

# JAIL SUICIDE/MENTAL HEALTH UPDATE

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## SECURITY AND MENTAL HEALTH PROFESSIONALS REVISITED: STILL A (TOO) SILENT PARTNERSHIP

by

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To long time readers of the *Jail Suicide/Mental Health Update*, much of this article will look familiar, and it should. In large part, this is the same article first published in what was then called the *Jail Suicide Update* in 1993, during a time when court activism around institutional health and mental health care was more pronounced than it is today. Experts, administrators, practitioners, politicians and academics were talking and writing about the importance of establishing and maintaining suicide prevention and crisis intervention services within the jail/ prison environment.

For more than two decades now, national jail standards have included a call for specific training for correctional officers on mental health and suicide issues. Civil rights, professional malpractice and negligence litigation resulted in many court orders demanding that jail (and prison) systems improve their mental health training programs by incorporating into them information on dealing with suicidal prisoners. Some courts also required facilities to hire mental health staff, through either contractual agreements or employment in the state or local government.

While all the latest evidence — the recently released Bureau of Justice Statistics (Mumola, 2005) report on data generated by the Death in Custody Reporting Act, for one example — indicates that jail systems have jumped on board the movement to do what it takes to ensure the well-being of the inmate and the overall health of the jail system, there is still little written about what, in 1993, I called the “cooperative” (now more commonly referred to as “collaborative”) relationship between security and mental health staffs and about how it can be maintained and nurtured. What do cooperation/collaboration entail? How are professional boundaries safeguarded while professional territoriality, often common and destructive in jails, is diminished? How do we maintain the security of the institution while being flexible enough to allow for the delivery of adequate mental health services — and vice versa? What special needs of detention officers and mental health staff still need to be addressed in order to affect or sustain a cooperative relationship?

And so those same questions bring me to this slightly revised article which reasserts that a cooperative relationship, in real terms not solely in spirit, can be developed and, in fact, must be developed, between both professional detention officers and mental health clinicians working within the jail environment. Why this revision now? Because while the death-in-custody data suggest that we have made strides in suicide prevention over the years, there are current threats to the status quo which cannot be

ignored. Over the last 13 years, methamphetamine use has significantly increased nation-wide and the not infrequently incarcerated victims of its use pose special health and management risks for every jail system. The health care-affordability quotient in this country has sunk ever lower and in certain communities, the jail has emerged as the primary health and mental health services provider. The second wave of deinstitutionalization has resulted in the closing of more state-funded in-patient psychiatric beds and a significant diminution of community mental health care both by population served and services rendered. The passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) sent every health care provider and every legitimate information seeker into a panic mode that continues to bubble to the surface even 10 years later. The demand and growth in jail and prison operations means there is significant competition in the marketplace for security personnel and anecdotally, at least, many jail managers complain that once trained, officers are frequently recruited away by agencies that pay better and offer more opportunities for promotion. Finally, because as challenging as the advances realized in jail operations have been, arguably the loftiest challenge lives on: maintaining what has been achieved; in other words, not losing ground. How many of us have worked in, visited or read about a jail system once regarded as having a model program that is now struggling to provide the basics while being called upon do more with less?

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I begin by reviewing some of the literature that exists that speaks to the subject of staff training in suicide prevention and mental health care, including some of the accepted national jail standards. Next, a brief look at the relevant case law is presented, noting various courts' involvement in mandating training requirements and in hiring mental health staff. The third section focuses on the struggle that exists between mental health and detention staff, still too often seen in territorial claims perhaps based more on philosophical-occupational and these days, on fiscal ideologies than on what is good for the inmate-client and the jail system. Finally, still-relevant strategies for achieving a true, cooperative, multi-disciplinary, multi-responsibility team approach towards preventing suicides and improving mental health conditions within the jail environment are presented.

### *Jail Standards and Related Literature*

All of the national jail standards call for a certain amount of orientation and follow-up training for custodial staff in suicide assessment, prevention and interdiction techniques. These standards also demand the participation of medical and mental health professionals in in-service training and other continuing education courses that may be required for professional licensure. The American Correctional Association (ACA)'s *Performance-Based Standards for Adult Local Detention Facilities* (2004) still call for the proper credentialing of health care employees (4-ALDF-4D-05) and training that deals with emergency responses to critical health-related incidents (4-ALDF-4D-08). In a similar vein, the National Commission on Correctional Health Care (NCCCHC)'s *Standards for Health Services in Jails* (2003) still specifies that a suicide prevention plan must be in place (J-G-05); that all staff having contact with inmates be trained to identify suicide potential (J-G-05); that health care staff hold applicable professional certification (J-C-01) and receive 12 hours of yearly in-service training (J-C-03); and finally, that correctional officers receive health-related training on a bi-yearly basis (J-C-04) — although yearly suicide prevention for all staff is highly recommended (J-G-05).

While all of these are appropriate accreditation mandates, jail standards are still understandably unable to spell out methods to ensure the establishment of a respectful and effective interplay between detention officers and medical/mental health staff so that suicide and crisis intervention services are truly based on a team approach. Much of the relevant literature reflects the struggle to adequately and inoffensively define “the team” and its duties (Cimino, 1987). Perhaps because of this struggle, the “team” is often described as being comprised of only mental health clinicians. For example, one multi-disciplinary mental health program described in the literature boasted an effective suicide prevention program, but its identified team members were all mental health clinicians (Long, 1991). This kind of description was pervasive in the literature when this article was first published and there is no compelling written evidence that suggests that a broader definition of the team has been widely adopted. The narrow interpretation of “team” places correctional officers in a double bind with regard to their job performance. On one hand, officers and supervisors receive training by a mental health clinician in an effort to enable them to identify suicidal crises and symptoms of mental illness. On the other hand, despite receiving this training they are rarely treated as though they are part of the mental health team.

Researchers have recognized that the cooperation of both mental health and security staffs are required to prevent jail suicides. Both need to be able to assess the potential for self-destructive behavior (Jerrell & Komisaruk, 1991). However, even innovative mental health programs in jails have been presented as being entities separate from the security operation — reinforcing the isolative nature of many of the ancillary services offered in jails (e.g., mental health, education, substance abuse and religious programs). Other authors have recommended separate training goals for security and mental health staffs, but advise the establishment of a program review process where jail and mental health staff members meet periodically to “increase the accountability of jail and mental health staff for providing security and treatment” (Landsberg, 1992, p. 110). A 1991 Report to Congressional Requesters regarding the mental health operations of the Federal Bureau of Prisons (FBOP) noted that not all inmates were being screened for mental health and suicide problems. By the mid-1990s, however, suicide risk assessment screening upon admission to jail was a common practice in the federal system as well as in the majority of local jails across the country (Center for Mental Health Services, 1995), thanks in large part to the national attention on the issue by national studies (Hayes and Rowan, 1988) and the *Jail Suicide/Mental Health Update* newsletter.

Detention officers and mental health clinicians do, of course, have different primary areas of expertise within the detention facility. Experience tells us, however, that neither can function optimally without the other and when seen in this light, both types of professionals are naturally part of two teams: the security team and mental health team. The courts have implicitly recognized this for years.

### *Court Involvement*

Since this article first appeared in 1993, important changes in the law and in court rules have impacted the amount and extent of inmate-related litigation against jail and prison institutions. *Farmer v. Brennan*, the U.S. Supreme Court clarified the standards for determining the presence of “deliberate indifference” in civil rights litigation. The Prison Litigation Reform Act of 1995 had some effect on the amount of inmate litigation by mandating exhaustion of administrative remedies and payment of full court fees and by limiting the number of actions that could be filed by any one inmate. In *Olmstead v. L.C.*, the Supreme Court paved the way for individuals with disabilities to be cared for in appropriate non-institutional environments, when their continued institutionalization was a decision made for fiscal reasons without consideration of the whole context of the problem and the resources which might be brought to bear to address it. And more recently, *Brad H. v. City of New York* suggests that the jail's responsibility to the inmate with a serious mental illness extends beyond the walls of the institution and well into his or her reintegration into the community.

Still, the fundamental principle established in the late 1960s and early 1970s still reigns: a pretrial detainee has a right to some kind of mental health care, if needed, while incarcerated (*Bowring v. Godwin*, 1977; *Inmates of Allegheny County Jail v. Pierce*, 1979). Since that time, the nature and extent of this care has largely been left undefined, at least by the courts; perhaps because of the

difficulty in differentiating between inmate behaviors which require custodial versus clinical intervention (O'Leary, 1989). Generally, pretrial detainees are entitled to diagnostic services, some level of treatment so that inmates are not emotionally worse off than when they were admitted, and the maintenance of accurate and confidential records (Collins, 1998; Cohen, 1998; and see the oft cited *Ruiz v. Estelle*).

In fact, treatment within the jail is still most often limited to short-term crisis intervention services, aimed at delivering support to the inmate during stressful periods of confinement (Dvoskin, 1989). One court noted:

The jail is not a mental health facility; nor do we intend that it become one. However, it must be organized and staffed to meet emergency situations, to make appropriate referrals, and to properly care for and protect those who must be housed in the jail for whatever reasons despite their mental illness. (*Inmates of Allegheny County Jail v. Pierce*, 1980, 643).

In this case, the court reviewed the jail's mental health services or, more accurately, the lack thereof and ultimately explicitly recognized the absence of a mental health staff member in the jail. Subsequently, the court ordered jail officials to hire a psychiatrist, psychologist or psychiatric social worker for the position of mental health administrator.

My own position as a mental health clinician in a county detention facility was secured by a consent decree following a series of completed suicides and serious suicide attempts in the early 1980s. In *Garcia v. Board of County Commissioners of El Paso County*, the parties consented to a judgment that in part, forced the jail to secure the on-call emergency assistance of a licensed mental health clinician 24 hours daily, and provide enhanced training in suicide prevention and mental illness for all security personnel. Though the El Paso County Sheriff's Department in Colorado Springs, Colorado went further and contracted for the delivery of daily on-site clinical services as well as for mental health/suicide prevention training for all detention personnel, it was recognized early on that the mental health worker acting alone could not effectively provide comprehensive psychiatric services. Similar to most jails in the country, the El Paso County Detention Center experienced an onslaught of prisoners during the 1980s, with its population increasing from 200 inmates in 1983 to nearly 800 inmates in 1991 and, reflecting a progression experienced by almost all detention centers in this country, currently hovers around the 1,500 mark. With the active participation of detention officers in suicide prevention and crisis intervention efforts, there were no completed jail suicides through one nine-year period (beating the odds with a combination of skill and luck) and, and I say this with some trepidation believing that even one suicide is too many, relatively "few" suicides over the past three decades.

### *The Dual Professional Struggles in Our Correctional System*

Jail administrators have sought to involve community mental health and criminal justice agencies in the effort to care for mentally ill inmates, but have faced "significant obstacles" in doing so, since jails have not historically been seen as institutions that

either "required or deserved their services" (Kalinich, et al., 1991). The blame, of course, cannot be placed on the community mental health system alone, since jails themselves have historically been operated "as closed systems without [inviting] outside review by...human service agency administrators and/or advocacy groups" (Cox & Landsberg, 1989, p. 185). In part, as a result of this polarization between jails and mental health agencies, some jail administrators have arranged for on-site contracted services with mental health staff, opted to use the crisis services available to the community at large, or have made no arrangements for mental health services at all. Indeed, much of the research in jail mental health problems and programs points to a serious need for an increase in the number of jail mental health clinicians (Torrey, et al., 1992). While waiting for the funds to become available to support these mental health workers, correctional staff who have the potential to fulfill some "paraprofessional" responsibilities have been largely ignored (Coleman, 1988).

While different correctional employees are expected to contribute to the identification of problem inmates, the provision of mental health services has traditionally been seen to be the sole responsibility of mental health staff (Coleman, 1988). Despite efforts to train detention officers and other employees in assessment and intervention strategies, mental health staff is quick to point out that actual therapeutic services belong to their domain alone. Not surprisingly, other professionals within the institution respond accordingly; the atmosphere can be territorial and competitive. Classification personnel see housing, work assignments and security risk assessment as their bailiwick; security officers see security enforcement as their mission; and medical employees focus on the physical health of the prisoners. In reality, a strong identification with one's principle area of expertise is desirable, evidencing personal "investment" in one's professional responsibilities. However, in terms of suicide prevention and crisis intervention, successful programming requires cooperation and coordination between various jail staff members.

At least on a philosophical level, some research has shown that detention personnel tend to support the value of mental health services within the jail facility. Steadman, McCarthy and Morrissey (1986) found "little support...for the thesis that correctional and mental health staff in jails operate from fundamentally opposite and antagonistic perspective" (p. 92). The professional struggles that do exist may have more to do with a lack of understanding about each others' roles than with disagreements about jail "treatment" ideologies. In one effort to facilitate understanding and respect, the National Institute of Corrections (NIC) - Jails Division sponsored a seminar in the mid-1980s designed for the participation by teams of one mental health worker and one security officer employed in the same detention facilities. The initial focus was placed on identifying and breaking down the mythical barriers to effective security-mental health interaction in the jail. Participants were asked to discuss their assumptions about a teammate's professional role and persona. Many of the old purposeless labels of "bleeding heart," "do-gooders," "molly-coddler," "jailer," "guard," etc. that conjured up negative images were dispelled, and identification of complementary security and mental health functions were pursued (with the assumption that new revelations would be acted on upon return to the team's facility).

Of course, it is much easier to facilitate open, honest and sometimes painful communication between security and jail mental health clinicians in a neutral environment (such as the NIC) over an extended period of time (3-5 days) than to do so in a matter of hours on the premises of a detention facility. This means that the mythical barriers to an effective secure mental health detention program must be brought down by *action* rather than solely by discussion. A description of appropriate actions follows in the next section.

### *Strategies for a True Team Approach*

**T**he key to an effective team approach in suicide prevention and crisis intervention is found in throwing off the cloaks of territoriality and embracing a mutual respect for the detention officer's and mental health clinician's professional abilities, responsibilities and limitations. All of us, regardless of professional affiliation, need to make a dedicated commitment to come forward and acknowledge that suicide prevention and related mental health services are only effective when delivered by professionals acting in unison with each other. Just as the security officer alone cannot ensure the safety and security of the jail facility, neither can the mental health clinician alone ensure the safety and emotional well-being of the individual inmate.

To succeed in this endeavor requires us to do away with some of the myths of correctional treatment. Where or why these myths developed does not matter; what matters is that we recognize them as working against the institution's efforts to prevent suicides and emotionally disruptive behavior. *The first two myths that must be discarded are those that suggest there must be total confidentiality of mental health services in jails and the notion that there are clear-cut boundary lines dividing the responsibilities of the security officer and mental health clinician.* Other myths that must also be destroyed are:

- 1) The mental health clinician (perhaps by osmosis?) has some inherent and proprietary knowledge of suicide prevention;
- 2) The detention officer is the only person who may regard suicide as an inevitable occurrence;
- 3) The detention officer has too many other responsibilities to worry about and, therefore, should not be burdened with feedback about an inmate's mental state;
- 4) The mental health clinician is not concerned about the security of the facility; and finally,
- 5) One professional is more capable, more intuitive and more skilled than the other at preventing suicides and de-escalating volatile emotionally-based reactions.

Recognizing that these myths exist is the first step, but working to dispel them must occur concurrently with the following change processes:

**Leadership.** The best suicide prevention programs in this country — in and outside of jails — are the ones that live out this message that comes from the top: *Every suicide is preventable.* Now I

know that a few of you have raised your eyebrows, not to mention your hackles, at this notion. In fact, I suspect you are wondering about your potential liability if you assert this claim. You may also be worried about how your staff would feel about this philosophy should a suicide actually occur. Some of you may not even believe that this is true, that every suicide is preventable. *But*, if you believe the basic premise of this article, that is, that cooperation is the key to a successful inmate management program, it is important to ask yourselves the following. How do I know which suicide is not preventable and how do I train staff to know who can be prevented from taking their lives and who cannot? The answer is the same for both questions; you cannot know and therefore you cannot train. Only when the administrator believes and organizes suicide prevention efforts around the belief that *every suicide is preventable* can staff be empowered to remain vigilant about the suicide prevention mission in your facility. Telling staff otherwise puts the burden on them to make a determination they cannot make no matter how much training and how much cooperation exists within your facility.

**Communication.** A communication system, written and oral, must be in place through which detention and mental health staff can share information about suicidal inmates. Common sense tells us that interdicting in the suicide process does not require an extensive review of an inmate's personal history by either professional. The threat of revealing confidential (and irrelevant) psychiatric information is removed when there is recognition that the most important information needed to prevent suicides is that which deals with the *here and now and the immediate future* (Lombardo, 1985). In reality, it is a security officer who invariably discovers the suicidal inmate, particularly during the intake process, but also during routine security checks. If the officer has adequate training in crisis intervention and is comfortable using the related skills, they often know about the issues with which the inmate is dealing. Looked at in this light, there is little reason to justify the silence or, at best, reluctance on the part of mental health staff when it comes to giving the officer information and/or feedback about the issues impacting the suicidal inmate. *The very worst jail suicide programming uses confidentiality as an excuse to justify a unilateral information delivery process.* If we want security officers to work together with mental health staff to prevent suicides, mental health staff must work together with them. There is no place in the jail for unidirectional flow of information — bilateral communication is essential.

What does this mean? Mental health staff must encourage correctional officers to engage in dialogue about inmate behaviors and/or emotional reactions that may signify suicide thoughts or mental illness. After assessing the inmate, the clinician should get back to the correctional officer with information that includes: discussion of the officer's accuracy or perhaps misinterpretation of the inmate's behavior; what the officer can do to assist in providing the inmate with continued mental health care; what the mental health clinician's continued role will be; and, of course, appreciation for the officer's concern that led to the initial referral. This dialoging must not be gratuitous; it must be sincere and done with the realization that it is an integral part of an effective multidisciplinary, multi-responsibility mental health program.

**Education.** This article has largely focused on officer-clinical intervention in suicide crises, but serious suicidal ideation and

intent do not present themselves when a person is in a rational state of mind — with the exception perhaps of those persons choosing to die because of serious illness rather than face a prolonged, painful “natural” death. There is almost always a window of opportunity during which effective intervention can be made in the suicide crisis. For the suicidal person, there is generally ambivalence about choosing life or death, an uncertainty that is both cognitive and emotional in nature and therefore susceptible to the impact of therapeutic intervention. In short, suicide is part of the experience of a larger mental health problem. This may diagnostically translate into depression, low self-esteem, psychosis, anxiety, etc.

Education (“training”) for detention officers *and* jail mental health staff must therefore include not only identification of the signs and symptoms of suicide, but also the recognition and means of dealing with the signs and symptoms of suicide and of mental illness/emotional problems. The benefits of this education extend far beyond the jail in society-at-large; no one can escape from witnessing the impact of mental illness on both the individual and greater society. Learning about mental illness increases our sensitivity to the difficulties experienced by and because of the mentally ill population. Further, in over 25 years of providing suicide prevention and mental health training, I cannot recall a seminar participant who had not been personally exposed to someone suffering from mental illness or suicidal thoughts. Many times these issues are seen in our own families, colleagues or circle of friends.

Finally, education must be geared toward both the correctional officer and mental health clinician. Crisis intervention and suicide prevention courses are generally offered, if at all, as electives during graduate school education. While assessment of depression and/or suicide and mental illness may be reviewed as part of the content in required course work on psychopathology, generally very little attention is paid to the specific topics of suicide prevention and crisis intervention. Not only do graduate schools of social work and psychology need to incorporate more specific information relative to these areas, they also should ensure that education on the mental health-related “issues and problems special to corrections and its offender population” is available to graduate students (Powitzky, 1981, p. 6). At least some in-service training should be designed for presentation to all the professional groups together, i.e., detention officers and mental health clinicians (Haddad, 1993).

**Team “Practice.”** One method of respecting an inmate’s right to confidential assessment and treatment, while maintaining a strategy of clinical-correctional teamwork, is to invite a security officer to join a mental health clinician in an assessment interview. The jail (or prison) mental health worker, as well as security officer, who denies having had the experience of being frightened to see an inmate alone is not being honest with him or herself or others. In reality, there is plenty of reason to be frightened of certain people, both in and out of jail. The unpredictability of behavior and beliefs that accompany some psychotic and suicidal conditions calls for caution on the part of the professional who must interact with an emotionally ill inmate. At these times, the mental health clinician who assesses the inmate should take the opportunity to invite an interested detention officer to sit in. There are three benefits to doing so — and are nearly risk-free if organized properly and in advance:

- 1) It is a learning experience for both professionals; an opportunity to learn about mental illness and how to assess a person suspected of having a mental illness or suicide crisis;
- 2) It provides an added measure of safety and security which contributes to a more complete interview and assessment process; and
- 3) It is an effective way to live out the kind of cooperative relationship we want to develop and encourage between mental health staff and detention officers.

Both the officer and mental health worker must agree that the inmate’s revelations are confidential and privileged. While not foolproof, if the officer is asked to reveal the inmate’s communication in court, the clinician can claim, on behalf of the inmate and under their professional code of ethics (and often under state statute), that the detention officer was working at the time under the clinician’s professional license and thus has a privileged relationship with the client/inmate (see, for example, state professional licensure statutes for psychologists, social workers, marriage and family therapists and other similar clinical practitioners. On the issue of privileged communications in psychotherapy, see *Jaffee v. Redmond*. While this hands-on practice may not appeal to all officers or clinicians, certainly both parties and the institution have much to gain from it.

Of course, mental health records are and should be considered as confidential documents in which the inmate has a right to expect

**ON YOUR WATCH:  
*The Challenge of Jail Suicide***

**T**ired of watching the same old training videotape on suicidal inmates that is not only outdated but poorly produced. Good news. A 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, 2125 19<sup>th</sup> Street, Sacramento, California 95818, (916/556-3480), or at <http://www.cimh.org>

privacy. It is important for mental health staff to safeguard the privacy of these records. However, even given HIPAA mandates, there is no excuse for withholding information about inmate crisis, suicidal and homicidal behavior, and security risk from detention staff. To effectively intervene in these types of emergency situations, all “caretakers” — mental health and security professionals alike — must share verbal information. The record may explain some inmate behavior to the clinician, but it does not alone magically enable any staff member to intervene in the situation at hand. Information in the record does not have to and should not be revealed, but information about the inmate’s current functioning and the treatment plan must be shared between all involved staff.

**The Team.** Every team has at least one leader. The mental health team should be led by a mental health clinician, but include detention officers. The security team should be led by a corrections professional, but include mental health clinicians. Neither can operate effectively without the other. It is imperative that jail administrators give their explicit support to this team concept and its work, but the team itself must be made up of at least some line staff. Perhaps one of the greatest deficiencies in national jail standards is that regularly scheduled meetings between representatives of the mental health staff, program staff and correctional staff (specifically line personnel) are not required. Much like the “staffings” that occur in schools, psychiatric hospitals and other human service agencies, these meetings can facilitate both the educational process and the interrelationship building process that must occur in a detention treatment program. While jail standards [e.g., NCCCHC (J-A-04)] call for quarterly meetings to discuss health/mental health care issues, they are designated as “administrative meetings” having a different focus than the interdisciplinary staffing would have. Front line mental health and security staff, along with supervisors and administrators, should meet regularly for informal, educational discussions on the subject of maintaining a secure, minimally emotionally disruptive environment. Certainly after a completed suicide occurs it is particularly important to bring the security and mental health staff together to review the incident through the psychological autopsy process.

And, in recent years jails around the country have implemented “special inmate behavioral management” committees — *teams* of security, mental health, health, classification and administration personnel who meet together on a regular basis to discuss and create behavioral plans for particularly challenging inmates. This team approach accomplishes many objectives: it provides a model of teamwork for the institution; its products provide officers and other personnel and the inmate with a clear and consistent behavior management plan; it involves the inmate — who is brought into the meeting to be made aware of the plan and who is given an opportunity for input; and it focuses on behavior, not on personality or on criminal charges or on diagnosis or likeability. As such, it reinforces that the management we do as a team in the jail is the management of the whole person.

### *Implications for the Future*

The relationship between security and mental health professionals is a partnership, one that must be brought to the forefront in detention facilities. As I wrote in 1993 and as true still today, all data indicate that the numbers of pretrial detainees are rising, with no end

in sight. Crime may be going down, but real numbers of persons committing crimes are going up. While there are interesting experiments with jail diversion and reentry efforts happening all over the country, concerns about homeland security, about terrorism, and about deviant behaviors, however defined, result in the detention of more people, many of whom who are at high risk for suicide because of substance use, untreated mental health challenges, histories of violent victimization, isolation from support systems, cultural pressures, economic disadvantage and poverty, oppression, institutional biases and so on.

Mental health and corrections professionals must be partners in the prevention of jail suicides and mental health-related critical incidents. It’s time to get vocal about it, to communicate about the issues on which we agree as well as disagree. The investment of time and energy to take this (too) silent partnership public will pay off in the numbers of lives protected and saved. Most of all, putting an end to this silence has the potential to make our own occupational positions more satisfying. In jail, silence is not golden.

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### About the Author

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**T**he *Update* has continually stressed the critical importance of communication to the suicide prevention process. Effective management of suicidal inmates in the facility is based on communication among correctional officers and other professional staff. The communication breakdown between correctional, medical, and mental health personnel is a common factor found in the reviews of many preventable inmate suicides. Such was the case with Stephanie Snow. On August 16, 2005, the United States Court of Appeals for the Eleventh Circuit ruled that, if a jail officer had knowledge of an inmate's potential for suicide and failed to communicate that information to other personnel, such inaction could be found to be deliberately indifferent and serve as a basis for liability in the inmate's subsequent death. The decision in *Snow v. City of Citronelle, et al* (No. 04-14409, 420 F.3d 1262, 11th Cir.; 2005 U.S. App. LEXIS 17243; 18 Fla. L. Weekly Fed. C 836) is reprinted below.

Before CARNES and PRYOR, Circuit Judges, and FORRESTER, District Judge.

**OPINION:** PRYOR, Circuit Judge:

The issue presented in this appeal is whether city officials were deliberately indifferent to a strong likelihood that Stephanie Poiroux Snow (Poiroux) would commit suicide while in custody at the jail of the City of Citronelle, Alabama. Martin Snow, as administrator of his daughter's estate, filed this suit against the City, its mayor, and several employees of the police department. Snow alleged violations of his daughter's rights under the Eighth and Fourteenth Amendments to the United States Constitution and a claim for wrongful death under Alabama law. The district court granted summary judgment to all defendants on the federal claims and dismissed the state-law claims without prejudice. Because Snow presented evidence that Officer Marshall Chennault told Snow and Snow's wife, Esther, that Poiroux was suicidal and that Officer Chennault had information that Poiroux had recently attempted to slit her wrists, a genuine issue of material fact exists regarding Officer Chennault's knowledge that there was a strong likelihood that Poiroux would commit suicide. We, therefore, reverse the summary judgment entered against Snow's claim as to Officer Chennault. We affirm the summary judgment as to the federal claims against the remaining defendants, but we vacate the order of dismissal of the state-law claims. Although we reinstate Snow's state-law claims, we express no opinion on the merits of those claims.

### I BACKGROUND

**B**ecause summary judgment was entered against the plaintiff, we set forth the facts, drawn from the evidence presented, in the light most favorable to Snow. See, e.g., *Swint v. City of Wadley*, 51 F.3d 988, 992 (11th Cir. 1995).

On the evening of June 2, 2001, Poiroux was arrested for driving under the influence of alcohol or drugs after she was involved in

an automobile accident with Clarence Parker, Chief of Police of the City of Citronelle. Officer Keith Miller, who responded to the scene of the accident, observed that Poiroux was unsteady and her speech was slurred. Poiroux denied drinking alcoholic beverages, but failed the field sobriety tests. She was arrested and transported to the City of Citronelle Police Station.

At the police station, Poiroux was placed in the female holding area, and then placed into a cell after she let herself out of the holding area. Officer Jason Blankinchip, who assisted Miller at the accident scene, had to force Poiroux, who was approximately six feet tall and weighed 150 to 160 pounds, into the cell. After a few minutes in the cell, Poiroux took off her shoe and began to beat it on the walls and the door, and Poiroux stated that she wanted to get out of jail. Poiroux then climbed on the top bunk bed in the cell and began to hit the light fixture with her shoe. She ignored requests to stop this behavior and was charged with destruction of city property.

After ten to fifteen minutes, when Poiroux had become calm, Miller moved her back into the holding area. In the holding area, Poiroux began crunching a Pepsi can. Miller and Blankinchip then went into the room and removed the can and all other materials. When asked why she had been crunching the can, Poiroux responded that she was angry.

After Poiroux complained of seizures, the emergency medical unit was called. Poiroux's vital signs were normal, but Poiroux continued to complain of seizures and stated that she wanted to go to the hospital. Officer Clint Jordan took Poiroux to Springhill Memorial Hospital.

At Springhill Memorial, Poiroux was seen initially by a triage nurse. Jordan overheard Poiroux tell the nurse that she had experienced a seizure early that night, was taking prescription medications, and suffered from migraine headaches and asthma. Jordan also overheard Poiroux tell the nurse that she had tried to overdose on medicine in the past. Poiroux was next examined by a doctor, who found nothing physically wrong with her, but stated that, in the light of Poiroux's comments about her overdose attempt, she might need to go to Mobile Infirmary. Poiroux was released from Springhill Memorial with no medications and no instructions.

Because Springhill Memorial was unable to take blood and urine samples, Jordan transported Poiroux to USA Medical Center emergency room for blood and urine samples. After a nurse took the samples, Poiroux was seen by an emergency room doctor. Jordan again overheard Poiroux tell the doctor that she had seizures, migraines, and asthma, she was on a number of medications, and she had attempted suicide by overdose in the past. Jordan did not hear when the overdose had taken place.

At USA Medical Center, Dr. Wan ordered tests and contacted Mobile Mental Health to have someone see Poiroux, but Mobile Mental Health would not send someone to see Poiroux while she was under arrest. After he received the test results, Dr. Wan prescribed some medications for Poiroux. Jordan was given specific written information regarding how and when the medication should be dispensed. Poiroux was released from USA Medical Center, and Jordan transported her back to jail.

Poiroux's outpatient records from USA Medical Center show that Poiroux told a doctor or nurse that she had attempted suicide four times in the past and that she had suicidal ideation. Dr. Wan, the emergency room doctor at USA Medical Center, testified at his deposition that ordinarily either he or the nurse would have told the officer about the suicidal ideation of the patient, but Wan had no personal recollection of Poiroux or of communicating that information to Jordan. Jordan denies that any information concerning possible suicide was communicated to him by the medical personnel at USA Medical Center, and he denies seeing any of Poiroux's outpatient records.

At the jail, Jordan turned Poiroux, who was crying and upset, over to Dispatcher Yvonne Willman and Officer Chennault. Jordan told the dispatcher and Chennault to watch Poiroux because she had been in an automobile accident and had been given medication at the emergency room. Jordan also gave Chennault the written prescriptions and instructions from the doctor. Jordan ended his shift and went home. He had no further involvement with Poiroux.

Chennault then placed Poiroux in the female holding area. A few minutes later, Chennault allowed Poiroux to make several telephone calls from the dispatcher's office. He then brought Poiroux back to the holding area where she began to beat on the door. Because he thought that she was mentally unstable, Chennault called Poiroux's parents and asked them to take custody of her. Chennault spoke first with Poiroux's mother and then her father. The Snows testified at their depositions that Chennault told them Poiroux was suicidal. The Snows did not agree to pick up Poiroux, but they agreed to bring her medications to the jail.

After he ended the call with Poiroux's parents, Chennault looked into the holding area and saw Poiroux climbing on the sink in cell number two. Chennault got Poiroux off the sink and locked the door to cell number two, at which point, Poiroux became upset and charged at Chennault. After a struggle, Chennault managed to close the door to the holding area. Poiroux then began beating on the window with the telephone receiver. When Chennault entered the holding area to get her to stop, Poiroux tried to hit him with the receiver. After another struggle, Chennault sprayed Poiroux in the face with pepper spray to subdue her. Poiroux immediately stopped struggling and was placed in the shower to be rinsed. Chennault's wife, who was present at the jail, helped Poiroux out of her dress and into a blanket so that the dress could be dried.

Several hours later, Poiroux's parents arrived with her medication and spoke with Chennault. Chennault told the Snows he thought their daughter was mentally unstable, he was having difficulties with her, and he had to use pepper spray to subdue her. The Snows testified that Chennault also told them Poiroux was suicidal. The Snows declined to take Poiroux home. At some point during his shift, Chennault called the Washington County jail, and a jailor there told Chennault that, sometime within the last month, Poiroux had tried to cut her wrist while at the Washington County jail and had been troublesome. Chennault went off duty approximately one hour after meeting with the Snows and did not have any further problems with Poiroux.

There is no evidence that Chennault told any official of the jail that he thought Poiroux was suicidal, and it is undisputed that Chennault did not monitor Poiroux as if she were suicidal. Had he

believed that Poiroux was a suicide risk, Chennault stated that he would have told the dispatcher to check on Poiroux every fifteen minutes, removed items from the cell with which Poiroux could have harmed herself, and perhaps would have placed Poiroux in the drunk tank. Chennault also stated that, had he received information from USA Medical Center that Poiroux had suicidal ideation, he would have instructed that she be returned to the hospital for treatment and observation.

Chennault was replaced on duty by Miller. When Miller started his shift, Poiroux was asleep in the holding area. A little while later, the dispatcher notified Miller that Poiroux had taken down the shower rod in the bathroom and was using it to reach into cell number two, which was locked, and beating on the walls with it. Miller took the rod and replaced it in the shower. About ten minutes later, Poiroux again took the shower rod down. Miller returned to the holding area, took the shower rod, and talked to Poiroux. After speaking with Miller, Poiroux took a shower and had a meal at approximately six o'clock.

At six o'clock, Willman's shift ended, and Eva Henderson came on duty as dispatcher. A couple of hours after the duty switch, Poiroux began repeatedly knocking on the window between the holding room and the dispatcher's office in an attempt to talk to Henderson. Henderson called Miller, who told Poiroux to stop knocking on the window or she would be locked in a cell. Miller then went into the docket room to do paperwork. Henderson remained in the dispatcher's office watching the cells through the monitors. One monitor was directed constantly on the holding area. Henderson observed Poiroux in the holding area at least every thirty minutes and sometimes more frequently. At some point, Henderson saw Poiroux sitting on the bunk in cell number one tearing strips of what appeared to be toilet paper.

At a few minutes before nine o'clock, Poiroux requested medication from Henderson and stated that she wanted to get out of jail. Henderson told Poiroux to lie down and that she would inquire about the medication. A few minutes after nine o'clock, Miller returned to the dispatcher's office and looked through the window to check on Poiroux. When he did not see her through the window, Miller went to look through the door of the holding area.

Miller found Poiroux hanging from the air conditioning vent above the sink. There is also testimony that Henderson discovered Poiroux hanging when she looked through the cell window. Poiroux hung herself with strips from a blanket and was in full view of the monitor. On the monitor, it appeared to Henderson that Poiroux was leaning over the sink to wash her face. Attempts to revive Poiroux were unsuccessful.

Snow, as administrator of Poiroux's estate brought this action against the City of Citronelle, the Mayor of the City of Citronelle, and several members of the City of Citronelle police department. Snow alleged violations of Poiroux's rights under the Eighth and Fourteenth Amendments for the officers' deliberate indifference to a substantial likelihood that Poiroux would commit suicide while at the City of Citronelle jail. The district court granted summary judgment to all defendants in their individual capacities on the grounds of qualified immunity. The district court found that the defendants did not violate Poiroux's constitutional rights, and, in the alternative, if her rights were violated, the law was not clearly established. The district court

also granted summary judgment in favor of the City of Citronelle and the defendants in their official capacities because it found that Poiroux's rights were not violated. The district court declined to exercise supplemental jurisdiction over the remaining state-law claims and dismissed them without prejudice. Snow appeals.

## WE'RE STILL LOOKING FOR A FEW GOOD PROGRAMS

**F**uture issues of the *Jail Suicide/Mental Health Update* will be devoted to exemplary suicide prevention programs operating within correctional facilities throughout the country. Does your facility's suicide prevention policy contain, and do your practices reflect, the following critical elements?

- ◆ Intake screening to detect both current and prior suicidal behavior, as well as further and periodic assessment of suicide risk by mental health staff;
- ◆ Suicide prevention training for correctional, medical, and mental health staff;
- ◆ Levels of communication between outside agencies, among facility staff, and with the suicidal inmate;
- ◆ Suicide-resistant, protrusion-free housing of suicidal inmates;
- ◆ Levels of supervision for suicidal inmates;
- ◆ Timely emergency intervention by correctional and medical personnel following a suicide attempt;
- ◆ Provision of critical incident stress debriefing to affected staff and inmates, as well as completion of a multidisciplinary mortality review following an inmate suicide and/or serious suicide attempt; and
- ◆ A low rate of inmate suicides for an extended period of time.

If you believe your correctional facility operates an exemplary suicide prevention program, and would like it to be considered as a possible case study in an upcoming issue of the *Update*, please send copies of your suicide prevention policy, screening/assessment forms utilized to identify suicidal inmates, and total number of suicides and your facility's average daily population for each year from 1995 thru 2004 to:

Lindsay M. Hayes, Project Director  
*Jail Suicide/Mental Health Update*  
40 Lantern Lane  
Mansfield, MA 02048  
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## II. STANDARD OF REVIEW

This Court reviews the grant of summary judgment by the district court de novo and applies the same legal standards as the district court. *Crosby v. Monroe County*, 394 F.3d 1328, 1331-32 (11th Cir. 2004). “Summary judgment is proper only when the evidence before the court establishes ‘that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.’” *Id.* at 1332 (quoting Fed. R. Civ. P. 56(c)). “All evidence must be viewed in the light most favorable to the nonmoving party.” *Id.*

## III. DISCUSSION

Although Snow brought claims under both the Eighth and Fourteenth Amendments, “the Eighth Amendment prohibitions against cruel and unusual punishment do not apply to pretrial detainees,” like Poiroux. *Belcher v. City of Foley*, 30 F.3d 1390, 1396 (11th Cir. 1994) (quoting *Tittle v. Jefferson County Comm’n*, 10 F.3d 1535, 1539 n. 3 (11th Cir. 1994)). The key issue in this appeal, therefore, is whether Snow alleged facts sufficient to withstand summary judgment on his claim that the defendants were deliberately indifferent to a strong likelihood that Poiroux would commit suicide while at the City of Citronelle jail in violation of the Fourteenth Amendment. Snow faces a difficult burden.

“In a prisoner suicide case, to prevail under section 1983 for violation of substantive rights, under...the...Fourteenth Amendment, the plaintiff must show that the jail official displayed ‘deliberate indifference’ to the prisoner’s taking of his own life.” *Cook ex rel. Estate of Tessier v. Sheriff of Monroe County, Fla.*, 402 F.3d 1092, 1115 (11th Cir. 2005) (internal quotation marks and citation omitted). “To establish a defendant’s deliberate indifference, the plaintiff has to

show that the defendant had (1) subjective knowledge of a risk of serious harm; [and] (2) disregarded...that risk; (3) by conduct that is more than mere negligence.” *Id.* (internal quotation marks and citation omitted). “In a prison suicide case, deliberate indifference requires that the defendant deliberately disregard ‘a strong likelihood rather than a mere possibility that the self-infliction of harm will occur.’ ‘The mere opportunity for suicide, without more, is clearly insufficient to impose liability on those charged with the care of prisoners.’” *Id.* (citations omitted). An officer “cannot be liable under [section] 1983 for the suicide of a prisoner who never had threatened or attempted suicide and who had never been considered a suicide risk.” *Id.* at 1116 (internal quotation marks and citation omitted).

To resolve this appeal, we must address four matters. We first address why the district court correctly entered summary judgment in favor of five of the defendants in their individual capacities. Second, we address why the district court erred in entering summary judgment in favor of Officer Chennault. Third, we explain why the district court correctly entered summary judgment in favor of the City and its employees in their official capacities. Finally, we explain why we must reinstate Snow’s claims under state law without deciding any issue about the merits of those claims.

### A. *The District Court Correctly Entered Summary Judgment for Jordan, Henderson, Parker, Reid, and Miller*

Snow sued Mayor Presnell and six members of the City of Citronelle police department in their individual capacities: Jordan, Chennault, Henderson, Parker, Reid, and Miller. Snow does not appeal the summary judgment as to Presnell. Of the remaining defendants, Snow’s claims against Jordan, Henderson, Parker, Reid, and Miller fail because Snow has not presented any evidence that these five defendants had subjective knowledge of a strong likelihood that Poiroux would attempt to commit suicide. Although Poiroux’s emergency room records show a strong likelihood that she would attempt to commit suicide because Poiroux told the emergency room staff she had attempted suicide four times in the past and the doctor’s notes show that she had suicidal ideation, there is no evidence that these defendants knew about that information. There is no evidence that any of these five defendants suspected that Poiroux was suicidal.

The closest issue as to these five defendants involves Jordan, but there is insufficient evidence that Jordan was aware of a strong likelihood that Poiroux would commit suicide or that he acted with deliberate indifference to this likelihood. Jordan, who was the only officer to speak with medical personnel, stated that he was not informed of Poiroux’s suicidal ideation. Jordan overheard Poiroux tell the medical personnel that she had attempted suicide in the past, but Jordan did not know when the attempt had taken place. The testimony of Dr. Wan, that he or the nurse ordinarily would have told an officer about a detainee’s suicidal ideation, does not establish that Jordan had that knowledge, because Dr. Wan did not have any present recollection of Poiroux. Wan’s testimony was nothing more than speculation. In addition, it is undisputed that Jordan did not see Poiroux’s outpatient records. Viewed in the light most favorable to Snow, the only evidence presented to establish the first element regarding Jordan was his knowledge of Poiroux’s previous suicide attempt, but this knowledge, without more, is not sufficient to put Jordan on notice of “a strong likelihood rather than a mere possibility that the self-infliction of harm will occur.” *Cook*, 402 F.3d at 1115.

## 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](http://www.ncianet.org/cjjsl.cfm)

Check us out on the Web!  
[www.ncianet.org/cjjsl.cfm](http://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](http://www.hhpub.com/journals/crisis/1997)  
[www.nicic.org/jails/default.aspx](http://www.nicic.org/jails/default.aspx)  
[www.ojp.usdoj.gov/managingoffenders/mentalhealth.htm](http://www.ojp.usdoj.gov/managingoffenders/mentalhealth.htm)  
[www.ncjrs.org/html/ojdp/jjnl\\_2000\\_4/sui.html](http://www.ncjrs.org/html/ojdp/jjnl_2000_4/sui.html)  
[www.pbstandards.org/resources.aspx](http://www.pbstandards.org/resources.aspx)  
[www.gainsctr.com](http://www.gainsctr.com)

No other defendant had contact with the medical personnel and could have learned of Snow's suicidal ideation from the doctors and nurses who treated Snow, and Snow did not present other evidence that Henderson, Miller, Parker, or Reid had subjective knowledge of a risk of serious harm. The district court, therefore, correctly entered judgment against Snow on his claims against Jordan, Henderson, Miller, Parker, and Reid in their individual capacities.

**B. The District Court Erred in Granting Summary Judgment for Chennault**

Whether Snow presented sufficient evidence to create an issue of fact with regard to Officer Chennault is another matter. Taken in the light most favorable to Snow, a jury could find that Chennault had subjective knowledge that there was a strong risk that Poiroux would attempt suicide and deliberately did not take any action to prevent that suicide. First, Chennault testified in deposition that he telephoned the Washington County jail, and a jailor told him that, sometime in the last month, Poiroux had tried to cut her wrist while in custody there and had given them a lot of trouble. Second, the Snows testified that Chennault told them Poiroux was suicidal. Third, it is undisputed that Chennault did not communicate any information regarding his belief that Poiroux was a strong suicide risk to anyone else at the jail. Finally, Chennault stated that he did not take the actions he would have taken had he regarded Poiroux as a suicide risk.

Chennault did not inform Henderson to check on Poiroux every fifteen minutes. Chennault did not remove items from the cells with which Poiroux could have harmed herself. Chennault did not place Poiroux in the drunk tank, and Chennault did not return Poiroux to USA Medical Center for treatment and observation. In short, Chennault did nothing.

That evidence of Chennault's complete failure to take any action after Poiroux was returned to the jail from USA Medical Center creates a substantial issue about whether the suicide of Poiroux was avoidable. Although Henderson testified that she monitored Poiroux fewer than fifteen minutes before Poiroux's suicide, the jury could infer that Henderson and other employees would have been more vigilant had they been informed that Poiroux was suicidal. In addition, a jury could find that, if either Poiroux had been placed in the drunk tank and items she could have used to harm herself removed from her reach or Poiroux had been returned to USA Medical Center, then Poiroux would not have committed suicide.

Although Chennault denies telling the Snows or anyone else that he thought Poiroux was a suicide risk, the conflicting testimony creates an issue of fact for a jury to decide about Chennault's knowledge. Viewing the facts in the light most favorable to Snow, a jury could find that Chennault subjectively believed that there was a strong risk that Poiroux would attempt suicide and deliberately did not take any action to prevent her suicide. Those facts, if found by a jury, would establish a constitutional violation. Because, at the time of Poiroux's death, it was clearly established that an officer's deliberate indifference to the risk of serious harm to a detainee is a violation of the Fourteenth Amendment, the district court erroneously granted summary judgment on Snow's claim against Chennault. *McElligott v. Foley*, 182 F.3d 1248, 1255 (11th Cir. 1999).

**C. The District Court Correctly Entered Summary Judgment in Favor of the City and its Officials**

In addition, Snow sued the City of Citronelle and Parker, Reid, and Presnell in their official capacities. The district court properly granted summary judgment on these claims. "Because suits against a municipal officer sued in his official capacity and direct suits against municipalities are functionally equivalent," we address Snow's argument in relation to the City of Citronelle. *Busby v. City of Orlando*, 931 F.2d 764, 776 (11th Cir. 1991).

A municipality may not be held liable under section 1983 on a theory of respondeat superior. *City of Canton v. Harris*, 489 U.S. 378, 385, 109 S. Ct. 1197, 1203, 103 L. Ed. 2d 412 (1989). "It is only when the 'execution of the government's policy or custom...inflicts the injury' that the municipality may be held liable under [section] 1983." *Id.* (quoting *Springfield v. Kibbe*, 480 U.S. 257, 267, 107 S. Ct. 1114, 1119, 94 L. Ed. 2d 293 (1987) (O'Connor, J., dissenting) (quoting *Monell v. Dep't of Social Servs.*, 436 U.S. 658, 694, 98 S. Ct. 2018, 2037-38, 56 L. Ed. 2d 611 (1978))). To hold the municipality liable, there must be "a direct causal link between a municipal policy or custom and the alleged constitutional deprivation." *Id.* at 385.

Snow erroneously argues that the City of Citronelle should be liable because the failure of the city to have a suicide policy constituted deliberate indifference to a known, substantial risk of suicide. Although the jail did not have a written suicide policy, all of the officers stated that an unwritten policy existed regarding suicidal detainees. Even assuming the absence of any suicide policy, however, the evidence does not establish a causal link between Poiroux's suicide and the alleged lack of a suicide policy at the City of Citronelle jail. The evidence is undisputed that Chennault, the only officer who may have had knowledge that Poiroux presented a strong likelihood of suicide, did not communicate that information to his colleagues. The officers on duty, therefore, would not have known to put Poiroux on a suicide watch even if there was a policy. Furthermore, Chennault stated that, had he suspected Poiroux was suicidal, he would have taken the actions a suicide policy would require: he would have told the dispatcher to check on Poiroux every fifteen minutes, removed items from the cell with which Poiroux could have harmed herself, and placed Poiroux in the drunk tank. Because the record shows that Chennault believed he should have taken these actions if a detainee was suicidal and Snow does not argue that the Constitution required Chennault to do more, his failure to do so cannot be attributed to the alleged lack of a suicide policy.

Neither can the municipality be held liable for failure to train, failure to supervise, or inadequate staffing. Snow has not presented any evidence that Poiroux's suicide is attributable to any of these alleged failures. The municipality, therefore, cannot be held liable, and the district court correctly entered summary judgment.

**D. The State-Law Claims Must Be Reinstated**

After the district court granted summary judgment on the federal claims, the court declined to exercise supplemental jurisdiction over Snow's state-law claims and dismissed them without prejudice. Because we reinstate Snow's federal claims, we must vacate the discretionary dismissal of the state-law claims, but we express no opinion on the merits of those claims. See *Vaughan v. Cox*, 343 F.3d

1323, 1334 (11th Cir. 2003). Because Snow concedes that his state-law claims against the City of Citronelle and Mayor Presnell should be dismissed, the state-law claims are reinstated as to all other defendants.

#### IV. CONCLUSION

We reverse the summary judgment entered in favor of Chennault because there is an issue of fact regarding Chennault's subjective knowledge of a substantial likelihood that Poiroux would commit suicide. We affirm the summary judgment as to all remaining defendants, because Snow did not present any evidence that the remaining defendants had subjective knowledge of a substantial likelihood of a suicide attempt, and Poiroux's suicide cannot be attributed to a failure of the City of Citronelle to have a suicide policy. Finally, we vacate the dismissal of Snow's state law claims as to all defendants, except the City of Citronelle and Mayor Presnell, but express no opinion on the resolution of those claims.

**AFFIRMED IN PART, REVERSED IN PART, VACATED IN PART, AND REMANDED.**

### THE DEATH OF RYAN MOSHER

Ryan Mosher, 27-years-old, was originally arrested on a charge of assault on October 2, 2002. He was taken to the Stearns County Jail in St. Cloud, Minnesota. During both the intake screening and initial classification processes, Mr. Mosher stated that he suffered from depression and was receiving mental health services in the community. The following day, he informed jail staff that he was not feeling well. Mr. Mosher was observed vomiting into his toilet and admitted to the jail officer "that yesterday he had drank some anti-freeze in an attempt to commit suicide and he was having severe abdominal pain because of it.... Upon further clarification he stated it was 'Liquid HEET' that he had drank. He also stated that he had been drinking heavily last night... At this time he was lying on his bed crying. I explained to him that I needed to know if he honestly had drank Liquid HEET as we had learned that it may cause loss of eyesight and brain damage. He stated that he had indeed drank a bottle of it yesterday." Mr. Mosher was then transported to the St. Cloud Hospital and remained there for several days receiving kidney dialysis treatment.

On October 18, 2002, Mr. Mosher was committed to the Willmar Regional Treatment Center from the Stearns County District Court because he was "found to be a mentally ill and chemically dependant person in need of judicial commitment." During his five-month stay at the psychiatric hospital, Mr. Mosher revealed an extensive history of mental illness, as well as a prior personal and family history of suicidal behavior (including the death of his mother from suicide in 1993 when he was 18-years-old). He was diagnosed with Bi-Polar Disorder, Borderline Personality Disorder, Attention Deficit Hyperactivity Disorder, and Alcohol and Poly-Substance Abuse. His course of treatment at the hospital included individual and group counseling, as well as psychotropic

medication to treat his depression, anxiety, agitation, mood, paranoia, and suicidal ideation. He periodically continued to exhibit suicidal ideation throughout his hospital stay. Upon discharge to a both a residential group home and day treatment by a community mental health provider on March 18, 2003, Mr. Mosher's psychotropic medications included Lithium, Trazodone, Paxil, Colace, Risperdal, Lamictal, and Seroquel.

From March 18 through May 4, 2003, Mr. Mosher made progress in the treatment for his co-occurring disorders. He attended daily counseling sessions and refrained from taking illegal substances. In late March, however, Mr. Mosher was briefly hospitalized at St. Cloud Hospital for a suicide gesture of consuming a large quantity of alcohol-based mouthwash (which he initially suggested was Liquid HEET). Upon discharge from the hospital on April 1, he was briefly detained again in the Stearns County Jail and housed in the booking area on "close observation" because of the suicide gesture. According to the intake screening form completed that day, Mr. Mosher admitted to attempting suicide a few days ago, as well as in October 2002, and "reports continued suicidal ideation." He was referred to mental health staff for a suicide risk assessment.

On April 3, Mr. Mosher was released from custody and returned to the group home prior to completion of the requested suicide risk assessment. Although maintaining a regular treatment regime, he also expressed periodic concern of anxiety and hopelessness, as well as frustration that his psychotropic medications were being adjusted by his psychiatrist. According to his medical records, Mr. Mosher's last contact with a mental health clinician was May 2, 2003.

On May 4, when Mr. Mosher failed to return to his residential group home placement on time, the county social worker initiated a petition to charge him with contempt of court for violating his release order. He was arrested, observed to be intoxicated with "significant" lacerations on his face apparently sustained in a fight, received medical treatment at St. Cloud Hospital, and was then transported to Stearns County Jail. Both the intake screening and initial classification forms completed the following day again documented his histories of depression, Bi-Polar Disorder, and suicidal ideation. Physician orders for various psychotropic medication (included Abilify, Neurontin, Depakote, Famotadine, Paxil, and Seroquel) were received by the Stearns County Jail nurse for Mr. Mosher. According to a classification note, based upon his behavior and background, Mr. Mosher was housed "in G-Unit for closer observation." The level of observation was *not* specified. On May 17, a housing unit officer wrote on an incident sheet that Mr. Mosher "was crying in cell — didn't want to discuss it. Once again had security light removed." There was *no* indication that Mr. Mosher was ever assessed by a mental health clinician during his 26-day confinement in the Stearns County Jail from May 4 through May 30, 2003.

On May 30, Mr. Mosher was transferred from the Stearns County Jail to the Benton County Jail in Foley, Minnesota for a pending assault charge. Upon intake, he was provided with intake screening by a jail nurse which disclosed his anxiety, Bi-Polar Disorder, depression, suicide attempts, and "large amount of meds" for his mental illness. Medical staff also received his psychotropic medication, as well as various records from Stearns County Jail.

Although a classification evaluation failed to take notice of Mr. Mosher's extensive mental health and suicidal behavior histories, resulting in his initial assignment to general population, another jail tracking form dated May 31 indicated that Mr. Mosher was relocated to a "special management cell" due to "anxiety problems." However, despite his extensive mental health and suicide risk histories, the Benton County Jail nurse who completed his medical assessment form on June 10 simply suggested that Mr. Mosher's plan of care was to "see as needed." A mental health referral was never initiated.

According to the statements of several Benton County Jail inmates, Mr. Mosher was acting very strangely in the days leading up to June 15, 2003. He was described as intoxicated, very unsteady on his feet, walking throughout the housing unit with little clothing on (and, in fact, was given a verbal reprimand for not wearing underwear on June 11), and suspected of being under the influence of an unknown substance. In fact, one inmate believed that he was snorting his psychotropic medication and/or drinking "SPLASH," a poisonous window cleaner.

At approximately 6:15pm on June 14, Mr. Mosher alerted Benton County Jail staff that he was feeling ill and "eury." When an officer arrived at his cell, Mr. Mosher said "where are you I can't see." When told that the officer was standing in the doorway, the inmate replied, "I still can't see you." According to the officer, Mr. Mosher "was hyperventilating and seemed to be upset." He then began to vomit. The officer left the cell, conversed with a supervisor, and returned to take Mr. Mosher's blood pressure. The supervisor subsequently called the jail's medical director, who advised the jail staff by telephone to "monitor" Mr. Mosher's behavior. The term "monitoring" was not defined, but according to the daily shift log, as well as a videotape recording of the special management housing unit, Mr. Mosher was provided with a level of observation similar to that of all other inmates in the unit — i.e., at approximate 30-minute intervals.

During the next few hours, jail staff periodically "monitored" Mr. Mosher's behavior. The inmate continued to vomit and complain of lost vision in both eyes. His breathing became labored. He was given his evening dosage of psychotropic medication and had to be assisted back to his cell by an officer. He then became unresponsive to verbal commands, and one of his eyes was unresponsive to light. Although jail staff "found this to be odd and repeated the light test with the same results," they simply told Mr. Mosher to lie down and rest. At approximately 9:30pm on June 14, jail staff again called the medical director and, according to the jail supervisor, the physician told her that Mr. Mosher "was primarily a psych. patient" and was not "a high risk for medical issues." Jail staff was again advised to "monitor" Mr. Mosher's behavior and call the doctor in the morning. The jail supervisor also called Stearns County Jail and provided that shift supervisor with an update of Mr. Mosher's medical condition.

According to the daily shift log, Mr. Mosher was observed to be "breathing heavy and unresponsive" during a cell check at 3:00am on June 15. A supervisor was called and again responded to the cell. At this point, Mr. Mosher was unresponsive and lying on the floor. He began moaning and was carried back to his bed by an officer and supervisor. There were excessive amounts of vomit

### 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](http://www.nicic.org)

observed in both the sink and toilet. At this point (approximately 3:30am), instead of transporting Mr. Mosher to the emergency room, the supervisor decided to again call the Stearns County Jail and request that they come and pick up Mr. Mosher. According to the supervisor's incident report:

“When I returned to my office I notified Sgt. Gacke, Stearns County Jail, of everything that had been happening. She asked if I wanted to come and pick him up. I told her it would be best if they did pick him up and take him back to their jail where they could evaluate Mr. Mosher and decide how they wanted to handle the problem. She informed me that they were very busy but would get someone here to pick him up as soon as possible.”

At approximately 4:10am on June 15, 2003, an officer conducted a cell check and observed that Mr. Mosher was no longer breathing. An emergency was called, backup personnel arrived and initiated cardiopulmonary resuscitation, but Mr. Mosher was subsequently pronounced dead at the scene. The medical examiner later determined that Mr. Mosher had ingested liquid SPLASH in the Benton County Jail and died from “acute methanol toxicity.”

The family of Ryan Mosher subsequently filed a federal lawsuit against both Stearns and Benton counties, as well as their jail personnel, alleging that their negligence and deliberate indifference were the proximate causes of Ryan Mosher's death. In January 2006, the defendants agreed to pay the Mosher family \$500,000 to settle the lawsuit. As Benton County Attorney Robert Raupp told the *St. Cloud Times*, “I think the settlement decision was the result of a number of factors — the allegations made, the cost of litigation if the matter continued and the possibility that if the plaintiff succeeded at trial defendants would be required to pay attorney fees.” □

## 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.*

### California

Angela Ramirez, 22-years-old was arrested by officers from the San Mateo Police Department (SMPD) on March 5, 2003, and charged with being under the influence of a controlled substance and (later for) providing false information to peace officers. She was initially transported to the SMPD for questioning and admitted to ingesting methamphetamines a few days earlier. Ms. Ramirez also was observed to have scratched the front part of her neck, chest, and hand. She was subsequently transported to the San Mateo County Jail. Ms. Ramirez was booked into the county jail at approximately 9:00pm on March 5. The SMPD transporting officer was required to complete a form indicating whether the arrestee was observed to be a medical, mental health, and/or suicide risk. The completed form did not give any indication of risk. Ms. Ramirez

underwent standard booking and classification at the San Mateo County Jail; her demeanor was described as cooperative, but nervous. The booking officer administered an intake screening form to Ms. Ramirez in which she answered “no” to all problem areas except for indicating she had scratched her neck area. She denied feeling suicidal or having a prior history of suicidal behavior. Ms. Ramirez also denied currently taking medication. Following completion of the booking and classification process, she was transported to the San Mateo County Women's Correctional Center (WCC).

Ms. Ramirez's confinement in the WCC initially appeared to be unremarkable. On March 13, she was sentenced to 210 days in jail on the pending charges. On March 16, Ms. Ramirez received a standard history and physical examination, and no medical problems were noted. Two days later on March 18, she requested Elavil and was referred to mental health staff. During the afternoon of March 22, Ms. Ramirez threatened suicide and was subsequently seen by a jail nurse. She “contracted for safety” until assessed by mental health staff, and was given a three-day supply of Atarax to help her sleep and relieve symptoms of anxiety.

On March 25, Ms. Ramirez was assessed by mental health staff. She denied feeling suicidal or having a prior history of suicidal behavior, although she expressed anxiety and felt either “embarrassed, ashamed or humiliated.” She informed the clinician that she only threatened suicidal over the weekend because she wanted medication for anxiety. Because she appeared to be deceptive, and the mental health clinician was reluctant to recommend psychotropic medication to an inmate with an alleged history of drug abuse, Ms. Ramirez was instructed to ask her family to bring in the medication.

During the late evening of March 28, Ms. Ramirez was seen by medical staff after complaining that she had hit her forehead in the shower. She again denied any suicidal ideation, claimed the injury was an accident, and requested to be transferred to the honor camp because she did not get along with several inmates in the dorm. Per the request of correctional staff, Ms. Ramirez was placed on a referral list to see mental health staff. She was seen by mental health staff on April 1 and repeated her earlier request for medication. She was again told to ask her family to bring in the medication.

Sometime before 7:00pm on April 6, 2003, Ms. Ramirez was observed by several other inmates in her housing unit to be walking toward the bathroom and shower area with a sheet loosely draped around her shoulders. A few of the inmates observed her to be crying. An officer, who had not observed Ms. Ramirez walk into the shower area or saw her crying, then escorted several inmates out of the dorm for recreation. Upon returning at approximately 8:00pm, two of the inmates entered the shower area and observed Ms. Ramirez hanging from a bed sheet that was attached to the shower rod. They began to yell for assistance, and an officer arrived at the shower stall and, with assistance from another inmate, removed the noose from around the victim's neck and laid her on the floor. A second correctional officer arrived shortly thereafter, and cardiopulmonary resuscitation (CPR) was initiated by the officers. Emergency medical services personnel arrived within several minutes and continued CPR efforts. Their efforts were unsuccessful and Angela Ramirez was subsequently pronounced dead.

The family of Angela Ramirez subsequently filed a federal lawsuit alleging that her death was the result of both negligence and deliberate indifference by San Mateo County and its personnel. Specifically, it was alleged that Ms. Ramirez was suicidal throughout her confinement and never received either proper mental health treatment or observation for her self-injurious behavior. In January 2006, San Mateo County agreed to pay the Ramirez family \$475,000 to settle the lawsuit. Although the county did not specifically admit to any wrongdoing in Ms. Ramirez's death, County Counsel Tom Casey told the *San Mateo County Times* that "there were obviously some things that weren't done exactly as the manuals prescribed. Whether that had anything to do with this particular death is just pure speculation," he said.

According to Sheriff Don Horsley, there were a number of problems at time of Ms. Ramirez's death — a personnel shortage to an aging facility, too many inmates, and a poor physical plant layout that made it difficult to supervise inmates. "It's a sad case," the sheriff stated. "If we had taken it all the way to trial, we could have won it ... But the truth of the matter is she came in there alive."

### Kentucky

In November 2005, 42-year-old Joseph Carmen was found hanging from a telephone cord in the Boone County Jail in Burlington. Mr. Carmen had a long history of mental illness and prior suicide attempts. His sister, Lisa Childress, reacted with disbelief to his death. "They can't tell me they didn't know my brother was capable of this, because I called and told them he was," she told a local television station. Ms. Childress said her brother was on suicide precautions some of the time he was in the Boone County Jail, but even then, she said he would call her and threaten suicide. "He said, 'I bet I could kill myself with this phone cord, and I think I'm going to try when I hang up,'" she said. Ms. Childress stated that every time he made the threat, she called the deputy in charge. "I was told he's on suicide watch and that's not possible — he can't do that," she said. "Well, apparently it is possible. It was possible because he did it."

Lisa Childress also stated her brother was not even on suicide precautions when he killed himself. Rather, he was in an isolation cell after doctors at a state hospital determined that he was no longer suicidal. Although Mr. Carmen's cell was under closed circuit television (CCTV) surveillance, jail personnel did not notice the suicide attempt until it was too late. "They said it looked like he was kneeling down, using the telephone," Ms. Childress stated.

A spokesperson for the Boone County Sheriff's Department stated that suicidal inmates are observed at 20-minute intervals, as well as placed in cells with CCTV monitoring. The death of Joseph Carmen remains under investigation.

### Wisconsin

Matthew Sanville was an inmate confined in the Waupun Correctional Institution (WCI) when he committed suicide in July 29, 1998. He had an extensive history of mental illness and suicide behavior. A week after his WCI admission in February 1998, Mr. Sanville was seen for a psychiatric assessment by Dr. Yogesh Pareek. Because he was having problems with nausea and vomiting, Dr. Pareek advised Mr. Sanville to go off his psychotropic medication

until the problems subsided. As it turned out, Mr. Sanville had an inflamed appendix, which required an emergency appendectomy on March 6, 1998. On March 10, his mother contacted the hospital to express concern that he had been taken off his medication. After the prison was contacted, the staff physician assured her that Matt's anti-psychotic medication had been reordered.

On March 26, 1998, approximately a week after his return to WCI from the hospital, Mr. Sanville saw Dr. Pareek for the second time. The doctor noted that the inmate had a "history of psychotic disorder, but he [was] refusing to take medication" and that he denied "ever hearing voices or ever seeing things [or] ever being paranoid." Dr. Pareek decided to discontinue psychotropic medication "at the patient's request" and agreed to see him again in eight weeks.

While un-medicated, Mr. Sanville's behavior became increasingly bizarre. In April, he defied an order to return to his cell, for which he was sent to solitary confinement. In early May, he scrawled venomous, nonsensical threats on his bed sheets ("kill the rapist [sic] and snitches" and "go to hell"). On June 9, he flushed his socks and underwear down the toilet. Yet he also displayed some evidence of competence (perhaps consistent with his diagnosis that he exhibited "very paranoid behavior with sense of reality"). The day prior to the sock flushing incident, he requested to be placed in an anger management class. He also filed a lawsuit based upon the failure of one correctional officer to respond to his requests for medical attention during the appendicitis incident.

In late June, Mr. Sanville asked to see Dr. Pareek, but then reported no mental health concerns and persisted in his decision to remain off his medication. Dr. Pareek provided no further treatment to the inmate. At this point, Mr. Sanville had lost 17 pounds since his WCI admission. On July 11, 1998, he assaulted another inmate and was placed in segregation. He then drafted a last will and testament (collected by correctional staff at an undetermined time) that was addressed to his mother and contemplated his imminent death. While in segregation, Mr. Sanville's bizarre behavior continued. After receiving conduct reports for refusing to return his meal tray and bag lunch, he was served "nutri-loaf. His weight loss continued and a subsequent autopsy confirmed that he lost about 45 pounds during his five months at WCI, 25 pounds of which occurred in the final month of his life while in segregation. Mr. Sanville complained to his mother about the nutri-loaf; she called medical personnel at WCI and relayed her concern that her son was paranoid, suicidal, and in serious trouble. On July 29, 1998, Matthew Sanville was found hanging from a bed sheet in his cell.

The Sanville family subsequently filed a federal lawsuit against various medical and correctional personnel at the Wisconsin Correctional Institution. The case eventually reached the United States Court of Appeals for the Seventh Circuit. On September 21, 2001, the federal appeals court ruled that the doctors who assessed and treated Matthew Sanville were not deliberately indifferent to his medical needs, but might have been negligent:

"... the evidence does not support a finding that the medical professionals at WCI were deliberately indifferent to Matt's serious medical needs.... The ultimate problem seems to be that none of the doctors ever noted that Matt might be a suicide risk, an observation that would not have seemed too

obscure considering his mental illness and history of suicide attempts. Yet the doctors' failure to correctly diagnose and treat Matt is not, in this instance, evidence of anything more than medical malpractice. . . . we note that plaintiff is certainly free to pursue her state law medical malpractice claims in state court" (*Sanville v. McCaughtry*, 266 F.3d 724).

In October 2002, however, in a strange turn of events, a federal jury found that both Dr. Pareek and a prison psychologist liable for the suicide of Matthew Sanville, and ordered that they pay \$1.825 million in compensatory and punitive damages (see *Jail Suicide/Mental Health Update*, Volume 11, Number 4, pages 9-10). Further, in March 2003, a federal court judge found that Dr. Pareek's medical treatment was negligent in Mr. Sanville's case and partly responsible for his death.

In November 2005, the state Medical Examining Board ruled that Dr. Pareek was suspended from practicing medicine or surgery at any state correctional facility for a period of two years. The doctor was also ordered to pay \$6,000 in court costs and complete 20 hours of continuing medical education in correctional psychiatry, with an emphasis on preventing suicide by mentally unstable inmates.

### Washington (State)

Years of cuts in mental health funding have created backlogs at Western State Hospital, where defendants are often sent to determine whether they are competent to stand trial. As a result, some defendants are spending more time in jail waiting for a mental health evaluation than they would if they were convicted, *The Daily News* of Longview reported in November 2005.

Alen Bolic was arrested in July 2005. As a first-time burglary defendant, he would probably spend about 30 days in the Cowlitz County Jail if convicted. Instead, he was confined in the jail for more than four months waiting for a mental health evaluation. The funding cuts, accompanied by a methamphetamine-driven increase in the numbers of defendants needing evaluations, have forced inmates to wait an average of two months to be evaluated for competency at the hospital. "The situation is absolutely ludicrous," Cowlitz County Superior Court Judge Stephen Warning told the newspaper recently. "It's past 'big problem' — it's ridiculous."

According to Dr. Murry Hart, supervisor of the in-patient evaluation program at Western State Hospital, "It's not just a crisis in Washington State. This is a national issue. We're not doing well with these people." Western State Hospital, which serves 19 counties, provides evaluation and treatment for adults before trial, after conviction or after they are acquitted by reason of insanity. Competency evaluations take 15 days. Dr. Hart said the hospital previously handled 500 in-patient felony cases a year. In 2004, it handled twice that and, in 2005, the number exceeded 2,000. Since 2001, state budget cuts have forced Western State Hospital to eliminate 150 beds.

"There are more people needing mental evaluations, no question about that," Judge Warning told *The Daily News*. "I lay most of it at the feet of the meth problem. People who come in on meth appear to be mentally ill, and if they use it awhile they are mentally

ill." The state Department of Social and Health Services, which oversees the hospital, sends a form letter after every evaluation referral stating that it could take at least six to eight weeks before the hospital can complete the evaluation. "The wheels of justice are stuck, not moving, dead in the water," Judge Warning said. "The only thing that continues is housing the person, and their continued deterioration."

It costs Cowlitz County little to house an inmate at Western State Hospital, but every day an inmate sits in the county jail costs taxpayers approximately \$67, said Corrections Director Dan Price. "The cost is substantially higher" than that for the mentally ill because of medication and overtime for increased supervision, he said. At the low end of \$67 a day, an inmate waiting 60 days to enter Western State Hospital would cost taxpayers \$4,020 for housing.

In 2005, the state legislature appropriated \$6.3 million year to allow the hospital to open a 29-bed forensics ward, but the ward soon filled up, and the waiting list is just as long as it was before, Dr. Hart said. "This is another one of the gazillion examples of how the state balances their budget by dumping functions that are theirs onto the county — and the county picks it up," Judge Warning complained.

### California

An 18-year-old youth hanged himself at the N.A. Chaderjian Youth Correctional Facility in Stockton last summer after spending eight weeks in solitary confinement — a practice that juvenile officials had promised to halt. In a damning report released in December 2005, investigators from the state Office of the Inspector General detailed the tragic two years Joseph Daniel Maldonado spent behind bars — from his unanswered pleas for mental health services to facility staff taking 38 minutes before entering his cell after they sensed trouble on the night he was found hanging from a bunk bed. A gang member, the youth was confined in the facility for car theft.

The lockdown at the N.A. Chaderjian Youth Correctional Facility came despite a statement made by the head of the state's troubled juvenile justice system in 2004 to end the practice of banishing youth to their cells. The report said that Joseph Maldonado, along with many other youth, spent eight weeks confined to his cell, and that he and the other wards were only allowed out three times a week for showers, and prohibited from attending school, exercising, or interacting with mental health personnel. According to investigators, "The effects of this eight-week isolation and service deprivation may have contributed to the ward's suicide."

The report, entitled *Special Review Into the Death of a Ward on August 31, 2005 at the N.A. Chaderjian Youth Correctional Facility*, prompted one lawmaker to charge that Governor Arnold Schwarzenegger's prison reforms have been hollow rhetoric. "The state is liable for the death of this ward," state Senator Gloria Romero told the *San Francisco Chronicle*, characterizing the weeks-long lockdown as abominable. A spokesman for the state Division of Juvenile Justice (formerly known as the California Youth Authority) said lengthy lockdowns were no longer used as punishment, but were sometimes necessary to maintain order.

According to the report, the “Division of Juvenile Justice failed several times to properly assess the Ward’s mental health to determine if he was properly placed in general population at N.A. Chaderjian. The division also missed several signals that should have caused it to provide him with mental health services. For example, the Ward requested four times to be seen by mental health staff, but he was never seen. In addition, it appears that the division failed to recognize possible mental health issues when the Ward first arrived at the Preston Youth Correctional Facility and it neglected to make an appropriate referral to obtain an in-depth mental health assessment.” The youth apparently told one caseworker that the lockdown had left him feeling claustrophobic and agitated.

“This is the first report that directly links their practices with a death,” Don Specter, director of the Prison Law Office, told the *Chronicle*. Governor Schwarzenegger had settled a conditions of confinement lawsuit (*Farrell v. Hickman*) in 2004 and pledged to make significant changes, but his administration has missed several court-imposed deadlines to implement reforms, including policies regarding suicide prevention, according to Specter.

Bernard Warner, chief deputy secretary of the Division of Juvenile Justice within the state Department of Corrections and Rehabilitation, called the youth’s death a tragedy and said the agency is still investigating the incident to determine if employees should be disciplined. “This report is an indictment of the violent and tense conditions that existed at the facility,” he said, but noted that assaults on wards and staff have dropped significantly in the past few months.

State Senator Romero said she felt betrayed by juvenile officials, who had pledged to end lockdowns in youth prisons. Walter Allen, who was director of the California Youth Authority before its name was changed last summer, told the state Senate in 2004 that the kind of lockdown used at Chaderjian would no longer be used (see *Jail Suicide/Mental Health Update*, Volume 13, Number 2, page 19). But a spokesperson for the agency stated that Mr. Allen meant that officials would not use lockdown as a punishment against unruly youth. “The intent of the lockdown is to restrain a population for a short period of time to gain control,” J.P. Tremblay told the *Chronicle*, while acknowledging that a weeks-long lockdown was “not something we would normally condone.”

With regard to the Maldonado case, the Office of the Inspector General report noted that facility staff “failed several times to properly assess and act on the Ward’s mental health needs.” Not only were his requests to see mental health personnel unmet, but an assessment completed when he first arrived at the facility, noting that he had alcohol and anger issues, was lost from his file. The report also detailed the length of time it took facility staff to get into the cell after discovering the youth had obstructed the window. An officer first noticed the covered window at 6:15 pm on August 31, but waited an additional 15 minutes before reporting it to a supervisor, and then it took another 23 minutes before officers opened the cell to find that the youth had committed suicide.

In a prepared statement that accompanied the report, Roderick Hickman, secretary of the Department of Corrections and Rehabilitation stated that “We agree that there are deficiencies to be addressed. Accordingly, DJJ will develop a comprehensive plan,

including specific timelines for implementation, to address the deficiencies identified....”

A copy of *Special Review Into the Death of a Ward on August 31, 2005 at the N.A. Chaderjian Youth Correctional Facility* is available from the California Office of the Inspector General, P.O. Box 348780, Sacramento, CA 95834, (916) 830-3600, <http://www.oig.ca.gov/>

**NOW AVAILABLE: HANDBOOK OF  
CORRECTIONAL MENTAL HEALTH**

**E**edited by Charles L. Scott, MD, and Joan B. Gerbasi, JD, MD, the *Handbook of Correctional Mental Health* is designed to assist mental health professionals in providing effective care to inmates and understanding both the unique living environment and stressors faced by inmates in a variety of correctional settings and the legal context in which they provide that care.

Each of 12 chapters, written by 26 nationally recognized experts, is clearly organized by overview, clinical case vignette, and key summary points, following the individual from arrest through probation. Each chapter combines basic background information for providers new to the world of corrections with more advanced material for seasoned correctional providers. The chapters are: 1) “Overview of the Criminal Justice System” (Charles L. Scott, MD); 2) “Practicing Psychiatry in a Correctional Culture” (Kenneth L. Applebaum, MD); 3) “Prevalence and Assessment of Mental Disorders in Correctional Settings” (Henry C. Weinstein, MD, Doonam Kim, MD, Avrum H. Mack, MD, Kishor E. Malavade, MD, and Ankur U. Saraiya, MD); 4) “Suicide Prevention in Correctional Facilities” (Lindsay M. Hayes, MS); 5) “Psychopharmacology in Correctional Facilities” (Kathryn A. Burns, MD, MPH); 6) “Mental Health Intervention in Correctional Settings” (Shama B. Chaiken, PhD, Christopher R. Thompson, MD, and Wendy E. Shoemaker, PsyD); 7) “Assessment of Malingering in Correctional Settings” (Michael F. Vitacco, PhD and Richard Rogers, PhD); 8) “Female Offenders in Correctional Settings” (Catherine F. Lewis, MD); 9) “Individuals with Developmental Disabilities in Correctional Settings” (Barbara E. McDermott, PhD, Kimberley A. Hardison, PsyD, and Colin MacKenzie, MD); 10) “Offenders with Mental Illnesses in Maximum and Super-Maximum Security Settings” (Gary E. Beven, MD); 11) “Management of Offenders with Mental Illnesses in Outpatient Settings” (Erik Roskes, MD, Judge Charlotte Cooksey, Richard Feldman, LCSW-C, Sharon Lipford, LCSW-C, and Jane Tambree, LCSW-C) and 12) “Legal Issues Regarding the Provision of Mental Health Care in Correctional Settings” (Fred Cohen, LLB and Joan B. Gerbasi, JD, MD).

For more information regarding the availability of the *Handbook of Correctional Mental Health* (2005), contact the American Psychiatric Publishing, Inc., 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209, (800/368-5777) or e-mail at [appi@psych.org](mailto:appi@psych.org), website: [www.appi.org](http://www.appi.org).

## Texas

According to the Harris County Sheriff's Office, the six-member Emergency Response Team who stunned and subdued inmate Daryl Dwayne Kelley with a Taser gun shortly before he died on January 13, 2006 may not have known he had Bi-Polar Disorder and were not trained to handle the mentally ill. The response team that was called to move the uncooperative, 6-foot, 300-pound inmate to a cell on the Harris County Jail's mental health unit strives to "safely control" violent inmates, regardless of their mental state, Major Don McWilliams told the *Houston Chronicle*. "All of their training protocols are designed in such a way that it really is not an issue whether or not someone is mentally ill. If they're (disruptive) to the point that they have to be physically controlled, the method doesn't vary," he said.

However, according to one law enforcement expert, mentally ill individuals are among those considered to be most at risk for injury resulting from a Taser. "They're just not good subjects for Tasing," said Albert Arena, a project manager with the International Association of Chiefs of Police (IACP), who has been studying Taser use in law enforcement for 18 months. The Harris County Jail policy regarding Taser use concerned Mr. Arena, who has authored the IACP guidelines for Taser use. "You would hope that the policies, procedures and training all had a scenario that would address the handling, transport or restraining of someone that's got a mental condition," he told the *Chronicle*.

Major McWilliams said there has been no change in any agency policy and "no indication at all that that's necessary. We're very confident at this point that everything that our employees did is in order," he added.

Daryl Kelley, 29-years-old, had been arrested in April 2005 and charged with assaulting his girlfriend because "the devil was inside" her. In the midst of being arrested, he tried to steal a police car and was charged with auto theft. He then became irate and incoherent, "laying back on the sidewalk and mumbling statements about the 'devil being inside him.'" According to jail records, Mr. Kelley displayed unusual behavior throughout his confinement, and was temporarily housed at West Oaks Hospital, a care center for mentally ill patients. On December 30, 2005, he was transferred back to the Harris County Jail and, for unknown reasons, assigned to general population. His family believes that Mr. Kelley began refusing his psychotropic medication at this point. On January 12, 2006, Mr. Kelley was placed in a padded observation cell because of his disruptive and threatening behavior to other inmates.

Following a restless night in the observation cell, jail officials decided to transfer Mr. Kelley to the mental health unit on the second floor of the facility. When he refused to leave the cell, the six-deputy Emergency Response Team entered the cell and shocked Mr. Kelley once on his lower hip with the full force of the Taser, and then stunned several times with less powerful jolts meant to cause pain, according to Major McWilliams. Medical staff then entered the cell and subdued him with an injection of psychotropic medication. Mr. Kelley was then escorted to the mental health unit, where he was initially conscious and communicable. Approximately 30 minutes later, however, he collapsed and was rushed to a local hospital. Daryl Kelley was pronounced dead later that afternoon (January 13).

The Kelley family has called for a federal investigation into the Harris County Jail system and its methods for handling the mentally ill in their jails. Dr. Britta Ostermeyer, a forensic psychiatrist and assistant professor of psychiatry at Baylor College of Medicine, told the *Chronicle* that jail officials have a responsibility to ensure that all mentally ill inmates receive proper treatment, including psychiatric care, and should recognize the psychotic behavior that Mr. Kelley exhibited in his final days "not as a sign of being bad, but as a sign of somebody.... in need of help."

The results of the Daryl Kelley's autopsy rare pending. Major McWilliams told the *Houston Chronicle* that he was confident his death was not caused by the Taser. "There's not a smidgen of evidence by any medical professional that a Taser has ever caused a death," McWilliams said. However, according to an investigative series by the *Arizona Republic* in July 2004, medical examiners in 27 of the 167 cases in the United States and Canada since 1999 where death has followed the use of a Taser, have said Tasers were a cause, a contributing factor, or could not be ruled out in the deaths.

## California

By all accounts, Derick Dawson should be dead or in prison. He grew up on the mean streets of Hunters Point, stealing, taking hard drugs, doing time in youth homes — and suffering from schizophrenia. By late 2002, narcotics cops were busting Dawson almost daily for drug offenses and low-level felony theft and assault cases. But he was so deranged by drugs and his disease he couldn't recognize the plainclothes officers who had arrested him the day before.

Today Dawson, 42, has two jobs and is drug free. His miraculous turnaround came about when he was sent to San Francisco's Behavioral Health Court, a 3-year-old program that gives criminal defendants with serious psychological problems a chance for reform through the city's mental health clinics and regular monitoring by the court's three-person staff. The court claims a recidivism rate of 12 percent.

"I was getting writ up, citations to come to court, I was having drugs on me, going to the station and they would find all the drugs on me," said Dawson in an interview. "Then release, go back over and smoke. Run around and then they bust me again."

After violating the terms of his parole in 2003 — Dawson has spent time in San Quentin, Pelican Bay and Folsom prisons as well as Atascadero and Patton State Hospitals — he was referred to the Behavioral Health Court and Deputy Public Defender Jennifer Johnson took over as his attorney. Johnson said Dawson was a particularly troubled client. When the animated former basketball player entered the program, he continued to get arrested, she said, which threatened to derail his progress in treatment programs. Finally, exasperated, she went to the narcotics officers and asked them to make an exception.

"We'd had a lot of interaction with Jennifer and we respected her, so when she asked us to give Derick a break, we said OK," said Officer Pete Richardson, who works in the Mission District. "He was just a low-level drug dealer. We never found any major quantities on him, so it wasn't a major issue to cut him some slack."

San Francisco's Behavioral Health Court is part of a two-decade-long push in American jurisprudence to find alternative methods to

incarcerating people like Dawson, who are mentally ill or repeat drug-use offenders. The “problem-solving courts,” as they are known, emerged in the 1980s with drug courts and are growing out of a recognition that, for some, doing time in prison will not prevent further crime and will be more costly to taxpayers than treatment.

“Mental health courts are popping up all over the nation,” said Allison Redlich, senior research associate with Policy Research Associates in New York. “About once a week, a new court pops up somewhere in the United States. There are about 120 overall so far.”

Redlich’s organization is in the beginning stages of a three- to four-year study of mental health courts in San Francisco, Santa Clara County, Orleans Parish, La., and Hennepin County, Minn. “There is very little data available on the success of these programs,” Redlich said. “It’s important to know what factors determine success or failure. Is it demographics? Gender? Age? Availability of treatment facilities?”

The Bureau of Justice Administration says the rate of mental illness in U.S. jails and prisons is 16 percent, more than three times the average for all Americans, and at least 75 percent of those people have substance abuse problems. With 2 million people behind bars in the United States, and 10 million booked into jails every year, cities, counties and courts are looking for ways to ease the burden.

Barry Mahoney, president emeritus of the Justice Management Institute in Denver, said mental health courts are proving to be useful, and that the interest and momentum is there to bring more of them online in the near future. “Everywhere we look, we see the benefits of these courts,” he said in a telephone interview. “They work better for the mentally ill, there is less recidivism and less use of drugs. The courts may not necessarily save money, but society certainly does.”

Dawson developed schizophrenia young, but wasn’t aware of his illness until he was an adult. Different diagnoses — ordered by the court when he was supposed to stand trial — indicated he had residual schizophrenia and paranoid schizophrenia. His IQ is low, though not to the level of mental retardation, and drug use made things worse. He once overdosed on crack cocaine and lost all vital signs. The doctor told him he was lucky to survive, but then he went right back to using.

San Francisco’s Behavioral Health Court isn’t really a court in the traditional sense. It is an agreement between San Francisco’s offices of the district attorney, the public defender and the Superior Court to come together once a week and oversee the clients who participate.

The program works as follows: When an individual is arrested and taken to jail, a psychological evaluator at the jail might recommend the inmate be referred to Behavioral Health Court, or the person’s attorney might ask for such a referral. Most important, the person has to volunteer for the program. Once accepted, the client agrees to abide by the decisions of the court and to work with whatever mental health agency takes him on. If the client stays in the program, take their medications and keeps out of trouble, the original charges are reduced or dismissed. Many of the clients are in the court because they violated the terms of probation. When the district attorney agrees to drop the charge or reduce probation, the clients officially graduate from the program.

The court had its first graduation ceremony in November 2004, with Dawson participating. Of the 65 clients who finished the program, 12 percent re-offended or broke the terms of their probation and went back in the criminal court system, said Johnson. Some went back to Behavioral Health Court.

Last year, Johnson said, the court accepted 157 clients covering 281 criminal cases. Of those, 37 graduated, resulting in the dismissal of 51 separate cases. Of the 120 other clients, 87 are still in the court, 16 have been terminated for lack of compliance and were returned to the regular court system, nine were sent to a locked mental health facility because their problems were too great to be served by the community mental health services, six voluntarily dropped out of the program and two died.

Behavioral Health Court convenes every Thursday. Johnson represents the public defender’s office, Cynthia Johns represents the district attorney’s office and the judge is Herbert Donaldson, who is otherwise retired but shows up once a week to handle these cases. Donaldson, 78, said he enjoys his work with the court because it makes a difference in people’s lives. “It grows on you,” he said. “You are actually able to impart some stability on people’s lives. Many of these people have no homes, they have no skills. They have mental illness and we don’t have treatment facilities to treat them. And sometimes terrible things happen to them.”

Donaldson understands that some people view Behavioral Health Court, and other problem-solving courts, as bleeding-heart attempts to coddle criminals. “The fact is, you can’t hold people who are mentally ill to the same standard as those who are not,” he said. “Some of the people we deal with are developmentally disabled. Some of these people have such low IQs that it’s difficult for them to function. They often get caught up in the jaws of the law because people take advantage of them.”

In the morning session, Johnson, Johns and Donaldson meet in a conference joined by representatives of the county jail and various mental health programs. The judge and attorneys first discuss new cases that have been referred to the court. In order to qualify, the individual must be diagnosed with an “Axis I mental disorder,” such as schizophrenia, bipolar disorder, major depression or post-traumatic stress. In addition, the crime at issue cannot involve arson, sex crimes, domestic violence or assault resulting in great bodily injury.

This is where Johns and Johnson often spar, because some clients are in a gray area of acceptance. Someone who got into a fight, for example, might qualify if the attorneys believe it was a one-time incident resulting from the potential client not taking prescribed medications. If a client is not accepted, he or she returns to the regular court calendar for trial, or plea bargaining. Johnson and Johns also argue occasionally over whether to send a client back to the regular criminal justice system if the client habitually violates the terms of the program he or she is in. That’s the stick approach, and the only real punishment available to the officers of the court. But apart from that, it’s a fairly collegial atmosphere.

At the Thursday morning meetings, the mental health professionals give updates on the various clients. In the afternoon, all the parties, along with the client, meet in open court and the judge speaks with each person individually.

Donaldson, who sits on the judge's bench in a black judicial robe set off by a thick shock of white hair, doesn't dispense justice the way other judges do. He functions more as a father figure, a stern but friendly official to whom the clients must answer. "Mr. Brown, I understand you're keeping off the alcohol?" Donaldson said to a man in a brown blazer who stepped up to the podium. "Yes, your honor, but it's real hard during the holidays," the man replied. "I know, and you're to be commended for it. Let's have a round of applause for Mr. Brown." There's polite applause from the attorneys, the bailiffs and the assorted clients in the audience.

Donaldson asks for applause because, he said, "People try so hard to make it. I think it's important for them to know we're pulling for them." "We don't want them to be afraid to come to court," Johnson said. "For some of them, just getting to court is an accomplishment."

Johnson, a petite woman with intense black eyes, is the driving force behind the court. Others are heavily involved, but she's been there from the beginning, and believes an alternative court can save money, not just for the courts, but for the police and the city. Every client who is in a mental health program, she said, is not spending time in jail, or the hospital emergency room or otherwise draining tax dollars.

Her counterpart, Johns, also praises the court. "I think it really accomplishes something," she said. "We hear from the clients and even the bailiffs about how much this improves their lives. Some of these people really need help. They need medication and people to watch over them."

That's soft talk coming from a hard-nosed prosecutor, and Johns admits that a lot of prosecutors are leery of the various problem-solving courts and diversion programs that do anything but put criminals in jail. "The difference is, we're not a drug court and we're not a diversion program," she said. "The people who appear before the court have genuine mental problems, and you can see that." But she also has fears — that one of the clients will commit a horrible crime while out on the street, and the Behavioral Health Court will be held responsible.

Jeff Adachi, San Francisco's public defender, said the Behavioral Health Court is a good antidote to the huge numbers of mentally ill people in the court system. But so far it's a drop in the bucket, he said, considering that the program handles a couple hundred cases out of the 20,000 to 30,000 going through San Francisco's courts every year.

The Behavioral Health Court is also limited in what it can accomplish due to the finite number of beds in mental health facilities. Many inmates sit in jail for days or weeks while waiting for a bed to open up. "It's a small program, but it's valuable," Adachi said. "It's just not right to put people in jail if they committed a crime as a result of mental illness. Now the question is: Can it work on a much larger scale?"

*The above article — "An Alternative to Incarceration: Behavior Health Court Offers Counseling to Criminal Defendants with Psychological Problems. Cheaper than Jail, It's Changing Lives" — was written by John Koopman, a staff writer for the San Francisco Chronicle, and appeared in the January 23, 2006 edition of the newspaper. Copyright 2006, San Francisco Chronicle. All rights reserved. Used with permission.*

## JAIL SUICIDE/MENTAL HEALTH UPDATE

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

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

### AVAILABLE JAIL/PRISON/JUVENILE 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)  
*Juvenile Suicide in Confinement: A National Survey* (2004)  
*Jail Suicide/Mental Health Update* (Volumes 1-14)

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

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