JAIL SUICIDE/MENTAL HEALTH UPDATE

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THE TRAGIC AND PREVENTABLE DEATH OF MAURICE SHAW

Maurice Shaw was 19-years-old when booked into the San Joaquin County Adult Detention Facility in French Camp, California on February 15, 2000. He was charged with possession of drugs. Mr. Shaw had an extensive mental health history, and had been involuntarily hospitalized for psychiatric evaluations on numerous prior occasions during his young life. Diagnosed with paranoid schizophrenia and adjustment disorder, he was very familiar to both the county jail and mental health systems. Upon his arrival at the jail facility, Maurice was assigned to the Sheltered Housing Unit, a placement for inmates at high-risk for medical and/or mental health issues. Two days later on February 17, he met with a psychiatric technician (i.e., an unlicensed mental health worker). Maurice appeared tearful and suicidal, and was placed on suicide precautions in a safety cell within the Medical Housing Unit. He requested to be transferred to the San Joaquin Psychiatric Health Facility, as well as have his psychotropic medication restarted. The technician reviewed his county mental health records, verified that Maurice had previously been prescribed both Haldol and Cogentin, and told the inmate she would confer with the jail psychiatrist, Robert Hart, MD. The technician saw Maurice again later that evening and wrote a progress note that said: "Seen again in safety cell. He is calm, denies suicidal ideations, will clear to Sheltered Housing Unit."

On February 18, Dr. Hart reviewed the medical chart and prescribed Haldol and Cogentin to Maurice. A psychiatric evaluation was not performed. A few days later on February 22, Maurice was seen again by a psychiatric technician. He again requested to be transferred to the Psychiatric Health Facility in order "to serve his time there," but was informed that he must first resolve the pending legal matters. The psychiatric technician then began to formulate Maurice's individual treatment plan, which included encouragement of medication compliance, stabilization on medication, observation of any signs of adverse effects of the medication, and continued observation of his mental illness. The plan did not mention Maurice's suicidal ideation.

On February 29, Dr. Hart conducted a court-ordered forensic evaluation of Maurice. He reported that, since the age of 13, Maurice had been hospitalized on six prior occasions due to paranoid schizophrenia, substance abuse, and borderline intellectual functioning. Dr. Hart found that Maurice's symptoms were in remission and he did not require hospitalization. Maurice was released from custody the following day. On March 3, however, he was again involuntarily committed to the San Joaquin Psychiatric Health Facility. By March 14, Dr. Hart had determined that Maurice was "gravely disabled" as a result of "schizoaffective disorder." He stated in a declaration recommending conservatorship that after 11 days of treatment at the facility, Maurice "continues to show outbursts of rage, episodes of shadow boxing, and inappropriate sexual advances towards staff and peers. Diagnosis is Paranoid Schizophrenia and renders him gravely disabled. Temporary conservatorship is sought to manage future treatment."

On March 17, Maurice was released from the Psychiatric Health Facility for a family visit. He did not return to the hospital. Two weeks later on May 31, Maurice was rebooked into the San Joaquin County Adult Detention Facility on a warrant for failure to appear in court. He was again assigned to the Sheltered Housing Unit. Dr. Hart again reviewed the chart, prescribed psychotropic medication, but did not evaluate his patient. A psychiatric technician saw Maurice the following day, and he refused to take medication. Following five days of refusing his medication, Dr. Hart reviewed the chart and wrote the following: "Inmate adjusting okay to jail despite medication refusal. Will discontinue, save staff time, await developments."

Several weeks later on June 21, a psychiatric technician attempted to speak with Maurice at the request of housing unit officers who reported that the inmate was "agitated, verbally abusive and rambling" about his lockdown status. Due to his agitated behavior, the technician was unable to speak with Maurice and wrote in the progress notes: "Will continue to monitor his behavior on Sheltered Housing Unit, will attempt to reassess when calmer." Maurice was not seen again by mental health staff until approximately 10:45am on July 15 when a psychiatric technician was called to the housing unit in response to the inmate's acting-out behavior. Maurice had apparently decompensated during the past several weeks, refusing to shower, urinating on the floor, and spreading feces around his cell. He became agitated and verbally abusive when an officer instructed him to clean his cell and take a shower. He then became threatening and waved a

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sharpened pencil and toothbrush at officers. Maurice eventually calmed down and was escorted to the safety cell in the Medical Housing Unit. Within a few hours, Maurice was removed from the safety cell after he was "able to give a verbal contract of no harm to self or others." He was returned to his lockdown status in the Sheltered Housing Unit.

On July 18, Dr. Hart attempted to evaluate Maurice for his competency to stand trial. Due to his continued agitated state, the brief interview was held through the food slot of the inmate's cell door. Dr. Hart noted that Maurice's speech was rapid and loud, and the inmate presented paranoid trends and disorganized thoughts. Dr. Hart concluded his patient was incompetent to stand trial and that he "is likely to require state hospitalization to ensure adequate treatment due to his refusal of medications." Dr. Hart did not, however, recommend that Maurice be hospitalized at the county's Psychiatric Health Facility pending commitment to a state hospital.

On July 21, Maurice was seen by a psychiatric technician for "his monthly follow-up." He was observed to be "shadow boxing" and continuing to display poor hygiene. He was also delusional, stating he was feeling well, did not need his medication, and was planning to find a job when released from custody later that day.

Less than a week late on July 27, Maurice refused an officer's request to relocate into another cell in the Sheltered Housing Unit. When correctional staff became to enter the cell, he threw a cup of urine on them. As a result, Maurice was extracted from the cell and placed in five-point restraints. He was then involuntarily medicated with Haldol. Maurice was seen the following day (July 28) by a psychiatric technician, gave a "verbal contract" to control his behavior, was released from restraints and seclusion, and transferred to a safety cell in the Medical Housing Unit.

During the next several days (July 29 through August 6), Maurice's behavior was described as "bizarre" and "psychotic," his hygiene remained poor and he continued to refuse medication. He voiced delusions, appeared tearful, paced the cell, observed to be masturbating, displayed wild mood swings, and talked to himself. The psychiatric technicians had difficulty approaching Maurice's cell to assess the inmate's "verbal contract" because of the overwhelming odor emanating through the cell door. Throughout this time period, Dr. Hart simply placed a notation on the chart signifying that it was reviewed.

On August 7, Maurice was observed banging on the glass window in the safety cell. He refused to stop, remaining uncooperative and verbally abusive to staff. He was again placed in five-point restraints and involuntarily medicated with Haldol. Maurice was released from restraints the following morning (August 8) and moved to a ward room in the Medical Unit. He was given an increased dosage of Haldol. During the next week, Maurice was seen daily by a psychiatric technician and observed to be shadow boxing, acting bizarre, singing loudly, displaying inappropriate laughter, disorganized, but compliant with medication. He also remained confused, requesting to go home. On August 18, Maurice was seen by a psychiatric technician, gave a "verbal contract" to control his behavior and remain medication compliant, and was transferred back to the Sheltered Housing Unit. Dr. Hart continued to place a notation on the chart signifying that it was reviewed.

On August 22, Maurice went to court and learned that he had been committed to the state psychiatric hospital for a maximum term of three years. (He had been formally declared incompetent to stand trial at a court hearing on August 15.) Upon return from court on August 22, Maurice appeared upset and informed the transportation officers that he was suicidal. He was placed on suicide precautions in the Medical Housing Unit's safety cell. Several hours later, Maurice was seen by a psychiatric technician, gave a "verbal contract" not to engage in self-injurious behavior, and was transferred back to the Sheltered Housing Unit.

Two days later at approximately 10:00am on August 24, Maurice threatened suicide to correctional staff and was referred to a psychiatric technician. He subsequently informed the technician that the Sheltered Housing Unit cell "was making him feel suicidal." According to the technician, Maurice was tearful and had active thoughts of suicide, but no plan. He was again placed on suicide precautions in the Medical Housing Unit's safety cell. Maurice was seen again a few hours later by a psychiatric technician and again stated that the Sheltered Housing Unit cell "made him suicidal." At approximately 6:30pm he was seen a third time by a psychiatric technician, gave a "verbal contract" not to engage in self-injurious behavior, and was transferred back to the Sheltered Housing Unit. Four days later on August 28, Maurice requested to speak to mental health staff because he felt they could assist him in contacting the NAACP. He was seen by a psychiatric technician, stated he did not want to go to the state hospital, and requested to speak with his lawyer and case manager.

At approximately 3:00pm on August 31, 2000, a correctional officer found Maurice hanging from a bed sheet tied to the wall vent in his Sheltered Housing Unit cell. Life-saving measures were initiated, and Maurice was transported to the San Joaquin County General Hospital where he was later pronounced dead. According to the "Detex Electronic Watchclock" system in operation at the facility, Maurice's cell was last checked by correctional staff 70 minutes earlier at 1:50pm.

The Lawsuit and Trial

The mother of Maurice Shaw subsequently filed a lawsuit in the United States District Court for the Eastern District of California in Sacramento alleging that various Defendants — including San Joaquin County, Sheriff Baxter Dunn, Dr. Robert Hart, and several jail and mental health personnel — were both negligent and deliberately indifferent to her son's medical needs, the proximate cause of which was his suicide. Specifically, the civil complaint alleged that the defendants provided "inadequate mental health care and treatment for suicidal, mentally ill and/or incompetent pretrial detainees, including Maurice Shaw, in that Defendants:

1) Failed to establish appropriate policies and procedures to prevent mentally ill inmates from self-harm;

2) Failed to train and supervise on the policies and procedures in place to prevent mentally ill inmates from self-harm;

3) Failed to provide adequate staffing to provide adequate mental health care;

4) Failed to have and enforce the use of effective policies to hospitalize acute-care mental health patients when medically called for;

5) Failed and refused to provide adequate monitoring of cells that house inmates at risk for suicide;

6) Failed to comply with the Americans with Disabilities Act and Section 504, namely through their failure to reasonably accommodate detainees and inmates with mental disabilities such as Maurice Shaw in their facilities, program activities, and services; and

7) Failed to comply with the Americans with Disabilities Act and Section 504 by not reasonably modifying their facilities, program activities, and services to accommodate detainees and inmates with mental disabilities."

The federal jury trial in *Shaw v. San Joaquin County et al* (No. 2:01-CV-1668-MCE-PAN) commenced on January 4, 2006 in the Sacramento, California courtroom of United States District Court Judge Morrison C. England, Jr. During the two-week trial, numerous witnesses and hundreds of exhibits were presented to the jury. Detailed below is a summary of affidavit, deposition and trial testimony of both the plaintiff and defense experts in the case.

The Plaintiff Experts

A national expert in the standard of care relating to sound correctional policies and practices for the management of suicidal inmates hired by the plaintiff opined that both mental health and correctional staff violated several standards of care, as well as their own policies, in Maurice's case. The expert was particularly critical of the extensive use of psychiatric technicians in managing the case. For example, according to the Institute of Medical Quality's *Review of Mental Health Services in San Joaquin County Adult Detention Facilities*, the system of mental health services within the San Joaquin County Detention Facility (SJCDF) "relies almost entirely on psychiatric technicians….The psychiatric technicians are excellent employees that are doing an outstanding job under very difficult circumstances. The staff essentially operates *without* any clinical supervision." According to the Institute of Medical Quality, psychiatric technicians are *not* licensed clinicians and yet, at the SJCDF:

> "perform all levels of mental health services, including determining the necessity for forced medications, seclusion and restraint. Psychiatric technicians should not make such clinical decisions…The psychiatric technicians are operating out of their scope of practice as evidenced by their duties that include performing assessments, formulating diagnoses, and developing treatment plans. They are determining the level of care necessary to treat patients. Their acts infringe upon the other areas of practice (medicine and nursing) and are at serious risk of violating various practices as well as significantly increasing liability for the county."

During the three-month period (from May 31 through August 31, 2000) of his confinement in the SJCDF, Maurice's care and treatment was exclusively provided by psychiatric technicians. In fact, he was personally seen only *once* (July 18) during this time period by the psychiatrist for an estimated period of 15 to 20 minutes. During this time, Maurice was placed in, and released from, restraints on two occasions (July 27 and August 7) by psychiatric technicians and *without* a direct order and/or evaluation from the psychiatrist or other physician. In addition, during this time, Maurice was placed in, and released from, a safety cell for suicidal behavior on four other occasions (July 15, August 18, August 22, and August 24) by psychiatric technicians and *without* a direct order and/or evaluation from the psychiatrist or other physician. In fact, additional records disclosed during the discovery phase of the case indicated that on August 12, 2000, a few weeks prior to Maurice's death, a consultant from the San Joaquin County Mental Health Department audited mental health services at the SJCDF and found that "inmates with psychiatric histories, and who have a recent history of bizarre, psychotic or suicidal behaviors should be observed and documentation done every shift *until stable as determined by the psychiatrist*."

According to the plaintiff expert, the actions of the psychiatric technicians, as well as the inactions of the psychiatrist or other physician, in Maurice's case not only violated the California Institute for Medical Quality's *Accreditation Standards for Adult Detention Facilities*, but even the San Joaquin County Correctional Health Care Services' suicide prevention policy. That policy states that "an inmate may be removed from suicide observation, based on Correctional Health Care Staff recommendation and *subject to the psychiatrist's approval*." On each of the four occasions in which a psychiatric technician removed Maurice from suicide precautions, the action was performed *without* the approval of Dr. Hart (who simply periodically reviewed the chart).

The county's suicide prevention policy also stated that "once an inmate has been removed from suicide risk observation, she/he should then be placed on the Frequent Contact List." According to the deposition testimony of Dr. Hart, the "frequent contact list" was maintained on a black board in the Medical Housing Unit and required psychiatric technicians to observe and assess Maurice on a *daily* basis while he was housed in the Sheltered Housing Unit. However, Maurice's medical records indicated that he was not observed on a daily basis by psychiatric technicians during his confinement in the Sheltered Housing Unit. In fact, during the seven-day period beginning on August 25 and leading up to his suicide on August 31, Maurice was seen only *once* by a psychiatric technician and that was only by his request on August 28 to discuss assistance in contacting the NAACP.

According to Dr. Hart's deposition testimony, Maurice "was on the top 10 list" of severely mentally ill inmates in the SJCDF. He also stated:

> "our focus in jail is so heavily on suicide assessment, that really is our number one priority, followed closely — quite closely but followed by the need to make sure that severe mental illness and suffering is treated. That, I'd say in the jail, I'm most vigilant of all my locations to issues of suicide. Our mental health system in in-patient has a much more elaborate catch system for suicidal inmates. We have a much better environment to monitor everyone all the time because they're all in a day room or in individual rooms; whereas, if

jail is necessary, people are partitioned away in cells, so I tend to be more vigilant in jail for suicidal issues because I know we don't have as good an ability to observe people all the time."

According to the plaintiff expert, this self-serving testimony that he was "most vigilant" regarding suicide prevention in the facility was incredible and contrary to Maurice's medical records indicating that Dr. Hart (the facility's lone clinician) only periodically reviewed the chart, *never* provided a suicide assessment to Maurice, and only saw the patient (who he considered one of the most severely mentally ill patients in the jail) for 15 to 20 minutes during his three-month jail confinement. Dr. Hart worked at the SJCDF for 10 hours per week and, by his own admission, he rarely saw patients. The vast majority of his time at the jail was spent reviewing charts.

In addition, the medical records indicated that Maurice's brief stays on suicide precautions were highlighted by the fact that psychiatric technicians utilized "verbal contracts" to determine whether the inmate was at continued risk for self-harm. The plaintiff expert opined that there were *no* written policies regarding the use verbal contracts at the SJCDF, and their issue is controversial throughout the country, due in large part to how the contract is used. When utilized as *the* determining factor as to whether the inmate is suicidal, or is stabilized and no longer in need of suicide precautions, it can have a deadly effect. When utilized by a clinician *only* as a tool to establish a therapeutic relationship and gauge behavior, it can have a positive effect. Most experts agree that once an inmate becomes acutely suicidal, their written or verbal assurances are no longer sufficient to counter suicidal impulses. As offered by two clinicians in a previous issue of the ***Jail Suicide/Mental Health Update*** (Summer 2003, Volume 12, Number 2): "We do not think that one can reason reliably with persons in severe suicidal crisis, any more than one can reason with a person who believes God is sending them personal messages via advertising billboards....there is no harm associated with 'suicide contracts' so long as the therapist does not succumb to the illusion that the contract is likely to prevent a suicide." And perhaps more importantly, the intent of contracting for safety should not only be to commit the inmate to no-harm, but also the facility and therapist to appropriate treatment.

The plaintiff expert was also critical of the inadequate observation afforded to Maurice while he was confined in the Sheltered Housing Unit. According to SJCDF policy, inmates housed in the Sheltered Housing Unit "require normally close monitoring by Custody staff and Correctional Health Care Staff." The policy also required that correctional officers conduct "welfare checks" of these inmates "*at least* once every thirty (30) minutes." The two correctional officers who were working in the Sheltered Housing Unit on August 31, 2000 were aware that Maurice was assigned to the unit based upon his mental illness. At least one of the officers was also aware that Maurice was taking psychotropic medication and had previously been placed in both restraints and the safety cell for suicidal and/or combative behavior. Despite these officers' knowledge of Maurice and the requirement to observe him at 30-minute intervals, they continuously violated the SJCDF policy on August 31, 2000. For example, according to the "Detex Electronic Watchclock" system in operation at the facility, Maurice's cell was checked by these officers at the following times that day:

6:34am
7:12am
7:44am
8:26am
10:19am
12:23pm
13:06pm
13:50pm
15:00pm

Each of the above time intervals exceeded the 30-minute requirement of the SJCDF policy. Most importantly, when Maurice was found hanging at 3:00pm, he had not been observed by any correctional staff since 1:50pm — a period of 70 minutes.

The issue of inadequate supervision of inmates who committed suicide in the SJCDF was apparently not confined to Maurice's case. In at least two other cases (e.g., the suicides of George Barrows in January 1996 and Bobby Sensabaugh in February 1999) medical personnel noted that the victims' bodies displayed rigor mortis, an indication that they had been dead for several hours. In fact, the case of George Barrows was strikingly similar to Maurice's case. Mr. Barrows had a history of mental illness and suicidal behavior, and had been placed in restraints during his SJCDF confinement. On January 13, 1996, Mr. Barrows complained of auditory and visual hallucinations, as well as depression, and was transferred from his administration segregation cell to a safety cell in the Medical Housing Unit for observation. He was seen the following day by a psychiatric technician, discharged from the safety cell without assessment and/or approval of the psychiatrist, and returned to his administration segregation cell. Mr. Barrows committed suicide less than a week later on January 20, 1996. Although correctional staff was required to conduct "welfare checks" in this housing unit at 30-minute intervals, Mr. Barrows was left unobserved for more than six hours.

The plaintiff expert concluded that "as a severely mentally ill inmate who had threatened suicide several times during his confinement, both the San Joaquin County Sheriff's Department and San Joaquin County Correctional Health Care Services had a responsibility to provide reasonable care to Maurice Shaw. Instead, their staff grossly violated several standards of care, including their own policies and procedures, and failed in the duty to provide reasonable care to the decedent."

Next up for the plaintiff was a nationally-recognized physician expert in the area of medical care in correctional facilities. This expert's opinion focused upon the clinical judgment of Dr. Hart and the role of psychiatric technicians in Maurice's case — "Shaw needed acute care hospitalization. There was no acceptable acute medical care offered at the jail. The only tools afforded the mental health staff at the jail were restraint, seclusion and medication. However, there was no clinical staff at the jail to oversee such treatment. Psychiatric technicians are not equipped to evaluate disruptive inmates and make the determination as to whether the outburst is based on a psychiatric emergency or is behavioral in origin." The plaintiff physician expert further opined that the Defendants and their staff deviated from, and fell far below, the standard of care and skill ordinarily exercised in the county jail by:

1) "failing to provide Maurice Shaw with appropriate and timely medical/psychiatric treatment, appropriate hospitalization and level of care, and undertaking reasonable, necessary, and consistent behavioral health counseling and therapy for him by a trained licensed physician for his mental illness;

2) continually failing to provide and ensure Maurice Shaw with appropriate medical care, observation, a safe environment, medication, psychological evaluation, counseling and therapy immediately following the decision to restrain him in five-point restraints and involuntarily administered Haldol Decanoate on;

3) failing to provide medical/psychiatric care and treatment including hospitalization in a licensed acute care facility immediately following the first decision to place him in five-point restraints and involuntarily administered Haldol Decanoate on July 27, 2000, August 7, 2000, and August 8, 2000;

4) adjusting the amounts of Haldol prescribed on August 10, 2000 without a physician's evaluation;

5) lowering the level of care and taking Shaw out of the medical unit on August 22, 2000 and August 24, 2000, without medical or psychiatric oversight, supervision, recordation or review, adequate follow-up procedures, psychological counseling, evaluation and direct and constant observation; and

6) failing to adequately monitor the use, efficacy, and side effects of Haldol on Maurice Shaw."

The plaintiff physician expert concluded his testimony by stating that Correctional Health Care Services and the San Joaquin County Detention Facility "were deliberately indifferent to the behavioral health care and treatment required for Maurice Shaw following his detention there on May 31, 2000. Due to under-staffing, poor training, and lack of any reasonable medical/ psychiatric supervision, Dr. Hart, CHS, and SJCDF ignored Maurice Shaw's severe and acute mental illness, and mental health needs thereby causing his death."

The Defense Experts

To justify the adequacy of the mental health care provided to Maurice Shaw in the San Joaquin County Detention Facility, the defense offered the testimony of Dr. Hart, as well as its own two experts. Dr. Hart's testimony was provided through affidavit, deposition, and trial testimony. With regard to the role of psychiatric technicians, Dr. Hart stated in his affidavit that: "I clinically directed and supervised six licensed psychiatric technicians. The psychiatric technicians did not do diagnoses of patients. Rather, the technicians filled in the blank space on a form for the evaluation done as the inmate first came into the jail. I reviewed every move that was made with regard to a patient. The psychiatric technicians observed and reported behavior and symptoms. Then I would provide a treatment

plan." With regard to the issue of Maurice's involuntary commitment to a hospital for psychiatric evaluation, Dr. Hart stated that "At no time when Mr. Shaw was incarcerated from May 31, 2000 until his death on August 31, 2000 did he qualify as a W & I 5150 danger to himself or others. He could not be considered gravely disabled because he was provided for by the jail with his clothing, housing and food."

With regard to Maurice's suicidal and bizarre behavior displayed during confinement, Dr. Hart stated that "I do not believe that Mr. Shaw's mention of suicide warranted a face-to-face interview….Although Mr. Shaw often refused to shower, that is a personal hygiene issue and not a mental health issue. Similarly, Mr. Shaw's tendency to 'shadow box' was not a sign of mental illness. Rather, shadow boxing is very common behavior among inmates as a way to deal with boredom and stay in physical shape….In August of 2000, Maurice Shaw did not exhibit any behavior which gave the mental health staff, including myself, any indication of a realistic or urgent threat of suicide."

The defense also offered the opinion of a local "police practices expert and law enforcement management consultant" who opined that correctional officers conducted cell checks within the required time intervals, Maurice Shaw had never previously attempted suicide in SJCDF custody; and "I did not detect any deficiencies in the actions of jail staff, or in the policies and procedures of the SJCDF that would have attributed to the death of Mr. Shaw."

Finally, the defense offered the opinion of a nationally-recognized physician expert in the area of medical care in correctional facilities. This expert's affidavit declaration is stated in its entirety as follows:

1) "The health care services (medical, dental and mental health) provided by the health care staff to Mr. Shaw while he was incarcerated in the San Joaquin County Jail from February 15, 2000 to August 31, 2000 were consistent with the standards set forth by the California Medical Association's Institute for Medical Quality and the National Commission on Correctional Health Care.

2) The health care services provided to Mr. Shaw were timely, appropriate, and consistent with the community standard.

3) There is no evidence that the health care providers denied Mr. Shaw access to health care services, nor did they violate his civil rights, as they pertain to access to health care services.

4) The housing areas where Mr. Shaw was assigned (MHU [Medical Housing Unit/Infirmary] and SHU [Sheltered Housing Unit]) were appropriate for the level of his assessed acuity at the time of those housing assignments.

5) The variance in the amount of documentation in the health record from the MHU and the SHU are appropriate given the difference in the defined nature of the two housing units.

6) The psychiatrist (Dr. Hart) and the psychiatric technicians had a well established working relationship that helped facilitate addressing the unmet and unfounded needs of the mentally ill inmates.

7) The mental health team, in lieu of additional needed resources, utilized strategies to address the basic mental health needs of their clients such as daily team meetings, frequent contact lists and patient contracts not to commit suicide.

8) In addition, Correctional Staff were well oriented and trained with respect to the issue of Suicide Prevention and the importance of timely referral to the health professionals.

9) The Correctional Officers acted in a timely and appropriate manner in each instance where Mr. Shaw presented with a medical and dental complaint, moreover, in those instances when Mr. Shaw made statements remotely suggested that he may possibly harm himself, Custody Officers quickly notified the appropriate health care staff.

10) There is no evidence that the Correctional Staff denied Mr. Shaw access to health care services, nor violated his civil rights in any form or fashion.

11) Given the increasing mental health workload demands, the rising cost of mental health medications and the lack of sufficient funding to implement programs and to hire staff, the Mental Health Staff have developed innovative methodologies to accomplish meeting the constitutional rights of the incarcerated mentally ill."

The Verdict

The trial concluded on January 19, 2006 and the jury deliberated for several hours before reaching a verdict that San Joaquin County, Sheriff Baxter Dunn, and Dr. Robert Hart were all "deliberately indifferent to Maurice Shaw's rights by": 1) failing to train, supervise and/or discipline the employees at the San Joaquin County Jail at the time of Maurice's incarceration; 2) failing to protect Maurice; and 3) failing to provide medical care to Maurice. The jury then awarded Maurice's mother the amount of $758,200 in damages.

The jury's work, however, was not done. It reconvened on February 21 to decide whether Dr. Hart and/or Sheriff Dunn should also be required to pay punitive damages for their role in Maurice's suicide. The award of punitive damages in an inmate suicide case is extremely rare. According to the jury instructions given by Judge England, "The purposes of punitive damages are not to compensate the plaintiff, but to punish a defendant and to deter a defendant and others from committing similar acts in the future." The following day, the jury found that Dr. Hart's conduct "was malicious, oppressive or in reckless disregard" of Maurice's rights. It then awarded an additional $100,000 in punitive damages against Dr. Hart.

As a result of the jury verdict and awards, Assistant San Joaquin County Counsel David Wooten told *The Record* of Stockton on February 28 that the San Joaquin Sheriff's Office will begin to review operational procedures to determine if corrective action is necessary. "It's pretty obvious the jury was trying to send a message to the county," he said. Geri Green, the plaintiff attorney in the case, told *The Record* that "The county should be aware that they now can't do business as usual. The scary, really frightening thing is that it goes on every day in every jail. That was abhorrent to this jury, as it should be to all of us." ❑

BEST PRACTICES: ACCESS TO BENEFITS FOR PRISONERS WITH MENTAL ILLNESSES

by the
Bazelon Center for Mental Health Law

People with mental illnesses who have been in jail or prison need access to public-assistance benefits in order to re-enter their communities successfully. Although the federal rules on how and when inmates may receive these benefits are complex, opportunities do exist for them to obtain federal entitlements upon release. This paper lists promising state and local approaches to ensuring the prompt reinstatement of benefits.

Policies that states and localities can adopt include:

- screening for mental illness upon entry to prison or jail;
- screening for prior benefits upon entry to prison or jail;
- suspending rather than terminating Medicaid benefits for inmates;
- establishing transition teams and community collaborations for re-entry;
- helping prisoners complete applications;
- arranging expedited review and processing of applications;
- ensuring that inmates have valid IDs prior to release;
- providing coverage for services and medication after release, while applications are pending;
- providing specialized parole supervision;
- appointing a single agency to coordinate release planning;
- sharing information across agencies, including through interagency agreements and task forces;
- using web-based applications, combining benefit applications and eliminating in-person requirements for applications; and
- working with the Social Security Administration on pre-release benefit applications.

Summarized below are state and local initiatives that adopt such policies.

These communities have taken advantage of the flexibility in federal rules to ensure that individuals with mental illnesses are expeditiously connected to health and mental health care coverage, income support, veterans' benefits and other assistance. Such programs help close the revolving door between community and incarceration for people with mental illnesses.

The summary is organized to show various options at different stages of the process. As a result, comprehensive programs are often summarized piecemeal, under various sections. Where information was available, contacts are listed in the endnotes. Also, because policy development for prison re-entry and release from jail pose different problems and are under different jurisdictions in the states, the summary indicates whether a policy or program applies to prisons, jails or both.

UPON ENTRY TO A CORRECTIONAL SETTING

Screen for Mental Illness

In Jails

- In Arizona, the Council on Offenders with Mental Impairments uses a state of the art electronic data system to identify offenders with mental impairments in both Maricopa and Pima county jails. (1)
- In Summit County, Ohio, jail staff use a three-tiered approach to screen inmates for mental illness upon admission. Admitted inmates receive an initial screening from the booking officer, a cognitive-function examination by a mental health worker and an evaluation by a clinical psychologist. (2)
- In Montgomery County, Maryland, Department of Correction and Rehabilitation staff use a set of seven questions to screen jail inmates for suicide risk at three points of intake: at central processing, upon institutional intake and as part of medical screening. (3)
- In Cook County, Illinois, the Cook County Jail electronically transfers its census every day to mental health clinics in the Chicago area. Clinic staff review the list to identify any of their clients. The goal is for mental health clinics to begin the process of aftercare planning immediately for members who have gone to jail. (4)

In Prison

- In Oregon, the Department of Corrections' Intake Center program uses an automated assessment program for every inmate to identify physical and mental health barriers to productive citizenship in the inmate community and to safe and successful re-entry. (5)

- In Illinois, each newly admitted inmate of the Stateville and Dewight Correctional Centers receives psychological testing. Comprehensive admissions packets developed by a privately owned psychological firm serve as a guide for each new admission. (6)

- In Minnesota, all prison inmates are eligible for three separate screenings by correctional nursing staff and by a mental health professional. The screenings build on each other to identify inmates with mental health needs. (7)

Screen for Benefits

- In Minnesota, staff places a special note in the prison's information system if a prisoner is identified during the screening process as having Medicaid, SSI, SSDI or VA benefits. (8)

- In Oklahoma, prison officials are developing a system that flags incoming offenders who are already receiving SSI benefits. (9)

Suspend (Not Terminate) Benefits

- In Maryland, incarcerated Medicaid participants remain on the enrollment list, even if incarcerated longer than 30 days. The state notes the incarceration in its information system to prevent unauthorized claims payment. (10)

- In Lane County, Oregon, Medicaid payments for jail inmates continue for 14 days after arrest. After that, benefits are suspended — not terminated — so they can be reinstated immediately upon release. (11)

- In Washington, Medicaid enrollment is suspended rather than terminated for people in jail less than 30 days. (12)

RE-ENTRY PLANNING

Use Transition Planning Teams and Community Collaborations to Ensure Continuity of Care

In Jail

- In Hampden County, Massachusetts, jail inmates are assigned a treatment team that addresses treatment, housing and other concerns prior to release. In addition, inmates work with the same caseworker both inside the facility and after release. (13)

In Prison

- In Minnesota, if a discharge planner learns that the offender has a prior relationship with a social worker in the community, the social worker is invited to the prison to collaborate on the discharge plan. Then, at least 10 days before the first appointment, the prison transfers the offender's records to the community services provider and psychiatrist he or she is scheduled to see. (14)

- In Portland, Oregon, the Turning Point program at the Columbia River Correctional Institution uses a modified therapeutic community model of treatment six to 12 months prior to release for offenders with severe mental illnesses and co-occurring substance use disorders. The program includes assessment and treatment planning and focuses on the implementation of a transition plan three months prior to an inmate's release. (15)

Assist Prisoners in Completing Applications for Benefits

In Jail

- In Milwaukee, Wisconsin, a financial-services advocate from the Community Support Program manages entitlement claims of offenders with mental illnesses. (16)

- In Philadelphia, Pennsylvania, a case worker does release planning that includes advising the jail inmate of potential eligibility or providing information on where to obtain applications. (17)

- In New York City, case managers with the NYC Link program are responsible for creating a community-services plan for inmates at the city's jail (Rikers Island), filing benefit applications on inmates' behalf and providing housing referrals. (18)

- New York's Rensselaer County jail staff are trained by the Department of Social Services to help inmates complete entitlement forms and collect the necessary supporting documents, such as birth certificate, pay stubs, etc. If necessary, staff accompany inmates to the local Social Security office to finish their application process. As a result, many inmates receive their benefits within 24 hours of release. (19)

- In Jefferson County, New York, county social service staff go to the jail and complete Medicaid applications for offenders with mental illnesses who are about to re-enter the community. The county does not participate in the Medication Grant Program (MGP) but uses its allocation of MGP funds for its own program. (20)

- Albany County, New York social services staff go into the jail before an inmate's release and help

the inmate complete a Medicaid application, which is filed 45 days prior to the anticipated date of release. The application is registered, logged and held so it can be activated as soon as the inmate is released. The Social Services office not only processes the Medicaid application, but also assists released individuals in accessing general assistance payments, Food Stamps, etc. (21)

- In Hampden County, Massachusetts, a discharge planner from a local community health center completes and faxes a Medicaid application to the Medicaid agency within three months of an inmate's release date. Although the application is denied because the applicant is incarcerated, it remains on file. Once the discharge planner faxes the paperwork showing the applicant has been released from jail, the application is activated and approved. (22)

- King County, Washington jail staff notify the Department of Social and Health Services (DSHS) 45 days prior to an inmate's release date. A DSHS eligibility worker collects medical and financial information for the Medicaid eligibility process and provides Medicaid coupons to the inmate upon release. (23)

- In Los Angeles, the Sheriff's Department screens jail inmates and then sends the names of those who are veterans to the VA's Community Re-Entry Program. Outreach staff members from the program conduct assessments with inmates in the facility and help link them to services upon their release, including VA health care, housing and financial benefits. (24)

In Prison

- In Allegheny County, Pennsylvania, the Forensic Community Re-entry Program sends a Community Placement Specialist (CPS) to oversee the transition of female inmates who have a mental illness from the prison to the community. The CPS does all release planning and completes benefit applications. (25)

- In Pennsylvania, the prison's chief psychologist leads a Psychiatric Review Team in developing a re-entry treatment plan for every inmate identified as in need of mental health services within 12 months of release. Immediately after this meeting, and sometimes as part of it, the team meets with the inmate to discuss possible eligibility for various entitlement programs and how to apply. For inmates with the greatest need, a caseworker from the team completes the application for General Assistance, Medicaid, Food Stamps, cash assistance and other benefits. If necessary, inmates are referred to a Department of Public Welfare disability specialist, who helps them complete an SSI/SSDI application. (26)

- The Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) refers a prison inmate with a pending release date who is identified as having a history of receiving or needing mental health treatment to the regional mental health services and benefits coordination office in the county where the inmate expects to live. These offices send workers to meet with identified prison inmates and develop pre-release plans. If the inmate wants SSI and/or SSDI, the TCOOMMI worker makes a referral to the benefits eligibility specialist, who files an application 90 days prior to release. (27)

- In Boston, Massachusetts, a formal re-entry program initiates an application for Medicaid 30 days prior to an inmate's discharge from prison. All application paperwork is completed in advance so that the individual is poised for approval upon discharge. (28)

- In Wisconsin, Department of Corrections (DOC) staff complete applications for Medicaid benefits, which can be accepted and processed up to 23 days prior to an offender's anticipated release from prison. The DOC staff also complete entitlement applications, secure and/or verify an inmate's Social Security number, obtain a Social Security card if necessary and obtain medical and/or psychological documents for the past 12 months. (29)

- In Minnesota, at least 90 days before an offender is due to be discharged, an agent of the Department of Human Services trained in mental health is designated to serve as the primary person responsible for carrying out discharge planning activities, including completing and filing Medicaid application forms. If the application is approved, the county office mails a Medicaid eligibility card to the prison; the prison holds this card until the inmate's release date, when he or she receives the card. (30)

- In New York, outreach workers from the Division of Veteran Affairs coordinate with counselors from the Department of Correctional Services to develop a transition plan for incarcerated veterans beginning six to nine months prior to release. Outreach workers assist in determining prisoner eligibility for veterans benefits and other VA services. (31)

- The Oregon Department of Corrections (DOC) now gives released individuals "Offender Debit Cards" instead of checks for any money earned while incarcerated. Released prisoners can use the cards at most automatic teller machines to access SSI and Food Stamps for which they are eligible. (32)

In Both Jail and Prison

- In Portland, Oregon, the Multnomah County Department of Community Justice developed the

Transition Services Unit (TSU) to provide pre-release planning, referrals and/or connections to appropriate services and treatment programs for individuals transitioning into the community. TSU counselors and parole officers assist recently released jail and prison inmates in completing Medicaid and SSI applications. (33)

- In New York, the Medication Grant Program (MGP) is the primary mechanism to connect individuals with mental illnesses to benefits, such as Medicaid, Food Stamps and cash assistance after release. The program funds "transition managers" in jails and "pre-release coordinators" in prisons to assist inmates in the application process and to secure MGP cards upon their release. Under the MGP, a Medicaid application can be submitted up to 45 days prior to or within seven days after release. (34)

- In Colorado, the 2002 benefit-reinstatement law mandates that correctional facilities implement steps to facilitate benefit reinstatement for individuals leaving jails and prisons. (35)

Provide Expedited Service for Processing of Inmates' Benefits Applications

In Jail

- Lane County, Oregon Medicaid puts jail inmates' applications on a fast track for processing and most are processed in a day or two. Medicaid staff then fax temporary Medicaid cards back to the jail, ensuring that inmates have immediate access to Medicaid services upon release. (36)

In Prison

- In Texas, the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) pays for prison inmates' applications to receive expedited services, enabling inmates who are eligible for SSI/SSDI to access available services upon release. (37)

In Both Jail and Prison

- In Washington, SSI facilitators who specialize in the SSI application process use the state's own disability-determination process, rather than SSA's slower determination process, to authorize expedited Medicaid coverage for jail and prison inmates until a final SSI decision is reached. (38)

Ensure that Inmates Have a Valid ID Prior to Release

In Jail

- In New York's Rensselaer County, jail inmates are given a picture ID to facilitate their re-entry. (39)

In Prison

- The Louisiana Office of Motor Vehicles (OMV) is piloting a program at several prisons where state ID cards and license renewals are made on-site for inmates prior to their release. (40)

- The Montana Department of Corrections issues to inmates a prison card with a photo that also includes the inmate's date of birth and adult offender number, and the discharge certificate or parole order. Under Montana law, these documents can be exchanged within 60 days of release for a free state-issued ID. (41)

INTERIM COVERAGE

Provide Coverage and Medication While Applications are Pending

In Jail

- In Hampden County, Massachusetts, jail inmates receive a 30-day prescription for their medications upon discharge, along with a five-day supply. (42)

In Prison

- In Minnesota, legislation requires released inmates to receive a 10-day supply of medication and a written prescription for a 30-day supply with one refill of all necessary medications. (43)

- The Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) pays for medical services until Medicaid is activated and provides a 10-day supply of medications upon release. The state provides a stipend to released inmates until they receive their disability checks. (44)

In Both Jail and Prison

- In New York, offenders with serious mental illnesses who are currently taking prescribed psychiatric medications and appear to be eligible for Medicaid after release from jail or prison may participate in the Medication Grant Program (MGP). An individual must file a Medicaid application to enroll in MGP, which covers medications until Medicaid eligibility is determined. If the person is approved for Medicaid enrollment, the Office of Mental Health will retroactively bill Medicaid for medications dispensed to the individual in the community. (45)

POST-RELEASE (PAROLE OR NOT) FOLLOW-UP/ AFTERCARE

Provide Specialized Parole Supervision

In Jail

- The Cook County, Illinois Adult Probation Department's Mental Health Unit in the county jail

employs probation officers with a background in mental health to help clients access disability benefits and SSI and obtain medical cards. These officers also counsel probationers, help them budget their time and resources and support them with any difficulties they experience in treatment. (46)

In Prison

- In Pennsylvania, when there is a complication with an application filed from a prison, the county assistance office (CAO) has a single point of contact charged with contacting the Department of Corrections to resolve the problem. (47)

- Wisconsin Department of Corrections staff review benefit application disapprovals and assist prison inmates in appealing the decision. (48)

PROGRAM ADMINISTRATION—SIMPLIFY A COMPLICATED PROCESS

Appoint One Agency to Coordinate Release Planning for People with Mental Illnesses

- The Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) is the state's agency designated to meet the needs of prison inmates with mental illnesses. TCOOMMI staff are responsible for handling benefits and other re-entry issues at the prison level. (49)

Share Information

In Prison

- In Texas, health services agencies share information on individuals receiving health related services, ultimately helping officials to complete benefits applications on behalf of prisoners. A waiver from the federal Health Insurance Portability and Accountability Act was necessary to permit this exchange of medical information among state agencies. (50)

- Wisconsin Department of Corrections (DOC) staff assist prisoners in completing information releases to authorize exchange of information between DOC and SSA. (51)

Establish Explicit Interagency Agreements and Task Forces

In Jail

- In Duval County, Florida, a Continuity of Care Agreement was developed between mental health providers and the jail to ensure continuity of care for incarcerated individuals. The agreement also calls for an application for benefits prior to release so inmates will be linked to community-based treatment upon release. (52)

- In Albany County, New York, a group named the Options Committee manages the integration of existing health, mental health, substance abuse and social service systems to match jailed individuals' needs to available services. Committee member include representatives from the sheriff's department, County Executive's office, departments of health, mental health, probation and social services, office of the public defender and state division of parole. (53)

- In Rensselaer County, New York, a Forensic Task Force composed of officials from both the criminal justice and mental health systems negotiated an agreement with the county's Medicaid agency so that many applicants now receive Medicaid benefits within 24 hours of release from jail. In addition, as a result of the task force's efforts, community mental health providers are now willing to work with released inmates. (54)

In Prison

- The Minnesota Department of Corrections Mental Health Services completed a comprehensive interagency agreement for partnerships with Department of Human Services divisions, including Mental Health, Chemical Health and State Operated Services. (55)

- In Pennsylvania, a statewide Forensic Interagency Task Force composed of key forensic stakeholders is working to submit applications for eligible prison inmates before release to ensure their access to benefits on re-entry. Stakeholders include local and state agencies (PA Department of Corrections, PA Office of Mental Health and Substance Abuse Service, etc.) and advocacy groups (National Alliance for the Mentally Ill, PA Protection and Advocacy, etc.). (56)

- In Wisconsin, memoranda of understanding between the Wisconsin Departments of Corrections and of Health & Family Services and the Social Security Administration outline procedures for processing prison inmates' Medicaid and SSI applications. (57)

Use Web-Based Applications, Combine Benefit Applications and Eliminate In-Person Requirements

In Both Jail and Prison

- In Texas, applications to SSA for disability benefits also include an application for Food Stamps. Reinstatement of SSI benefits automatically triggers Medicaid coverage. (58)

- In New York, a combined Medicaid, cash assistance and Food Stamp application offers released inmates access to additional services for which they are potentially qualified. (59)

- The Pennsylvania Department of Public Welfare developed a web-based application, COMPASS (Commonwealth of Pennsylvania Access to Social Services), that allows trained non-specialists to submit electronically one collective application for multiple benefits (excluding SSI/SSDI) to appropriate offices. The face-to-face requirement has also been eliminated for the medical part of county cash assistance. (60)

- The King County, Washington Department of Social and Health Services (DSHS) waives the Medicaid and General Assistance face-to-face interview requirement for certain jail inmates with mental illnesses or addiction disorders. (61)

Work with SSA

In Prison

- In New York, pre-release staff at the Arthur Kill Correctional Facility work with local SSA staff to complete and file SSI/SSDI applications. Staff from the local SSA office meet personally with inmates previously identified as potentially eligible for SSI/SSDI, explain the program rules and help the inmates complete their applications. With the applicant's consent, the pre-release coordinator provides the medical evidence from the Office of Mental Health record and the Department of Corrections' Health Services record as part of this process. (62)

- The New York State Division of Parole (DOP) and the SSA have entered into a memorandum of understanding (MOU) regarding procedures for submitting a pre-release application for SSI and SSDI benefits. The MOU provides that state Office of Mental Health (OMH) staff submit the applications on behalf of prisoners with mental illnesses, while parole officers submit applications on behalf of prisoners with other disabilities. (63)

- In Oklahoma, the Medical Services Division of the Department of Corrections partners with the SSA to connect prison inmates with SSA benefits prior to release. A reintegration specialist at each correctional facility works with a counterpart at the local SSA office to pull together applications. (64)

- In Texas, each local social security office has a pre-release point person to work with prison coordinators on SSI/SSDI and Food Stamp applications. (65)

- In Wisconsin, by agreement with SSA, completed applications for SSI/SSDI claims are accepted and processed up to 90 days prior to a prisoner's anticipated release date or 30 days for a non-disability claim. Each Department of Corrections (DOC) facility and regional office identifies a point of contact within the local SSA offices and maintains contact information (telephone, fax, e-mail). The DOC also provides to SSA a list of DOC staff (with their facsimile signatures) who are authorized to assist offenders in the process. (66)

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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Notes

(1)Arizona Council on Offenders with Mental Impairments, 150 N. 18th Ave, 2nd Floor, Phoenix, Arizona 85007; (602) 364-4558; www.azdhs.gov/bhs/ocouncil.htm
(2)Summit County Jail, 205 E. Crosier Street, Akron, OH 44311; (330) 643-2171, (330) 643-4138 Fax; www.co.summit.oh.us/sheriff/corrections.htm
(3)Montgomery County Department of Correction and Rehabilitation, 51 Monroe Street, Rockville, MD 20850; (240) 777-9975; www.co.mo.md.us/services/docr
(4)Cook County Department of Corrections, 2700 South California Avenue, Chicago, IL 60608; (773) 869-7100; www.cookcountysherrif.org
(5)Operations Manager, Oregon Department of Corrections, 2575 Center Street, NE, Salem, OR 97301; (503) 945-9090; www.oregon.gov/DOC/index.shtml
(6) The Illinois Department of Corrections, FY 2003 IDOC *Annual Report Information*; www.idoc.state.il.us
(7)Council of State Governments, *Ensuring Timely Access to Medicaid and SSI/SSDI for People with Mental Illness Released from Prison*: *Minnesota*; www.reentrypolicy.org (8)*Id.*
(9)"Oklahoma DOC Partners with Social Security Administration to Benefit Inmates," *Prison Talk Online*; www.prisontalk.com/forums/showthread.php?t=10739
(10)Eiken, S., & Galantowicz, S. (2004), *Improving Medicaid Access for People Experiencing Chronic Homelessness: State Examples*, Washington, DC: The Medstat Group, Inc.; www.cms.hhs.gov/medicaid/homeless/homeless32904.pdf
(11)Lane County Diversion Program, Rebecca McAlexander; (541) 682-2176; Rebecc.mcalexander@co.lane.or.us
(12)Eiken & Galantowicz. (2004)
(13)Brightwood Health Center, Hampden County Correctional and Community Health Program, 380 Plainfield Street, Springfield, MA 01107; (413) 794-8375
(14)Council of State Governments: *Minnesota*
(15)Maria Torres, Turning Point Program Manager, 9111 NE Sunderland Avenue, Portland, OR 97211; CRCI: 503-280-6646, ext. 297; http://egov.oregon.gov/DOC/OPS/PRISON/CRCI_TurningPoint.shtml
(16)Community Support Program, Wisconsin Correctional Service, 2023 W. Wisconsin Avenue, Milwaukee, WI 53233; (414) 344-6111; www.wiscs.org
(17)Council of State Governments: *Pennsylvania*
(18)Assistant Commissioner Forensic Services, 93 Worth Street, Rm 611, New York, NY 10013; (212) 219-5181, (212) 219-5191 Fax
(19)Rensselaer County Jail, 4000 Main Avenue, Troy, NY 12180; (518) 270-5448
(20)Council of State Governments: *New York*
(21)Albany County, Department of Social Services, 162 Washington Avenue, Albany, NY 12207; (518) 447-7300
(22)Brightwood Health Center, Springfield, MA
(23)Eiken & Galantowicz (2004)
(24)Coordinator, Community Re-entry Program, VA Los Angeles Ambulatory Care Center, 351 East Temple St., Los Angeles, CA 90012; (213) 253-2677, ext. 1 or ext. 4787
(25)Director of Forensic Services, Office of Behavioral Health, Allegheny County Department of Human Services, 304 Wood Street, 4th Floor, Pittsburgh, PA 15222; (412) 350-7337
(26)Chief Psychologist, Pennsylvania Department of Corrections, 2520 Lisburn Road, P.O. Box 598, Camp Hill, PA 17001; (717) 731-7797; www.cor.state.pa.us
(27)Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), Dee Wilson, Director, 8601 Shoal Creek Road, Austin, TX 48757; (512) 406-5406, (512) 406-5416 Fax; www.tdcj.state.tx.us/tcomi/tcomi-home.htm
(28)Eiken & Galantowicz (2004)
(29)State of Wisconsin, Department of Corrections, 3099 East Washington Avenue, Post Office Box 7925, Madison, WI 53707; (608) 240-5000, (608) 240-3300 Fax
(30)Council of State Governments: *Minnesota*
(31)NYS Division of Veterans' Affairs, #5 Empire State Plaza, Suite 2836, Albany, NY 12223; www.veterans.state.ny.us
(32)Deputy of Correctional Programs, Oregon Department of Corrections, 2575 Center Street NE Salem, OR 97301; (503) 947-1040
(33)Program Administrator, Multnomah County Department of Community Justice, Transition Service Unit, 421 SW 5th Avenue, Portland, OR 97204; (503) 988-4054, (503) 988-4898 Fax; www.co.multnomah.or.us/dcj/acjtsu.shtml
(34)Council of State Governments: *New York*
(35)C.R.S.A. § 17-1-113.5 (inmates held in correctional facilities) and C.R.S.A. §17-27-105.7 (offenders held in community corrections programs)
(36)Lane County Diversion Program
(37)Texas Correctional Office (TCOOMMI)
(38)Eiken & Galantowicz (2004)
(39)Rensselaer County Jail, Troy, NY
(40)Re-entry Program Coordinator, Dixon Correctional Institute, P.O. Box 788, Jackson, LA 70748
(41)Montana Code Annotated 61-12-504
(42)Brightwood Health Center, Springfield, MA
(43)Council of State Governments: *Minnesota*
(44) Texas Correctional Office (TCOOMMI)
(45)Council of State Governments: *New York*
(46)Adult Probation Department, Cook County Administration Building, 69 W. Washington Street, Suite 2000, Chicago, IL 60602; (312) 603-0240; www.cookcountycourt.org/services/programs/adult-probation/probation.html#8
(47)Council of State Governments: *Pennsylvania*
(48)State of Wisconsin Department of Corrections
(49)Texas Correctional Office (TCOOMMI)
(50)Council of State Governments (October 2004), "Federal Benefits and Re-Entry: Stopping the Revolving Door for People with Mental Illness Released from Prison," *Monthly Issue Brief*; www.csgeast.org
(51)State of Wisconsin Department of Corrections
(52)Bazelon Center for Mental Health Law, Federal Benefits for Individuals with Serious Mental Illnesses Who Have Been Incarcerated: Fact Sheets; www.bazelon.org/issues/criminalization/factsheets/benefits
(53)Bazelon Center for Mental Health Law (2003). *A Better Life, A Safer Community: Helping Inmates Access Federal Benefits*; www.bazelon.org/issues/criminalization/publications/gains/restoringstateloc.htm
(54)*Id.*
(55)Council of State Governments: *Minnesota*
(56)Council of State Governments: *Pennsylvania*
(57)State of Wisconsin Department of Corrections
(58)Texas Correctional Office (TCOOMMI)
(59)Council of State Governments: *New York*
(60)Council of State Governments: *Pennsylvania*
(61)Eiken & Galantowicz (2004)
(62)Council of State Governments: *New York*
(63)*Id.*
(64)*Prison Talk Online*
(65)Texas Correctional Office (TCOOMMI)
(66)State of Wisconsin Department of Corrections

About This Brief Issue

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is the leading national legal advocate for adults and children with mental disabilities. The staff uses a coordinated approach of litigation, policy analysis, public information and technical support for local advocates to end the segregation of people with mental disabilities and ensure them the opportunity to access needed services and supports. Bazelon Center for Mental Health Law, 1101 15th Street, NW, Suite 1212, Washington DC 20005, (202) 467-5730, Fax: (202)223-0409; www.bazelon.org ❑

Mentally Ill Falling Through Cracks: Those Who Refuse Treatment and Break the Law End Up in Jail

Robert "Simon" Gilmore is in jail. Again. He's been arrested eight times in the past three weeks. The last time — April 3 — he asked the judge to leave him in jail for 90 days. "He said if they let him out, he'd just get arrested again," city prosecutor Jerry Little said. "So the judge set his bond at $500. He's still in jail." Gilmore, who will soon turn 50, is the homeless man who's often seen sitting or sleeping on the sidewalk in front of either Weaver's department store or The Replay Lounge downtown. He's known for wearing white socks on his hands and, when it's cold, wrapping himself in a thrift-shop blanket. Legally blind and intensely private, he rarely says more than a few words to strangers. Family members say Gilmore has been diagnosed as paranoid schizophrenic.

Mental health advocates and law enforcement authorities say he has become a prime example of how the mentally ill, especially those who refuse treatment, are falling through ever-widening cracks in the social service network. Since moving to Lawrence in the early 1980s, Gilmore has been arrested more than 50 times, usually for wandering on private property, urinating in public, disobeying a police officer or obstructing traffic. "He can't see very well, so he tends to walk in the street," Little said.

Gilmore's latest troubles stem from a new city ordinance that prohibits camping on a downtown public right-of-way. Sleeping on the sidewalk in considered camping. City commissioners passed the ordinance in response to downtown merchants' complaints of people sleeping in doorways, sidewalks and alleys. The ordinance was not aimed specifically at Gilmore, Mayor Mike Amyx said. "The ordinance is very fair," Amyx said. "It concerns all kinds of folks, not just him."

"The Only Place"

Little said jail wasn't the best place for Gilmore. But for someone who's mentally ill and who insists on breaking the law, it's the only place. "We're at a loss as to what to do with him," Little said. "He's very independent." Gilmore has refused help from Bert Nash Community Mental Health Center. Recent efforts to have him committed to Osawatomie State Hospital have been denied, Little said.

To have Gilmore committed, Little would have to prove that Gilmore is a danger to himself or others and incapable of making reasoned decisions. "I could probably get one — 'danger to himself or others' — but I can't get both," Little said, noting that in the past, Gilmore's mental illness hasn't been considered severe enough to hinder his decision making.

Under the law, Gilmore has the right to choose to be mentally ill. "I'd be glad to work with any agency in town that thinks it can work with Mr. Gilmore," Little said. Bert Nash stands ready to help, but Gilmore has rejected the mental health agency's overtures. "I cannot comment on this or any other individual's circumstances," said Dave Johnson, Bert Nash executive director. "But I will say that people have the right to refuse services. You don't lose your rights because you're mentally ill. "But when that's the case," he said, "we don't have a solution."

Gilmore's troubles are fast becoming a burden on jail staff, Douglas County Undersheriff Kenny Massey said. "He can be very demanding," said Massey, who is in charge of jail operations. "He becomes upset, he trashes his cell, he makes a lot of noise." Gilmore's being in jail serves no long-term purpose, Massey said. "We manage him," he said. "We don't treat him."

"Overwhelmed"

John Tucker, 41, has battled schizophrenia most of his adult life. "I've been in treatment," he said. "I deal with it now." Tucker, who lives in Lawrence and is active in the Douglas County chapter of National Alliance on Mental Illness, said he sympathized with Gilmore. Tucker said he, too, has felt "overwhelmed" by his illness and unable to find "virtue" in his life. Still, he said, people who are mentally ill have an obligation to themselves and to society to seek treatment. "If (Gilmore) chooses not to do that, then that decision should be made for him," Tucker said. "That may mean having to go to Osawatomie State Hospital and being kept there until he's ready to get better." He added, "Jail isn't the answer."

Douglas County Jail isn't just a jail. "We've become the mental health unit of Douglas County," said Undersheriff Kenny Massey. "We deal with a lot of people here who really ought to be dealt with somewhere else. We're not set up for this." Last year, Massey said, the jail logged 40 suicide watches at Level 3, which is considered "very serious." "It means they're in a special cell," he said. "It means you have to check on them every few minutes. "That's not easy when you've got a lot going on, like last weekend. We booked 61 people into jail," said Massey, who oversees the jail. "That's a lot."

Massey and his boss, Douglas County Sheriff Ken McGovern, said using the jail to house mentally ill offenders was shortsighted and ineffective. But at any given time, they said, about 15 percent of the jail's 192 beds are filled by people who are mentally ill. The national average is close to 30 percent, but the local numbers are still a lot to handle. "There needs to be a better way to help the mentally ill than jail," McGovern said. "There needs to be something that's long-term."

It's expensive: 40 percent of a recent $18,000 pharmaceutical bill at the jail was for psychotropic drugs. It can be violent, and it can be messy. Some mentally ill inmates trash their cells, smear feces or throw food. "Bathing is a huge issue," Massey said. "If they refuse to bathe, the staff assists them. It's a health issue."

Revolving Door

Massey and McGovern said it was especially frustrating that many of the mentally ill inmates — they don't have an exact count — don't fare well in the community and end up back in jail. "We don't have any programs that help them long-term because they're not here long enough," McGovern said, noting the average stay is about nine days. It's not unusual, he said, for mentally ill inmates to leave the jail — they're driven into town and dropped off at 11th and Massachusetts streets — without medications, a job or a place to live. They are, however, strongly encouraged to call or visit Bert Nash Community Mental Health Center. Some do, but many don't.

"The biggest gap in the system is what happens after they leave the front door of the jail," said Christy Blanchard, coordinator of forensic services at Bert Nash. Blanchard is on a newly formed committee that hopes to hasten inmates' access to Bert Nash and to housing and employment opportunities. The committee next meets April 17. "The connection (with Bert Nash) needs to be made, and the resources for housing, employment and supervision need to be there," Blanchard said.

But Bert Nash employees can't do much more than plug former inmates into existing services, most of which already are stretched thin. "We don't have the money" for new programs, said Bert Nash executive Dave Johnson. "So much of what we're talking about is tied to Medicaid — it's what we've built our health care system on," he said, referring to the federal- and state-funded program that underwrites health care for the poor. "But Congress is doing everything it can to reduce Medicaid spending, to rein in the budget."

In Between

The jail's troubles come nine years after lawmakers voted to close Topeka State Hospital, which offered care and treatment for mentally ill patients. "A lot of people we're seeing now would have been sent to Topeka State Hospital back when it was still open," McGovern said. The state hospital in Osawatomie continues to treat Douglas County residents whose illness is so severe they cannot safely remain in the community. But their stays are short-term, usually two or three weeks. After their conditions stabilize, they are returned to Douglas County where they may or may not take advantage of the services at Bert Nash.

Some end up at the Salvation Army shelter for the homeless, 946 N.H. "It's not a good thing," said Mathew Faulk, a Salvation Army case manager. "It's a situation that's exacerbated by the fact that we live in a society that thinks nothing about paying ballplayers millions of dollars a year but gets up in arms over spending a few thousand dollars helping people in their own community." Faulk opposes adding beds to — or lengthening stays in — the state hospital system. "We need something in between the big hospitals that are run like prisons and a society that's dog-eat-dog," he said.

No Alternative

Several attempts at interviews with mentally ill adults who had spent time in the Douglas County Jail were unsuccessful. Robert Shipp's son, Ed, has been in and out of jail several times. "It's a sad, sad situation," said Robert Shipp, of Lawrence. "It's like a revolving door — they go in, they come out, they go back in."

Shipp said his son, who's paranoid schizophrenic, was in Osawatomie State Hospital last fall. "They did a good job with him," he said. "But when he got out, the first thing he did was go off his meds. He's back in Lawrence now. He's living in our basement, but there's no communication. He doesn't talk to us. We don't want him there; we don't think it's good for him," Shipp said. "But there's no place else for him to go. We're afraid that if he was out on his own, he'd end up back in jail, and we don't want that either."

In Lawrence, the jail situation isn't expected to show much improvement anytime soon. "Over the years, there have been so many cuts in funding and resources at both the local and state hospital level that, in a lot of circumstances, jail is just about the only place left to go," said Douglas County Dist. Atty. Charles Branson. "The alternatives just aren't there."

But Gary Daniels, secretary at the Kansas Department of Social and Rehabilitation Services, said change was on the horizon. "This isn't just an issue in Douglas County or in Kansas; it's nationwide," Daniels said, noting Gov. Kathleen Sebelius has convened a planning council on mental health policy, and a legislative committee is reviewing possible changes in state laws affecting the mentally ill in jail. "Just about everybody agrees the burden doesn't belong on the jails," he said.

The above article — "Mentally Ill Failing Through Cracks: Those Who Refuse Treatment and Break the Law End Up In Jail" — was written by Dave Ranney, a staff writer for the ***Lawrence-Journal World****, and appeared in the April 9-10, 2006 editions of the newspaper. Copyright 2006,* ***Lawrence-Journal World****. All rights reserved. Used with permission.* ❑

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.

Ohio

Other than wages and health care, the most contentious issue in the recently concluded state-employee contract negotiations is a new requirement that has some state correctional officers very upset — having to administer mouth-to-mouth resuscitation to an inmate in an emergency. "I will not do CPR on a inmate!!!!!!" one correctional officer wrote in a message posted in a discussion forum on the Ohio Civil Service Employees Association's website. "I guess I'll never see an inmate that I think needs CPR," another wrote. "Those

guys can 'sleep' anywhere, you know." A third officer groused that wardens and other senior officials will not be required to be CPR-certified but "will simply order us to put our mouth on a dirty, freaking inmate. And if the sorry-a__ inmate dies, we will probably be disciplined or even lose our jobs."

Peter Wray, spokesman for the 35,000-employee union, said the requirement that state workers become CPR-certified has many up in arms but said the state will be required to provide prison officials and other employees with safety equipment such as mouthpieces and gloves. "We don't know whether an inmate has a communicable disease; thus our people are instructed to act like everyone has a communicable disease," he told on *Cleveland Plain Dealer* on March 3, 2006. "It's incumbent on the state to provide the proper equipment."

For some officers, however, handing out mouthpieces and gloves is simply putting lipstick on a frog. Mr. Wray acknowledged that some correctional officers simply do not like inmates and do not want to get face-to-face with someone who, say, just passed out from a drug overdose or from drinking bad homemade prison wine. "Sometimes it's difficult for corrections employees to feel empathetic to situations in which inmates caused their own problems, but they still do their jobs," Mr. Wray said. "They're professionals and they understand what they're expected to do." State employees eventually approved the three-year contract by a 2-to-1 ratio.

Michigan

Ottawa County appears to be doing a good job of getting jail inmates with mental health problems into treatment programs. However, a recent study by the Mental Health Jail Diversion Task Force said there were several areas where the county could improve its services, including the establishment of a 24-hour crisis drop-off center, development of a mental health court, and developing in-jail services for inmates found to be too violent or unstable to be placed in a diversion program. "It all comes down to funding," Gerry Cyranowski, executive director of Community Mental Health, told the *Muskegon Chronicle* after he presented the study findings to the agency's board of directors on January 18, 2006.

Of the 2,370 individuals who were booked into the Ottawa County Jail between November 2004 and January 2005, 13 percent were found to have problems related to mental health, and 4 percent (102 individuals) were identified as having a moderate to severe mental health condition. In addition, of the 313 individuals found to have mental health problems, 136 were identified by law enforcement. Of that group, 84 percent were diverted to treatment programs outside of the jail. "They were diverted to in-patient centers, they were diverted to a crisis home or to out/patient services," Mr. Cyranowski said. However, of the 177 individuals found by jail personnel to have mental health problems, only 5 percent were recommended for diversion into a treatment program, and only 2 percent were diverted, the report said. Those individuals who were charged with a violent felony offense (approximately 26 percent) were not eligible for diversion.

Mr. Cyranowski noted the county does not have a 24-hour drop-off facility for people struggling with mental illness, meaning that individuals seeking treatment may end up having to go to a local hospital. "We don't have the kind of resources (needed) to support (an around-the-clock facility) on a full-time basis," he said.

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

Indiana

An inmate who recently committed suicide in Bartholomew County Jail in Columbus should have received more attention from jail staff to prevent his death, according to the man's family. The suicide of 37-year-old Michael Dean Ward, however, was apparently a shock to local law enforcement officials because they claimed he had acted optimistically about his future the day he died on February 23, 2006. Mr. Ward was scheduled to testify at the upcoming trial of an individual suspected of killing four people.

Mr. Ward had been arrested two days earlier on February 21 after a standoff with police on a warrant for failure to appear in court. During the standoff, Mr.Ward threatened to shoot himself in the head, as well as overdose on methamphetamines. His mother, Sheryl Vance, along with a neighboring sheriff, were able to convince Mr. Ward to surrender. His fiancée, Loni Hamm, and mother said they told Bartholomew County Jail officials that Mr. Ward was suicidal. "They should have had him watched like he should have been," Ms. Hamm told *The Republic* in Columbus. "There should have been another officer or a nurse to keep an eye on him." Mr. Ward's ex-wife, Jessica Ward, told the newspaper that he called her four times and threatened suicide the first night he was in jail. "He told me he was going to pass over," Jessica Ward said. "I called the jail four times to tell them he was suicidal."

Ms. Hamm and family members said that Michael Ward was scared for his life because he was a witness in the case against Robert Bassett, the accused murderer, and had received death threats. In 2001, a jury convicted Mr. Bassett of the four murders, but the state Supreme Court had overturned the conviction and ordered a new trial. "(Ward) knew he would be a dead man if he stepped foot back in Bartholomew County," Ms. Hamm said. "I tried to call (prosecutors)….I tried to get him out of Bartholomew County. No one seemed to care."

Bartholomew County Prosecutor Bill Nash stated that Mr. Ward was listed to testify against Mr. Bassett, but he declined to reveal what role Mr. Ward would have had in the case. "He was not our star witness," Mr. Nash told *The Republic*. "I cannot tell you any specifics as to what he would testify had he not killed himself. Everyone in law enforcement here had every incentive to take good care of Mike Ward. No one wanted anything to happen to him."

Major Mark Gorbett of Bartholomew County Sheriff's Department said he was aware of the threats against Mr. Ward and that jail staff had made efforts to keep him safe. Mr. Ward was taken to Columbus Regional Hospital for a medical evaluation shortly after being admitted into the Bartholomew County Jail. He spent the night at the hospital and was released back to the jail on February 23. Major Gorbett stated Mr. Ward told him he had stayed awake approximately 30 days because he had used methamphetamines, and he tried to get treatment for his addiction, but was turned away because he had no insurance or money.

According to Major Gorbett, following his release from the hospital, Mr. Ward was optimistic and showed no signs of being suicidal. "He was upbeat and looking forward to going to that treatment facility," he said. "Based on his interaction with the nurse, it was completely unexpected what he did that day."

Although housed in a cell equipped with closed circuit television (CCTV) monitoring that was situated approximately 10 feet away from the nurse's station in the jail's medical wing, Mr. Ward was able to successfully commit suicide by hanging because the nurse's station was un-staffed, and he stood outside the view of the CCTV monitor.

Mississippi

In March 2006, a federal court monitor hired to oversee conditions at the state's two juvenile correctional facilities reported serious civil rights violations, including alleged assaults by staff and inadequate care for both suicidal and mental ill youth. The findings were contained in two quarterly reports as part of an agreement that ended a U.S. Justice Department lawsuit against the state over conditions at Oakley and Columbia training schools (see ***Jail Suicide/ Mental Health Update***, Volume 12, Number 3, pages 19-20). The state officials, who entered a four-year consent decree with the Civil Rights Division of the Justice Department in May 2005, disagreed and has stressed that they have been working diligently to correct problems. "Many of these findings have been corrected," Don Taylor, executive director of the Department of Human Services (DHS), recently told *The Clarion-Ledge* in Jackson. "We are in compliance in several areas and we have implemented a facility improvement plan to correct the remainder."

The first report, which covered May and June of 2005, acknowledged some improvements at the juvenile facilities and noted "an air of urgency" by the state to meet requirements outlined in the consent decree. However, it also detailed a litany of failings, ranging from dead rodents in a cafeteria storage area to privileges being rescinded arbitrarily. "I observed a bed with springs exposed in a room shared by three girls at Columbia," court monitor Joyce L. Burrell wrote. "I was quite surprised to find it still in the room when I returned a month later." In the second report, which covered the period of August through December 2005, Ms. Burrell wrote that "Although progress was made during this period, it was significantly hampered by the devastating impact of Hurricanes Katrina and Rita on Mississippi in the summer of 2005."

In 2003, the Justice Department sued DHS on behalf of youth after an investigation substantiated allegations that juveniles had been hogtied, punched, left alone for days in a dark room and forced to eat their vomit after exhausting exercises. Last year, the state admitted wrongdoing and agreed to make changes. Under the agreement, in addition to the court monitor, the state agreed to develop suicide prevention, medical, dental, special education and harm prevention programs at a cost of approximately $12 million.

The monitor noted initial medical assessments were not thorough, and staff at both facilities were not properly trained to deal with the range of mental health and suicide risk issues among the youth. State officials have acknowledged many of the problems were the result of chronic under-funding that led to a 35 percent staff vacancy rate. Youth had reported student fights or being physically harmed by correctional officers.

The cafeteria at the Oakley Training School in Raymond was dirty and greasy, and had dead rodents in its storage cabinets, Ms. Burrell found in the first report. In addition, damaged shelves were accessible to juveniles who might hang a sheet or pair of pants for a suicide

attempt. "There were exposed metal bedsprings on a bed without a mattress that could be used as a very dangerous weapon," she said.

DHS Executive Director Taylor said DHS has implemented a training program for staff on de-escalating confrontation, and the Justice Department is offering technical assistance on behavior management this summer. "Nurses are now following protocol. The repairs to the furniture have been made. The bed with exposed springs down at Columbia was an empty cottage, but we've gotten rid of those exposed bed springs. And the cafeteria at Oakley has been cleaned," he told *The Clarion-Ledge*. The report also noted that the state had ended use of the "Dark Room" to isolate and punish girls at the Columbia facility.

But Sheila Bedi, a Mississippi Youth Justice Project attorney who represents Oakley juveniles, said the reports of improvements were not satisfactory. "It's worse than I expected, and I know that the agency in some regards has been under-funded, but there's no amount of money that will stop staff from abusing children," she said. The problem, she said, is the state focuses too much on incarceration and not enough on community-based programs.

In early February, Paulette Pinkham alleged an Oakley employee assaulted her 16-year-old son, Richie. The employee said the youth was required to take off his clothes in order for staff to place a suicide smock on him as a suicide precaution measure. But instead of putting on the smock, he allegedly left the youth naked on the floor bleeding, with a fist mark on his stomach, and cuts on his lip and back of his head, she said. Ms. Pinkham, who claimed her son was not suicidal, said she was frustrated by the conflicting responses when she tried to report the incident to the agency. "He's getting treated worse in there than he would if he was living out on the streets," she told the newspaper. DHS would not comment on the account, citing its on-going investigation. Ms. Bedi said her organization was also looking into the allegation.

In May 2006, the DHS announced that it had reduced the population at the Oakley Training School from 184 to 149, bringing it in line with the staff-resident ratio requirement of the settlement agreement.

South Carolina

In March 2006, Richland County officials announced plans to nearly double medical staffing and increase other spending by 42 percent to help prevent inmate suicides and other problems that plagued the Alvin S. Glenn Detention Center in recent years. The county was in the process of negotiating a $2.7 million annual contract with Correct Care Solutions to provide medical and mental health services to the jail.

"It's unfortunate that it took the deaths of three people to come to this position," Dave Almeida, executive director of the state chapter of the National Alliance on Mental Illness, told *The State*. "Hopefully, this is the end of a very sad chapter." Mr. Almeida had who lobbied the county council to fire the previous health care provider, Prison Health Services (PHS). In September, the county terminated its contract with PHS following concerns about the deaths of three mentally ill inmates (see ***Jail Suicide/Mental Health Update***, Volume 14, Number 2, pages 17-18).

Under the new contract with Correct Care Solutions, the number of full-time medical staff at the jail would increase to approximately 28 from 15 under the PHS contract, county spokeswoman Stephany Snowden said. The jail has a current average population of approximately 1,000 inmates; its capacity is 836. Greg Pearce, council vice chairman, said the proposed contract shows the council is "completely united in that we have an obligation to provide quality medical care in the jail." Mr. Pearce said the county will also have its own nurse and an administrator at the jail to monitor the contract, which had not previously been done.

From July 1, 2001, through Feb. 2006, seven inmates died under questionable circumstances, including an inmate with mental illness who died of complications from hypothermia and two other inmates with mental illness who committed suicide. The families of the three inmates who committed suicide — Bobby Mott, Marc Washington and Antonio Richburg — sued Prison Health Services. Two of the lawsuits were settled last year for a total of more than $600,000. PHS recently settled its part of the Richburg lawsuit for $500,000. In January 2006, 29-year-old Joe Frank Sampedro committed suicide, but he was not thought to have experienced mental illness.

Wisconsin

On May 1, 2006, the Civil Rights Division of the U.S. Justice Department issued a 20-page findings letter to the Governor and state Department of Corrections regarding its investigation of the Taycheedah Correctional Institution, a 680-bed prison in Fond du Lac for female inmates. From May through October 2005, Justice Department attorneys and expert consultants inspected the facility, reviewed documents and interviewed staff and inmates amid allegations of unconstitutional mental health treatment.

Following its investigation, the Justice found that the Taycheedah Correctional Institution: "1) fails to timely and appropriately provide psychiatric treatment, including monitoring of psychotropic medications and performing laboratory tests; 2) fails to provide an adequate array of mental health services to treat its inmates' serious mental health needs; 3) fails to ensure that administrative segregation and observation status is used appropriately; 4) fails to ensure that mental health records are accessible, complete, and accurate; 5) fails to respond to medical and laboratory orders in a timely manner; and 6) fails to ensure that an adequate quality assurance system is in place."

Investigators found numerous example of inadequate mental health treatment, particularly in the area of crisis intervention:

> "We observed that a large number of Taycheedah's inmates are severely psychotic, imminently suicidal, or physically aggressive, due to decompensation of their conditions. Their decompensation is no doubt due, in part, to the lack of programming and use of segregation to control behaviors associated with their illnesses. We noted a large void in crisis services available to inmates, resulting in actual harm and significant risk of harm. As is typically the case where no other alternative exists, Taycheedah staff resort to the use of segregation and observation status to control inmates' dangerous

behavior, which not only fails to solve the problem, but often exacerbates it.

For example, on June 19, 2005, Inmate #58 fatally asphyxiated herself while in administrative segregation. This inmate was severely mentally ill, exhibiting almost daily incidents of aggression and self-injurious behavior, using virtually any property she could access to harm herself. She swallowed pen inserts and other solid objects, resulting in numerous trips to the emergency room. She went on periodic hunger strikes, during which she would refuse to ingest food and liquids for days at a time. This inmate had only recently returned to Taycheedah at the time of her death, after a long stay at Winnebago. She was discharged from that facility when it was determined that she could no longer benefit from the services and her behavior was too difficult to manage in the less secure environment. Inmate #58 clearly needed an intensity of mental health services that the State was unable to provide given the current options for incarceration of seriously mentally ill female inmates.

Inmate #51 has a very severe degree of mental illness and exhibits serious suicidal ideation. She has been back and forth between Winnebago and Taycheedah for over a year. Her behavior is difficult to manage in both facilities because of her serious attempts at self-mutilation. She expressed her ability to manipulate both institutions when she stated, 'I know what to do to get back to Winnebago.' However, Winnebago staff members state that after significant attempts, they have no further treatment options that will improve her condition; thus, they send her back to Taycheedah. At the time of our second visit to Taycheedah, this inmate was under one-on-one supervision, while in observation status, to prevent her from hurting or killing herself. None of the staff members we spoke with regarding this inmate believe that she is receiving appropriate treatment, yet noted that they had no better alternative.

This inmate is also in need of therapeutic treatment, such as individual and group counseling, that Taycheedah does not presently offer. Taycheedah's failure to provide alternatives to manage psychiatric emergencies is unacceptable."

The Justice Department also found that prison staff inappropriately utilized segregation for inmates with severe mental illness: "Taycheedah's use of administrative segregation and observation status for inmates with severe mental illness violates their constitutional rights because Taycheedah imposes a significant penalty on inmates whose behaviors are symptomatic of their mental illness." For example:

"We found that many inmates at Taycheedah with mental illness are placed in administrative segregation due to threats or attempts to kill themselves. During our review of inmate disciplinary charges which resulted in segregation, we found that, as a result of attempting to harm themselves with writing instruments or parts of mattresses, certain inmates had been charged with "misuse of state property" (i.e., facility writing instruments and mattresses). Executive staff corroborated this finding by informing us that inmates are sometimes charged with self-abuse as a disciplinary infraction. Punishing inmates for behaviors that they lack control over is ineffectual and destructive, but appears to be a practice that Taycheedah consistently resorts to because of the lack of appropriate alternatives."

In order to address the constitutional deficiencies identified above and to protect the constitutional rights of inmates at the Taycheedah Correctional Institution, the Justice Department recommended implementation of the following remedial measures:

- Provide adequate on-site psychiatry coverage for inmates' serious mental health needs. Ensure that psychiatrists see inmates in a timely manner and that psychotropic medication orders are reviewed by a psychiatrist on a regular, timely basis;
- Ensure that medications are provided to inmates in a timely manner and that they are properly monitored;
- Provide nurse staffing adequate for inmates' serious mental health needs. Ensure that nursing functions, such as distribution of medications, are performed by nurses or other properly trained staff;
- Provide adequate on-site psychology coverage to ensure that psychologists see inmates in a systematic and timely manner to evaluate inmates for their serious mental health needs. Provide adequate staffing to ensure timely and appropriate mental health screening and referrals;
- Provide an adequate array of mental health programming, including individual and group therapy, to meet inmates' serious mental health needs and prevent decompensation and mental health crises;
- Ensure that adequate crisis services are available to address the psychiatric emergencies of inmates;
- Provide adequate programming in the Monarch Unit to meet inmates' critical mental health needs;
- Ensure that administrative segregation and observation status are not used to punish inmates for symptoms of mental illness and behaviors that are, because of mental illness, beyond their control;
- Ensure that Taycheedah's mental health records are centralized, complete, and accurate;
- Ensure timely responses to orders for medication and laboratory tests and prompt documentation thereof in inmates' charts; and

- Ensure that Taycheedah's quality assurance system is adequate to identify and correct serious deficiencies with the mental health system.

Coming at the heels of the Justice Department investigation, the American Civil Liberties Union (ACLU) also recently charged that the state prison system puts the lives of Taycheedah Correctional Institution inmates at risk through grossly deficient medical care and provides far inferior mental health treatment as compared to men. The class-action lawsuit, also filed on May 1 seemingly to coincide with the Justice Department findings letter, requested the court to order reforms to the system so that constitutionally adequate care is made available. "When the government puts someone behind bars, it has an obligation to provide humane treatment," said Gouri Bhat, a lawyer with the National Prison Project. "The women at Taycheedah are in prison to pay their debt to society, not to be subjected to untreated disease and premature death. But that is exactly what they are enduring at Taycheedah."

The complaint, entitled *Flynn v. Doyle*, summarizes the allegedly inadequate health care provided to several named plaintiffs in the case. One of the plaintiffs, Debbie Ann Ramos, was not seen by a gynecologist for seven years after arriving at Taycheedah, despite a diagnosis of chronic endometriosis and progressively worsening vaginal bleeding. Ms. Ramos ultimately needed a hysterectomy that might have been avoided by timely care, according to the complaint. Another inmate, Tammy Young, developed painful, bleeding sores on her scalp in November 2003. Despite her repeated requests for treatment for more than 18 months, the medical staff at Taycheedah failed to test Ms. Young for MRSA, a highly contagious form of staph infection that plagues prisons and other institutions. Today, numerous inmates at Taycheedah are allegedly infected with MRSA. Plaintiff Kristine Flynn had received no group or individual therapy in five years at Taycheedah, even though she had been diagnosed with Bipolar Disorder. Ms. Flynn attempted suicide six days after her eight medications were abruptly discontinued by mental health prison staff. And Vernessia Parker, another plaintiff who had been suicidal, was found by a court to be in need of in-patient mental health treatment, but has never left Taycheedah. She rarely saw mental health staff and her requests for crisis intervention went unanswered for weeks

"These situations are not isolated mistakes," said Larry Dupuis, the ACLU of Wisconsin's legal director. "They are manifestations of a system that has been in crisis for years, and the state has made no meaningful effort to address its underlying problems." According to Chris Ahmuty, the ACLU of Wisconsin's executive director, "It is time for Wisconsin to live up to its constitutional obligations to provide decent health care to women in its custody," said "Since the legislature and the administration can't muster the political will to do so voluntarily, we are asking the courts to order these reforms, before more women suffer and die unnecessarily."

The 20-page findings letter of the Justice Department's *Investigation of the Taycheedah Correctional Institution* can be accessed at the Justice Department's website: http://www.usdoj.gov/crt/split/documents/taycheedah_findlet_5-1-06.pdf ❑

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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