious harm to Gibson, and enough circumstantial evidence exists that a reasonable jury could infer that County policymakers knew that this risk existed and chose to ignore it.

C. The Second Route to Municipal Liability

To impose liability against the County under *Canton*, a plaintiff must show: (1) that a County employee violated Gibson’s rights; (2) that the County has customs or policies that amount to deliberate indifference (as that phrase is defined by *Canton*); and (3) that these policies were the moving force behind the employee’s violation of Gibson’s constitutional rights, in the sense that the County could have prevented the violation with an appropriate policy. *Amos v. City of Page*, 257 F.3d 1086, 1094 (9th Cir. 2001).

1. A County Employee Violated Gibson’s Rights

As the record now stands, a jury could find that the nurse who was on duty at the jail on the night of Gibson’s death was deliberately indifferent to Gibson’s serious medical needs. As discussed above, for the nurse to have been deliberately indifferent

(as the phrase is defined by *Farmer*) to Gibson's needs, she must have been aware of a substantial risk of serious harm. *Farmer*, 511 U.S. at 837; *Frost*, 152 F.3d at 1128-30.

A jury could find that the nurse knew that Gibson was in the throes of a manic state on the basis of three facts: she had medical training, she knew that Gibson was exhibiting behavior consistent with mental illness, [18] and she knew that Gibson possessed psychotropic medication "that would stabilize somebody." A jury could also conclude that a trained nurse would know that hospitalization could have relieved Gibson's condition, and that if Gibson remained in jail, he presented a danger both to himself and to others. If the nurse knew that a substantial risk to Gibson's health existed and she declined to act upon this knowledge, she was deliberately indifferent to Gibson's constitutional right to receive medical care.

2. Deliberate Indifference under Canton

A jury could find, on the present record, that the nurse's constitutional violation arguably resulted from an omission in the County's policy regarding the handling of prescription medication.[19]

In *Canton*, the Supreme Court held that a "failure to train" police officers may serve as the basis for liability under §1983 "where the failure to train amounts to deliberate indifference to the rights of persons with whom the police come into contact." 489 U.S. at 388. Policies of omission regarding the supervision of employees, then, can be "policies" or "customs" that create municipal liability under *Monell*, but only if the omission "reflects a 'deliberate' or 'conscious' choice" to countenance the possibility of a constitutional violation. *Id.* at 389-90; see also *Oviatt*, 954 F.2d at 1474 ("[A] local governmental body may be liable if it has a policy of inaction and such inaction amounts to a failure to protect constitutional rights."). A jury may infer that a municipality made such a deliberate choice "when a municipal actor disregarded a known or obvious consequence of his action." *Board of County Comm' rs*, 520 U.S. at 410. Whether a local government has displayed a policy of deliberate indifference to the constitutional rights of its citizens is generally a jury question. *Oviatt*, 954 F.2d at 1478; *Blair v. City of Pomona*, 223 F.3d 1074, 1079 (9th Cir. 2000).

The *Canton* Court recognized that when the need to remedy the omission "is so obvious, and the inadequacy so likely to result in the violation of constitutional rights,....the policymakers of the city can reasonably be said to have been deliberately indifferent to the need." 489 U.S. at 390. The need to act may be obvious because any reasonable person would recognize the need; for example, because armed officers will often arrest fleeing felons, it is obvious that a municipality must train its officers in the constitutional limitations on the use of deadly force. *Id.* at 390 n.10. Unlike the deliberate indifference standard used to determine if a violation of a detainee's right to receive medical care took place, this standard does not contain a subjective component. *Farmer*, 511 U.S. at 841. As a result, there is no need for Ms. Gibson to prove that the County policymakers actually knew that their omissions would likely result in a constitutional violation.

In this case, the County had a policy that required the arresting

officers to give the nurse any prescription medications found with an incoming detainee. The policy further required the nurse to either place the medications in "secured property or in the Infirmary for follow up care." Significantly, the policy failed to suggest that the nurse should act on any information that the medication might bear, even in the event that the nurse was unable to perform a medical evaluation because city policy precluded medical evaluations when the detainee is uncooperative, combative, or intoxicated.

A jury could also find that this omission was sufficiently likely to result in the violation of a detainee's right to medical care that the County was deliberately indifferent to these needs. As discussed above, County officials actually knew that some detainees who arrived at the jail would have urgent medical and mental health needs requiring immediate hospitalization. The policymakers also knew that people suffering from mental illness are sometimes combative. In addition, the County had created a mental health screening position, so policymakers knew that jail employees needed to identify and address mental illnesses in order not to neglect the medical needs of prisoners.

Given that the County policymakers actually knew that the jail staff would regularly have to respond to detainee mental health needs, it should have been obvious that the County's omission could well result in a constitutional violation. [20] Because county policy forbids medical evaluations on incoming detainees who are combative and uncooperative, it was obvious that someone who had a mental illness that made them combative and uncooperative would not be evaluated. If, however, a combative detainee arrives with prescription psychotropic medication in their own name, there is an alternative way to identify those with medical needs. Although a jury could conclude that the nurse actually did identify Gibson as a person in need of mental health treatment, the County's medication policy did not instruct her to act upon this realization. When policymakers know that their medical staff members will encounter those with urgent mental health needs yet fail to provide for the identification of those needs, it is obvious that a constitutional violation could well result.

3. Moving Force

Having determined that summary judgment is inappropriate on the question whether the County's omission amounted to deliberate indifference to the constitutional rights of citizens with whom the sheriff's department came into contact, we must consider whether these omissions were the "moving force" behind the violation of Gibson's constitutional rights. We find that there is sufficient evidence to preclude summary judgment on this question as well.

In order to be a "moving force" behind Gibson's injury, we must find that the "identified deficiency" in the County's policies is "closely related to the ultimate injury." *Canton*, 489 U.S. at 391; see also *Oviatt*, 954 F.2d at 1478. The plaintiff's burden is to establish "that the injury would have been avoided" had the County had a policy directing its medical staff to use information obtained from prisoner's medication to determine whether he should be jailed or hospitalized and, if the former, under what conditions. *Oviatt*, 954 F.2d at 1478.

Had the County had a policy instructing the medical staff to use information obtained from a prisoner’s medication to screen incoming detainees, the nurse, after observing Gibson’s behavior in light of his medication, likely would have concluded that Gibson was in the midst of a manic phase and recommended transporting him to a mental hospital. There, Gibson could have received the treatment he needed, rather than face conditions that only made his outlook worse. Alternatively, the nurse could have considered administering the medication on an emergency basis.

Individual Deputies’ Liability

A. Deliberate Indifference to Medical Needs

The individual defendants in this case were the sheriff’s deputies who had contact with Gibson after he was admitted to the jail. Their behavior, while it proved fatal to Gibson, was not unconstitutional. The record does not support the conclusion that the individual defendant deputies were deliberately indifferent, under the subjective *Farmer* standard, to Gibson’s mental health condition.

Of all the individual officers who had contact with Gibson on the night of his death, only Miranda and Hodges knew that Gibson’s behavior might be connected to mental illness, because they found and discussed Gibson’s prescription medications. Miranda and Hodges are not defendants, however, and there is no evidence that, upon bringing Gibson into the jail, they told any of the deputies there (as opposed to the nurse) about the medicine containers. Similarly, there is no evidence that, having received the medicine containers from Miranda and Hodges, the nurse on duty — also not a defendant — informed any of the individual deputy defendants that Gibson’s medications suggested that he was mentally ill. According to the summary judgment record, only Deputy Bowlin was even aware that any drug containers came into the jail with Gibson, but he did not know what the medications were, or their purpose.

In short, all the deputies at the jail knew about Gibson’s mental condition was what they could observe of his behavior. Although several remarked on his peculiar mood swings and dramatic shifts from combativeness to compliance, there is no evidence that any of them actually knew that this behavior connoted serious, treatable mental illness. Nor can we say that Gibson was so obviously mentally ill that the deputies, who had received no training regarding the diagnosis and treatment of mental illness, must have known that Gibson was exhibiting symptoms of mental illness. The lapses in communication at the jail are hardly commendable, but the deputies who, because of these lapses, remained unaware of Gibson’s mental condition cannot be held liable for having been “deliberately indifferent” to it. See *Farmer*, 511 U.S. at 838.

B. Excessive Force

Ms. Gibson claims that the individual defendant deputies used excessive force in restraining Gibson, resulting in his death. The magistrate found that the force used by the deputies was reasonable, and therefore, that the defendants were not liable. We agree.

The Due Process clause protects pretrial detainees from the use of excessive force that amounts to punishment. *Graham v. Connor*, 490 U.S. 386, 395 n.10 (1989). Although the Supreme Court has not expressly decided whether the Fourth Amendment’s prohibition on unreasonable searches and seizures continues to protect individuals during pretrial detention, *id.*, we have determined that the Fourth Amendment sets the “applicable constitutional limitations” for considering claims of excessive force during pretrial detention. *Pierce v. Multnomah County*, 76 F.3d 1032, 1043 (9th Cir. 1996), *cert. denied*, 519 U.S. 1006 (1996). *Graham* therefore explicates the standards applicable to a pretrial detention excessive force claim in this circuit.

In *Graham*, the Supreme Court explained that determining whether a defendant officer’s use of force was “reasonable” under the Fourth Amendment “requires a careful balancing of the nature and quality of the intrusion on the individual’s Fourth Amendment interests against the countervailing government interests at stake.” 490 U.S. at 396 (internal quotations omitted). This analysis requires “careful attention to the facts and circumstances in each particular case, including the severity of the crime at issue, whether the suspect poses an immediate threat to the safety of the officers or others, and whether he is actively resisting arrest or attempting to evade arrest by flight.” *Id.*; see also *Tennessee v. Garner*, 471 U.S. 1, 8-9 (1985) (whether seizure is reasonable under the Fourth Amendment is judged by the “totality of the circumstances”). [21]

Finally, the *Graham* Court admonished courts to examine the circumstances underlying a Fourth Amendment claim from the viewpoint of the reasonable officer on the scene, “rather than with the 20/20 vision of hindsight.” 490 U.S. at 396. For, “[t]he calculus of reasonableness must embody allowance for the fact that police officers are often forced to make split-second judgments — in circumstances that are tense, uncertain, and rapidly evolving — about the amount of force that is necessary in a particular situation.” *Id.* at 396-97.

Applying these standards to the case before us, we conclude that the individual defendant deputies cannot be held liable for the use of excessive force against Gibson. From the moment Gibson arrived at the jail, he was struggling against the deputies, hurling invective, and generally behaving very strangely and violently. Because we have determined that there is no proof the deputies on duty at the jail were aware that Gibson’s behavior was connected to his treatable mental illness, we cannot hold them accountable for having treated Gibson as a dangerous prisoner rather than a sick one, despite the tragic consequences of this error.

Given that perspective at the time, the deputies’ conduct that night was reasonable. Because he was alone in his holding cell when he slipped out of his waist chain and began banging it against the window, Gibson — at that point — posed no immediate danger to anyone but himself. But Sgt. Williams was concerned that Gibson might shatter the window in his cell door, thereby placing both himself and any officers who might have to enter the cell at risk of harm. The decision to enter Gibson’s cell and restrain him was therefore reasonable.

Moreover, once the deputies began to restrain Gibson and move him to the special watch cell, he fought back vigorously. No more than

three minutes passed from the time the deputies brought Gibson into the special watch cell and his death. During that time, Gibson was fighting hard against the deputies' efforts to restrain him, creating precisely the kind of situation in which officers must make split-second decisions. Under all the circumstances, the deputies' decisions under these difficult circumstances resulted in restraining Gibson no more forcefully than was reasonably necessary. We therefore affirm the district court's grant of summary judgment for the individual deputy defendants and Sgt. Williams.

AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.

Each party to bear its own costs on appeal.

REINHARDT, Circuit Judge, concurring:

While I concur fully in the court's opinion, I write separately to expand on a point that the opinion relegates to a footnote (n.9). Although *Farmer v. Brennan*, 511 U.S. 825 (1994), establishes a subjective test for determining deliberate indifference in the case of individual defendants, in that case the Supreme Court made it reasonably clear that the same standard does not apply in actions against government entities involving the adoption of affirmative government policies. The *Farmer* Court stated that, while a subjective standard is appropriate for determining the liability of prison officials, "considerable conceptual difficulty would attend any search for the subjective state of mind of a governmental entity, as distinct from that of a governmental official." *Id.* at 841.

Here, whether we import the more stringent *Farmer* subjective standard or apply the less stringent objective standard employed in *City of Canton v. Harris*, 489 U.S. 378, 388-89 (1989), [22] the record, when viewed in the light most favorable to Ms. Gibson, shows that the County's failure to respond to her husband's medical needs was a direct result of an affirmative County policy that demonstrated deliberate indifference to this need. Thus, there is no cause in this case to resolve definitively the question of which standard applies to the County, regardless of how obvious the answer may be. We can instead, for purposes of this decision, simply apply the more stringent standard.

Footnotes

[1] Washoe County contracted with the City of Reno for its police dispatch services.

[2] The County's procedures regarding when the jail's medical staff should evaluate incoming detainees appear somewhat to contradict one another. One procedure states that the nursing staff will be requested to make an evaluation "[i]f the prisoner has visible or claimed injuries." Another procedure states that a medical staff member "will check *all* inmates, upon arrival to the facility." (emphasis added).

[3] Deputies Miranda and Hodges, who arrested Gibson, were not named as defendants, nor was the nurse on duty.

[4] Ms. Gibson also alleged a § 1983 cause of action for deprivation of her liberty interest in her husband's consortium, and two state-law negligence claims. The district court granted the defendants' motion for summary judgment on the consortium claim and declined to exercise supplemental jurisdiction over the state-law claims. See 28 U.S.C. §1367(c). Ms. Gibson has not appealed these rulings.

[5] Section 1983 states in part:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress....

[6] "A *caipias* is a writ of attachment commanding a county official to bring a subpoenaed witness who has failed to appear before the court to testify and to answer for civil contempt." 475 U.S. at 472 n.1.

[7] The municipal defendants (the County and its policy-makers, Sheriff Kirkland and Chief Deputy Sheriff Wright) assert that if we conclude, as we do, see *infra*, that the individual deputy defendants are not liable for violating Gibson's constitutional rights, then they are correspondingly absolved of liability. Although there are certainly circumstances in which this proposition is correct, see *City of Los Angeles v. Heller*, 475 U.S. 796, 799 (1986) and *Quintanilla v. City of Downey*, 84 F.3d 353, 355 (9th Cir. 1996), it has been rejected as an inflexible requirement by both this court and the Supreme Court.

For example, a municipality may be liable if an individual officer is exonerated on the basis of the defense of qualified immunity, because even if an officer is entitled to immunity a constitutional violation might still have occurred. See, e.g., *Chew v. Gates*, 27 F.3d 1432, 1438-39 (9th Cir. 1994). Or a municipality may be liable even if liability cannot be ascribed to a single individual officer. *Owen v. City of Independence*, 445 U.S. 622, 652 (1980) (a "'systemic' injury" may "result not so much from the conduct of any single individual, but from the interactive behavior of several government officials, each of whom may be acting in good faith.") (citation omitted). And in *Fairley v. Luman*, 281 F.3d 913 (9th Cir. 2002), we explicitly rejected a municipality's argument that it could not be held liable as a matter of law because the jury had determined that the individual officers had inflicted no constitutional injury. *Id.* at 916. "If a plaintiff established he suffered constitutional injury *by the City*, the fact that individual officers are exonerated is immaterial to liability under § 1983." *Id.* (emphasis in original); see also *Hopkins v. Andaya*, 958 F.2d 881 (9th Cir. 1992).

In any event, in this case, the constitutional violations for which we hold the County may be liable occurred *before* the actions of the individual defendants at the jail, so the County is not being held liable for what those deputies did. The County's violations, as we develop later, involved the decision to commit Gibson to the custody of the jail deputies despite his mental illness, and to do so with no direction to treat that illness while he was in jail or to handle him specially because of it.

[8] Because the Eighth Amendment's deliberate indifference standard looks to the subjective mental state of the person charged with violating a detainee's right to medical treatment, it — somewhat confusingly — differs from the *Canton* deliberate indifference standard, which we also apply in this opinion. The *Canton* deliberate indifference standard does not "turn upon the degree of fault (if any) that a plaintiff must show to make out an underlying claim of a constitutional violation;" instead it is used to determine when a municipality's omissions expose it to liability for the federal torts committed by its employees. *Canton*, 489 U.S. at 388 n.8; see also *Collins v. City of Harker Heights*, 503 U.S. 115, 122 (1992). As opposed to the *Farmer* standard, which does not impose liability unless a person has actual notice of conditions that pose a substantial risk of serious harm, the *Canton* standard assigns liability even when a municipality has constructive notice that it needs to remedy its omissions in order to avoid violations of constitutional rights. *Farmer*, 511 U.S. at 841 (explicitly distinguishing the two standards on this basis).

[9] Because that is so, we do not address whether it is necessary to prove the subjective *Farmer* state of mind in suits against entities rather than individuals. *Cf. Farmer*, 511 U.S. at 841 (“considerable conceptual difficulty would attend any search for the subjective state of mind of a government entity, as distinct from that of a government official”).

Similarly, we do not consider whether there are instances in which pretrial detainees, as opposed to convicted prisoners, may establish a constitutional violation without meeting the *Farmer* deliberate indifference standard. *Frost* applied the *Farmer* standard by analogy to the due process rights of pretrial detainees, but does not indicate whether the subjective standard applies in all such instances. See *Frost*, 152 F.3d at 1128-30.

Farmer explained that the protections provided to convicted prisoners are limited because of the presence of the word “punishments” in the Eighth Amendment, basing the subjective standard on the need to prove “punishment.” *Farmer*, 511 U.S. at 838-39; see also *Wilson v. Seiter*, 501 U.S. 294, 300 (1991). This limiting word does not, however, appear in the Fourteenth Amendment, and pretrial detainees, not having been convicted, are not subject to punishment. Furthermore, the Fourteenth Amendment ensures that states will provide not only for the medical needs of those in penal settings, but for anyone restricted by a state from obtaining medical care on his own. *DeShaney*, 489 U.S. at 200; *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982). It is quite possible, therefore, that the protections provided pretrial detainees by the Fourteenth Amendment in some instances exceed those provided convicted prisoners by the Eighth Amendment.

[10] As noted in the previous footnote, the Supreme Court has commented that it is difficult to determine the subjective state of mind of a government entity. *Farmer*, 511 U.S. at 841. This statement does not, however, *preclude* the possibility that a municipality can possess the subjective state of mind required by *Farmer*. First, it is certainly possible that a municipality’s policies explicitly acknowledge that substantial risks of serious harm exist. Second, numerous cases have held that municipalities act through their policymakers, who are, of course, natural persons, whose state of mind can be determined. See, e.g., *Board of County Comm’rs*, 520 U.S. at 403-04 (citing *Monell*, 436 U.S. at 694).

[11] Counsel for the County stated at oral argument: “The policy is to do a medical evaluation when the person comes in....Mr. Gibson prevented that from happening by being combative so they put him in a place to calm him down. He didn’t calm down. He escalated the situation.”

[12] Deputy Hodges stated that he said to the nurse: “Here, they were in the truck. I don’t know if he’s taking them. I don’t know if they are psychotropics or what.” Then, according to Hodges, the nurse told him that “they were mental health kinds of medicines that would stabilize somebody.”

[13] Deputy Hodges stated that because of Gibson’s “mood swings” he believed that Gibson “was mentally ill and wasn’t taking his meds, or he was on some kind of drug.” Deputy Eric Nagl stated “it was weird how he was acting” and that his behavior “was almost like a light switch.” And Deputy Mike Garrow stated that Gibson’s cursing was not of “the type that you hear from someone that’s just....drunk....this was someone that was obviously upset....and irrational, incoherent....not incoherent to where you can’t hear....or understand what they’re saying, but incoherent to making sense.”

[14] This portion of the psychotropic drug policy states: “Psychotropic medications will not be forcefully administered by healthcare staff unless a court order exists or there is imminent danger to self or others.”

[15] The record is not clear about the precise role of the mental health screening professional. If the job description’s duties included screening incoming detainees for mental illness, then all the more

basis exists to conclude that the County knew of the need to screen incoming detainees for mental illness and chose to ignore it.

[16] It appears from the transcript of this interview that Dr. Tannenbaum elaborated on this possibility. However, because this transcript of the interview is only partly legible, an accurate quotation of this elaboration is not possible.

[17] The pattern of lapses in communicating the ATLS in this case is regrettable, and probably negligent, but, under these facts, it does not violate Gibson’s substantive due process rights. With some exceptions, including when a person is in police custody or when an officer’s conduct places a person in peril, “[t]he 14th Amendment does not generally require police officers to provide medical assistance to private citizens.” *Penilla v. City of Huntington Park*, 115 F.3d 707, 709 (9th Cir. 1997) (citing *DeShaney*, 489 U.S. at 197). Thus, prior to Gibson’s arrest, the police had no duty to provide medical assistance to Gibson. As a result, the County’s deficient system for communicating ATLS cannot be the basis for a violation of Gibson’s right to receive medical services prior to Gibson’s arrest.

Once the police arrested Gibson, however, he was in police custody and the police did have a duty not to remain deliberately indifferent to his serious medical needs. *DeShaney*, 489 U.S. 199-200. But no evidence supports the inference that the County’s policymakers knew that the County’s defective policies for communicating police dispatches between shifts and between field and jail employees created a substantial risk of serious medical harm to those people placed in police custody. *Farmer*, 511 U.S. at 842.

[18] When asked if he told the medical staff that Gibson was “demonstrating bizarre behavior consistent with someone who was mentally ill,” Deputy Hodges responded: “Yes, they would have known the story because he was combative at that time....[W]e were telling everybody what happened, you know, with the mood swings in particular. I don’t know how much detail I would have went into. I would have mentioned the mood swings. To me, that was the significant factor.”

[19] As was her prerogative, Ms. Gibson did not name the nurse as a defendant. This fact does not affect our determination that the nurse may have committed a constitutional violation and, in the event that she did, whether the County is legally responsible for that violation.

[20] *Canton* itself concerned a claim that the defendant City had failed to train its police officers in dealing with the emotionally disturbed. Concurring in part and dissenting in part, Justice O’Connor wrote that “the diagnosis of mental illness is not one of the ‘usual and recurring situations with which [the police] must deal,’....such that lack of training therein would be the kind of omission that can be characterized, in and of itself, as a ‘deliberate indifference’ to constitutional rights.” 489 U.S. at 397 (O’Connor, J., concurring in part and dissenting in part) (citing *Canton*, 489 U.S. at 391). Even if this claim is correct in the absence of a record to the contrary, it is not correct on the record in this case. Sheriff Kirkland testified that the Washoe County jail housed more mentally ill people than all but a handful of Nevada institutions. As a result, whatever can be said of jails in general, the necessity of diagnosing mental illness is a usual and recurring situation in the Washoe County jail.

[21] In the context of pretrial detention rather than arrest, it is clear that all the factors mentioned in *Graham* — whether the suspect is resisting arrest or attempting to flee, for example — will not necessarily be relevant.

[22] See also *Farmer*, 511 U.S. at 841 (“It would be hard to describe the *Canton* understanding of deliberate indifference....as anything but objective. *Canton*’s objective standard, however, is not an appropriate test for determining the liability of prison officials under the Eighth Amendment as interpreted in our cases”). □

NEWS FROM AROUND THE COUNTRY

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

Florida

In October, the parents of a 16-year-old boy who committed suicide in a boot camp for juvenile offenders received a \$240,000 settlement from local and state authorities, as well as a private health provider. Chad Franza hanged himself from an air conditioning vent with his boot laces on August 17, 1998. He had been in the Polk County Juvenile Boot Camp in Bartow, a six-month residential program, for 24 days. The state Department of Juvenile Justice, Polk County Sheriff's Office (which ran the facility), and EMSA Correctional Care (health care provider at the time) all initially denied any responsibility for the death, but finally agreed to settle the lawsuit that had been filed by the youth's parents in 2000.

The county's lawyer told the *Associated Press* that since Chad had a prior history of suicidal behavior, he should never have been sent to the boot camp. In fact, the youngster's mother had told a staff member of the Department of Juvenile Justice that "if Chad goes to the boot camp, he needed to be watched because he said he would kill himself." Such information was apparently not communicated to the boot camp, whose director said that it was not uncommon for youth to threaten suicide when they first enter the program. Although stating his staff had followed all facility procedures, he acknowledged that several changes were made immediately following the incident, including suicide prevention screening of youth as they enter the program, removal of belts and shoe laces at intake, and increased security rounds from 60- to 15-minutes.

In a suicide note found after the incident, Chad Franza said he missed his family and could not handle the atmosphere at the camp. The youth had been committed to the facility for trespassing on school grounds after he had been charged with bringing a gun to school.

South Carolina

A mentally ill man who has languished in the Chester County Detention Center for over two years will finally receive the hospital treatment a judge had ordered last year, according to the prosecutor handling the case. On October 31, 2002, prosecutor Michael Hemlepp told the *Charlotte Observer* that state Department of Mental Health officials told him they had finally accepted Kenneth Wilks into the state hospital. Mr. Wilks, who suffers from schizophrenia, had been confined in the county jail in Chester for two years after being charged with resisting arrest. The courts took a year before determining in November 2001 that he was unable to stand trial. A judge ordered that Mr. Wilks be hospitalized, but that never happened. "I'm relieved that he's going to get the treatment he needs, but overall, I'm sad that it took so long," the prosecutor said.

The case outraged advocates for the mentally ill who said it was a shocking case of mistreatment. Jail officials had said that Mr. Wilks' condition deteriorated in the months he had been waiting for a hospital bed. Because he refused to take his medication, Mr. Wilks had become increasingly violent and suffered from hallucinations and delusions.

State mental health officials have said they do not have enough employees to staff all their beds because of budget cuts. They declined to discuss Mr. Wilks' case. Mr. Hemlepp said that instead of ignoring the judge's order to admit Mr. Wilks, state Department of Mental Health officials should have told court officials they were having problems. "Every state agency in South Carolina is feeling the bite of budget cuts," he said. "But the agencies are still dependant on each other."

Mr. Wilks is one of 60 or more inmates held in county jails throughout the state despite court orders that they be hospitalized. He had been confined the longest and was apparently next in line for hospital admission.

California

State prison officials agreed in October not to put mentally ill inmates in a new segregation unit unless the move is approved in advance by a federal judge in Sacramento. Civil rights attorneys had sought a restraining order after being told by prison officials that up to 52 of the inmates would be placed in one of the new cellblocks as a "pilot project" to learn how well they could cope in an extremely isolated environment. According to a state Department of Corrections memorandum, the pilot program was necessary to determine if the "building design results in extreme sensory deprivation that may be detrimental to the mental health of inmates."

In court papers, the prisoners' attorneys said that housing their clients in the new "Supermax is actually a cruel, inhumane and illegal human experiment on unconsenting" inmates. Michael Bien, the lead plaintiff attorney, told the *Sacramento Bee* that the new "Supermax" cells "are designed to offer not outside stimulation. That can exacerbate mental illness and increase the risk of suicide. The harm that comes from going into these units for certain kinds of human beings is permanent." Countered an angry Steve Green, assistant secretary of the California Youth and Adult Correctional Agency, "This is not a 'Supermax'....Calling it an experiment is crap."

The prisoners' attorneys had asked United States District Judge Lawrence K. Karlton, who presides over a 12-year-old class-action lawsuit (*Coleman v. Wilson*, now entitled *Coleman v. Davis*) on behalf of all mentally ill inmates in the state prison system, to bar the housing plan. A hearing was scheduled for October 10, but attorneys for both parties notified the judge a day before the hearing that they had reached an agreement indefinitely prohibiting the placement of mentally ill inmates in the special housing units. Judge Karlton signed the agreement on October 11.

The agreement targets the new unit at the California Substance Abuse Treatment Facility in Corcoran, which opened to non-mentally ill inmates in May, 2002, and the other nine new segregation units scheduled to open in the next several months. None of them can be occupied by mentally ill inmates "unless and until ... court approval

has been obtained.” The agreement also mandates that if they seek court approval, prison officials must submit a plan that calls for:

- Enough clinical staffing to provide more frequent therapy and treatment than usual for mentally ill patients in the unit;
- Enough custodial and escort staffing to support the expanded treatment program;
- More out-of-cell time than other prisoners; and
- A screening mechanism to assure that placement in the unit is medically appropriate.

The agreement “protects our clients and sets up an orderly process, which is what we were seeking out of the injunction,” said Mr. Bien. “This is what we wanted, for the court to have control.”

Maine

Citing 17 deaths in county jails and prisons throughout the state during the past five years, the National Alliance for the Mentally Ill in Maine has called for the state to improve the treatment of mentally ill prisoners. In September 2002, the agency released a “Report on the Current Status of Services for Persons with Mental Illness in Maine’s Jails and Prisons: 2002,” which stated that “Any other publicly funded and publicly governed institution in Maine where Maine citizens are housed and for whom government is responsible, that had 17 deaths would be investigated and possibly lose its license.” Of the 17 inmates deaths, 14 committed suicide and the others died from causes associated with drugs, alcohol and illness. In 2002 alone, seven inmates have committed suicide.

The report said community-based mental health services have been slow to materialize since the state scaled back widespread hospitalization for the mentally ill — “The fact that Maine’s correctional facilities are the largest providers of mental health services in Maine document the failure of deinstitutionalization and the failure of the state to meet its promise to people with mental illness and their families.”

The report calls for a series of initiatives, including, but not limited to the following:

- Build an additional 24 forensic beds at the new state mental hospital now under construction in Augusta;
- Spend the \$9 million needed to fully implement the results of a legislative study which called for training judges on how to divert mentally ill people from the criminal justice system and improving transitional services for inmates released into the community;
- Require prisons to treat, rather than punish, people who act out because of mental illness;
- Increase the state reimbursement for jails that receive national accreditation;
- Conduct independent reviews of the mental health services in the state prisons and all 15 county jails

and implement any recommendations that stem from them.

The Maine Sheriff’s Association and Maine County Commissioners Association cooperated in the preparation of the report, but some members of those groups worried it could send the wrong message. “This report seems to suggest or at least could lead legislators to conclude that the trick is to convert jails into quasi-mental health clinics,” Mark Dion, sheriff of Cumberland County and president of the Maine Sheriff’s Association, told the *Portland Press Herald*. “We have some concerns that that’s inconsistent with the mission of a jail. What’s needed instead is to increase the number of acute care beds in the community for those experiencing mental health crisis.”

Illinois

In July 2002, jail officials said that they did what they could to determine whether David Gargac was suicidal, even calling in a crisis intervention caseworker to evaluate him the day after he arrived at Madison County Jail in Edwardsville. Mr. Gargac hanged himself in his cell on July 29. He had been held without bail at the facility since July 10, approximately 24 hours after Alton police arrested him following an eight-hour standoff on a charge of aggravated battery with a firearm. During the standoff, Mr. Gargac held a gun to his head and taunted police to shoot him.

Based on Mr. Gargac’s threats during the standoff, he was placed on suicide watch in a holding cell at the Alton Police Department during the late evening of July 8. As Alton Deputy Chief Jody O’Guinn told the *Edwardsville Telegraph*, “Just due to the fact that we had a standoff with him and he said he was suicidal, we would have done a 10-minute watch on him until he left our jail.” Mr. Gargac was transported to the county jail the following evening.

When the Madison County Jail nurse asked the inmate on July 10 whether he was suicidal, Mr. Gargac answered “no.” Not totally convinced, the nurse decided to call a caseworker from Chestnut Health Systems, a community crisis intervention agency, for a second opinion. According to Madison County Sheriff Bob Churchich, “The head nurse wanted that extra precaution, mainly because of the picture she had seen in the newspaper of him holding a gun to his head. But there was no indication whatsoever of him contemplating taking his life.”

New York

Eugene Barbagallo was a 36-year-old plumber from Yorktown who suffered from depression and bipolar disease. He was arrested by local police in mid-June after threatening his mother with a gun and transported to the Westchester County Jail in Valhalla. On June 29, 2002, Mr. Barbagallo became agitated, fought with correctional officers, and was placed under “close watch” in the facility’s psychiatric unit. Soon thereafter, he was dead.

According to an “inmate aide” assigned to watch over him, Mr. Barbagallo had been injected with Haldol at approximately 1:00 am on June 29, suffered convulsions for four hours, and did not receive any medical attention before he died. Vincent Dispaltrio,

who was confined in the facility on a charge of fraud, claimed he repeatedly warned a correctional officer that Mr. Barbagallo seemed to be having a bad reaction to the injection. "I watched that kid suffering for four hours, and he never got medical attention," Mr. Dispaltro told *The Journal News* of White Plains in August, 2002. "Maybe they could have saved him. It's not like he died in his sleep."

Jail officials refused to comment on Mr. Dispaltro's version of Eugene Barbagallo's final hours, citing open investigations by county police and the state Commission of Correction. "If there's any validity to that, I'm sure it will be in the state report," spokeswoman Victoria Hochman told *The Journal News*.

While questions linger over how Eugene Barbagallo died, some critics are targeting a longstanding policy at the county jail where certain inmates are picked to watch over mentally ill and/or suicidal inmates in return for a \$2 credit toward snack purchases from the jail commissary. "That doesn't happen in state prisons, and I'm shocked to hear that it does there," said Tom Terrizzi, director of Prisoners' Legal Services of New York. "I can't imagine any correctional system allowing inmates to do that," Mr. Terrizzi said. "I mean, they obviously have a duty to protect people, and that's not a duty they can transfer to an inmate. It just seems way too risky."

James E. Lawrence, Director of Operations for the state Commission of Correction, the state agency that oversees all county jails in New York, acknowledged that having inmates supervise at-risk prisoners is "not a very common policy," because most upstate jails do not have a large enough prisoner population to make it feasible. Still, he maintained that the policy is sound and only served to supplement increased supervision by officers in special housing units. "The use of carefully selected and trained inmates for mental observation-type supervision is acceptable," Mr. Lawrence said. "It doesn't replace uniformed supervision by trained personnel at enhanced levels already — it is merely an adjunct to that enhanced supervision."

The policy manual at the Westchester County Jail, however, allegedly does not contain any specific provisions for the training of inmates aides. And Richard Jacobs, an inmate who was responsible for watching Mr. Barbagallo the day before he died, said he had not received any training, in fact, he just signed up for the job and was assigned the task two days later. Mr. Dispaltro said aides are told only to make sure they can see the inmate's hands and face at all times. If the inmate refuses to stay in plain sight, they are restrained. The job can also be monotonous and routine. According to Mr. Dispaltro, "I'm not going to lie to you. Sometimes, you do doze off."

There was nothing routine, however, about the last hours of Mr. Barbagallo's life. According to inmate aide Dispaltro, delusional and stripped out of his paper gown, Mr. Barbagallo was lying on the concrete floor halfway underneath his bed. He moaned, sweated and thrashed throughout the early morning hours, at times violently banging his legs and fists against the metal underside of his bed. "Gaines, look at what he's doing," Mr. Dispaltro allegedly recalls telling the officer on duty. The reply from Officer Fred Gaines, according to the inmate, was "Yeah, he's gonna be black and blue tomorrow." By 6:00 am, Eugene Barbagallo was dead. □

JAIL SUICIDE/MENTAL HEALTH UPDATE

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

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AVAILABLE JAIL/PRISON SUICIDE PREVENTION MATERIALS

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

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

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