JAIL SUICIDE/MENTAL HEALTH UPDATE

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WAS IT PREVENTABLE?: THE COMPREHENSIVE REVIEW OF AN INMATE SUICIDE

*Despite a declining rate of suicide in county jails throughout the country (if recent Bureau of Justice Statistics are accurate), there remains the lingering problem of too many preventable suicides occurring alongside our feeble ability to comprehensively review the deaths. Several years ago, we addressed this topic and offered practical advice on the mortality review process for inmate suicides (see **Jail Suicide/Mental Health Update**, Winter 1999, Volume 8, Number 3). In revisiting this issue, we again offer guidelines for conducting for the comprehensive review of inmate suicides, as well as an explanation of the psychological autopsy process — a time-consuming endeavor that has been both misunderstood and misused within the correctional environment yet remains the most effective way to learn about the thought process of suicide.*

On the evening of May 17, 1997, George Moffat (a pseudonym) was arrested for domestic violence against his wife Sheila and transported to a county jail in a mid-western state. During transport, he tried to cut his wrists while handcuffed in the back of the patrol car. Although the wounds appeared superficial, Mr. Moffat was transported to the local hospital for medical treatment. "It's a common thing. People cut their wrists thinking it will keep them out of jail. It doesn't work," commented Matthew Stevens, the arresting and transporting officer.

Upon arrival at the county jail, Mr. Moffat was booked and processed without incident, although jail staff determined that he was currently on probation for burglary. Nurse Laura Thompson completed a medical intake screening form. The 54-year-old inmate listed several problems, including gout, high blood pressure and back pain. Mr. Moffat also admitted that he had attempted suicide approximately four months earlier by cutting his wrists, and he had spent three days in the state hospital. No mention was made of the self-harming behavior in the patrol car a few hours earlier and Mr. Moffat denied any current suicidal ideation. Although Nurse Thompson did not feel that his prior suicide attempt several months earlier justified any current preventative measures, as a precautionary matter, she filled out a referral slip for further assessment the following morning by the facility's mental health staff. The referral slip was placed in the mental health services' mailbox in the receiving and discharge unit. Mr. Moffat was then classified and subsequently placed in a general population housing unit.

George Moffat remained in the county jail for approximately six months. During this time, he received medical treatment when requested for his gout, high blood pressure, and back pain. He never requested mental health services, nor was he ever assessed by clinicians as a result of Nurse Thompson's initial referral. Mr. Moffat appeared in court several times, eventually pleading guilty to the domestic violence charge and receiving a county jail sentence. A separate hearing on whether to revoke his probation, which in all likelihood would result in a state prison sentence, was scheduled for the first week of December 1997. During his six months of incarceration, Mr. Moffat had little contact with his family. His two adult daughters refused to visit him in jail and his wife had contacted an attorney with the intent of filing for divorce.

On Saturday, November 22, 1997, Mr. Moffat called his wife over a dozen times and threatened to kill himself if she filed for divorce. He also appeared distraught at the prospect of going to prison. During one telephone call, Mr. Moffat told his wife that he was tearing his bed sheet into strips. Because she had heard her husband threaten suicide in the past and, in fact, he had attempted suicide at the same facility the previous year, Sheila Moffat was concerned about her husband's state of mind and called the county jail. She spoke with Lieutenant Skip Morrow who gave assurances that her husband would be safe. Following the telephone conversation, Lieutenant Morrow went to Mr. Moffat's housing unit and instructed Officer Daniel Anders to check the inmate's cell. When Officer Anders approached the cell he noticed that a strip of bed sheet was tied to the cell bars. Mr. Moffat was sitting on his bunk and appeared nervous. When the officer inquired as to why the cloth was tied to the bars, Mr. Moffat offered no explanation other than to deny that he was contemplating suicide. Officer Anders removed the cloth from the bars, confiscated the remainder of the bed sheet, and reported back to Lieutenant Morrow. The officer was instructed to write a report of the incident (to include the fact that Mr. Moffat had denied being suicidal) and forward a copy to mental health staff.

During the next several hours, Officer Anders checked Mr. Moffat's cell on an hourly basis and the inmate appeared to be sleeping during

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a cell check at 11:10pm. However, during a cell check at approximately12:07am on November 23, the officer observed George Moffat sitting on the floor with his back to the cell door. The leg of his jumpsuit was tied around his neck and through the cell bars. Officer Anders ran back to the control booth in the housing unit, instructed the officer to call for back-up support and medical personnel, grabbed a pair of medical shears from the first aid kit, and returned to the cell. The officer used the shears to cut the cloth away from the bars. Mr. Moffat's body fell to the floor. Other correctional staff arrived, the cell door was opened, and the inmate was pulled out into the hallway. An officer checked for vital signs and found none. Rather than initiating cardiopulmonary resuscitation (CPR), the officers waited for medical staff to arrive. A jail nurse arrived several minutes later and initiated CPR, assisted by a correctional officer who used a mouth shield from a pouch attached to his belt. Emergency Medical Services personnel arrived at 12:16am and continued CPR. Mr. Moffat was subsequently transported to the hospital and pronounced dead upon arrival. Following his death, timely notification was made to both designated facility officials and Mr. Moffat's family.

Several investigations were conducted into the suicide of George Moffat. The first inquiry was the medical autopsy in which a forensic pathologist concluded that the cause of death was "asphyxia due to hanging." Next, the state police conducted an inquiry. Trooper David Dickinson interviewed several correctional staff, reviewed incident reports from all involved staff, and inspected the cell area. His investigation lasted almost a full day and a subsequent two-page report concluded that the death was a suicide with no signs of foul play. Trooper Dickinson later testified at a coroner's inquest of Mr. Moffat's death held on April 9, 1998. The following exchange took place:

> **Coroner**: Officer Dickinson, could you briefly summarize your findings in the death of George Moffat?
>
> **Dickinson**: Sure. There were no signs of foul play. From talking to the jail personnel, they advised me that the inmate was alone in his cell. There was no suicide note found. That's basically it.
>
> **Coroner**: Did you review any of the facility's operational policies?
>
> **Dickinson**: No.
>
> **Coroner**: Did you investigate as to whether the resuscitation efforts were appropriate?
>
> **Dickinson**: No.
>
> **Coroner**: Do you have any other comments to make which might be helpful to this inquest?
>
> **Dickinson**: Well, there were no signs of foul play and everyone was very cooperative.

The coroner's inquest lasted approximately two hours and included testimony from several other individuals, including correctional and medical personnel. At the conclusion of the testimony, the jury left the courtroom to deliberate. It returned five minutes later and stated: "We declare that the cause of death was suicide, the person causing the death was George Moffat, the death occurred on November 23, 1997, the instrument causing the death was a jumpsuit, and the manner in which death occurred was hanging."

As per departmental policy, the county jail's mental health services administrator also reviewed Mr. Moffat's suicide. The inquiry was limited to a review of the inmate's medical file, and did not include any staff interviews. The mental health administrator summarized her document review of George Moffat's suicide in a one-page confidential report self-titled a "psychological autopsy." The report is reprinted in its entirety as follows:

> The inmate, George Moffat, was admitted to the county jail on May 17, 1997. This inmate had written several medical requests, all of which were related to such discomforts as foot problems, colds, lower back pain, and rashes. He never requested mental health assistance, therefore Mental Health Services never had an opportunity to interview, evaluate or treat him throughout the six months of his incarceration. Based upon a review of the medical file, there is no evidence that this inmate's death could have been prevented.

The mental health administrator did, however, conduct a one-hour suicide prevention workshop for correctional personnel several months after Mr. Moffat's death, the first such training for any departmental personnel in over 10 years.

George Moffat's suicide was also reviewed by the county prosecutor's office. An investigator from that office reviewed Mr. Moffat's institutional and medical file, state police report, autopsy report, and transcription of the coroner's inquest. Based upon this review, the county prosecutor wrote a letter to the county sheriff which stated, in part, that "we limited the scope of our investigation to reviewing whether or not George Moffat died as a result of an unlawful homicide or suicide. It is clear that he died from his own actions. It is impossible to determine whether or not this inmate intended to take his own life. He may well have died accidentally while feigning suicide. Quite frankly, that was not really our concern. He clearly died by his own actions. We consider this case closed."

The primary purpose of a morbidity-mortality review is two-fold: *What happened in the case under review and what can be learned to help prevent future incidents?*

Shortly after receiving the county prosecutor's letter, Sheriff Roy Hamilton issued a press release on April 27, 1998 stating that George Moffat's suicide had been investigated thoroughly by several agencies and each concluded that there was no criminal wrongdoing by any county jail personnel. When asked by a local newspaper reporter the following day whether he planned to make any changes in the 850-bed jail in light of Mr. Moffat's death, as well as two other inmate suicides during 1997, Sheriff Hamilton responded that "as far as I'm concerned, this matter is over. There was no criminal involvement here. My concern is more if we suspect foul play. I have no idea why these inmates commit suicide in my jail. If I did, I could probably do a better job of preventing it."

The Preferred Aftermath: A Morbidity-Mortality Review Process

Why did George Moffat commit suicide? What really happened? Did mental health staff ever receive the referral from Nurse Thompson shortly after his arrival into the facility? Was anyone aware that Mr. Moffat had attempted suicide in the facility during the previous year? Why did correctional officers wait until medical personnel arrived before assisting with CPR? Should George Moffat have been placed on suicide precautions when he looked suspicious during the late evening of November 22 with a strip of bed sheet tied to his cell bars? Had any personnel received suicide prevention training prior to the incident? Was Mr. Moffat's suicide preventable? Were there any similarities between his death and the other two suicides during 1997? These and many other lingering questions remain unanswered in this case, as well as in several hundred other suicides that occur in correctional facilities each year simply because many agencies choose not to address them. While verifying the cause of death and ruling out foul play remain the staples of routine investigations, correctional agencies remain reluctant to comprehensively review an inmate suicide and determine whether or not it was preventable.

In order to fully understand why an inmate committed suicide, as well as whether the agency was in the best possible position to prevent the incident, every suicide and serious suicide attempt (i.e., requiring hospitalization) should be examined through a comprehensive morbidity-mortality review process. The process is separate and apart from other formal investigations that may be required to determine the cause of death (e.g., autopsy, state police inquiry, coroner's inquest, etc.).

The primary purpose of a morbidity-mortality review is two-fold: *What happened in the case under review and what can be learned to help prevent future incidents?* To be successful, the morbidity-mortality review team must be multidisciplinary and including representatives of both line and management level staff from the corrections, medical and mental health divisions. Exclusion of one or more disciplines will severely jeopardize the integrity of the review.

The morbidity-mortality review should include: 1) critical review of the circumstances surrounding the incident; 2) critical review of facility procedures relevant to the incident; 3) synopsis of all relevant training received by involved staff; 4) review of pertinent medical and mental health services/reports involving the victim; 5) review of possible precipitating factors (i.e., circumstances which may have caused the victim to engage in self-injury/suicide) resulting in the incident; and 6) recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures.

Based upon the eight (8) critical components of a comprehensive suicide prevention program that have been previously offered in the ***Update***, detailed below is a recommended format and areas of inquiry for conducting a morbidity-mortality review.

1) Training

- Had all correctional, medical, and mental health staff involved in the incident received both basic and annual training in the area of suicide prevention prior to the suicide?

- Had all staff who responded to the incident received training (and were currently certified) in standard first aid and cardiopulmonary resuscitation (CPR) prior to the suicide?

2) Identification/Referral/Assessment

- Upon this inmate's initial entry into the facility, were the arresting/transporting officer(s) asked whether they believed the inmate was at risk for suicide? If so, what was the response?

- Had the inmate been screened for potentially suicidal behavior upon entry into the facility?

- Did the screening form include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); and history of suicidal behavior by family member/close friend;

- If the screening process indicated a potential risk for suicide, was the inmate properly referred to mental health and/or medical personnel?

- Had the inmate received a post-admission mental health screening within 14 days of his/her confinement?

- Had the inmate previously been confined in the facility/system? If so, had the inmate been on suicide precautions during a prior confinement in the facility/system? Was such information available to staff responsible for the current intake screening and mental health assessments?

3) Communication

- Was there information regarding the inmate's prior and/or current suicide risk from outside agencies that was not communicated to the correctional facility?

- Was there information regarding the inmate's prior and/or current suicide risk from correctional, mental health and/or medical personnel that was not communicated throughout the facility to appropriate personnel?

- Did the inmate engage in any type of behavior that might have been indicative of a potential risk of suicide? If so, was this observed behavior communicated throughout the facility to appropriate personnel?

4) Housing

- Where was the inmate housed and why was he/she assigned to this housing unit?
- If placed in a "special management" (e.g., disciplinary and/or administrative segregation) housing unit at the time of death, had the inmate received a written assessment for suicide risk by mental health and/or medical staff upon admission to the special unit.
- Was there anything regarding the physical design of the inmate's cell and/or housing unit that contributed to the suicide (e.g., poor visibility, protrusions in cell conducive to hanging attempts, etc.)?

5) Levels of Supervision

- What level and frequency of supervision was the inmate under immediately prior to the incident?
- Given the inmate's observed behavior prior to the incident, was the level of supervision adequate?
- When was the inmate last physically observed by correctional staff prior to the incident?
- Was there any reason to question the accuracy of the last reported observation by correctional staff?
- If the inmate was not physically observed within the required time interval prior to the incident, what reason(s) was determined to cause the delay in supervision?
- Was the inmate on a mental health and/or medical caseload? If so, what was the frequency of contact between the inmate and mental health and/or medical personnel?
- When was the inmate last seen by mental health and/or medical personnel?
- Was there any reason to question the accuracy of the last reported observation by mental health and/or medical personnel?
- If the inmate was not on a mental health and/or medical caseload, should he/she have been?
- If the inmate was not on a suicide watch at the time of the incident, should he/she have been?

6) Intervention

- Did the staff member(s) who discovered the inmate follow proper intervention procedures, i.e., surveyed the scene to ensure the emergency was genuine, called for back-up support, ensured that medical personnel were immediately notified, and initiated standard first aid and/or CPR?
- Did the inmate's housing unit contain proper emergency equipment for correctional staff to effectively respond to a suicide attempt, i.e., first aid kit, gloves, pocket mask, mouth shield, or Ambu bag; and rescue tool (to quickly cut through fibrous material)?
- Were there any delays in either correctional or medical personnel immediately responding to the incident? Were medical personnel properly notified as to the nature of the emergency and did they respond with appropriate equipment? Was all the medical equipment working properly?

7) Reporting

- Were all appropriate officials and personnel notified of the incident in a timely manner?
- Were other notifications, including the inmate's family and appropriate outside authorities, made in a timely manner?
- Did all staff who came into contact with the inmate prior to the incident submit a report and/or statement as to their full knowledge of the inmate and incident? Was there any reason to question the accuracy and/or completeness of any report and/or statement?

8) Follow-Up/Morbidity-Mortality Review

- Were all affected staff and inmates offered critical incident stress debriefing following the incident?
- Were there any other investigations conducted (or that should be authorized) into the incident that may be helpful to the morbidity-mortality review?
- As a result of this review, were there any possible precipitating factors (i.e., circumstances which may have caused the victim to commit suicide) offered and discussed?
- Were there any findings and/or recommendations from previous reviews of inmate suicides that are relevant to this morbidity-mortality review?
- As a result of this review, what recommendations (if any) are necessary for revisions in policy, training, physical plant, medical or mental health services, and operational procedures to reduce the likelihood of future incidents. ❑

Inmate Suicide and the Psychological Autopsy Process

by
H.G. Sanchez, Ph.D.

In simple terms, the *psychological autopsy* is a retrospective reconstruction of a decedent's life initiated in order to gain a better understanding of their death (Shneidman, 1981). It has been used in a variety of settings, with various populations, and as part of both group and individual studies (Clark and Horton-Deutsch, 1992; Spellman and Heyne, 1989). Although not currently a routine practice in the correctional environment, psychological autopsies can provide valuable information about the process by which certain inmates become increasingly suicidal and eventually make the decision to end their lives. Prison life is highly structured and closely supervised. Inmates follow strict routines and are under regular supervision. They have daily contact with a variety of staff. Furthermore, they develop relationships with fellow inmates, some of whom get to know them quite well. This environment allows for an accumulation of information that is not typically accessible in a community setting. Both the institutional and health records may contain background history relevant to understanding the suicide, such as family history of mental illness or suicide. The wealth of information available from a variety of sources provides a unique opportunity to study suicide, as well as to subsequently offer recommendations, where appropriate, to help prevent future inmate suicides.

Method for Completing Psychological Autopsies in a Prison Setting

Conducting a psychological autopsy requires reviewing various information, including incident reports, prison files and health records, as well as examining the death scene and interviewing numerous individuals. In order to maintain the integrity of the review, the reviewer should not have had any prior association with the decedent or the staff members responsible for the inmate's care and custody. In some situations it may be better to have an outside expert, perhaps from another facility, conduct the psychological autopsy. The psychological autopsy could also be completed by a team of mental health professionals, provided that it is led by a clinician with expertise in human behavior, suicidology, crisis theory, diagnosis, and interview skills.

There are several steps in completing the psychological autopsy in a correctional setting. Although these steps do not have to be completed in the order prescribed, adhering to the sequence offered below will allow the reviewer(s) to obtain the information in a logical and efficient manner while minimizing possible contamination and distortion.

Review of the Incident Reports

First, the reviewer should examine the incident reports which give identifying information about the decedent, date and time staff discovered the victim, location of the incident, method used to cause death, and life-saving interventions by staff. These reports provide facts about the incident but do not offer any official conclusions about the death. The coroner's office typically uses these reports in conjunction with the medical autopsy to make a statement about the cause and mode of death. In situations of confirmed suicide the information in the reports may provide insight into the decedent's degree of intent in wanting to end his

WE'RE STILL LOOKING FOR A FEW GOOD PROGRAMS

Future 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 1996 thru 2005 to:

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life. All staff who came into contact with the victim immediately prior to the incident and/or responded to the emergency should have been required to submit an incident report. The reviewer should interview these individuals because they may provide valuable information not contained in their reports.

Review of the Prison File

The reviewer should examine the prison file to obtain background information about the decedent's criminal history, family history, educational background, employment history, and use of leisure time. The prison file may help the reviewer identify or confirm historical risk factors that are related to suicide. The prison file should contain documentation pertaining to the inmate's institutional functioning such as disciplinary problems, pending appeals of adverse actions against the inmate, pending grievances or complaints, pending referrals to the district attorney's office for crimes committed while in prison, legal setbacks on attempts to gain release, general programming, structured extracurricular activities, trust account information (including recent transactions), and visiting records. In addition, special housing unit (e.g., administrative and disciplinary segregation) records should be reviewed. Following examination of the prison file, the reviewer may want to interview additional staff (e.g., teachers or work supervisors) who may be able to provide information about the inmate's functioning in the weeks prior to the suicide.

Review of the Health Record

The health record provides information about the decedent's health care contacts while in prison, including medical, mental health, and dental care. Because of the high association between suicide and certain mental illnesses, a careful review of the mental health section is critical. The mental health section should contain information about current diagnosis, treatment, findings of most recent mental status examination, and details of the last mental health contact. The health record may also contain reports of prior mental health contacts and/or hospitalization in the community for suicidal behavior.

In addition, if the inmate had been receiving medication, the reviewer should examine the health record to determine medication compliance because mental decompensation related to medication non-compliance can contribute to suicide (e.g., stopping an antidepressant can lead to an increase in depression and suicidal ideation). The medication record, however, does not always reflect medication compliance. While inmates are typically supervised to ensure that they actually take their medication at the time it is dispensed, some inmates may dispose of the medicine once they leave the supervised area. In such cases, toxicology studies (see below), not medication records, will be a more accurate measure of medication compliance.

The medical section of the health record should be thoroughly reviewed because serious, life-threatening medical problems may contribute to suicidal behavior. In some cases, simply the fear of a catastrophic illness (e.g., AIDS) can trigger a suicide attempt. In addition, the medical section should contain information about the medical interventions used at the time staff discovered the victim, as well as the time a physician pronounced death.

Medical Autopsy/Toxicology Findings

The medical autopsy report may contain information relevant to understanding the death, as well as physical evidence of any contributing factor (e.g., physical or sexual assault). The autopsy may also help establish a time frame for the inmate's death. In some cases the reviewer may find it helpful to speak with the coroner or medical examiner who conducted the autopsy. Toxicology studies can provide information about medication levels in the inmate's blood system and help determine if the decedent had a therapeutic level of medication. The toxicology findings can also reveal if the inmate had illegal drugs, alcohol or other non-prescribed medication in his system — critical information in cases of suspected overdose.

Inspection of the Death Scene

Inspection of the death scene, including a review of the method used and time of day the death occurred, can often provide information about the inmate's state of mind immediately prior to the suicide. Studying the death scene can offer a perspective of how the inmate viewed the world and organized his life. For example, a dirty cell may suggest deterioration in mental functioning. Inspection of a suicide note(s) will undoubtedly provide insight into the inmate's thought process, and the reviewer should be familiar with the research on suicide notes (Leenaars, 1988). An inmate may have also left written communications on the walls or in other locations within the cell. These communications may provide clues as to what troubled him. An examination of the inmate's possessions often provides clues of his interests. For example, the choice of reading materials, letters or poetry, and diaries can be helpful. The investigator should verify written material by comparing it with available writing samples belonging to the inmate. Sometimes letters found in the cell received from family and friends provide insight into the decedent's mental functioning. For example, family members may question why the inmate had not written them or express concern about the negative tones of prior correspondence.

Because the location of the suicide is typically treated as a crime scene, it is important for the reviewer to elicit the cooperation of correctional officials. The death scene cannot be preserved indefinitely, so the reviewer should take detailed notes describing the setting, including items that are present or missing. In cases where the reviewer was unable to view the death scene, photographs taken by other investigators and an inventory report of the property found in the cell may be helpful.

Interviews

Inmate and staff interviews serve several important purposes. First, interviews can help confirm historical factors that may be relevant to the suicide, such as a family history of suicide or depression. Second, interviews provide information regarding the inmate's personality dynamics, including impulse control, stress tolerance, coping abilities and lifestyle within the prison. Third, interviews allow the reviewer to explore the precipitating events that may have contributed to the suicide. Fourth, interviews help verify any recent medical or mental health changes not documented in the health record that may be important in understanding the

suicide. Finally, interviews may provide a picture of the inmate's pre-suicidal functioning and changes in mental status, behavior, mood, and attitude — all of which may have been indicative of suicidal intent.

Several writers have provided guidelines for conducting psychological autopsy interviews (Beskow, Runeson and Asgard, 1990; Rudestam, 1979; Shneidman, 1981). From these writings, general rules for conducting interviews have emerged. First, the reviewer should use a private area where an individual can speak freely. In addition, the reviewer should fully explain the issue of confidentiality and inform the individual that they are conducting a study of the inmate's suicide and would like to ask some questions. The reviewer should begin the interview with open-ended questions that encourage the informant to talk about their observations. Direct questions will also be necessary if the open-ended approach is not yielding useful information or if specific questions are required to obtain more detailed information.

As an initial step, the reviewer should produce a list of inmates and staff who may have information relevant to the suicide. The reviewer needs to identify the inmate's circle of friends and those who lived in his immediate area, as well as any staff who routinely had contact with the decedent. The unique peculiarities of a prison setting warrant close attention to the time interval between the suicide and the interview. Inmates are paroled, transferred, or moved within the same institution. Correctional staff work various shifts and schedules, and can be away from the institution due to regular days off, vacation, or reassigned to different posts. In addition, the prison culture is very prone to rumors and the sooner the reviewer interviews potential informants, the better they will be able to make a judgment about both the credibility of the informants and the reliability of information provided.

A delicate issue facing the reviewer is how to conduct interviews with family members or others identified as next of kin. Logistics often make it difficult, if not impossible, to conduct face to face interviews, so interviews with family members will most likely occur by telephone. The reviewer must be prepared to express sympathy and support to family members whose reactions could include shock, disbelief, anger, sadness, and suspicion. The reviewer may want to wait a few days or weeks to give the family time to deal with their grief. While perhaps the most difficult interviews to conduct, family members can provide helpful information since they have both access to background information not available in records and knowledge about the decedent's relationships (or lack of) and functioning outside the prison. Family members may also have information about long-term problems or recent difficulties facing the decedent that was previously unknown to prison staff. They could also provide information about recent telephone calls or letter correspondence with the inmate. At the minimum, the reviewer should attempt to interview the inmate's spouse (or companion) and parents if listed as next of kin. Sometimes these family members will direct the reviewer to other individuals who were closer to the inmate or who may have additional information.

Following completion of the interviews, it may be helpful to conduct follow-up interviews in order to clarify conflicting information or to obtain additional data. The reviewer should keep a log of the names and dates of the interviews and note the relationship of each person to the inmate. This log should also contain the names of individuals who were judged to be relevant informants but refused to be interviewed. In addition, the log should contain the names of those individuals who appeared to be important informants but who could not be located. This information may be important at a later date should there be further inquiry into the suicide.

Finally, the reviewer needs to be sensitive to the emotional state of the informants and be alert for individuals who may need professional help, e.g., critical incident stress debriefing (Meehan, 1997). The reviewer also needs to be aware that the information provided by these individuals may be distorted for various reasons. Obviously, in the case where an informant is mentally ill, caution is warranted both in interviewing the informant and weighing the reliability of the information. Informants sometimes offer their opinion about what may have contributed to the suicide. The reviewer must not allow the informant's opinions to bias the investigation. There may also be situations where inmates do not want to cooperate with the investigator. This may be due to secretive relationships that, if revealed, may cause embarrassment or shame, and possibly loss of respect or status among the inmate population. Occasionally, some inmates will attempt to use the suicide to advance their own agenda. They blame the administration or identify a particular staff person, whom they dislike, as being responsible for the suicide. However, most inmates will probably identify with the decedent and want to help. Staff may also be reluctant to provide information because of fear they did something wrong. Issues about confidentiality become especially important in these types of situations. As such, the reviewer may need to make several attempts at conducting the interviews.

Motive for the Suicide

Once the reviewer has gathered all the necessary data, the task becomes one of organizing and analyzing this information in a manner that leads to an understanding of the death. In essence, what was the motivation for the suicide? Offered below is a brief discussion about several risk factors (historical, personal, environmental and clinical) relevant to inmates that should help the reviewer formulate hypotheses about the possible precipitators for the suicide.

Historical risk factors refer to unchangeable aspects of the inmate's life that places him at risk for suicide. Such factors may include mental illness and medical problems, family history of mental illness and suicide, prior suicidal behavior, and membership in a particular group that is a high risk for suicide. Personal risk factors are characteristics that define the inmate's personality and also increase the risk for suicide. Examples may include low stress tolerance, poor impulse control, rigid thinking, and impaired problem solving skills. Environmental risk factors are any changes that create stress and contribute to a disruption in functioning. These stressors could originate from inside of prison (e.g., sexual assault or segregation for an extended time period) or outside of prison (e.g., dissolution of marriage or death). Clinical risk factors are most relevant for those inmates who have mental health problems, including pre-existing depression, schizophrenia, panic disorder, or a substance abuse disorder. Any changes that worsen their condition could increase the risk for suicide.

OUTLINE FOR COMPLETING A PSYCHOLOGICAL AUTOPSY OF AN INMATE SUICIDE

INMATE NAME: _____

PRISON NUMBER: _____

INSTITUTION: _____

HOUSING: _____

DATE OF BIRTH: _____

DATE OF DEATH: _____

TIME DISCOVERED: _____

METHOD: _____

I. **INCIDENT:** Name, marital status, age, race; date and time death discovered; location of death; method of causing death; who discovered inmate and under what circumstances; and correctional staff's response (reference incident reports). Medical interventions and outcomes (reference incident reports and health record). Time and location of pronouncement of death (reference health record). Presence or absence of suicide note(s) (reference incident reports and death scene data). Statement as to whether the case was referred to the medical examiner's office for an autopsy (reference incident reports and health record).

II. **AUTOPSY/TOXICOLOGY FINDINGS:** Significant findings from autopsy such as signs of trauma to the body (e.g., rape); results of drug screens for street drugs and alcohol; cause of death; mode of death; and approximate time of death (reference medical examiner's autopsy report). Information from toxicology findings (i.e., in cases where medication was prescribed) to determine levels of medication or presence of non-prescribed medication (reference toxicology report).

III. **BACKGROUND INFORMATION:** Criminal history (committing offense, length of prison term, date of crime, date of conviction, date entered prison, date arrived at current institution, prior arrests and convictions, and placement on probation and commitments to jail or prison, parole performance, juvenile criminal behavior); pending criminal charges or holds; drug use history; family history (family upbringing and current family situation); educational background; employment history, including receiving Social Security income benefits; social history, including living arrangements; and use of leisure time (reference documents in the prison file and information from interviews).

IV. **MENTAL HEALTH HISTORY:** Mental health treatment while in the community (in-patient treatment, out-patient treatment, substance abuse treatment) and/or under the supervision of the prison system such as Parole Out-patient Clinic (reference prison file, health record, and information from interviews). Prior suicidal behavior and/or self-destructive lifestyle; mental illness associated with suicidal behavior; and family history of mental illness and suicide (reference health record and information from interviews). Results of reception center's mental health screening and treatment (if applicable), current treatment (if applicable), and compliance with treatment plan, including medication orders (if applicable); findings of most recent mental status examination and current diagnosis; and details of last contact with mental health professional (reference health record).

V. **MEDICAL HISTORY:** Major medical problems and treatment while in the community and/or while in prison (reference heath record).

VI. **INSTITUTIONAL FUNCTIONING:** Disciplinary record, programming (e.g., job assignments, vocational programs, school), extracurricular activities (e.g., religious groups, clubs, sports, hobbies); and family visits (reference prison file and information from interviews).

VII. **PERSONALITY DYNAMICS:** Personality features or lifestyle that may link the deceased to suicidal behavior such as impulsivity and poor judgment, dangerous or self-destructive lifestyle; fascination with death as evidenced

in choice of reading material, music, celebrities, etc.; diagnosis associated with suicide; low stress tolerance, poor coping skills and/or emotionally labile; religious preoccupation (reference prison file, health record, suicide note(s), death scene data, and information from interview).

VIII. **PRECIPITATING EVENTS:** *Major life stressors* from inside and outside the institution (e.g., physical assault, threats against life, dissolution of significant relationship, crisis in family such as death of family member, added time to sentence, and diagnosis of serious medical condition) or *anniversary dates* (e.g., crime, conviction, commencement of prison term, birthday(s) of significant people and wedding date); *acute onset of mental illness or exacerbation of a mental disorder* (e.g., agitated psychosis with depression and command hallucinations to kill oneself), or *longstanding mental illness* (e.g., chronic depression with suicidal ideation); *breakdown of support systems* from inside and outside the institution (e.g., breakup with lover or abandonment by family members). Observations of the last person(s) to see inmate alive. Investigate the *process* of suicide, i.e., how the decedent became suicidal and made the decision to end life (Reference prison file, health record, suicide note[s], letters [if available], and interviews).

IX. **PRESUICIDAL FUNCTIONING:** Changes in *mental status* (e.g., acute deterioration in mental functioning, onset of major mental illness, agitated psychosis with command hallucinations, psychosis with depression and severe depression); *behavior* (e.g., social withdrawal, agitation, provocativeness, increased or decreased appetite, disturbed sleep, etc.); *mood* (e.g., depression, hopelessness, helplessness, fearfulness, unfounded happiness, lability, anger, and hostility); and *attitude* (unrealistic sense of the future, apathy, overly optimistic and overly pessimistic). *Specific behaviors suggestive of suicide planning* (e.g., giving away possessions, saying good-bye to friends, telephoning or writing to family and/or friends to say good-bye, talking about death and/or suicide, rehearsing suicidal act, asking about ways to die and accumulating medications, threatening suicide). (Reference prison file, health record, death scene data, suicide note[s], letters, and interviews).

X. **MOTIVE FOR SUICIDE:** Hypothesis about the decedent's state of mind based on all the information obtained from the prison file and health record; interviews with staff, inmates, and family members; suicide note(s); letters; death scene data; method of suicide; and lethality of suicide method. Consider viewing suicide as a function of risk factors in the following areas: *historical factors* (e.g., mental health history, medical history, long term suicide risk level, marital status, sexual orientation, ethnicity, substance abuse and family history of suicidal behavior); *personal factors* (e.g., personality dynamics, including stress tolerance and coping skills); *environmental factors* (e.g., precipitating events such as major stressor or breakdown of support systems); and *clinical factors* (e.g., recent changes in mental health or medical status). (Reference prison file, health record, incident reports, suicide note[s], letters to and from family and friends, death scene data, and information from interviews).

XI. **SUMMARY/CONCLUSIONS:** Name, marital status, age, race; date of suicide, location and method of suicide; committing offense, length of prison term, date committed offense, date of conviction, and date entered prison, and date arrived at this institution; presence or absence of mental illness contributing factors to the suicide; opinion about the psychological intent for committing suicide (use death scene data, lethality of method used, time of day act committed, and psychological process leading to suicide).

XII. **RECOMMENDATIONS:** List recommendations specific to the circumstances of this suicide. May include recommendations for mental health and medical standards of care, suicide prevention policy and procedures or changes in environmental design, or training. Identify the person(s) responsible for implementing the recommendations and expected completion date.

XIII. **REVIEW AND SIGNATURES:** The psychological autopsy report is signed by the author of the report. Both the Mental Health Administrator and Facility Administrator should review and sign the report.

XIV. **COPIES OF THE REPORT:** One original copy is kept in a locked confidential file. A copy of the report is forwarded to the Mental Health Services' central office.

XV. **SUPPLEMENTAL REPORT:** Submit a supplemental report if other pertinent information is discovered after the submission of the psychological autopsy.

Most suicides are the result of an interaction of risk factors, some of which are stronger than others. In addition, not all risk factors are relevant in all suicide cases. Another important consideration is that the process of committing suicide may occur over an extended period of time. An inmate who is under constant stress may become increasingly suicidal over several months before actually committing suicide. In contrast, an inmate may commit suicide immediately in response to heightened stress. While the above discussion makes a distinction between historical and personal risk factors, there is some commonality between these two categories. Both refer to unchangeable aspects of an inmate's history or pervasive manner of dealing with the environment. They are both important parts of the inmate's identity, as well, as being chronic risk factors. Environmental risk factors can operate in an insidious or acute manner and thus can be viewed as either chronic or acute risk factors. Clinical risk factors can be acute or sub-acute changes that raise the risk for suicide within a short time period, within hours, or a few days or weeks. Finally, in all suicide cases, the reviewer should consider the possibility that suicide was not the intended outcome, and that the decedent only wanted to initiate a response or effect a change in his current situation.

The Psychological Autopsy Report

A detailed outline of the psychological autopsy report is presented on pages 8 and 9. For purposes of reliability, it is important that the reviewer follows this outline and includes all the relevant data for each of the sections and documents where the information can be found. If particular information is missing, the reviewer should state so in the relevant section of the report. On occasion, information may surface later that is important in understanding the suicide or that may even alter the conclusions. If this occurs, the reviewer should complete a supplemental report and explain how this new information changes the original findings and conclusions.

Use of the Psychological Autopsy Report

The psychological autopsy report should be an integral part of the correctional facility's quality improvement program. The general purpose of the quality improvement program is to regularly monitor the quality of health services provided to the inmate population. Following an inmate suicide, the process should include an administrative or "mortality" review of the death. As described earlier in this ***Update*** issue, the goal of a morbidity-mortality review is to critically examine the suicide and make recommendations, when appropriate, that would assist in the prevention of future suicides. The morbidity-mortality review should be a multidisciplinary effort that includes both correctional and health care personnel, including the psychological autopsy reviewer.

Ethical and Legal Issues

The reviewer conducting the psychological autopsy should be aware of the ethical concerns posed with this method (Beskow, Runeson and Asgard, 1990). There must be sensitivity to the needs of the family and friends who may be at different stages of the grieving process and respect for their wishes to refuse or postpone participation in the investigation. As previously discussed, the reviewer must also be sensitive to confidentiality issues surrounding the decedents and informants. However, given the context of this review, the reviewer should specify limits to confidentiality that may be relevant to the correctional setting (e.g., during an interview an informant reports that the decedent had been raped by a group of inmates).

Another important issue to consider is the possibility of litigation. Before proceeding, the reviewer should clarify the purpose of the psychological autopsy with appropriate facility officials, discuss any legal issues relevant to the case, and check the applicable state laws governing the confidentiality of the psychological autopsy process. Within the legal arena, one way to possibly protect against discoverability of the psychological autopsy report in the event that litigation is filed over the suicide is to incorporate the whole process into the facility's morbidity and mortality review program. However, the reviewer should remain objective and not let the threat of a lawsuit affect the investigation. Clearly the best way to avoid litigation or to prevail in the event of litigation is to ensure that suicide prevention policies and procedures were available and that personnel were practicing acceptable standards of care. In addition, a correctional facility's commitment to the psychological autopsy process will demonstrate the willingness for critical self-examination. Although commitment to the process will not serve as a lead defense in an inmate suicide lawsuit, it could lessen the impact of litigation.

Conclusions

Jails and prisons provide a unique opportunity to study suicide. The correctional environment is much more structured and controlled than the community. Such uniqueness allows for access to a variety of information typically not available in most settings. The psychological autopsy method can be used to examine the *process of becoming suicidal*. The knowledge gained from psychological autopsies can be used to improve models for identifying high-risk inmates, intervention strategies, suicide prevention programs, and architectural designs. The standard method for conducting the psychological autopsy and the format for preparing the report as outlined herein will make it easier to compare individual cases and to formalize studies. The psychological autopsy can also be used to study other types of suicidal behavior, including suicide attempts. Studying attempted suicide can undoubtedly add to our understanding of suicide since we would have the unique opportunity to interview the survivor. Finally, knowledge gained from all these information-gathering venues will only place us in a better position to prevent future inmate suicides.

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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.

Oregon

A recent survey shows that nearly 9 percent of inmates in the state's 30 county jails are persons with serious mental illnesses, and concludes that both the inmates and jails would benefit from their diversion to other types of programs. "By and large, the survey found that many of these people have committed lesser crimes and don't pose significant risk to the public," said Bob Nikkel, mental health and addictions administrator in the state Department of Human Services (DHS). "Most would benefit from treatment and do not belong in jail," he stated in a DHS press release in July.

The survey, prompted by a recommendation of the Governor's Task Force on Mental Health, was conducted with cooperation from members of the Oregon Jail Managers Association. All 30 jails responded to the survey. The jails reported that the typical cost for an inmate with mental illness was a third greater than that for other inmates, or approximately $100 a day compared with less than $76 — a result of more psychotropic medication, staff time and medical care.

Mr. Nikkel stated jail managers reported that inmates with serious mental illness, defined as schizophrenia, severe depression and bipolar or manic-depressive disorder, have more trouble following simple rules, require more staff supervision, spend more time in isolation cells and require more medical attention than other inmates. On any given day, the jails house approximately 6,100 inmates of whom about 500 experience serious mental illness. "It's troubling that jail managers told us inmates who are mentally ill go to jail more often, spend more time in jail for the same crimes and are more likely to be physically or sexually assaulted than other inmates," he said. "Nearly half the jails reported that these inmates receive no community mental health services while behind bars."

The survey findings led to the following recommendations:

- Create diversion programs that will get people with mental illness arrested for minor misdemeanors into treatment rather than being booked into jail.
- Establish more mental-health treatment courts such as those in Clackamas, Lane and Yamhill counties.
- Deliver training for jail personnel through the state Department of Public Safety Standards and Training, county mental health programs, DHS or a combination. (Although all but two of the jail managers said staff were trained in "basic mental health issues," fewer than 20 were trained in "the nature of serious mental illness" or in how to handle a psychiatric emergency.)
- Establish a voluntary database from which police and jail personnel could obtain mental-health treatment information for people who are arrested or jailed.
- Make arrangements for local jails to prescribe and purchase in bulk modern psychiatric medications.
- Provide mental health appointments, prescriptions and medications to inmates upon release.
- Improve re-entry resources for released inmates such as more housing, community treatment and professional follow-up.

The new survey findings come as the state is considering how to replace Oregon State Hospital and strengthen the community mental health system. For more information on the jail survey, contact Jim Sellers, Oregon Department of Human Services, 500 Summer Street, NE, Salem, OR 97301, (503) 945-5738, www.oregon.gov/DHS

Texas

Jailers had watched her frantic distress for five days. Stopping up the toilet to flood her cell. Trying to hang herself with her gown. Announcing that she was pregnant with Jesus' child. At 10:15pm that Thursday, though, Christi Ball was resting, snoring even, with her back against the door. Things were finally peaceful in cell 24, pod 63D, of the Tarrant County Correction Center.

But when a sheriff's officer checked on Ball a half-hour later, the snoring had ceased. Another officer opened the cell door. Ball slumped into the doorway. Blood oozed from her mouth. She was naked, soaked in urine, not breathing. An ambulance was

summoned, but doctors pronounced Ball dead at John Peter Smith (JPS) Hospital at 11:45pm on October 21, 2004. She became a statistic: one of 10 Tarrant County Jail inmates to die that year.

Ball had no criminal record. She was accused of only one crime: refusing to leave JPS, where she was seeking help.

Could she have been saved? Her family says there were so many chances that slipped away. If only JPS had committed her, rather than arrested her. If only Mental Health Mental Retardation of Tarrant County had put her back on her medication. Perhaps even with the best of care, she would have died. An autopsy found that Ball, who was 35, died of an inherited heart defect that had never been detected.

But those who loved Ball are tormented by the thought that she was put at risk by her arrest and the minimal care provided by JPS. At the least, they say, she might have been spared the anguish of her final days. Instead, she was isolated from her family, unable to even ask for them because she was in the grip of the mania that comes with bipolar disorder.

"JPS put a bond against her," said her sister, Tiffany Dean. "Somebody there made that call. Somebody made the ultimate call to turn her away." Because Ball's father, Michael Wayne Dean, consulted an attorney to look into his daughter's death, JPS officials would not discuss the hospital's treatment of Ball. But JPS spokeswoman Drenda Witt said that every person, regardless of what he or she may have done, receives medical care. Someone is arrested only if the person refuses to leave after receiving medical care, she said.

The October Spiral

Ball, born Christi Michele Dean, had just finished her freshman year at Texas Wesleyan University when she first showed signs of mental illness in 1989. Her younger sister, Tiffany, was the first to notice. Her parents didn't believe her. Christi had always been the perfect child: smart, organized. She had graduated seventh in her class at Richland High School just two years before. But as time wore on, the symptoms became too powerful to ignore. Her manic phases were punctuated with combative moments, wild spending and grandiose ideas of what might be accomplished.

With medication, Ball was able to complete her college degree in biology, get married and hold down a job in a food lab. But every few years, the sickness would wreck her life. In one cycle, her marriage shattered.

Each time, doctors would stabilize her, and Ball's mother and grandmother would help her rebuild her life. But with each recovery, a little bit of the sweet Christi they knew as a child would be gone.

Ball's relatives could tell she was getting sick whenever she started calling around the clock. The pattern churned up again in early October. Ball began hinting that she might stop taking her psychiatric medication so she could get pregnant, even though her relatives counseled her against ever having a child.

On October 4, she visited MHMR's Mid-Cities office in Bedford, complaining of lightheadedness, irritability and mood swings. Doctors adjusted her medication. Three days later she was back, and her meds were adjusted again. By then, Ball was in full manic mode. On October 11, she sent her relatives into an uproar when she announced that she was getting married and having a child. She told them she had moved in with a 73-year-old who lived in a retirement community.

She had also gone on a $6,000 credit-card spree at Neiman Marcus for the wedding and charged hundreds more at a day spa where she had her armpits waxed and her eyebrows shaped. On October 12, MHMR adjusted her meds a third time.

Seeking Help

Ball began her odyssey to area hospitals with a visit to Harris Methodist H.E.B. that same day, complaining of lightheadedness. She looked disheveled. When a doctor hinted that she was manic, Ball got angry, said her mother, Connie Jaynes. "She was wanting the doctors to convince us that there was nothing wrong with her," said Jaynes, who met her at the emergency room. "Well, we knew when she was sick."

The next day, Ball sought help at Baylor Regional Medical Center at Grapevine for the lightheadedness. Her blood pressure and heart rate were up. A nurse noted "hypermania." Ball refused treatment and left.

The next evening, Ball arrived at hospital No. 3: Baylor Medical Center at Southwest Fort Worth. Ball refused treatment but also refused to leave. Just after midnight, the hospital called Fort Worth police. When Officer M. Kuzenka arrived, he urged Ball to go —

UPDATE
ON THE INTERNET

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

www.ncianet.org/cjjsl.cfm

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

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

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

and to take the plants she had brought to the emergency room. Ball's reply: "I will kill you and the people inside this hospital." Kuzenka shot her legs with his Taser to get her into his squad car. Then he took her to yet another facility: John Peter Smith, the county's public hospital. In the early hours of Friday, October 15, she was sent to the psychiatric unit on the 10th floor.

First Appeal to JPS

"I am Jesus Christ Almighty and you will burn in hell. You don't know who you are detaining," Ball screamed. At JPS, Ball charged a nurse, pinched a mental health technician and attempted to wrestle police to the floor, according to medical records. JPS staff injected her with medicine in her right hip to try to control her, then placed her in seclusion. After about 90 minutes, doctors told Ball she could be released from seclusion. Apparently, she was supposed to leave, although terms of her release were not included in paperwork the *Star-Telegram* obtained from the hospital.

Instead of going home, Ball got on the phone. Then she took off her clothes. Less than three hours later, she was back in seclusion. A little before 9am, the hospital discharged her again — even though Ball told JPS officials that she wanted to be in a hospital somewhere and that she had no place to live. To make sure she stayed away, an officer with the JPS Police Department escorted her from the psychiatric unit and gave her a warning ticket for criminal trespassing.

5 Hospitals in 2 Days

Fort Worth police gave Ball a ride to her mother's office that Friday morning. But her mother was home in Decatur. Co-workers called her, but they also called an ambulance. Ball was taken to her fifth hospital in two days: Baylor All Saints Medical Center at Fort Worth. "I can speak all languages," Ball told the Baylor staff. Once again, Ball refused the offered treatment and left sometime that afternoon.

In the meantime, Jaynes was frantically trying to get her daughter committed to a psychiatric hospital. She failed. Ball's relatives were told that all the judges had already left for the weekend. What's more, Jaynes was told, it wasn't obvious that Ball could hurt herself or others — the criteria for involuntary commitment. At JPS, "they treated her just enough to get her stabilized a little bit. That's what hurt us as far as getting a mental health warrant," Jaynes said.

At about 8pm, Ball was picked up by a MedStar ambulance at a hotel that had complained about a psychotic woman. MedStar took Ball back to Baylor All Saints at Fort Worth. Within 90 minutes, Baylor called Fort Worth police to report that Ball was threatening other patients. When an officer arrived, Ball told him that if she was not seen by the hospital staff, she would punish him. "I'll kick your ass, too," she said. Fort Worth police took her into custody, transported her to JPS hospital and filled out an application for her mental detention there.

For the third time that day, JPS ordered Ball into seclusion. A note in the medical record explained what happened: "Patient attempted to wrestle staff to floor. Pt. charged toward staff in search room, then sat down on floor, refusing to dress after disrobing."

Later that night, the hospital discharged Ball again, with advice to follow up with MHMR. Apparently, she again refused to leave. At 1:33am Saturday, October 16, almost 24 hours after she had first visited JPS, the hospital's police force gave her another warning ticket for criminal trespass and showed her the door.

A Trip to Jail

At 6:30am Saturday, an ambulance was called to a Fort Worth department store. MedStar employees found Ball inside, next to a broken glass door. She said she was pregnant and needed to get clothing for the baby God gave her. MedStar took her back to JPS. Not long after, Fort Worth and JPS police were called to the emergency room to deal with a combative woman. JPS officer Christopher Jolly wrote that he found a woman "that was yelling and cursing at the officer and stating, 'I'm having God's baby and that I need to leave.'"

The officers took Ball to the psychiatric unit, this time for a voluntary commitment, Jolly wrote. That might have saved her, her relatives believe. But the staff turned her away, telling Jolly that she had just been released. "The subject was then escorted off the property and advised that she was not to return to this location unless it was for medical attention," Jolly wrote.

Ball whipped around. "I am 12 months pregnant," she said. God informed her to have her baby sometime that night at JPS, she told them. At that, Jolly arrested Ball, citing her with criminal trespass. He took her to the Tarrant County Jail and filled out a referral form for MHMR of Tarrant County, which has the mental health contract for inmates.

Hospital officials declined to comment on why Ball wasn't committed. But Witt described the circumstances that the hospital might consider committing patients against their will: "The involuntary admission criteria to the inpatient psychiatric unit is based on the determination by a physician that the patient has a valid psychiatric diagnosis that cannot be managed in an outpatient setting and is dangerous to self or others," she wrote.

Naked in a Single Cell

Ball was booked and taken before a magistrate judge, who advised her of her rights and set bail at $2,500. Ball refused to sign the paperwork. A second form, Request for Appointed Counsel, was also not signed. It had a notation: "unable to understand."

At the jail, Ball went through a medical screening that JPS conducts as part of its contract to provide medical care for inmates. Scrawled across the form's boxes is this note: "Unable to get any answers from patient." Ball was assigned to an individual cell in general population, with a recommendation that MHMR follow up.

That afternoon, during the hour inmates can visit the day room, Ball came out of her cell — naked — and went to the phone. Sheriff's officers told her to put her uniform on. She cried, "Never!"

The next day, logs show that Ball was yelling incoherently. The sheriff's jail staff filled out another request for mental health services.

On Monday, October 18, Ball's relatives — panicked that they hadn't heard from her in 48 hours — tried to file a missing persons report. Fort Worth police checked the jail logs and found her name. Ball's sister called the jail and talked with an MHMR caseworker. She told the caseworker that Ball had probably been off her medication for at least four days and that her relatives wanted to help her. The caseworker said that Ball would have to sign a signature card before relatives could see her — something she had so far been unable to do. But he assured Dean that Ball would be safe, that she would see a doctor and get her medications. "The only reason we did not take her out is because we thought she would get the help she needed," Jaynes said. Later that day, jailers found Ball lying face-up on the floor with blood coming out of her mouth, the result of a 20-second seizure.

Her Last Day

On Tuesday, October 19, Ball was moved to the jail infirmary — run by JPS — for evaluation. The next day, she was sent back to her pod. "Doesn't need medical, per Dr. Green," was a notation on her patient history. Medical records also say that she appeared disoriented. "Doesn't know why she is here," the history said.

Back in her pod, Ball started tearing her paper uniform and wrapping the pieces around her neck, abdomen and ankles. Sheriff's officers called the code for a suicide attempt and placed her on enhanced supervision.

Later that day, Ball was visited by a MHMR psychiatrist, who wrote a prescription to address the mania. A psychiatrist saw her again Thursday, October 21, after she was found with feces all over her bed. "Staff reports that she has been refusing Psych meds," someone noted in her chart.

The psychiatrist wrote more prescriptions for agitation and a prescription for Haldol — a medicine that Ball's relatives said she was allergic to. "Though disorganized, appears less confused, improving," the MHMR doctor noted.

Caseworkers didn't force medication on her — they only do that in extreme circumstances, a spokesman said. A few hours later, Ball was found lifeless.

The What-Ifs

Ball's relatives cannot help but wonder what might have happened had she received the help she needed. They learned from the coroner's report that she died of hypertrophic cardiomyopathy, an inherited defect that causes thickening in the lining of the heart. But they wondered whether her uncontrolled mania added to the stress on her heart.

Dr. Eric Popjes, a cardiologist at Penn State Heart and Vascular Institute in Hershey, Pennsylvania, said that stress can exacerbate symptoms of the disorder. Stress can also cause abnormal rhythms. But no one knows whether a link exists between manic behavior and the likelihood of death from the condition, said Dr. Barry Maron, director of Hypertrophic Cardiomyopathy Center at the Minneapolis Heart Institute Foundation. "Whether that did it or not, you know, anything is possible. Is it probable? There would be no way to know," Maron said.

Ball's relatives also wonder why MHMR didn't work to get her out of jail and into a psychiatric facility. But that process requires a lawyer, and Ball was never assigned one.

Sonja Gaines, chief of mental health services at MHMR of Tarrant County, said she doesn't know what else could have been done for Ball. "This is not to minimize her death," Gaines said. "We were dismayed with her death. But we have psychotic people in the jail, especially with such limited state hospital space. On any given day, you might have several psychotic people there. She's not the sickest person we've seen."

In the end, Ball's relatives believe that her fate was sealed by JPS' decision not to keep her in the psychiatric ward. Ball was sick enough to deserve help, her relatives said, and she never got it.

*The above article was written by Jennifer Autrey, a staff writer for the **Fort Worth Star-Telegram**, and appeared in the October 3, 2005 edition of the newspaper. Copyright 2006, **Fort Worth Star-Telegram**. All rights reserved. Used with permission.*

California

In July 2006, a federal judge in Sacramento ordered the Schwarzenegger administration to expand the scope of a special legislative session on corrections to include a new budget proposal to beef up mental health care staffing in the prison system. United States District Court Judge Lawrence K. Karlton's order, dated July 28, instructed the administration to "present to the special session of the Legislature" a request in next fiscal year's budget for over 530 new permanent positions and another 21 limited-term jobs.

The order followed a special master's recommendation in *Coleman v. Schwarzenegger* (No. Civ. S-90-0520-LKK-JFM-P), former known as *Coleman v. Wilson* in which plaintiffs won a 1995 judgment. In that case, the California Department of Corrections and Rehabilitation (CDCR) was ordered to rectify mental health delivery shortfalls in the system, which has now grown to 33 prisons.

In a 15-page report that came out the day before Judge Karlton's order, Special Master J. Michael Keating blasted the state Department of Finance for not seeking the necessary resources — sought by the CDCR — to bring prison mental health staffing in compliance with the *Coleman* case's requirements. "Inmates placed by the state of California in overcrowded and understaffed administrative segregation units are killing themselves in unprecedented numbers, while the Department of Finance parses charts to impede the Department of Corrections and Rehabilitation's efforts to procure staffing to address the problem," the special master stated.

Judge Karlton's order also approved a special master request to include Department of Finance Director Michael Genest as a defendant in the case in his official capacity. The finance agency's chief counsel, Molly Arnold, suggested the inclusion was unnecessary in that the court already has "sufficient control" over the department in the authority it exercises over the

Schwarzenegger administration. Ms. Arnold told the *Sacramento Bee* that her agency had sought to make sense of the prison budget in recent years, a budget she characterized as being in "disarray" in accounting for its authorized positions. She also said the her agency did not add the extra positions because they "already existed" in the CDCR's accounting system. Still, Ms. Arnold pledged that the Department of Finance will work with the Legislature in either the special session or in its normal financing process "to provide the necessary budget for CDCR to do their job."

Corrections spokeswoman Elaine Jennings told the *Sacramento Bee* that the state "is working to respond to the psychological needs of its inmates" and that "whether or not the special session is the proper vehicle to do that remains to be seen. But certainly this is an issue where we will continue to work with the court and comply with the court order and work with Finance to see that positions are funded."

Michael W. Bien, one of the plaintiff attorneys who successfully litigated the *Coleman* case against the state, said the new positions would range from psychiatrists to psychiatric technicians, and the cost ranged from $30 million to $50 million a year. Mr. Bien also said that at least 40 inmates committed suicide in the CDCR in 2005, with the rate of inmate suicides in segregation units "astronomically out of proportion" to national averages. Worse, the suicide rate has increased through the first six months of 2006, with 25 inmate suicides recorded throughout the CDCR.

Judge Karlton's recent order comes months after his May 1 order that the state spend more than $600 million to improve mental health services in the DCCR, including additional acute in-patent beds, intermediate in-patient beds, and mental health crisis beds.

Illinois

The family of a man who hanged himself in the Will County Jail last year is alleging in a recent lawsuit that police should have noticed his suicidal behavior and acted to prevent his death. In August 2005, 33-year-old Gary Oakley was arrested after leading local and state police on a chase that began at his home and ended when he crashed into a median on an interstate highway. Mr. Oakley, a suspect in a home invasion and on parole for residential burglary, pretended to have a gun and dared a state trooper to shoot him. He then tried to jump in front of an on-coming truck. Illinois State Police officers arrested Mr. Oakley and turned him over to officers from Mokena Police Department, who took him to the Will County Jail in Joliet.

Bruce Bozich, attorney for the Oakley family, said that Mr. Oakley's actions — particularly during his arrest on the interstate, as well as behavior during the home invasion when he told the homeowner that "I'm lost and crazy" — should have raised red flags. The Mokena Police Department should have warned jail staff that Mr. Oakley was suicidal or taken him to a hospital to be evaluated, the lawsuit alleges.

Officer from the Illinois State Police told Mokena Police Department officers they were concerned about Mr. Oakley's erratic behavior, according to accounts published in the *Herald News* in Joliet. Mokena police officers were quoted as saying Mr. Oakley's actions were those of someone desperate to escape. Kenneth Grey, Mokena's village attorney, would not comment on what state police said to village officers. But he said Mokena officers did not see any sign Mr. Oakley was suicidal during the four hours they had him in custody. "He was arrested for a very serious felony," Mr. Grey told the *Herald News* in July 2006. "He made no claim to be nor acted suicidal." Other than to deny that Mokena police officers ever relayed any concerns about Mr. Oakley's behavior to jail staff, a spokeswoman for the Will County Sheriff's Department declined to comment on the lawsuit.

Mississippi

In August 2006, the Jackson County district attorney called for increased staffing at the Moss Point City Jail following the second suicide in the facility in less than six months. No jail staff were on duty when 39-year-old Billy Ray Evans hanged himself with his boot strings on July 30. The lone jailer in the 40-bed facility was on disability leave. "I am deeply concerned about the continuous problems that appear to be coming out of the Moss Point city jail," District Attorney Tony Lawrence told the *Associated Press*. "If it's a funding problem or an administrative problem, the individual who makes any one of those decisions needs to consider the problem and address it."

As a result of the recent deaths, Moss Point Mayor Xavier Bishop instructed his police chief to keep personnel at the jail at all times. Suggesting that providing staff at the jail would be an "extraordinary measure," Mayor Bishop told the *Associated Press* that "if there are extraordinary measures that we have to take then we have to take them. There are no intentions to close down the city jail.... I wanted to take immediate steps now to ensure it doesn't happen again."

On August 1, Police Chief Demetrious Drakeford said he planned to ask the Moss Point Board of Aldermen to reinstate two jailer positions that were previously taken away by budget cuts. The following day, his request was granted as the aldermen reinstated the two jailer positions, added a third position, and approved the hiring of two additional dispatchers to assist the only dispatcher currently in the police department. "This was the wake-up call," the chief told the *Sun Herald*. "I think this board is the one that's going to take action. Since (Mr. Evans' death) happened, I believe the board understands our needs. We just can't pinch pennies in areas such as the police department. We need a certain amount of money to run a department. I thing the board knows that now."

Following a preliminary review of Mr. Evan's death, Chief Drakeford suspended two police officers without pay for three days because of some "areas of ineffectiveness" on their behalf. The chief declined to identify the officers or the specific reasons for the suspensions. However, according to current procedures, in the event of the jailer's absence, police officers on duty are required to periodically observe inmates in the jail.

The Evans family did not initially suspect foul play in connection with Mr. Evan's death, stating that he had been depressed for several weeks following his son's death. But,

following the department's disclosure that there were no jail staff on duty, as well as their allegation that a family member warned arresting officers that Mr. Evan was depressed, they are now angry. "Someone was supposed to be watching my brother, Dorothy Scott told *The Mississippi Press*.

In March 2006, 50-year-old Jesse Earl Hubbard died after police said he used a t-shirt to hang himself. The death was ruled a suicide. Mr. Hubbard had been arrested for disorderly conduct and public intoxication. His family has since filed a civil lawsuit against the police department and the officers involved in his case. According to the lawsuit, an independent pathologist performed a second autopsy that suggested Mr. Hubbard's injuries were the result of a chokehold, and not strangulation.

Texas

While most Texas counties have struggled with the way they handle mentally ill people caught up in the criminal justice system, Bexar County's Center for Health Care Services in San Antonio has emerged as the gold standard for community mental health care around the state and the country.

At a presentation to county commissioners on August 1, program officials showed a 20-minute film highlighting the program's accomplishments, which they say have kept thousands of defendants with mental illness out of jail. "Bexar County Story," produced, in part, by AstraZeneca, a pharmaceutical company which has donated approximately $3 million to the center over the past three years, as well shown the film throughout the country to mental health organizations seeking to implement similar programs.

"The center was reduced to almost rubble until the Commissioners Court rescued us and brought in University Health System to work with us," Dr. Roberto Jimenez, chairman of the center's board, told the *San Antonio Express News*. "Now we are the top community mental health center in Texas — by all measures."

In 2001, County Judge Nelson Wolff convened a health care summit that asked law enforcement, the justice system and health care providers to work together to get the mentally ill out of jail and into treatment. The result was the Jail Diversion Program, and later, Cognitive Adaptive Training, which sends social workers to the homes of those who have been released from jail or the hospital to teach them ways to stay on their medications and in society. Typical police calls that bring officers in contact with the mentally ill include disturbing the peace, loitering and other nonviolent minor offenses. In the past, such offenders languished in jail for two to three times longer than average inmates.

In 2003, its first year, the program saved taxpayers between $3.8 million and $5 million, according to a policy report from the Center for Pharmacoeconomic Studies at the University of Texas at Austin, and reduced the jail stays or completely avoided incarceration of more than 1,700 people. Since September 2005, the program has diverted 4,100 people, according to Gilbert Gonzales, director of the center's Crisis and Jail Diversion Services.

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

In 2005, the Center for Health Care Services opened a 24-hour crisis care facility aimed at providing non-violent detainees with mental health services quickly while diverting them from clogged emergency rooms and the county jail. The Crisis Care Center at the University Health Center-Downtown, in the old Brady-Green hospital, also helps law enforcement agencies by allowing officers to return to patrol duties more quickly. Previously, an officer could wait in an emergency room with a detainee for up to 15 hours. The new drop-off center is designed to get officers back into service within 15 minutes.

According to program descriptions, the Bexar County Jail Diversion Program has identified and operationalized separate and distinct penetration into the current "arrest-detention process" that reduces or eliminates the incarceration of adult offenders with mental illnesses by:

- Education and training of law enforcement personnel, the courts, the legal community, and the public.
- The development, collaboration and utilization of the Crisis Intervention Team with SADP to minimize to the greatest extent possible on-site arrests in response to incidents involving adult offenders with mental illness.
- The development and establishment of one centralized location to which all responding law enforcement agencies in Bexar County may transport adult offenders with mental illness.
- The development of a respite residential facility providing a structured treatment environment for adult offenders with mental illness.
- The development of significant linking of services within the community to ensure the prompt and effective delivery of mental health treatment services and community-based support services to minimize jail incarceration and/or court-ordered mental health services.
- The development of a timely and effective screening process to identify those qualifying adult offenders with mental illness who have been arrested and charged with minor non-violent criminal conduct.
- The development of an effective and prompt screening process and identification of those adult offenders incarcerated in the Bexar County Jail evidencing symptoms of mental illness which require a judicial determination of competency; consideration for and approval of release on a special mental health bond; or who may be eligible for assignment to a special mental health docket for early disposition of the pending charges.
- The development of required community support and delivery of clinical services for the treatment of mental illness of adult offenders who have been released from the criminal justice system back into the community as a condition of community supervision or parole, to enhance successful adherence to the terms and conditions of release, to stabilize the individual for a successful integration into the community, and significantly reduce recidivism.

For more information regarding the Bexar County Jail Diversion Program, contact Gilbert Gonzalez, Director, Bexar County Crisis and Jail Diversion Services, Center for Health Care Services, 527 North Leona, Suite A212, San Antonio, TX 78207, (210) 358-9804, www.chcsbc.org

Michigan

Timothy Joe Souders lived a hard life and, on August 6, died an even harder death in a segregated prison cell in Jackson. Souders, 21, spent most of his last four days naked, without physician or psychiatric care, his arms and legs bound to a steel bed in four-point restraints. He was in a bare, all-steel isolation cell about the size of a walk-in closet.

He went to the cell August 2 because of unruly behavior. He lay in urine — "agitated, disoriented, psychotic" — as the cell felt close to 106 degrees at times, according to a report written by a federal monitor assigned to scrutinize medical care for Jackson prisons. Souders was found dead on his bed around 4:00pm, two hours after staff had removed his shackles. The death of the severely mentally ill inmate is a glaring example of a troubled state prison health care system, riddled with misdiagnoses, delayed or denied treatment and inadequate accommodations for people with disabilities.

The Jackson prison complex, including the Southern Michigan Correctional Facility where Souders died, has been under federal oversight for more than 20 years. Corrections officials are investigating the death. Autopsy results might not be available for two or three weeks.

The Michigan Attorney General's Office, which represents the Department of Corrections, disputed the account by the federal monitor, whose report this week brought Souders' death to light. "The governor's office is very concerned about the issue of prisoner health care," Liz Boyd, spokeswoman for Gov. Jennifer Granholm, said Saturday. "We want to make sure that prisoners are getting appropriate health care and that taxpayer dollars are being spent wisely. Be assured, the issue of prisoner health care will be reviewed and, if changes are warranted, changes will be made."

The Corrections Department had issued a heat alert the day Souders went into isolation. Such alerts are issued when the combined temperature and humidity index reaches 90 degrees. Alerts are supposed to trigger actions to ensure that inmates have adequate water and ventilation.

Dr. Robert Cohen, the court-appointed monitor, uncovered Souders' death during a visit to the Jackson medical complex on August 8-10. Disturbed by what he found, he issued a special report to U.S. District Judge Richard Enslen in Kalamazoo, who is enforcing

federal oversight of the facilities. "Although the circumstances of Mr. S.' death overwhelmed my visit....there are a number of additional continuing serious deficiencies in the medical program which require immediate attention, some of which may have contributed to the abject failure to provide Mr. S. with medical care," Cohen wrote.

"There is a critical shortage of medical staff" at the Jackson facilities "and serious medical staff shortages throughout the medical program. This is an emergency situation which has gone on for too long and is having an extremely adverse effect on patient care." Souders' death was "predictable and preventible," Cohen wrote, "a terrible, unnecessary tragedy."

Souders was serving a sentence of 1 to 4 years for resisting arrest, assault and destroying police property. Because he was taking medications for multiple medical conditions — including manic-depression, psychosis and hypertension — he was at high risk for heat-related injury or death, Cohen wrote. Still, a physician did not see him from the time he was restrained until he died. He was seen and monitored by nurses, however, Department of Corrections spokesman Russ Marlan said.

Mental health staff at the Southern Michigan Correctional Facility tried to transfer Souders to Huron Valley Center in Ypsilanti, a psychiatric hospital for prisoners, but he wasn't moved, Marlan said. At least one person involved in the transfer has been removed, Marlan said. The department is reviewing policies on prisoner restraint.

A 'Lack of...Responsibility'

In response to Cohen's letter to the judge, the Attorney General's Office, which represents the Corrections Department, questioned some of Cohen's findings. The office pointed out in an e-mail to Cohen that the day Souders died, a nearby cell was only 83 degrees, with 58% humidity, which wouldn't produce a heat index of 106. Shortly after 10 on the morning he died, Souders, 5-foot-8 and 235 pounds, was able to walk to the shower outside the cell, Marlan said. He was returned to the cell, placed in restraints and covered with a blanket, the Attorney General's Office noted. He was released from the restraints just before 2:00pm. By 3:58pm., according to the Attorney General's Office, he was "found to be unresponsive and without pulse and respiration" on the bed.

"It's a tragic example of what we've been trying to illustrate to the court, and to the department, for a long, long time," said Patricia Streeter of Ann Arbor, an attorney for prisoners in what is known as the *Hadix* case, which triggered the federal oversight. "There's a lack of leadership and responsibility. The doctors are overworked. The Jackson facilities have become essentially a hospital, and they're still treated like a prison with average, healthy people."

The Corrections Department has been under a federal consent decree in the *Hadix* case since 1985 to improve medical care and other conditions at Jackson prisons. The decree covered a range of issues, including sanitation, fire protection, crowding, medical care, access to courts, mental health care and prisoner safety.

In June, the *Detroit Free Press* reported on Lloyd Byron Martell, whose cancerous polyp had gone untreated. Martell, 41, was sent home last week to die.

A Hard and Desperate Life

Souders of Adrian had bipolar disorder, among other conditions, according to court records. Over the last three years, he supported himself with Social Security checks, odd jobs and Dumpster diving. Attempts to reach a family member Thursday and Friday were unsuccessful.

Souders' prison sentence stems from convictions for resisting arrest, destruction of police property and assault. In March 2005, after stealing two paintball guns from a Meijer store, he walked with a stolen knife toward a police officer. "Go ahead and kill me," he told the officer, who stunned him with a Taser. Souders told a probation officer that he wanted police to put him out of his misery.

While in an isolation cell in the Lenawee County Jail on those charges, he tried to hang himself with a noose made with fabric from jail coveralls. He was charged with malicious destruction of police property. This was on top of a record of five misdemeanors, including possession of marijuana.

Souders started his sentence November 1 and was transferred to Jackson on March 2. While locked up, he received seven misconduct reports, including two for fighting.

In response to Souders' death, Cohen called an emergency meeting Wednesday with prison administrators, resulting in some of the Department of Corrections review. Cohen's investigation could take weeks and will include a review of tapes, incident reports and medical records.

Critics say the Legislature, governor and correction officials have failed to properly oversee the $190 million a year the state spends on prison medical care, including the state's $70-million contract with Correctional Medical Services Inc. "Responsibility is so dispersed between state agencies, a private contractor, line staff and administrators," said Sandra Bailiff Girard, executive director of Prison Legal Services of Michigan. "No one is held responsible — so there's little incentive to follow the rules."

The above article, entitled "Neglect in Custody — A Special Report: Mentally Ill Inmate Dies in Isolation," was written by Jeff Gerritt, editorial writer and columnist for the ***Detroit Free Press****, and appeared in the August 20, 2006 edition of the newspaper. Copyright 2006,* ***Detroit Free Press****. All rights reserved. Used with permission.*

Editor's Note*: On Monday, August 21, the day after Mr. Gerritt's article appeared in* ***Detroit Free Press****, Governor Jennifer Granholm ordered an independent review of health care services for inmates within the prison system. The comprehensive review will not be performed by an agency within state government. Department of Corrections spokesman Russ Marlan told the* ***Detroit Free Press*** *that the review "will include everything. It will cover CMS, our employees, our interaction with the Department of Community*

Health, and both the mental and physical aspects of health care."

Florida

In August 2006, the state Department of Juvenile Justice (DJJ) announced plans to shut down the Umatilla Academy for Girls following reports of mistreatment and neglect. A DJJ review of the understaffed facility's troubled first year found numerous failures to meet state standards, including youth on suicide watch who were left unsupervised; an incident in which an employee dragged one girl down a hallway by her ankles; another incident in which workers chose not to send a girl to the hospital after she had swallowed 2-inch nails; and following an incident in which another youth tried to kill herself by swallowing 10 doses of psychotropic medication, a staff member delayed calling for assistance, suggesting that "It's not up to me to call 911."

Although Umatilla Academy officials complained that many of the youth often lied about practices within the facility, the DJJ audit found the facility's treatment fell so far below state standards that it decided to close the program five months after its first formal review. "We won't wait for an incident to happen," DJJ spokeswoman Cynthia Lorenzo told the *Orlando Sentinel* on August 18. "We're stepping in and shutting Umatilla down."

The president of the company running the facility said closing it ignores progress made since the review in early March 2006. Joshua Ford told the *Orlando Sentinel* that evaluating the academy barely a year after it opened prevented his company, Diversified Behavioral Health Solutions, from working out "bumps in the road." However, some of those bumps included the facility's 124 police calls — mainly for battery charges when girls assaulted one another or staff members. Problems were so common that Umatilla Police Chief Doug Foster set up a booking station on site.

The Umatilla Academy was under contract to treat up to 96 female youth with histories of mental illness and assaultive behavior. Problems began three weeks after the facility opened at an old children's hospital site in March 2005. Three girls kicked out a window and escaped for hours. State officials began visiting and gathering evidence ultimately used to close it. The state stopped sending girls to the academy in January 2006, the same month a staff member was arrested for dragging a resident down a hallway after the youth refused to go to her room. Surveillance cameras captured the incident and the employee was fired. Subsequent reviews of the facility by DJJ found that employees cut corners by falsifying room check logs, as well as records about CPR instruction and other required training. At was also revealed that one-third of the employees had started work without undergoing criminal background checks.

Washington, D.C.

More than half of all prison and jail inmates, including 56 percent of state prisoners, 45 percent of federal prisoners and 64 percent of local jail inmates, were found to have a mental health problem, according to a new study published in September 2006 by the Justice Department's Bureau of Justice Statistics (BJS).

The findings represent inmates' reporting symptoms rather than an official diagnosis of a mental illness. The study determined the presence of mental health problems among prison and jail inmates by asking them about a recent history or symptoms of mental disorders that occurred in the last year.

Among the inmates who reported symptoms of a mental disorder:

- 54 percent of local jail inmates had symptoms of mania, 30 percent major depression and 24 percent psychotic disorder, such as delusions or hallucinations;
- 43 percent of state prisoners had symptoms of mania, 23 percent major depression and 15 percent psychotic disorder;
- 13 percent of both state prisoners and local jail inmates had attempted suicide in the past; and
- Only 34 percent of state prisoners, 24 percent of federal prisoners, and 18 percent of local jail inmates received any mental health treatment during confinement, the vast majority of which was only psychotropic medication.

Mental health problems were primarily associated with violence and past criminal activity. An estimated 61 percent of state prisoners and 44 percent of jail inmates who had a mental health problem had a current or past violent offense. Inmates with a mental health problem also had high rates of substance dependence or abuse in the year before their admission:

- 74 percent of state prisoners and 76 percent of local jail inmates were dependent on or abusing drugs or alcohol.
- 37 percent of state prisoners and 34 percent of jail inmates said they had used drugs at the time of their offense.
- 13 percent of state prisoners and 12 percent of jail inmates had used methamphetamines in the month before their offense.

Among inmates who had mental health problems, 13 percent of state prisoners and 17 percent of jail inmates said they were homeless in the year before their incarceration. About a quarter of both state prisoners (27 percent) and jail inmates (24 percent) who had a mental health problem reported past physical or sexual abuse.

Approximately one in three state prisoners with mental health problems, one in four federal prisoners and one in six jail inmates had received mental health treatment since admission. Taking a prescribed medication was the most common type of treatment — 27 percent in state prisons, 19 percent in federal prisons, and 15 percent in local jails.

The findings were based on a nationally representative sample of prisoners (in 2004) and jail inmates (in 2002). Approximately 14,500 state prisoners, 3,700 federal prisoners and 7,000 jail inmates completed face-to-face interviews. The report, "Mental Health Problems of Prison and Jail Inmates" (NCJ-213600) was written by

BJS statisticians Doris J. James and Lauren E. Glaze, and can be viewed at: http://www.ojp.usdoj.gov/bjs/abstract/mhppji.htm

Wisconsin

Two correctional officers were fired and four others suspended in connection with the suicide of an inmate at the Milwaukee Secure Detention Facility in June 2006. The disciplinary action came after a state Department of Corrections (DOC) investigation into the June 1 death of 41-year-old Russell Lee Murray. The victim was found hanging by a bed sheet suspended from a pipe inside a janitor's closet at the jail. A county medical examiner's report stated that staff at the facility, which houses probation and parole violators, waited approximately nine minutes before cutting Mr. Murray down and beginning resuscitation efforts. However, an inmate who claimed he held Mr. Murray up to take the weight of his body off the ligature estimated more than 20 minutes elapsed before the ligature was removed. The unidentified inmate also claimed a correctional officer instructed him to let go of Mr. Murray, who died at a hospital more than four hours later.

"We had strong concerns regarding initial reports by staff about the response," John Dipko, DOC public information director, said in a statement issued on September 22 and published in the *Milwaukee Journal Sentinel*. "We noted that we would take strong personnel action against any staff member if it was determined they acted inappropriately," Mr. Dipko said. "Our employees are expected to respond quickly and in a safe way to life-threatening situations," he said. "We will not tolerate inappropriate actions by staff in our prison system."

Russell Murray had been held at the state-run Milwaukee Secure Detention Facility for approximately three weeks after violating terms of his probation. On June 1, 2006, the day he was found hanging, Mr. Murray was told he would be transferred to the Dodge Correctional Institution to finish a 15-year sentence regarding a sexual assault on a child conviction. The DOC investigation indicated that at 7:29pm, after Mr. Murray was reported missing in the facility, a correctional officer unlocked the closet and discovered him hanging. He was cut down and cardiopulmonary resuscitation (CPR) was started approximately nine minutes later at 7:38pm. According to the report, fire department paramedics, who were contacted at 7:32pm, were delayed 15 minutes because they were sent to the wrong location.

According to an inmate witness who was interviewed by the *Milwaukee Journal Sentinel*, correctional officers did not take Mr. Murray's disappearance seriously when he was reported missing from his pod, and that one officer even joked about Mr. Murray fearing his up-coming prison transfer. The inmate told investigators that he was with the officer who found Mr. Murray and that he rushed into the closet and hoisted the victim's body up to ease the pressure on his neck. The officer then ordered the inmate to release the victim, and Mr. Murray allegedly grabbed the inmate's hand as he removed his arms from around the victim's waist. The inmate, who was ordered to return to his cell, remained in the area and estimated there were at least three nurses and six officers looking into the closet. He estimated that another 15 minutes elapsed before staff entered the closet and initiated CPR. ❑

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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