JAIL SUICIDE/MENTAL HEALTH UPDATE

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INNOVATIONS TO REDUCE JAIL SUICIDE — *A KENTUCKY INITIATIVE*

by
CONNIE MILLIGAN, LCSW AND RAY SABBATINE, MA

Introduction

In 2002, a *Louisville Courier-Journal* investigative series revealed that there were 17 inmate suicides (and 2 restraint deaths) during a recent 30-month period within Kentucky jails. The news was shameful. It illustrated flaws at every level of care. An inmate who was actively psychotic died while flailing in restraints; others died from simple lack of supervision. The deaths not only highlighted a lack of resources available to jails — from staff with limited knowledge about mental illness, untimely supervision of inmates, inadequate medical and mental health treatment, to a lack of services from state psychiatric hospitals and other mental health providers. Most hospitals do not accept inmates with felony charges. The investigative series also indicated that fiscal barriers kept inmates with behavioral health problems from being anyone's service priority. It was shocking information for the general public to learn that inmates with mental illness could languish and die in jail. And it was a welcome beginning of changes for Kentucky jailers.

The Kentucky legislature responded to the newspaper expose by mandating that all jailers receive four hours of mental health training, and provided funding to the community mental health centers (CMHC) to provide the workshops. The CMHCs were also encouraged to offer consultation and enter into contractual relationships with their local jails to provide services. It was a small beginning with a big goal of forcing entire systems of care to make needed changes.

During the training workshops, the jailers indicated that while they appreciated the information, what they really needed was more mental health services. They wanted additional resources to assist them in making day-to-day decisions about the management of inmates who were suicidal and/or experiencing mental illness. As a result, the idea for a Telephonic Behavioral Health Triage Service, offering 24-hour, 7-day a week access to mental health professionals, was proposed by Ray Sabbatine, a corrections consultant and former jailer of the Lexington-Fayette Urban County Detention Center. Connie Milligan from the Bluegrass Regional Mental Health-Mental Retardation (MH-MR) Board (the local CMHC in Central Kentucky) collaborated with Mr. Sabbatine to develop and initiate the program.

Suicide/Behavioral Health Risk — Problem Review

The limited data about mental illness in jails are well known. We know that the suicide rate in jails is much higher than in the community. We know that approximately 50 percent of all jail suicides occur within the first 24 hours of confinement. And while national data indicates more than 16 percent of inmates have mental illness, and those with substances abuse problems represent as high as 80 percent of the jail population, many believe the numbers are growing. While these figures illustrate the potential for suicide, they do not identify the contributing factors or possible solutions. It is time for all our systems of care to take a closer look and begin problem-solving.

The safe management of inmates who are suicidal and/or have mental illness includes providing for the safety of all inmates and staff, while also meeting the constitutional obligation to provide quality care. A jail's management options are limited. They include making decisions about housing, supervision, clothing, and property, while providing appropriate physical and verbal intervention to complex symptoms of behavioral disorders. What most jails need, but are unable to provide unless filing for civil commitment, is a comprehensive mental health evaluation of inmates. The reality is that the majority of Kentucky's rural jails lack the staff and training to adequately respond to many behavioral health problems, and financial constraints have limited their ability to purchase mental health services. Likewise, the majority of CMHCs across the state are unable to offer mental health services to jails without financial compensation. This has left the majority

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of Kentucky jails without the resources to manage high-risk inmates with mental health problems.

It is not difficult to understand why many jails fail miserably in the management of mental illness and the prevention of suicide. Jail philosophy, building design, staffing, training, and supervision are all contrary to the best practices of the behavioral health disciplines. Let's take a brief look at these issues.

Jails are created to house criminal offenders. Their primary goals of public and institutional safety have created facilities designed to isolate those of high risk. Isolation is often the only solution available for providing safety and care to a person at risk due to symptoms of mental illness. It is also often the only solution available for a person whose behavior is difficult to manage. And in truth, an individual's behavior problems will subside over time when given no stimulation. But, is this really the answer to these problems? And should we be surprised that these solutions breed fear and depression, making it fertile ground for suicidal behavior?

Jail staff are traditionally selected and trained with a very different set of criteria than meeting the unique needs of persons with mental illness. While jail staff are usually well-trained, the provision of educational information regarding mental illness and suicide prevention is not given top priority. In addition, it takes a great deal of experience to accurately assess those who are bad actors versus those who are acting bad as a consequence of their mental illness. Even a well-trained professional working in a jail can lose a compassionate mental health perspective as a consequence of having to separate those at risk from those who are manipulating to seek additional services. Yet every day jail personnel are expected to make sophisticated judgment calls to manage inmates with complex behavioral problems and symptoms of mental illness. It is a tough challenge to hire and train jail personnel to balance the divergent special needs of an inmate population, especially at entry-level salaries. It is also a situation that is fraught with liability for all jails.

Jail staffing ratios can be another source of liability. As budgets tighten, so do the ratios. The supervision needs of the population guide the staffing patterns. When an inmate is determined to be at high-risk and in need of more observation, the staffing ratios of a small jail can be stretched to an acute level. The provision of greater inmate observation is difficult for all but the largest of facilities.

It may seem simple — keep persons with mental illness out of jail because they do not belong there. But, if a person is a danger to himself/herself or others, the public demands protection from the threat of harm. The systems of public safety and behavioral health are called upon to provide this protection. If a person with mental illness commits a crime, it is not always ethically or legally possible to divert or drop charges in favor of mental health services. Until there are additional treatment and housing options for persons with mental illness who commit crimes, jails will continue to be charged with their care. How will jails meet this challenge?

Managing Suicide/Behavioral Health Risk

The task of managing risk in jails is daunting. Jails have always attempted to identify inmates who are at risk for suicide or other behavioral disorders. Yet various screening forms may over-identify inmates at risk for suicide. A screening instrument developed on the heels of a successful suicide may even be the checklist that was offered by a plaintiff's expert during the last litigation.

Those identified as being at risk are isolated, stripped of clothing and property, and supervised at more frequent intervals in an attempt to eliminate both means and opportunity. The resources necessary to manage this over-identification of risk are not always available. Inmates can languish for days, weeks, and even months in these depressed conditions. As jail staff decide whether to return property and clothing, they often engage in mental health decisions without the education or training to do so. When the return of either means or opportunity results in a suicide, successful litigation often follows. It has become quite clear that the two pressing needs of today's jails are the accurate screening of behavioral health risk and the need for professional behavioral health services to manage the assessed risk.

While there are some excellent examples of jail and community mental health collaboration for the provision of mental health services in jails, especially when combined with the use of effective classification, most jails are not so fortunate. Many of our nation's 3,300 county jails are small and cannot afford adequate mental health staffing coverage. Even when a jail identifies a person with mental illness or suicidal propensities, without consultation from a health care provider, jail deaths occur all too often. Since many jails and community agencies have budget constraints that preclude the provision of mental health services, who is offering the services? How can we help the majority of our nation's jails prevent suicide?

There are a number of innovations developed with this goal in mind. Jail diversion programs that begin with police officer training and conclude with special court diversion-to-treatment services are being implemented across the country. More jail personnel are being trained on the signs and symptoms of suicide and mental illness. Jails are now being designed to offer better visibility of at-risk inmates so that they, even in single cells, are not visually isolated from their caretakers.

Most detention centers are using some system to identify suicide and mental health risk factors during the booking and screening process. Following that, jails are being encouraged to implement an objective classification program that offers another in-depth look at an inmate so that the risks and needs are considered in determining housing and service requirements. The Kentucky Association of Counties, which insures most of the state's 90 jails, has implemented a risk management program to encourage the use of objective classification systems, as well as collaboration between jails and community mental health providers. The association offers risk management training and on-site consultation of risk containment strategies.

Even with these improvements, most jails in Kentucky are looking for ways to offer more effective mental health services. It is clear that if the risk and liability of providing care to inmates with mental health needs is going to be reduced, mental health providers need to be involved. For example, after the Lexington-Fayette Urban County Detention Center entered into a contract with the Bluegrass Regional MH-MR Board, the liability of providing care to inmates with mental illness was dramatically reduced. In the few

instances where negative outcomes occurred despite the collaborative efforts of jail and mental health personnel, courts ruled against the plaintiff because there was no indication of wrongful action, negligence, or deliberate indifference. Together, jail staff and mental health providers can reduce their liability exposure while providing appropriate service responses that save the lives of offenders with mental illness.

A Kentucky Solution — Telephonic Behavioral Health Triage

The Telephonic Behavioral Health Triage Service was developed by the Bluegrass Regional MH-MR Board with these lessons in mind. It offers jail officials immediate, 24-hour/7-day a week access to the expertise of a qualified mental health professional for identifying mentally ill and suicidal inmates in their facilities. A triage instrument, which identifies research-based risk variables that are endemic to the jail environment, matches the risk level to facility management protocols. These protocols ensure relative consistency in the management of persons identified as either suicidal and/or mentally ill. The triage assessment provides the first step in a process of identification, early intervention, follow-up treatment, and linkages with local providers. The service model, which also includes on-going training of jail personnel, is a helpful resource for smaller jails that lack immediate access to a mental health professional.

Pilot Project Results

Initially piloted in three jails within the Bluegrass Regional MH-MR Board area, the Telephonic Triage Service has since expanded to include two additional jails outside of the region. Although only operational since July 2003, project results have been interesting; substantiating not only the need for the Service, but also the merits of collaboration between jails and community mental health providers. Preliminary data and anecdotal stories highlight benefits of the Service that go beyond the initial expectations. In the largest jail that has utilized the program, data showed that 85 percent of the inmates who were triaged had significant mental health symptoms, 83 percent were exhibiting suicidal risk factors, and 50 percent had current substance abuse that posed a risk. These findings were not surprising. However, what is surprising was the fact that 25 percent of the inmates had recently been discharged from a psychiatric hospital and were not connected to follow-up mental health services. In addition, the Triage Service recommended that 69 percent of the inmates should have some type of follow-up mental health services.

The need for additional collaboration and services from mental health providers has become evident. Jail management options are limited. When a facility's staffing patterns are tight, there is little opportunity for one-on-one interaction with an at-risk inmate beyond the required custodial supervision. If a jail has medical staff, care decisions are often placed with them. This reliance on nursing staff to assume the role of mental health professionals is a convenient, yet not optimal solution. These staff are often already extremely busy with other responsibilities. Finding medical personnel with mental health experience is helpful, though not always possible. The best solution for both jail personnel and the inmate population is the provision of services from a CMHC.

The Triage Service data showed that there was a clear need for follow-up mental health services to at-risk inmates. The qualified mental health professional (QMHP) has an important role in offering consultation and service coordination for these services. In this role, there have been cases where the QMHP has collaborated with jail personnel to advocate and arrange for charges to be amended (in some cases dropped) so that treatment or early release could be arranged. We have discovered that the triage instrument is an excellent pre-screening tool to determine if an inmate may meet the criteria for civil commitment to a state psychiatric hospital. In those cases, the QMHP helps initiate those legal proceedings by calling in local CMHC providers. The Triage Service is providing answers to questions that are clearly best offered by a mental health professional.

In addition, the acuity levels of the triaged inmates showed that there was an opportunity to make some different judgment calls about risk management. The most common level of risk management utilized was *high*, where 65 percent of the inmates were categorized. Jail personnel were encouraged to call back if symptoms changed for inmates designated to this category. This guideline also offered an opportunity for staff to make a different triage assessment and move the inmate into a lower level of risk management or arrange for follow-up care (often hospitalization or face-to-face services). Preliminary data also showed that only 10 percent of the cases resulted in the inmate triaged at a *critical* level of risk requiring the use of restraints. In each of these cases, restraints were used for a brief period of time (i.e., less than three hours with the individual subsequently moved to the high level of risk management). In 17 percent of the cases the triage process assessed the inmate as being at a *moderate* level of risk, resulting in the inmate's placement in the general population with individualized observation. Finally, 8 percent of the cases resulted in the inmate being triaged as a *low* level of risk with no intervention required.

Kentucky's Statewide Model — "Jail Mental Health Crisis Network"

The success of the pilot project, combined with support from numerous interest groups, has prompted this initiative to be developed into a model of care that will serve the entire state of Kentucky. The Triage Service model has been drafted into legislation that is currently pending in the Kentucky Legislature for funding. The statewide model, entitled the "Jail Mental Health Crisis Network," will offer four specific components of care: 1) a standardized mental health screening instrument, 2) the Telephonic Behavioral Health Triage Service, 3) CMHC funding to provide in-jail and/or follow-up services, and 4) an infrastructure to manage the program, collect data, train staff, and provide quality assurance.

Component 1 — Standardized Screening Instrument

The success of the Jail Mental Health Crisis Network project hinges on the use of a standardized instrument in all Kentucky jails that will identify suicidal thinking, behavioral health risk factors, mental retardation, and acquired brain injury. Jails need accurate screening instruments supported by reliable sources of information gathered during the entire period of incarceration. The collection points should include, but not be limited to, the following:

- Intake triage by the arresting and/or transporting officer;
- Self-report screening of every arrestee at booking;
- Examination of "alert files" to determine high-risk activity during the inmate's prior confinement;
- Observation during incarceration;
- Outside reporting;
- Primary classification face-to-face interview; and
- Reclassification based upon event or request

If any of these collection points reveal a level of behavioral risk, jail personnel should seek a secondary level of assessment conducted by a QMHP.

Component 2 — Telephonic Behavioral Health Triage Service

The Telephonic Behavioral Health Triage Service was designed as the secondary level of assessment. It can be accessed during booking, classification, or at any point when an inmate displays signs of suicidal behavior and/or mental illness. Jail personnel simply access the toll-free crisis telephone line and are immediately connected to a trained and experienced QMHP who conducts a triage risk assessment.

The research-based triage instrument, developed with consultation from national experts, is utilized by the QMHP to identify a level of risk commensurate with specific behavioral health problems. It includes an assessment of risk related to the charge, substance abuse, suicide and several categories of mental illness (e.g., depression, mania, psychosis, and personality disorders). Other risk factors such as homicidal ideation, post traumatic stress disorder or trauma history, substance abuse history, mental retardation, and acquired brain injury are also factored into the triage assessment. Each one of these data elements is defined in a data dictionary that enables the QMHP and jail personnel to understand and speak the same language. More importantly, it offers consistency in identification and assessment, going beyond the subjective reliance on professional judgment.

The triage instrument is designed around the research variables that are typically indicative of the highest level of risk. The variables are ones that can be easily identified by custody staff and captured through the tools available to them, i.e., screening process, intake triage form, and observation. Because the telephonic triage is conducted by the QMHP who dialogues with the jail officer (and perhaps the inmate), it cannot be confused with a psychosocial or diagnostic assessment. Each field on the assessment form is limited to data elements that indicate high-risk or quickly observable symptoms in any category of mental illness. The variables reflect the latest data on risk of suicide, risk related to criminal charges, and observable diagnostic criteria (e.g., DSM-IV-R).

For example, in assessing risk of suicide, six risk factors are ranked from highest to lowest. Each risk factor, existing alone or in combination, is weighted to determine a risk level ranking of critical, high, moderate, or low. The highest risk factor is "current attempt." It carries the most immediate, restrictive level of intervention and is defined as "suicide attempt was the basis for arrest, happened during transport, *or* arrestee is currently exhibiting suicidal intent with self- harming/life-threatening behavior." The second highest suicide risk factor is "history of an attempt in jail," which factors in an inmate's prior history of risk-taking behavior in jail and research data indicating a 33 to 50 percent correlation between those that make previous attempts and those that commit suicide. The suicide risk level is factored into other mental health data elements, but is given more weight because suicidal behavior in jail is the source of the highest risk and liability in managing inmates with symptoms of mental illness.

The QMHP assigns a final level of risk (critical, high, moderate, or low) based upon the constellation of current and historical suicide and behavioral health symptoms. The risk level is linked to corresponding jail management protocols that define interventions related to housing, supervision, clothing, property, and food for each level of risk. Jail personnel are then responsible for implementing the management protocols that best meet the risk level. Operational protocols are recommended, but not mandated by the QMHP. It is this handshake between the mental health professional and jail personnel that can establish a "best practices" model of care for protecting the inmate from harm. For years, jail staff has been required to screen for risk, assess the likelihood of risk occurring, and respond with operational decisions. The collaborative nature of this program strengthens the likelihood of a positive outcome and creates a welcome level of defensibility in the case of a negative one.

Historically, most operational protocols have been based upon screening instruments which over-identify many inmates as being at high-risk. Without a secondary level of assessment, the continuum of operational protocol interventions usually begins with the most restrictive levels of restraint and isolation. Many facilities continue to utilize four-point restraints. Without mental health consultation services, restraint periods can be excessive, creating both a medical and suicide risk. As a result, restraint deaths have become more frequent as we have attempted to prevent suicide.

Only with a finding of critical risk is restraint suggested as an option by the triage instrument. It is recommended that a restraint chair be used for short durations with constant observation, frequent well-being checks, and release every four hours to allow for proper circulation, hydration, and toileting. The telephonic triage process not only narrows the use of restraint for those assessed as a *critical* risk, but further suggests a safer method of restraint and other protocols of frequent care.

If the instrument assesses an inmate as *high* risk, then operational protocols establish baselines of care in the areas of:

- Housing: Recommending a safe cell void of any means to commit suicide;

- Supervision: To be frequent and staggered virtually eliminating opportunity;
- Clothing: Suicide smock, gown, coveralls, or other quilted materials;
- Property: Suicide blanket or sleeping bag made of the same quilted material; and
- Food: Finger food void of bones or other potentially harmful items.

These baselines are suggested for the first period of incarceration or until a follow-up consultation suggests otherwise.

If the instrument finds that an inmate is of *moderate* risk, then decisions regarding housing, clothing, property, and food are made consistent with the individual's classified status and observable behavior subject to continued assessment. When indicated, this status can be reduced to *low* risk.

The standardization of these protocols will ensure a consistency of care that was previously non-existent in Kentucky jails. Because implementation of these operational protocols suggests specific jail resources, their incorporation into the triage instrument will assist jails in obtaining adequate funding for needed services. Insurers of the facilities also have baselines from which to judge insurability and level of required premiums. The telephonic service will be able to offset behavioral health decisions to a mental health professional, thereby reducing the jail's liability from making judgment calls that are outside their staff's area of expertise.

Component 3 — Community Mental Health Center Follow-up Care

The third component of the Jail Mental Health Crisis Network is for funding CMHC follow-up services. In Kentucky, as seen nationally, there is a continued trend of mentally ill inmates cycling through three systems of care — CMHCs, state psychiatric hospitals, and jails. Typically, the length of stay in outpatient and hospital-based care has been brief; long enough to be placed on medication, but not engaged in therapy or consistent follow-up services. In many cases, treatment has never reached a stage of symptom maintenance. Consequently, the treatment provider of choice or by default has become the jail. In fact, inmates with mental health problems may well represent a group of patients for whom appropriate treatment is yet to be developed.

It is hoped that increased funding to the CMHCs will allow for the opportunity of creative programming that best meets local jail and community needs. In rural areas where the CMHCs and jails have not worked together in the past, it offers new treatment dollars to bring mental health service providers into the jail. In areas where the relationship has been established for years, mental health providers may now be paid for services they had previously provided at no cost. In jails that have adequate mental health services (and several of Kentucky's larger jails do), this funding may provide the incentive to develop new programs that can address the jail recidivism problem for inmates with mental illness. New techniques are clearly needed to engage this treatment-resistant population into effective care. Focus groups looking at these problems have identified a need for case management services and housing in the community for this population. Case management at the time of discharge can offer important linkages into traditional service systems. It can provide follow-up care to ensure that services are consistently obtained, employment options are explored, and other service needs are met. Limited housing options for this population have been noted to be one of the factors that recycle this group of people back into contact with the legal system. Flexible funding will hopefully encourage some creative solution development.

Component 4 — Mental Health Crisis Network Infrastructure

A centrally managed infrastructure for the Jail Mental Health Crisis Network will include staffing to provide operational training for all the jails, crisis line providing the Telephonic Triage Service, statewide data system, and quality assurance. To initiate this service, personnel in each jail will be trained on the operation of the program. The training will include an overview of the importance of consistent implementation of the screening instrument and principals of classification. Local CMHC staff will be present for the training to encourage their knowledge, support, and collaborative participation in the project. Since the CMHCs will also be responsible for providing training on mental illness and suicide prevention, it is hoped that the spirit of collaboration will have been already established.

Staffing for the crisis line will include QMHPs trained on the protocols. In Kentucky, a QMHP requires a minimum of a master's degree in a mental health field, licensure, and at least three years of mental health experience. A QMHP is qualified by the Kentucky Revised Statutes to make a determination of a person's eligibility for civil commitment to a state hospital. Jail triage staffing at this level will ensure that the telephonic work is being provided by mental health professionals credentialed at the highest level of care and who are statutorily entrusted to make mental health risk determinations.

The data system will offer statewide tracking of all inmates assessed by the Triage Service, with access to historical records by inmate and jail. The tracking of each triage contact will establish a data bank offering a profile of high-risk inmates and provide information that has not previously been collected or known. With access to historical records, jails will have information that can alert them to the potential of future high-risk behavior. Jails will know how many inmates presented a risk for suicide, mental illness, and/or substance abuse problems during prior confinement. These risk factors will be identified along with their assessed level of risk and the suggested protocols of care. Jails will know how many of the identified inmates need follow-up services, when the care occurred, and the outcomes. Data on persons currently in treatment will include the treatment provider, medication, history of hospitalization, and criminal history. These factors will help determine appropriate follow-up care and possible diversion. The software and report generator will be able to evaluate the data in determining whether the instruments are valid and whether the Network is successful in obtaining expected outcomes.

In addition, data will be collected into a format that can be e-mailed or sent via facsimile so jails will have immediate access to the information. The data will offer Kentucky a heretofore unexamined look at the profile of inmates who are suicidal and/or have incidences of mental illness. We hope that this information will allow us to further develop protocols for safer management, intervention, and diversion.

Quality assurance standards will be developed and monitored to assure that the established standards of care are consistent from the triage call to follow-up services. From the outcome data, we will have the opportunity to begin establishing best practice guidelines for jail mental health services.

Expected Outcomes

If these efforts at statewide implementation are successful, we can expect many positive outcomes. In addition to tracking the data from triage calls, we will be able to identify the effectiveness of resources allocated to this underserved population and measure the impact of new interventions. The expected outcomes include:

- Better understanding of suicide and mental illness by jail personnel, as well as of jail operations by QMHPs;
- Development and delivery of on-going staff training on the identification and response to issues of suicide and mental illness in jails;
- Reduction of deaths in custody from suicide, mental illness, and other behavioral health causations;
- Minimization of utilizing restraint to manage behavioral health problems in custody;
- Improvement in the screening of initial risk for behavioral health issues in custody;
- Encouragement of the telephonic triage service usage for screening risk;
- Implementation of operational protocols that represent best practices in jail risk management;
- Encouragement to utilize the CMHC network for follow-up referral care needs; and
- Minimization of utilizing jails to manage behavior associated with mental illness.

From Pilot Project to Legislative Enactment

The development of a statewide model for jail services has been a natural outgrowth of the Telephonic Triage Service. Jails across Kentucky have expressed an interest in this service. In the process of meeting with jailers and reviewing the program, the politics of funding and authorization highlighted a difficulty faced by most jails. While the cost of this service is nominal, the process of obtaining fiscal authorization for a new service is a political process that is difficult, especially in our tight economy. Attempting to require *individual* jurisdictions in all 120 Kentucky counties to address these problems and negotiate service contracts with *each* of the 15 CMHC Boards would result in the same disparity and inconsistency in services that exists today. Governments cannot act in isolation on problems that cross all boundaries when scarcity of resources demands fiscal responsibility. A statewide infrastructure funded by state government provides a more fiscally responsible approach to this problem. Collaboration and cooperation is the key to developing a jail mental health crisis network that will survive party politics and electoral terms. Statewide implementation is the right thing to do, fiscally and logistically.

In pursuing legislative funding for a statewide service, it was essential to seek the endorsement of numerous interest groups. One of the first groups to learn of this project was a legislatively-mandated commission that examined the service needs of persons with mental illness. This workgroup, devoted to examining both criminal justice and behavioral health issues, was involved in the development of the mental health training for jails and endorsed this project from the beginning. It officially recommended that the legislature fund the statewide proposal.

An essential group, the Kentucky Jail Association, has also offered its official endorsement of the program. In Kentucky, jailers are elected officials who often have the strongest political support in their county. Their clout in getting legislation passed cannot be underestimated. The Kentucky Association of Counties, the insurer of most jails around the state, has a clear interest in seeing this service expanded. A statewide program like this can help reduce some of its highest risk as an insurer. Its endorsement has been essential in demonstrating the validity of this program from a risk management perspective. The National Alliance for the Mentally Ill (NAMI) has also provided solid support. Representatives from their state board of directors were involved in the initial mental health training to jails and have been kept apprised of the project's development. NAMI has been a strong advocate for the program because it provides safe management, consistency, and follow-up treatment for a group of people who have long been underserved and often misunderstood. Finally, the criminal justice subcommittee to the Governor's Commission on Acquired Brain Injury has endorsed the program. Its interest and support surfaced because jail screening and triage offers an opportunity for inmates who have a brain injury to be identified and triaged to appropriate service providers.

The most significant endorsement of the program has come from well-educated state senators and representatives who are guiding the legislation through the lawmaking process. The legislators recognize that this project addresses an issue needing correction.

Conclusion

If the alarming rate of in-custody suicide is going to be reduced, service providers at every level need to collaborate. Jails across the country are struggling with an increase in the percentage of inmates at risk for suicide and mental illness. Risk management measures in jails often over- identify the risk. Secondary levels of assessment that can more clearly define the risk and management

options are limited. If it is accepted that fiscally driven changes in our service delivery system may be at the heart of the problem, then the solution must go beyond the jails. Fiscal responsibility requires challenging our paradigms to create an infrastructure of programs that will survive the political process and assure responsible quality of care. In Kentucky, steps are being taken to include mental health providers as partners in innovative program development. Legislation is being sought that will legitimize these new services as standard operating procedures. Kentucky's Jail Mental Health Crisis Network demonstrates that when jails and mental health providers work together, their handshake can be the beginning of creative solutions.

About the Authors

Connie Milligan is the Regional Director for Intake and Emergency Services at the Bluegrass Regional MH/MR Board in Lexington, Kentucky. Ray Sabbatine is a corrections consultant (Sabbatine & Associates, LLC) and former jailer of the Lexington-Fayette Urban County Detention Center. Mr. Sabbatine can be reached at: tykerjs@bellsouth.net. For additional information regarding the Telephonic Behavioral Health Triage Service, contact Connie Milligan, Bluegrass Regional MH/MR Board, P.O. Box 11428, Lexington, Kentucky 40575, (859/253-1686 or e-mail: cpmilligan@bluegrass.org). ❑

Jail Suicide Liability and Communication

As we have previously opined in the ***Update***, certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and communicated to others, may prevent a suicide. There are essentially three stages of communication in preventing inmate suicides: (1) communication between the arresting/transporting officer, correctional staff; and/or family members; (2) communication among facility staff (including correctional, medical, and mental health personnel); and (3) communication between facility staff and the suicidal inmate.

In large measure, suicide prevention begins at the point of arrest. During initial contact, what an individual says and how they behave during arrest, transportation to the jail, and booking are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the arrestee. Arresting officers should pay close attention to the arrestee during this time because suicidal behavior, anxiety, and/or hopelessness of the situation might be manifested. Prior behavior can also be confirmed by onlookers such as family and friends. Any pertinent information regarding the arrestee's well-being must be communicated by the arresting or transporting officer to facility staff. In addition, the intake screening form should document whether the arresting/transporting officer believes that the inmate is currently at risk for suicide. It is also critically important for facility staff not to create barriers of communication between themselves and the inmate's inner circle of family and friends because this group often has pertinent information regarding the current and prior mental health status of the inmate.

Because an inmate can become suicidal at any point during incarceration, correctional officers must maintain awareness, share information and make appropriate referrals to mental health and medical staff. At a minimum, facility officials should ensure that appropriate staff are properly informed of the status of each inmate placed on suicide precautions. Multidisciplinary team meetings (to include correctional, medical, and mental health personnel) should occur on a regular basis to discuss the status of an inmate on suicide precautions. In addition, the authorization of suicide precautions for an inmate, any changes to those precautions, and observation of an inmate placed on suicide precautions should be documented on designated forms and distributed to appropriate staff.

Facility staff must also use various communication skills with the suicidal inmate, including active listening, staying with the inmate if they suspect immediate danger, and maintaining contact through conversation, eye contact, and body language. Correctional staff should trust their own judgment and observation of risk behavior, and avoid being misled by others (including mental health staff) into ignoring signs of suicidal behavior.

The communication breakdown between correctional, medical, and mental health personnel is a common factor found in the reviews of preventable inmate suicides. Recently, in two separate yet strikingly similar inmate suicide cases, federal courts ruled that

ON YOUR WATCH: The Challenge of Jail Suicide

Tired of watching the same old training videotape on suicidal inmates that is not only outdated but poorly produced. Good news. A new DVD is now available to supplement your suicide prevention training workshop. Written, directed, and produced by Dan E. Weisburd, an Academy Award nominee, ***ON YOUR WATCH: The Challenge of Jail Suicide*** presents seven short vignettes portraying the experiences of several individuals prior to, and during, their arrest and the tragic events that occurred following their initial incarceration. This 110-minute DVD is very polished and the production, filmed by an Emmy Award winning director of photography, includes 35 actors, as well as numerous correctional officers, mental health and medical professionals, and inmates. ***ON YOUR WATCH: The Challenge of Jail Suicide*** also includes a companion CD-ROM that offers a lesson plan outline for both one-hour and full-day suicide prevention training, as well as articles on active listening and jail suicide liability.

For more information regarding the availability and cost of ***ON YOUR WATCH: The Challenge of Jail Suicide***, contact the California Institute for Mental Health, 2030 J Street, Sacramento, California 95814, (916/556-3480), or at www.cimh.org

jurisdictions could be found deliberately indifferent if they had knowledge of an individual's potential risk for suicide and did not communicate such information to the receiving correctional facility (i.e., the first stage of communication between the arresting/transporting officer and correctional staff). The two cases, *Wilson v. Genesee County* and *Cavalieri v. Shepard*, are discussed below in detail.

Wilson v. Genesee County

Alvin Wilson, 26-years-old, was arrested by officers from the Flint Police Department on January 7, 2000 and charged with murder, possession of a firearm by a felon, and felony firearms. The arrest was related to a domestic incident between Mr. Wilson, his estranged wife and a family friend (Theodore Ruth). During the incident, Mr. Wilson allegedly shot Mr. Ruth by accident in the home they shared following Mr. Wilson's estrangement from his wife. In the aftermath of the shooting, Mr. Wilson held several family members hostage and became involved in a standoff with officers of the Flint Police Department. According to various police reports, Mr. Wilson safely released the hostages soon after initial discussions with the officers, but refused to submit to arrest. He alternated pacing between his front porch and house interior. Whenever he appeared on the front porch, Mr. Wilson was holding a handgun and officers repeatedly ordered him to drop the weapon. According to one officer's report:

> "I ordered the suspect to drop the gun, the suspect stated, 'I ain't dropping nothing.' I again ordered the suspect to drop the gun, the suspect stated, 'Shoot me.' At that time the suspect placed the muzzle of the weapon to the left side of his head and pulled the trigger. The weapon's hammer fell but no round was fired. The suspect repeatedly pulled the weapon's trigger, but no rounds were fired. Between pulling the weapon's trigger, the suspect held the weapon in front of him with the muzzle pointed upwards, and manipulated the cylinder area of the weapon. The suspect then went back into 409 Josephine and shut the door."

Police officers attempted to negotiate a peaceful resolution to the incident with Mr. Wilson for several hours. Following lengthy negotiations, Mr. Wilson eventually surrendered to police without further incident and was transported to the Flint Police Department. He was subsequently placed on suicide precautions in the police lock-up facility.

Two days later on January 9, 2000, Mr. Wilson was transported from the police lock-up to the Genesee County Jail in Flint by two police officers. The officers did *not* inform jail staff of the circumstances surrounding Mr. Wilson's arrest two days earlier. Mr. Wilson was booked into the facility without incident. As per county jail policy, a receiving screening form was administered to Mr. Wilson and he denied any current or prior suicidal ideation. During the booking process, however, a jail deputy noticed a smell of marijuana on his breath. Mr. Wilson acknowledged that he had been given the drug from another inmate in the holding cell. Both Mr. Wilson and the other inmate were relocated to the facility's Restrictive Housing Unit (RTU) to serve a 5-day disciplinary sanction for possession of contraband. On January 10, a classification deputy interviewed Mr. Wilson in the RTU. He was observed as cooperative and again denied any suicidal ideation.

Two days later on January 12, 2000, a jail deputy found Mr. Wilson hanging from a wall vent in his cell by a shoelace. The deputy called a medical emergency and other correctional personnel and a jail nurse arrived at the cell. Mr. Wilson was given cardiopulmonary resuscitation by jail personnel and subsequently transported to a local hospital where he was pronounced dead.

A lawsuit was subsequently filed by the family of Alvin Wilson alleging that the deliberate indifference of the Flint Police Department and its officers, as well as the Genesee County Sheriff's Department and its staff, were the proximate causes of his suicide. In March 2002, Judge Avern Cohn of the United States District Court, Eastern District of Michigan (Southern Division) issued an opinion in *Wilson v. Genesee County* that, for the most part, sided with the plaintiff. The court concluded:

> "In essence, this case is about a failure to communicate and/or have policies in place for adequately accessing and communicating an individual's suicide risk at all levels, and especially when transporting an individual from one facility to another. The evidence of record is sufficient to have this issue submitted to a jury to determine whether the individual defendant's action, and the City of Flint and Genesee County's policies and training amounted to deliberate indifference to Wilson's serious medical need to be adequately screened for suicidal tendencies and to be protected against taking his own life."

Wilson v. Genesee County continued for more than a year, with several defendants attempting to appeal Judge Cohn's ruling to the United States Court of Appeals for the Sixth Circuit, until it was finally resolved by a settlement to the Wilson family in November 2003. Under terms of the agreement, the City of Flint and Genesee County agree to pay the Wilson family $915,000, an undisclosed amount of which will go to the family of Theodore Ruth (the murder victim).

Cavalieri v. Shepard

On February 24 2003, the United States Court of Appeals for the Seventh Circuit ruled in *Cavalieri v. Shepard* that the mother of a jail inmate was entitled to pursue a civil rights claim against a police officer for his alleged failure to inform county jail officials that her son was on the verge of trying to commit suicide. The appeals court rejected the officer's argument that his duty to inform ended when the pretrial detainee was transferred from municipal custody to county custody. The court held the officer had an on-going duty despite surrendering custody of the individual to officials in a different agency, and also had a duty to inform any state-affiliated entity that next held custody over the detainee. In November 2003, the U.S. Supreme Court declined to review the appeals court decision. [*Cavalieri v. Shepard*, 321 F.3d 616 (7th Cir. 2003), cert. denied, *Shepard v. Cavalieri*, No. 02-1843,

2003 WL 21489910 (U.S. Nov. 10, 2003).] The United States Court of Appeals for the Seventh Circuit case of *Shepard v. Cavalieri* (No. 01-3745) is reprinted below.

Before POSNER, MANION, and DIANE P. WOOD, Circuit Judges.

DIANE P. WOOD, Circuit Judge:

Steven Cavalieri is in a vegetative state after attempting suicide in a holding cell in the Champaign County Correctional Facility (the CCCF). Steven's mother, Joann Cavalieri, brought this action under 42 U. S. C. § 1983 as the guardian of her son's estate, claiming that Steven attempted suicide after Donald Shepard, a police officer with the City of Champaign (the City), and others acted with deliberate indifference to his risk of suicide. Shepard now appeals from the district court's denial of his motion for summary judgment and claim of qualified immunity. We affirm.

I.

Although this is an interlocutory appeal, Shepard is entitled to bring it now, because he is raising the question whether he should have prevailed on his defense of qualified immunity, based on the facts taken in the light most favorable to Mrs. Cavalieri. See *Mitchell v. Forsyth*, 472 U. S. 511, 525-26 (1985). We must resolve a qualified immunity issue as early as possible in the proceedings, because it is an "immunity from suit rather than a mere defense to liability." *Saucier v. Katz*, 533 U. S. 194, 200 (2001) (emphasis in original). We present the facts below in the light most favorable to Mrs. Cavalieri, because we have no appellate jurisdiction to the extent disputed facts are central to the case. See *Johnson v. Jones*, 515 U. S. 304 (1995).

On June 4, 1998, Steven kidnapped Stephanie Rouse, his former girlfriend, and took her from Champaign to a remote area of Urbana. Using a gun, he threatened to kill both Rouse and himself. Rouse convinced Steven to drive back to town, and then she called his mother from a public phone. After speaking with Rouse, Mrs. Cavalieri called the Crisis Hotline in Champaign County. Rouse later placed a call to the Crisis Hotline as well. The Crisis Hotline contacted the Metropolitan Computer Aided Dispatch (METCAD), which called the City Police Department.

The Champaign Police Department dispatched two officers who were instructed that there was a hostage situation involving a man with a gun. At approximately 3:00 am, the officers knocked on Rouse's door; a male responded, but he refused to let the officers inside. The officers then called a hostage negotiation team and contacted Rouse by telephone. Rouse denied that Steven was present and that she might need assistance, but she also refused to leave her apartment. This standoff continued for several hours until approximately 6:00 am, when a member of the hostage negotiation team spoke with Mrs. Cavalieri. She advised the officers that her son was suicidal and needed to go to a hospital.

About an hour later, the SWAT team entered the apartment using pepper spray. They immediately handcuffed and removed all the occupants, including Steven, who was found hiding under a kitchen cabinet. Rouse was briefly interviewed at the scene. After the SWAT team located Steven, Rouse informed the officers of the events of the evening, specifically telling them that Steven had threatened to kill both himself and her.

After Steven arrived at the City jail, he met with defendant Shepard for approximately one hour. Steven asked Shepard if he could speak to a mental health counselor, and Shepard explained that jail personnel would arrange for him to speak with someone. At around 10:00 am, Steven was transferred to the CCCF. Despite the official transfer, Shepard remained personally involved with the case and continued to participate in interviews with both Rouse and Mrs. Cavalieri.

First, Shepard joined an ongoing interview with Rouse. Rouse explained once again that Steven had threatened to kill her and commit suicide himself. Rouse also told Shepard that this kidnapping came just a month after Steven was arrested for criminal trespass at Rouse's apartment. Finally, Rouse told Shepard that Steven claimed that he would kill himself if he ever returned to jail.

Next, Shepard interviewed Mrs. Cavalieri. Mrs. Cavalieri told Shepard that she wanted to make arrangements to ensure that her son saw a counselor. She also explained that her son's mental condition was fragile, and she told Shepard about the calls to the Crisis Line the night before. Finally, she told Shepard that Steven had been on suicide watch the month before at the CCCF, while he was being held there in conjunction with his criminal trespass arrest. Shepard advised Mrs. Cavalieri that Steven's mind was "on overload," that he seemed very upset, and that he believed Steven would need counseling. Mrs. Cavalieri told Shepard that Steven needed to be on suicide watch and should not be left alone. Shepard responded by promising Mrs. Cavalieri that Steven would not be alone.

Around 11:00 am, Shepard called the CCCF to speak with Steven. He informed Steven that Mrs. Cavalieri was with him and that she would arrange for him to have a counselor. During this conversation Steven told Shepard that he was doing fine and that he was looking forward to seeing his mother. Shepard then directed Mrs. Cavalieri to County Mental Health so that she could arrange for Steven to speak with a counselor.

Shepard asserts that after completing these interviews, he did not subjectively believe that Steven was a suicide risk. He emphasizes that Steven seemed calm when they spoke on the phone, was without weapons, and that during their phone conversation he stated that he was doing fine. Unfortunately, this was far from the case.

After Steven was transferred to the CCCF, he was not placed on suicide watch. Steven himself did not alert the CCCF staff to the fact that he was having suicidal thoughts. Indeed, during his intake he denied all the events of the early morning (having the gun, harming or threatening anyone, having suicidal thoughts or ever attempting to commit suicide). He did ask to speak to a mental health advisor, and was told he would receive one, but no advisor came before his attempt on his life. Steven was assigned to a holding cell in the booking area while he awaited further processing. The holding cell contained a telephone with a strong metal cord. Later that afternoon, Shepard called the CCCF to instruct the guards

to put a stop to Steven's phone calls, as he had been making annoying calls to Rouse. Shepard was then informed that around 2:10 pm, Steven had been found unconscious, hanging from the wire telephone cord. To this day, he has not regained consciousness and remains in an unresponsive state. He now lives in a nursing home near his mother.

II.

As the Supreme Court recently reminded us, in order to decide whether a defendant is entitled to qualified immunity, we must first determine whether (taking the facts in the light most favorable to the plaintiff) a constitutional right was violated, and second, if those facts would demonstrate a violation, we must decide whether the right in question was clearly established at the time the events took place. *Saucier*, 533 U. S. at 200. We review these issues de novo, *Dufour-Dowell v. Cogger*, 152 F. 3d 678, 680 (7th Cir. 1998). Viewing the record in the light most favorable to Mrs. Cavalieri, we conclude that Shepard can prevail in this case only if certain disputed facts are resolved in his favor by a trier of fact. Put differently, taking the facts from the required perspective, we conclude that Steven's constitutional rights were violated and that these rights were clearly established as of mid-1998.

A)

As an initial matter, we must determine whether Mrs. Cavalieri has alleged facts that would show that Shepard's conduct violated her son's constitutional rights. Mrs. Cavalieri first claimed violations of the Fourth Amendment, but she now correctly asserts that Steven's claim, which she is pursuing as his guardian, arises (if at all) under the Fourteenth Amendment. See *Bell v. Wolfish*, 441 U. S. 520, 535 n. 16 (1979). The Eighth Amendment does not apply to pretrial detainees, but as a pretrial detainee, Steven was entitled to at least the same protection against deliberate indifference to his basic needs as is available to convicted prisoners under the Eighth Amendment. *Id*.; *Payne v. Churchich*, 161 F. 3d 1030, 1039-41 (7th Cir. 1998); *Tesch v. County of Green Lake*, 157 F. 3d 465, 473 (7th Cir. 1998). Under both the Eighth and Fourteenth Amendment standards, the plaintiff has the burden of showing that (1) the harm to the plaintiff was objectively serious; and (2) that the official was deliberately indifferent to her health or safety. *Farmer v. Brennan*, 511 U. S. 825, 833 (1994); Payne, 161 F. 3d at 1041 ("A detainee establishes a § 1983 claim by demonstrating that the defendants were aware of a substantial risk of serious injury to the detainee but nevertheless failed to take appropriate steps to protect him from a known danger.").

The question is whether Shepard was aware that Steven was on the verge of committing suicide (which, if it occurred, surely would qualify as a serious harm). If the trier of fact believes Mrs. Cavalieri's account, the answer is yes. We realize that according to Shepard, the only facts available to him were (1) Rouse's statement that Steven attempted to kill her and himself, but that she had calmed him down and he apologized; (2) that Steven was calm when interviewed; (3) that Steven did not have a weapon and was under custody; and (4) that Steven said he was fine when Shepard spoke with him over the phone. Unfortunately for Shepard, if other evidence in the record is credited, a trier of fact could conclude that he knew much more. Since we must take the facts in the light most favorable to Mrs. Cavalieri, we must also consider four additional facts: (1) that Shepard told Mrs. Cavalieri that Steven was upset during his interview; (2) that Mrs. Cavalieri told Shepard that Steven should be on suicide watch; (3) that Shepard knew that Steven had been on suicide watch only a month before; and (4) that Rouse told Shepard that Steven had warned her that he would kill himself if he was ever returned to the jail.

Shepard argues that the fact that Steven had no weapon with him and was under the CCCF's custody trumps the testimonial evidence of the information he had at his disposal. Unfortunately, these precautions are not always enough to prevent this kind of event. Although weapons are obviously not permitted in jails and prisons, there are high rates of suicide in prisons (higher than in the general population), and even higher rates among pretrial detainees. See, e. g., *Jutzi-Johnson v. United States*, 263 F. 3d 753, 757 (7th Cir. 2001). As a result, prisons and jails have developed procedures for dealing with prisoners who display suicidal tendencies, such as removing items that could be used as a suicide weapon, like sheets or a sturdy telephone cord, or not leaving those prisoners unattended.

Shepard's deposition testimony that he did not think Steven was on the verge of suicide is also not enough to eliminate a genuine issue of fact. We recognize that "strange behavior alone, without indications that that behavior has a substantial likelihood of taking a suicidal turn, is not sufficient to impute subjective knowledge of a high suicide risk to jail personnel." *Estate of Novack ex rel. Turbin v. County of Wood*, 226 F. 3d 525, 529 (7th Cir. 2000). Indeed, had no one informed Shepard that Steven was at risk of suicide, this would be a different case. But both Mrs. Cavalieri and Rouse testified that they had alerted Shepard to this specific risk. Shepard was not forced to operate only on the basis of a brief observation, cf. *Mathis v. Fairman*, 120 F. 3d 88, 91-92 (7th Cir. 1997) (odd or unusual behavior without more did not place officers on notice that a detainee was at risk for suicide when the officers were unaware of any suicidal tendencies in the detainee). In the present posture of this case, we must take as a given that Shepard was aware that Steven had been arrested for attempting to kill both himself and Rouse, and that he had learned from both women that Steven was at risk for suicide.

Even assuming that Shepard knew about Steven's suicidal inclinations, Mrs. Cavalieri cannot prevail on Steven's claim unless she can also establish that Shepard acted with deliberate indifference to this risk. Deliberate indifference "describes a state of mind more blameworthy than negligence," and "something less than acts or omissions . . . with knowledge that harm will result." *Farmer*, 511 U. S. at 825. Applying a subjective recklessness test, the Court in *Farmer* found that "a prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety." *Id.* at 837. The same holds for a pretrial detainee's claim under the Fourteenth Amendment. Although this is a "high hurdle for a plaintiff," *Peate v. McCann*, 294 F. 3d 879, 882 (7th Cir. 2002), he "need not show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm." *Farmer*, 511 U. S. at 842.

Shepard insists that he did all that was required of him, and that even on the record taken in the light most favorable to Steven, no reasonable trier of fact could find that he was deliberately indifferent to Steven's suicide risk. He focuses on two specific actions he took: first, his telephone call to Steven to "check on his welfare" and tell him that his mother was coming to see him, and second, his offer to Mrs. Cavalieri to help her arrange for Steven to see a counselor. Of course, Shepard was not required to take perfect action or even reasonable action, even assuming he was aware of the suicide risk; his action must be reckless before § 1983 liability can be found. *Chapman v. Keltner*, 241 F. 3d 842, 845 (7th Cir. 2001). On the other hand, Mrs. Cavalieri is not required to show that Shepard intended that Steven harm himself. *Boncher v. Brown County*, 272 F. 3d 484, 487 (7th Cir. 2001). On this record, we conclude that the facts taken most favorably to Mrs. Cavalieri would show that Shepard was deliberately indifferent to Steven's safety. Indeed, if we consider Mrs. Cavalieri's version of events, Shepard may have deliberately misled her. He told her that Steven would not be alone and he also behaved as if he understood the severity of the information she provided him regarding Steven's mental health, yet he did not even take immediate measures that would have been quite easy for him, such as passing her warnings along to the CCCF staff. Perhaps Mrs. Cavalieri would have gone directly to the CCCF if she had known that Shepard did not intend to inform anyone of their conversation. Moreover, Shepard had multiple opportunities to present this information to the CCCF. His two calls to the CCCF demonstrate the ease with which he could have conveyed the information after Steven was transferred. Perhaps a jury would not believe this version, but on this record, a jury could find that Shepard's actions were reckless.

B)

Having established that Mrs. Cavalieri has alleged facts that, if proven, show that Shepard violated a constitutional right, we must still address Shepard's argument that he is entitled to qualified immunity because the constitutional right Steven is asserting was not clearly established at the time of these events. *Saucier*, 533 U. S. at 201. Whether a right is clearly established "must be undertaken in light of the specific context of the case, not as a broad general proposition." *Id*. The right must be clear enough that "a reasonable official would understand that what he is doing violates that right." *Id*. at 202. Although the officer must have knowledge of the right, it is not necessary that a case be "on all fours" with this one for the case to go to a jury. *Montville v. Lewis*, 87 F. 3d 900, 902 (7th Cir. 1996). Instead, the question we must ask is whether the law provided Shepard with "fair warning" that his conduct was unconstitutional. *Hope v. Pelzer*, 122 S. Ct. 2508, 2516 (2002) (rejecting the Eleventh Circuit standard that a previous case must be "fundamentally similar" to be clearly established).

Although Shepard and Mrs. Cavalieri differ over how the constitutional right should be characterized, we agree with the district court that at bottom, the right Mrs. Cavalieri asserts on behalf of Steven is the right to be free from deliberate indifference to suicide. There is no doubt that this right was clearly established prior to Steven's 1998 suicide attempt. See *Hall v. Ryan*, 957 F. 2d 402, 406 (7th Cir. 1992).

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

Shepard argues, however, that the present case represents an extension of earlier law because Steven was transferred from the custody of the Champaign Police Department (his employer) to the custody of the CCCF, a county facility. He likens this case to *Collignon v. Milwaukee County*, 163 F. 3d 982 (7th Cir. 1998), in which this court found that Milwaukee County was not responsible for the suicide of a pretrial detainee who killed himself after being released to his parents. The most important difference between *Collignon* and this case, however, is that in *Collignon* the detainee left state custody upon his transfer, and here Steven remained in state custody. Nothing in *Collignon* implies that the court was establishing a general rule of non-liability for transferees. In fact, Shepard's argument implies that he did not have to pass along any information to his colleagues in the county jail. No responsible officer in Shepard's position would have taken such a position. If Steven had been armed, Shepard could not have stayed silent and waited to see if the CCCF officials found the weapon; if Steven was prone to violent outbursts, Shepard similarly could not have left his colleagues and the other county detainees at Steven's mercy. While there are different arms of state government, the walls between them are not as high as Shepard implies. To the contrary, each must keep the other informed about material facts, including suicide risks. See *Farmer*, 511 U. S. at 832 (officials required to take adequate measures in response to known risk); see also *Viero v. Bufano*, 901 F. Supp. 1387, 1394 (N. D. Ill. 1995) (adequate measures include communicating likely suicide risk to transferee correctional facility). Even the *Collignon* court conceded that it would have been facing a different problem if the officials had known that the detainee was a likely suicide risk. *Id*. at 990.

Of course, the law did not require Shepard to sit by the telephone all day, communicating with the CCCF about transferred prisoners. The question is what he was supposed to do in the face of the knowledge of a life-threatening situation that he actually had. He made several telephone calls to the CCCF, but he passed by the opportunity to mention that he had been informed that Steven was a suicide risk, and that the jail itself had recognized this only a month earlier. If Shepard had known that a detainee had an illness that required life-saving medication, he would also have had a duty to inform the CCCF, or any other entity that next held custody over the detainee. See *Egebergh v. Nicholson*, 272 F. 3d 925, 927-28 (7th Cir. 2001) (denying a qualified immunity defense where police officers knew that the arrestee was an insulin-dependent diabetic, knew that such people need regular insulin injections, knew that the failure to give injections was potentially fatal, and nonetheless failed to make sure the injections were given, with fatal consequences).

We conclude that the law as it existed at the time of Steven's suicide attempt provided Shepard with fair notice that his conduct was unconstitutional. *Hope*, 122 S. Ct. at 2516. The rule that officials, including police officers, will be "liable under section 1983 for a pre-trial detainee's suicide if they were deliberately indifferent to a substantial suicide risk," *Hall v. Ryan*, 957 F. 2d 402, 406 (7th Cir. 1992), was clearly established prior to 1998. The fact that several state agencies were working together on his case, and that Steven happened to attempt suicide in the county's facility rather than at the police station, does not change this analysis.

III.

The judgment of the district court is AFFIRMED.

MANION, Circuit Judge, dissenting. The threshold inquiry we must undertake in a qualified immunity analysis is whether plaintiff's allegations, if true, establish a constitutional violation. *Saucier v. Katz*, 533 U. S. 194, 201 (2001). I disagree with the court's conclusion that the facts most favorable to the plaintiff are sufficient to allow a jury to conclude that Officer Shepard acted with deliberate indifference or with a reckless disregard for Steven Cavalieri's safety while Steven was detained at the Champaign County Correctional Facility (CCCF). Even if Shepard violated Steven's constitutional right by not informing CCCF of his suicide risk, he may nevertheless be shielded from liability for civil damages if his actions did not violate "clearly established statutory or constitutional rights of which a reasonable person would have known." *Harlow v. Fitzgerald*, 457 U. S. 800, 818 (1982). A constitutional right is clearly established when its contours are "sufficiently clear that a reasonable official would understand that what he is doing violates that right. . . . [I] n the light of pre-existing law the unlawfulness must be apparent." *Anderson v. Creighton*, 483 U. S. 635, 640 (1987). In this case, Shepard did not have reasonable notice at the time of Stephen's incarceration that the conduct alleged by the plaintiffs was unconstitutional. I therefore respectfully dissent.

The court finds that because Shepard failed to communicate Steven Cavalieri's possible suicide risk to intake officials at the CCCF, a jury could find that Shepard was deliberately indifferent under the Eighth and Fourteenth Amendments. Under the deliberate indifference standard Mrs. Cavalieri must allege facts that show that Shepard was aware of Steven's suicide risk and nevertheless acted or failed to act with deliberate indifference to a substantial risk of serious harm to Steven's health or safety. *Farmer v. Brennan*, 511 U. S. 825, 836 -37 (1994). See also *West v. Waymire*, 114 F. 3d 646, 651 (7th Cir. 1997) ("plaintiff must prove that the defendant, knowing that the plaintiff (or someone) was at serious risk of being harmed, decided not to do anything to prevent that harm from occurring even though he could easily have done so"). Because suicide is a serious medical risk, the alleged facts in this case must show, under the deliberate indifference standard, that Shepard demonstrated a "reckless disregard for the known serious medical need, by inaction or woefully inadequate action." *Hudson v. McHugh*, 148 F. 3d 859, 863 (7th Cir. 1998); *Sanville v. McCaughtry*, 266 F. 3d 724, 740-41 (7th Cir. 2001) (holding that "[t]o be liable under the Eighth Amendment for an inmate's suicide, 'a prison official must be cognizant of the significant likelihood that an inmate may imminently seek to take his own life and must fail to take reasonable steps to prevent the inmate from performing this act'" (citation omitted)). An official may not be liable for mere negligence. *Farmer*, 511 U. S. at 836. See also, *Soto v. Johansen*, 137 F. 3d 980, 981 (7th Cir. 1998) ("mere negligence or even gross negligence does not constitute deliberate indifference") (internal quotations and citation omitted). Moreover, officials may also escape liability "if they responded reasonably to the risk, even if the harm ultimately was not averted." *Farmer*, 511 U. S. at 844. However, by labeling as deliberate indifference Shepard's failure to communicate Steven's mother's and girlfriend's concerns over his suicide risk to CCCF intake officials, the court has equated

deliberate indifference with negligence. It is undisputed that Shepard did in fact take responsive action to Steven's emotional distress, but the court incorrectly holds that a jury could find that Shepard violated Steven's constitutional rights because he did not follow a better course of action.

The facts most favorable to Mrs. Cavalieri cannot establish that Shepard was deliberately indifferent to Steven Cavalieri's risk of suicide. Instead, under the "woefully inadequate" standard, *Hudson*, 148 F. 3d at 863, Shepard's rather intensive involvement with Steven should reduce rather than increase his liability for deliberate indifference. Nevertheless, it appears that court faults Shepard for being too attentive by remaining personally involved with the case.

After he arrived for duty, Shepard was sent to the location where Steven had just been captured after the kidnapping and three-hour standoff with the SWAT team. As the plaintiff's brief notes, "A SWAT operation is a major event, and one involving hostages did not occur often in Champaign." Clearly everyone at the correctional facility was fully aware of the crisis, as well as Shepard when he conducted a one-hour interview with Steven at the city jail after he was first arrested. Steven was then transferred to the CCCF, where he had been incarcerated under suicide watch only weeks earlier.

After the arrest, Shepard participated in an interview with the victim, Stephanie Rouse, where she spoke of Steven's suicide threats. He also interviewed Steven's mother where she informed him that she wanted to make arrangements for Steven to see a counselor. Mrs. Cavalieri also informed Shepard that during Steven's stay at CCCF one month earlier he was on suicide watch. Shepard placed a subsequent call to Steven at the CCCF at 11:00 am where he informed Steven that his mother would be contacting him about counseling. During this last discussion, Steven told Shepard that he was fine and looking forward to seeing his mother. Finally, Shepard directed Mrs. Cavalieri to County Medical Health so that she could arrange for Steven to speak to a counselor. When Shepard called the CCCF three hours later to inform them that Rouse had complained that Steven was making harassing calls to her, he was informed that Steven had attempted suicide.

This hands-on activity on Steven's behalf cannot be described as deliberate indifference to Steven's condition. No doubt, in Shepard's two calls to the CCCF he had ample opportunity to inform someone that he thought Steven might pose a suicide risk. Yet one of those calls was specifically placed to Steven personally in order to check on his welfare and inform him about Mrs. Cavalieri's ongoing efforts to secure counseling. As a matter of law, Shepard's time, attention and concern were reasonable responses to Cavalieri's suicide risk and therefore cannot be described as "woefully inadequate." See *Perkins v. Lawson*, 312 F. 3d 872, 875-76 (7th Cir. 2002) (finding no deliberate indifference when steps were taken to obtain treatment for inmate); *State Bank of St. Charles v. Camic*, 712 F. 2d 1140, 1146 (7th Cir. 1983) (finding officers had not acted with deliberate indifference because, in part, they had taken reasonable actions to prevent suicide). (1)

When examining a claim for deliberate indifference we are obligated to examine the totality of the circumstances surrounding the alleged actions or inaction. *Dunigan ex rel. Nyman v. Winnebago County*, 165 F. 3d 587, 591 (7th Cir. 1999); see also *Gutierrez v. Peters*, 111 F. 3d 1364, 1375 (7th Cir. 1996) (holding that isolated instances of neglect "cannot support a finding of deliberate indifference"). At most it was a negligent act for Shepard not to inform CCCF (where Steven had been under suicide watch only a month earlier) of Steven's current suicide risk. See *Lewis v. Richards*, 107 F. 3d 549, 553-54 (7th Cir. 1997) (stating that "[e]xercising poor judgment, however, falls short of meeting the standard of consciously disregarding a known risk to his safety"). Under the court's analysis, would Shepard be off the hook had he not shown continued concern for Steven's case and not spent additional time with the victim and his mother? Had Shepard simply called CCCF and said that Steven was a possible suicide risk, he apparently would have been dismissed from the case with the other defendants.

Deliberate indifference cannot rest on negligent actions or inactions, but must instead rest on reckless indifference to the plight of an inmate. See *Mathis v. Fairman*, 120 F. 3d 88 (7th Cir. 1997) (holding that prison officials could not be held liable under the reckless disregard standard for a prisoner's suicide when their actions were negligent at most). A single example of alleged neglect, based on choosing one reasonable course of action over another, will not create a jury question as to deliberate indifference, especially when the court has previously held that "showing deliberate indifference through a pattern of neglect entails a heavy burden." *Dunigan*, 165 F. 3d at 591 (7th Cir. 1999) (emphasis added). The standard threshold for "liability for negligently inflicted harm is categorically beneath the threshold of constitutional due process." *County of Sacramento v. Lewis*, 523 U. S. 833, 847 (1998). By equating possible negligence with deliberate indifference the court has impermissibly lowered the bar for prisoner claims under the Eighth and Fourteenth Amendments.

Even if we were to proceed with the qualified immunity analysis it has not been established that under the facts of this case, "it would be clear to a reasonable officer that his conduct was unlawful in the situation he confronted." *Saucier*, 533 U. S. at 202. Under the standard for liability for deliberate indifference described in *West v. Waymire*, it is clear that Shepard did, in fact, do something to alleviate the risk of Steven's suicide. *West*, 114 F. 3d at 651. Under this standard, and the wealth of case law equating deliberate indifference with inaction or woefully inadequate action, supra n. 1, Shepard would not have understood that his conduct was unlawful. The court cites *Viero v. Bufano*, 901 F. Supp. 1387 (N. D. Ill. 1995), as standing for the proposition that adequate measures in response to a suicide risk necessarily include communicating such risk to personnel at the correctional facility. In a subsequent proceeding in that same case, the district court noted that the officer did much less than just fail to communicate the prisoner's substantial risk of suicide to the committing institution. *Viero v. Bufano*, 925 F. Supp. 1374, 1384 (N. D. Ill. 1996). The officer also failed to take the prisoner's Ritalin prescription from her mother, and, in short, failed to "take any such reasonable steps in response" to the victim's medical needs. That is not what occurred in this case. The court also cites *Egebergh v. Nicholson*, 272 F. 3d 925, 927-28 (7th Cir. 2001) as relevant to the proposition that an officer must communicate all known medical information to the custodial entity. However, in *Egebergh* the officers in question were not liable for deliberate indifference because they failed to communicate

to Cook County Jail personnel that the diabetic prisoner had future medical needs. *Id*. Rather, the court stated that "a jury could infer that they knew that depriving him of his morning shot [when he was in the offending officer's sole custody] would endanger his health and that they deprived him of it for no better reason than to get him out of the police station." *Id*. at 928. I agree with the court that on the date of Cavalieri's nearly successful suicide attempt it was clearly established that a police officer on duty could not act with deliberate indifference toward a pretrial detainee who the officer believed was a substantial suicide risk. *Estate of Cole v. Fromm*, 94 F. 3d 254, 258 (7th Cir. 1996). However, under this standard, an officer is only required to act reasonably, and as a matter of law, Shepard took reasonable actions in this case.

Obviously if a jury believes Shepard when he testifies that he honestly believed, after talking with Steven, that he was not a suicide risk at that time, he will not be found to be deliberately indifferent. But before going to a jury the plaintiff must allege that Shepard knew of the risk (not just should have known), knew that he should inform CCCF personnel of the risk, but deliberately or recklessly failed to do so. Instead, the plaintiff has at most alleged a negligent failure to inform CCCF of the suicide risk. That is not enough. Shepard should have been granted summary judgment along with the other named defendants.

References

(1) Deliberate indifference has been found when the state actor did nothing or next to nothing in response to a substantial suicide or health risk. See *Egebergh v. Nicholson*, 272 F. 3d 925, 927-28 (7th Cir. 2001) (holding that a jury could infer that police officers were deliberately indifferent to insulin dependent patient when they transported him to another jail without administering an insulin shot); *Sanville v. McCaughtry*, 266 F. 3d 724, 740-41 (7th Cir. 2001) (holding that plaintiff had stated a claim of deliberate indifference as to prison guards when they did nothing for several hours in response to suicidal prisoner's covering of the window of his prison cell); *Reed v. McBride*, 178 F. 3d 849, 854 (7th Cir. 1999) (holding that where prison officials knew about periodic substantial deprivations of food and medicine to a prisoner and did nothing for almost two years to remedy the situation, the prisoner met his burden to show an inadequate response). See also, *Jacobs v. West Feliciana Sheriff's Dept*., 228 F. 3d 388, 395-99 (5th Cir. 2000) (holding that sheriff and deputy could be found to be deliberately indifferent to plaintiff's suicide risk when they took some preventative measures but those measures were obviously inadequate and therefore not objectively reasonable); *Woodward v. Myres*, 2002 WL 31744663 (N. D. Ill. 2002) (finding that plaintiff had alleged sufficient facts to establish that intake nurse, sheriff and correctional facility doctor had acted with deliberate indifference when no actions were taken protect suicidal detainee); *Wilson v. Genesee County*, 2002 WL 745975 (E. D. Mich. 2002) (finding arresting officers could be found deliberately indifferent when they did nothing in response to arrestee's substantial suicide risk); *Viero v. Bufano*, 925 F. Supp. 1374, 1384 (N. D. Ill. 1996) (finding that a fact question existed as to officer's deliberate indifference when officer did not take any reasonable steps in response to suicide risk of transferee).

Editor's Note: The lesson learned from both the ***Wilson*** *and* ***Cavalieri*** *cases is simple: law enforcement and correctional agencies should forge better means of communicating the potentially suicidal behavior of individuals taken into custody. One efficient mechanism would be for the receiving agency to include the following question on the intake screening form (or create and arresting/transporting officer questionnaire):*

> ***"Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency/facility, family member/guardian, etc.) that indicates inmate is a medical, mental health or suicide risk now?"*** ❑

News From Around the Country

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

Louisiana

Orleans Parish has filed a lawsuit blaming Louisiana State University (LSU) for the death of inmate Shawn Duncan. The lawsuit contends that the LSU Health Sciences Center, which had been contracted to run the Orleans Parish Prison's psychiatric ward, had left it understaffed at the time of Mr. Duncan's death from dehydration in August 2001. The death had spawned an earlier federal wrongful death lawsuit filed against Orleans Parish authorities by the victim's family in July 2003.

Mr. Duncan, 24-years-old, was charged with drunk driving on August 3, 2001 after he smashed his car into two parked vehicles. He died one week later and his autopsy report, as well as accompanying medical records, indicated that Mr. Duncan was held in restraints for approximately 40 hours before he was found dead by another inmate. The autopsy report concluded that the lack of fluids in Mr. Duncan's body was so severe that he had no fluid in his eyes, and his stomach was dry.

The initial lawsuit alleged that Mr. Duncan was held in restraints for 40 hours without food, water or bathroom privileges, despite a medical policy of the Sheriff's Office that an inmate could not be held in restraints for more than 12 hours. According to the lawsuit, in the morning just before his death, Mr. Duncan was heard "cursing, yelling or screaming," yet medical staff failed to intervene.

Then-Sheriff Charles Foti had initially stated that Mr. Duncan had been seen by a psychiatrist every day of his confinement, including at least 18 hours before his death. He attributed the death to complications from ingesting drugs Mr. Duncan had stolen from other inmates. However, the Sheriff's Office, now led by interim Sheriff William Hunter, has put forth a different version of events in the lawsuit filed against the LSU Hospital in January 2004.

According to the Orleans Parish Sheriff's Office, Dr. Michael Higgins was the psychiatrist LSU appointed to run the prison's psychiatric unit. At the time of Mr. Duncan's death, the new lawsuit alleges, Dr. Higgins was on leave and LSU had not named a psychiatrist to replace him. "As a result of this breach, the morning sick call was not conducted, Shawn Duncan remained in five-point restraints and (died) later that day," the lawsuit alleges. It is also alleged that Dr. Howard Osofsky, director of LSU's psychiatry department, was responsible for finding a psychiatrist to replace Dr. Higgins, but failed to do so. Instead, LSU "wrongfully appointed (prison medical director) Dr. Richard Inglese, who is neither a psychiatrist nor a physician from the LSU School of Medicine," the lawsuit states.

Although all of the defendants and their attorneys have refused to comment on the two lawsuits, Mary Howell, attorney for Mr. Duncan's family, believes the lawsuit filed by the Orleans Parish Sheriff's Office against the LSU Health Sciences Center might be a breakthrough in the case. "The good news, if there can be any good news from this type of tragedy, is that this will lead to policy changes to hopefully keep this from happening again," Ms. Howell told the *Times-Piscayne*. "The unfortunate thing is that, still, nobody wants to step up and take responsibility for what happened here. It was a terrible death, and it involved a great deal of suffering."

Indiana

Two sergeants working in the Vanderburgh County Jail were suspended for two days, and four civilian detention officers were suspended for three days, following an investigation into a recent inmate suicide at the facility in Evansville. Sheriff Brad Ellsworth announced the suspensions at a news conference on March 2, 2004.

Rodney Freeman Wilson, 49-years-old, was on suicide precautions at the time of his death on January 26, 2004. Sheriff Ellsworth said the investigation indicated that Mr. Wilson was left unobserved by correctional staff for more than four hours. Although required to be observed at 15-minute intervals, Mr. Wilson was last seen at 5:37pm before being found hanging at 9:51pm when an officer noticed something unusual on the closed circuit television (CCTV) monitor. The coroner's office later estimated that Mr. Wilson had been dead for more than an hour.

Mr. Wilson had been confined in the Vanderburgh County Jail since January 3, 2004, charged with robbing two local pharmacies in order to obtain OxyContin, a prescription painkiller to which he was addicted. On January 9, he was placed on suicide precautions following a threat of suicide and moved to an isolation cell for better supervision. According to the investigation, after taking a shower on the afternoon of January 26, Mr. Wilson apparently smuggled one or two towels into his cell and tore them into strips. He was then able to attach the strips to a metal mounting bracket in the middle of the wall that once held a CCTV camera. Although the camera had previously been relocated to a higher position, the old bracket remained in the cell.

"Our staff did nothing to cause Rodney Wilson to take his own life. However, the staff of our detention center did fail to adhere to our policies as it relates to inmate care," Sheriff Ellsworth told the *Courier and Press*. He called the suicide policy "solid," but added "people just got lax and were not adhering to the policy."

While professing that "when a person intends on harming himself or taking his own life, it is nearly impossible to prevent that," the sheriff also announced several corrective measures, including inmates being strip-searched when returning from a shower, counseling correctional and medical personnel on policies and procedures, removal of the metal bracket in Mr. Wilson's cell, and purchasing better CCTV equipment to increase visibility.

Florida

Clyde Fuller showed signs he was dying at least 45 minutes before he stopped breathing at the Leon County Jail in June. But he never asked for help, and deputies and nurses in the jail infirmary apparently didn't recognize the symptoms. Instead of treating him for cocaine toxicity, they locked the combative inmate into a restraint chair and left him unattended for 15 minutes. When a nurse returned, he was taking his last shallow breaths. An autopsy showed that Fuller may have died from a mysterious, drug-related condition known as "sudden custody death syndrome." Whether

UPDATE
ON THE INTERNET

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

www.ncianet.org/cjjsl.cfm

Check us out on the Web!
www.ncianet.org/cjjsl.cfm

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

www.hhpub.com/journals/crisis/1997
www.nicic.org/jails/defrault.aspx
www.ojp.usdoj.gov/managingoffenders/mentalhealth.htm
www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
www.performancebasedstandards.org
www.gainsctr.com

jail staff, including two nurses who saw him, should have known what was happening is not clear.

Street cops and pathologists have been conducting training on the syndrome for years. However, there seems to be little agreement on how far that information has spread among most law-enforcement and medical professionals. "It depends on your experience," said Dr. Emma Lew, an assistant medical examiner for Miami-Dade County. "We see it all the time, but someone who doesn't may not recognize it."

Fuller was the third inmate to die at the jail this year and the second in the infirmary, which is run by Prison Health Services. Ruth Hubbs, 39, died in May from an overdose of prescription anti-depressants.

What exactly is sudden custody death syndrome? The short answer: No one knows for sure. A South Florida pathologist documented it more than a decade ago in a study of unexplained deaths in police custody. There seemed to be several common factors but no obvious cause.

It occurs most frequently with long-term cocaine users, often in encounters with law-enforcement officers. Before or during an arrest, the victims progress from relatively normal to "bizarre" behavior, then they become incoherent and aggressive. They can show paranoia, increased strength and complete disorientation. Their body temperatures often surge. Medical experts call it "excited delirium," and it's the last stages of cocaine toxicity. Death can soon follow. "It's usually just when they're starting to quiet down, and it catches everybody by surprise," said Dr. Michael Bell, president of the National Association of Medical Examiners and a pathologist in Broward County.

There are some theories about why it happens, but there's little exact science. Some medical researchers think a combination of cocaine and sudden physical exertion overstresses the heart and respiratory system, causing them to stop working. Others attribute it to an increase in the number of dopamine receptors in the brain caused by long-term cocaine use. Too much dopamine floods the body, raising body temperature, causing delirium and taxing the heart and lungs until they shut down. "I'm not sure we know exactly what the trigger is," Bell said. "Is it the heart, the breathing, the brain? We don't know."

Clyde Fuller was arrested June 12 after he ran from Tallahassee police, reports show. Officers were tracking a kidnapping suspect on Holton Street and said Fuller fled into a nearby yard when they tried to question him. They charged the 27-year-old with trespassing in the yard. He spent two hours in a holding cell at the Leon County Jail then started the booking process. One of the first things the jail does is give new inmates a brief medical screening, which includes a check of vital signs and a health questionnaire. That's when Fuller said he was an alcoholic, suffered from seizures and was taking epilepsy medication - but had not recently taken any illegal drugs or had anything to drink, according to Sheriff's Office reports.

Then his behavior began to change. He had been speaking normally with a nurse but became increasingly agitated during the medical screening. The nurse described him as "bizarre" and uncooperative, and she decided to send him to the infirmary. The deputies who escorted him there said he was talking to himself and wouldn't respond to questions from a clinic nurse. That nurse told deputies to put him in an observation unit, a glass-walled cell in the infirmary where he could be watched.

Fuller went "ballistic," according to reports. He screamed that he didn't want to be put into a restraint chair - where straps would hold his arms and legs still - even though no one had mentioned using one, deputies said. He spit, kicked and wrestled with deputies and shouted incoherently as they struggled to pin him down. When he wouldn't stop, they used pepper spray. Finally, they decided to lock him into the restraint chair until he calmed down. The deputies strapped him down and the nurse gave him an injection of Ativan, an anti-anxiety drug. They turned him so he was facing away from the glass and left a deputy in the hall to watch over him. The nurse returned about 15 minutes later to find him slumped and barely breathing. He was dead within minutes.

Medical examiners ruled the death a result of cocaine toxicity and told detectives Fuller may fit the profile of sudden custody death syndrome. Detectives with the Leon County Sheriff's Office determined that no one was at fault and closed the case. "While the death of Clyde Fuller is tragic, it was clearly his own actions that led to his death," said Lt. Linda Butler, a spokeswoman for the Sheriff's Office. "We are confident that the staff at the jail handled this situation per Sheriff's Office policy, procedure and training requirements."

Fuller's family has hired attorneys and plans to have the files on his death reviewed by its own medical consultant. "We're pursuing it to determine what the facts are," said Fred Flowers, with the Flowers & White law firm.

One key question will be whether medical workers at the jail could have done anything to keep Fuller from dying. Figuring that out could be difficult. Knowledge about excited delirium is spotty, even within correctional facilities. So is training in how to recognize and treat the symptoms.

The deputies who restrained Fuller did not have such training, according to sheriff's officials. A Prison Health Services spokeswoman said the company's nurses do have orientation in the symptoms of overdoses and signs of drug intoxication, but she could not comment specifically on cocaine toxicity. "I don't think medical professionals know much about it," said Bell, the Broward pathologist. "It's been around for a while, but it's the medical examiners that know and recognize it."

Even officials with an organization that monitors inmate health care said last week they hadn't heard of cocaine-related sudden custody death syndrome. And it's likely not yet well-known in jails, said Judith A. Stanley, director of accreditation for the National Commission on Correctional Health Care. "I would say it is probably not, and I would like to look at that and see if we can do something about it," Stanley said. "When you're in the trenches, in this environment, any information you can get is good." Still, all medical workers should be alert for certain things, she said. While she wouldn't comment specifically on Fuller's case, Stanley said changes in an inmate's behavior can signal that something's wrong — and have to be taken seriously, even if the inmate may be faking it. "You would

expect that medical staff in a correctional environment would recognize red flags," she said. "I may not know the names of all the syndromes, but I should know as the nurse that there's a problem here. "Until you know the cause, you need to take the appropriate precautions until you can rule out medical or mental."

Bill DeVane is a former Florida police officer who teaches courses on sudden custody death syndrome and has trained with the Leon County Sheriff's Office. He said law-enforcement officers and the medical staff that work with them should be able to recognize the symptoms. It could give victims a better chance of surviving, DeVane said. Treatments for cocaine toxicity include using respirators and doses of Haldol, which reverses the rise in body temperature. But even prompt medical attention is no guarantee of survival. "We don't have enough understanding of what the actual mechanism of this arrest is to predict it," Bell said, "let alone prevent it."

The above article — "Illness in Inmate's Death Not Well Known" — was written by Tony Bridges, a staff writer for the ***Tallahassee Democrat****. It appeared in the August 11, 2003 edition of the newspaper and is reprinted with the permission of the* ***Tallahassee Democrat****.*

Maryland

Officials of the Wicomico County Detention Center (WCDC) in Salisbury were recently ordered to reinstate a correctional officer who was fired in connection with an inmate suicide. Officer Michael Brittingham, who had been charged by WCDC Director Douglas Devenyns with violating inmate supervision rules, was exonerated of those allegations by a five-member community panel appointed by the Wicomico County Council. "My client is overjoyed by the decision. He was found not guilty and his name has been cleared," William A. Clarke, attorney for the officer told the *Daily Times* of Salisbury on February 27, 2004. WCDC Director Devenyns reluctantly accepted the decision, commenting to a reporter that "the employee exercised his rights, and we'll abide by (the Personnel Board's) decision. Whether I agree with it is immaterial." The director has said little publicly about the inmate suicide, citing an on-going investigation.

What is known is that Justin Twilley, 23-years-old, was being held in a "medical observation" cell when he committed suicide by hanging on October 25, 2003. WCDC officials have not explained how Mr. Twilley, who had a history of suicidal behavior, was able to hang himself in a cell monitored by closed circuit television (CCTV). Jail policy also required that Mr. Twilley's cell was to be personally observed by jail staff at 30-minute intervals. Three correctional officers had previously been fired in connection with his death.

According to Officer Brittingham, he was in the facility's central control room at approximately 11:00am when he observed Mr. Twilley place a plastic bag over his head through the CCTV monitor. He went to Mr. Twilley's cell and the inmate proceeded to complain that he was not suicidal, yet had been given a special lunch tray reserved for inmates on suicide precautions. Officer Brittingham tried to calm Mr. Twilley down and subsequently provided him with another lunch tray. The officer then resumed his other assigned duties. Mr. Twilley was found dead several hours later.

Although Officer Brittingham and dismissed correctional officer Stacy Rush requested public appeals hearings, as allowed under Wicomico County law, the Personnel Board refused to open the sessions to the public. Ms. Rush, whose appeal was denied by the Personnel Board, said her rights were violated because of the county's desire to keep details of the case secret. "What they did to us was wrong, she told the *Daily Times*.

Ms. Rush said she was fired for following a longstanding "unwritten" policy that supervisors had directed employees to execute. Although Officer Rush was assigned to a separate department on the day of Mr. Twilley's death, she passed his cell at approximately 12:15pm. When she looked inside the cell, Mr. Twilley's back was turned to her. Assuming that he was not in any distress (and unaware that Mr. Twilley was already dead), Officer Rush said she signed the observation form and preceding time slots that other officers had not completed. Jail staff finally entered Mr. Twilley's cell at approximately 5:00pm and noticed he was hanging. It was estimated that the inmate had been dead for at least four hours.

Several correctional officers and a detention center captain testified during her appeals hearing that signing observation sheets for other officers had been practiced for years with the knowledge of supervisors, Ms. Rush stated. She said correctional officers routinely signed observation forms for other officers because the detention center was understaffed. "There aren't enough people there to sign the sheets," she told the *Daily Times*. Ms. Rush contended that she was unfairly singled out by Director Devenyns for punishment. "I was doing what has been done for the eight years that I've been there. If what I did was wrong, then you need to fire every person working there," she said.

Jennifer Calloway, the third correctional officer dismissed for events related to Mr. Twilley's suicide, also said she was fired for improperly signing observation forms. After her appeals hearing, Ms. Calloway said she and the other fired officers were being used as "scapegoats" by jail officials. But as WCDC Director Devenyns told the *Daily Times*, "that practice is not to be tolerated, and we're clarifying it so there can't be any misunderstanding."

Lost in the controversy regarding the right to a public appeals hearing and allegations of a falsified observation form are several more important issues, such as how could an inmate with a history of suicidal behavior and observed with a plastic bag over his head not be on suicide precautions, as well as remain unobserved (either through regular cell checks or CCTV monitoring) for several hours.

As Russell Twilley, the victim's father, told the *Daily Times*, "We thought he was in a place where he couldn't hurt anyone else or himself. Something went terribly wrong."

Colorado

In February 2004, an unnamed man was arrested by officers of the Durango Police Department in connection with a domestic dispute. He was subsequently transported to the La Plata County Jail in Durango, where he appeared intoxicated, belligerent and combative with staff. During the evening of February 23, the inmate tied one end of a sock to the desk in his cell and the other end

around his neck. He then sat down on the floor and began to asphyxiate himself. A correctional officer, conducting routine rounds of the housing unit, observed the inmate in distress. He quickly called for back-up personnel, entered the cell, removed the ligature from the victim's neck, and initiated life-saving measures. The inmate was transported to a local hospital for treatment and later returned to the jail without any significant injury. "Fortunately for everybody, the staff was making its rounds in a timely fashion," Sheriff Duke Schirard told the *Durango Herald*.

Florida

Built in 1987 with an operating capacity for 384 inmates, the Brevard County Jail in Sharpes has grown considerably and housed more than 1,400 inmates the day that John Harrison Brown attempted suicide on February 22, 2004. Mr. Brown, 38-years-old, died at a local hospital the following day and became the fourth inmate to commit suicide in the county jail since December 2003.

According to Mark Tietg, an attorney for the Brevard County Chapter of the American Civil Liberties Union, the occurrence of four inmate suicides in two months reflects the "abysmal" conditions at the overcrowded jail. "My office is flooded with calls from inmates" with complaints about the jail, Mr. Tietig told *Florida Today* in Melbourne. "It's a shameful situation. It's like the Middle Ages. What makes it even more of a travesty is the county has been under a court order to get the inmate-per-cell level down to civilized levels, and they still haven't done it." (A 1993 federal court-order had capped the population at 732 beds.) An annex to the main facility was built in 1997 and, with double bunking of many housing units, the Brevard County Jail now has an operating capacity for 1,036 beds. Although county commissioners recently voted to build a 256-bed jail annex to ease overcrowding, most agree that the infusion of a small number of new beds will not come close to solving the problem.

Mr. Brown was arrested on December 9, 2003 when he called police to the assisted-living home where he had been left in charge of three elderly residents. According to police, Mr. Brown said he called because he would rather be in jail than continue running the home. He was charged with being under the influence of alcohol, which violated the terms of his probation for a prior battery charge against him. Authorities moved the residents and closed the home. On February 11, Mr. Brown was sentenced to nine months confinement.

Mr. Brown was housed in the "400 Pod," a housing area originally designed for 96 inmates that now houses approximately 340 inmates. Each cell block in the pod consists of 16 cells, with three inmates housed in each cell. Some inmates are also assigned to mattresses on the day room floor. The four correctional officers assigned to the Pod are required to make rounds every hour. At approximately 8:15pm on February 22, other inmates alerted officers that they had found Mr. Brown hanging from a window grate in a cell with a sheet tied around his neck. Major Elizabeth Canada, the jail's assistant administrator, stated that Mr. Brow had not given staff any indication that he was suicidal. "I don't think it could have been prevented, unless there is more direct supervision," she said. "The 400 Pod is one of those pods that are just bursting with people. In my 23 years of working here, I have not seen a situation like this before."

Similar to the death of Mr. Brown, 24-years-old Anthony Fernandez was found hanging from a window grate in a cell by other inmates on December 20, 2003. According to available records, he did not have any history of suicidal behavior and had not given staff any indication that he was suicidal.

A few weeks later on January 13, 2004, Carl Ashley was found dead in his cell. The 24-year-old inmate had also tied one end of a bed sheet to window grate in the cell and the other end around his neck. Mr. Ashley had threatened suicide shortly after his arrival at the facility on December 5, 2003. He was placed on suicide precautions, later deemed to be stable by mental health staff, and released from the special watch on December 31. Charged with robbing a local pawnshop of several handguns and facing up to 30 years in federal prison, Mr. Ashley was also housed in the "400 Pod" at the time of his suicide.

Kendall Leon Rolle entered the Brevard County Jail on December 29, 2003. The 17-year-old youth had most recently been housed in the county's juvenile detention center where he had been placed on suicide precautions following a suicide attempt. Ironically, Mr. Rolle was a cousin of Carl Ashley, allegedly participated in the same pawnshop robbery, and was also facing up to 30 years in federal prison. Following Mr. Ashley's death, mental health staff at the jail interviewed the youngster but did not assess him as being at risk for suicide. However, during a bond hearing on January 30, the judge ordered that Mr. Rolle be given a psychiatric evaluation after family members expressed concern that he might be suicidal. On February 2, 2004, Kendall Rolle was found hanging by a bed sheet in the juvenile housing section of the jail. He was not on suicide precautions at the time of his death, and the court-ordered evaluation had not yet been scheduled.

Following Mr. Rolle's death, several Brevard County officials offered comments regarding the rash of suicides in the jail. "I would not attribute the suicides as being the result of the jail being overcrowded," Jail Commander Terry Altman told *Florida Today*. "It does affect the ability of the staff to monitor a particular element as we normally would. When you look at more than 400 inmates sleeping on the floor, it makes the job of the correctional staff that much more difficult. The numbers here do influence individualized attention."

Brevard County Commissioner Truman Scarborough said the turn of events indicates "a failure to fully understand the suicide threat," while County Manager Tom Jenkins offered that "I think everyone clearly recognizes we need to do something." One issue the Commander Altman would like to see resolved is the problem of inadequate staffing in the facility. The jail commander said that a staffing analysis conducted in December 2002 recommended an additional 75 new personnel, including 56 correctional officers. "Of those 65, I have been authorized to hire zero," Commander Altman told *Florida Today*. "It's a sense of frustration to recognize I have a need for staff and not be able to secure staff."

New York

The state Commission of Corrections (SCOC) has concluded that use of excessive force by jail deputies caused the July 2002 death of a 28-year-old man in the Erie County Holding Center in Buffalo. According to the SCOC, Michael T. Bennett, an individual

with schizophrenia, died from "traumatic asphyxia" when at least eight deputies tried to restrain him and one of them used a shoe or boot to apply considerable force to his back during a prolonged struggle. As reported by the *Buffalo News* in January 2004, the SCOC's findings followed a 19-month investigation by its Medical Review Board. "Had Bennett been afforded adequate emergency mental health care or been the subject of a properly supervised and controlled use of physical force, his death may have been prevented," the report stated.

Mr. Bennett was arrested on July 2, 2002 after police said they found him walking naked down a local street. He fought with officers when they tried to arrest him. The report said that during the three days of Mr. Bennett's confinement in the Erie County Holding Center, he tried to hang himself with a shoelace and repeatedly jumped off the toilet head first into the bars of his cell.

Among the SCOC's Medical Review Board findings: 1) on July 2, when Mr. Bennett was being booked at Buffalo Police Headquarters, he was eligible for admission to a psychiatric emergency program, but instead was kept in police custody for approximately 16 hours prior to his arraignment; 2) on July 5, a physician assessed Mr. Bennett from outside of his cell. The review board found that the doctor's "lack of intervention on Bennett's behalf was negligent and constituted professional misconduct;" 3) the physician did not prescribe any medication for Mr. Bennett, no treatment plan was established, and there was no request for his medical records; and 4) when deputies were trying to restrain Mr. Bennett on July 5, the "planned use of force violated virtually all of the Holding Center's policies and procedures governing use of force, including but not limited to the failure to make a mandated video record…"

The SCOC report also disputed the autopsy results from the county medical examiner's office. "A shoe or boot was applied to the deceased's back with pressure sufficient to inflict injury. Petechial hemorrhage was present in both eyes," the report stated. "These findings are fully consistent with and indicative of traumatic asphyxia. The Erie County Medical Examiner's office incorrectly attributed the cause of death to a fatal cardiac arrhythmia associated with….coronary artery disease."

According to Frederick C. Lamy, a commission member and chairman of the review board, there was no information contained within the autopsy report that indicated Mr. Bennett died from heart disease. Mr. Bennett's coronary arteries, the commissioner stated, were "unremarkable" and his heart "was of normal weight and size." In a letter to Dr. James J. Woytash, the county medical examiner, the SCOC and its Medical Review Board repeatedly disputed the autopsy findings. "The board and commission do not find your assertion that the mentally ill are known to have an increased incidence of mortality 'commonly related to cardiovascular events' to be persuasive or pertinent to the death of Mr. Bennett….The board's experience has been that local authorities not infrequently seek to explain deaths during law enforcement or custody restraint by calling them heart attacks when death is in fact due to interference with breathing," wrote Commissioner Lamy.

Donald J. Livingston, first deputy superintendent at the facility, told the *Buffalo News* that he could not comment on the case because of a continuing investigation (as well as pending lawsuit), but said the department was revising its policies and procedures for dealing with mentally ill inmates.

California

The Preston Youth Correctional Facility in Ione is one of 11 juvenile institutions operated by the California Youth Authority (CYA). In November 2003, 17-year-old Deon Whitfield was committed to the facility for drug possession and attempted burglary. Durrell Feaster, 18-years-old, was sent to the 640-bed facility in May 2003, charged with grand theft, fraud, auto theft and receiving stolen property. Due to disciplinary reasons, the two youth were eventually housed together in the Ironwood Lodge, a harshly restrictive unit for juveniles with behavioral management problems. The average length of stay in this special management program (SMP) is between 60 and 90 days, and many youth are locked in their cells for 23 hours each day. The one hour of out-of-cell time for SMP youth often occurs in a wire-mesh cage, euphemistically called a "special protective area" (SPA).

At approximately 1:20pm on January 19, 2004, an officer conducting routine rounds in the Ironwood Lodge discovered Deon Whitfield and Durrell Feaster each hanging by bed sheets tied to the upper bunk railing in their shared cell. Although correctional and medical personnel attempted life-saving measures, both youth were subsequently pronounced dead.

Several days after the suicides, the state Attorney General's Office coincidently released a series of consultant reports regarding conditions of confinement in CYA facilities. The assessments were commissioned in response to a lawsuit (*Farrell v. Harper*) filed by the Prison Law Office in San Quentin. One assessment, *Report of Findings of Mental Health and Substance Abuse Treatment Services to Youth in California Youth Authority Facilities*, was completed in December 2003 and authored by Eric W. Trupin, PhD., a child psychologist, and Raymond Patterson, MD., a forensic psychiatrist.

The report's authors found that many CYA youth with mental illness are often over-medicated and improperly punished, while treated by inadequately trained mental health staff who tend to intervene only when a crisis occurs. The report described a patchwork system of care that varies considerably from facility to facility, specifically citing 1) inconsistent and substandard practices on the use of psychotropic medications, including little measurement of the effects; 2) inappropriate use of punitive strategies, including the SPAs (or wire-mesh cages), as well as a lack of staff skill in de-escalation techniques and overuse of chemical restraints; 3) mental health assessments that are incomplete and lack developmental or family information; and 4) inadequate coordination of mental health professionals and routine lack of involvement of families in treatment plans, making it virtually impossible for the youths to re-enter society.

In regard to Preston's Ironwood Lodge, the report stated:

> "We opined early in the review process that the programs at Tamarack Lodge at Preston should be closed to any youth in need of mental health services. Remarkably, the facility response was to place these youths in Ironwood, where they are isolated and away from staff observation or interaction, and without adequate staff enhancement to

address their mental health needs. The use of the SPAs and OC (oleoresin capsicum) spray appear to be excessive and ineffective (some youth have had numerous incidents of OC spray and stays in the SMP, but their disruptive behavior has not changed in frequency and intensity). At the facility/ administrative level, there does not appear to be any input either prior to the use of these restrictive and punitive measures or after their use, to attempt to alter or develop any meaningful treatment plans or approaches. The frequent use of the SMPs, SPAs and OC spray as punishment exacerbates symptoms of mental illness."

Although acknowledging that progress had been made during their review of the nine CYA facilities, Drs. Trupin and Patterson concluded that "The vast majority of youths who have mental health needs are made worse instead of improved by the correctional environment," and the "California Youth Authority continues to fall short of meeting many recognized standards of care."

Commenting on all the consultant reports, CYA spokeswoman Sarah Ludeman told the *San Jose Mercury News* in late January 2004 that "the observations of the state experts in these areas are substantially correct, and our department is reviewing each of these reports to develop a plan to correct the issues raised." Deputy Attorney General Steve Acquisto, one of the lawyers representing the CYA in the lawsuit, stated that "to the extent problems have been identified, the YA is working diligently to address those problems, and to the extent that the solutions require additional financing, we're going to be working to get that."

Since 2000, there have been six suicides within CYA facilities; half of which have occurred since July 2003. Although CYA officials have not commented on the suicides of Deon Whitfield and Durrell Feaster, citing an on-going investigation, both youth were apparently on 23-hour lockdown status, both had histories of mental illness and were taking psychotropic medication, and one of the youths was awaiting placement into a mental health unit.

On February 10, 2004, the families of both youth filed a claim against the state, the first step toward a lawsuit, seeking at least $2 million in punitive damages. Officials with the state's Victim Compensation and Government Claims Board would not comment on the filing, but CYA spokeswoman Ludeman stated that the two youth had not been assessed as being at risk for suicide. "Our staff on a routine basis intervene and successfully save wards that attempt suicide," she told the *San Jose Mercury News* on February 12. "So this is a tragedy for the family and also for our staff that work with these young men and try to turn their lives around."

Yet as Gloria Romero, state senator and chairwoman of an oversight committee on corrections, told the *Los Angeles Times* on January 28, 2004, "These suicides put a human face on the tragedy of what happens when we do not pay attention to the mental health needs of incarcerated teenagers. The Youth Authority has a crisis in its health-care delivery, especially when it comes to meeting mental health needs."

To obtain a copy of the *Report of Findings of Mental Health and Substance Abuse Treatment Services to Youth in California Youth Authority Facilities*, contact the Prison Law Office, General Delivery, San Quentin, California 94964, (415/457-9144), or at www.prisonlaw.com ❑

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 through 11)

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

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

or

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