JAIL SUICIDE/MENTAL HEALTH UPDATE

(A joint project of the National Center on Institutions and Alternatives and the National Institute of Corrections, U.S. Department of Justice)

Winter 2006 **Volume 15 • Number 3**

MODEL SUICIDE PREVENTION PROGRAMS PART III

In September 1998, Scotty Sisk, a 22-year-old football player at Washburn University in Topeka, Kansas, was arrested by sheriff's department deputies on several serious charges, including an alleged sexual assault against his girlfriend. He eventually pleaded guilty several months later to disorderly conduct and criminal damage to property. Mr. Sisk was sentenced to 12 months probation with conditions that included a protective order not to have any further contact with the victim. He and his girlfriend, however, continued to have consensual contact and Mr. Sisk was eventually charged with telephone harassment and other violations of his probation. In June 1999, he was convicted on two counts of violating a protective order and sentenced to 12 months confinement in the Shawnee County Department of Corrections in Topeka, Kansas.

Mr. Sisk entered the Shawnee County Adult Detention Center on July 2, 1999. During the initial intake medical screening, he denied having any history of suicidal behavior or current suicidal ideation. Several days later, however, a shift supervisor at the jail received a telephone call from Mr. Sisk's mother stating that her son had threatened suicide during their telephone conversation and had written a suicide note that was to be given to the family following his death. The shift supervisor assured Mrs. Sisk that he would look into the matter and that her son would not be given the opportunity to commit suicide. The supervisor then instructed an officer to inspect Mr. Sisk's cell for the alleged suicide note. A short time late, the note was found in the cell and stated, in part, that:

> *"…Each day I feel more tempted to end my life to stop the pain and loneliness, but the only reason I have not is not wanting to hurt my parents anymore, but I feel they are better off without me around. I feel worthless…I feel as if I drag everything around me down. I love my family more than anything and I pray they do not cry over me, only enjoy the positive memories if any remain…"*

After reading the note, the officer talked with Mr. Sisk's cellmate who suggested that he "had been acting strange, sleeping all the time, giving away his food, not eating." The cellmate also told the officer that Mr. Sisk "made a statement today about being so angry he felt like taking a gun and shooting his girlfriend and then shooting himself." The officer reported this information to his supervisor and Mr. Sisk was subsequently placed on suicide precautions in the medical unit.

According to policy, there were two levels of suicide risk for inmates housed in the Shawnee County Adult Detention Center — "low risk" and "high risk." Mr. Sisk was considered to be a "high risk" for suicide. Pursuant to jail policy, he was to be housed in a protrusion-free cell, stripped of his clothing and issued a paper gown, mattress and blanket, and observed by closed circuit television (CCTV) at 15-minute intervals.

Mr. Sisk was placed in a medical unit cell at approximately 8:50pm on July 6, 1999. According to the observation sheet, he was observed at 15-minute intervals until 11:30pm when he was found dead in his cell by two officers. According to the officers, Mr. Sisk was found hanging by a strip of blanket that was tied around his neck and to a wall plate. Cardiopulmonary resuscitation was initiated and Mr. Sisk was later transported to a local hospital and pronounced dead.

On July 8, two days following Scotty Sisk's suicide, then Jail Director Thomas Merkel told a local newspaper reporter that the death was not preventable and the "policies and procedures that we have in place are appropriate….Upon review of this situation, the conduct (of jail staff) certainly was reasonable. Sort of what we've done, I don't know what you can do."

In early June 2000, the parents of Scotty Sisk filed a lawsuit in the United States District Court for the District of Kansas alleging that the Shawnee County Department of Corrections and several officers were both negligent and deliberately indifferent for not preventing his suicide. Later that same month, another inmate (Ernest Page) committed suicide by hanging in the facility. Two other inmate suicides would occur in the jail before the Sisk trial in 2003 — James Roberts in December 2001 and Anthony Stapleton in November 2002.

On April 15, 2003, the Sisk trial began in the federal courthouse in Topeka against several jail officers. The case against the

INSIDE. . .

county department of corrections was dismissed as a result of a legal technicality. The evidence presented at trial clearly established that Mr. Sisk's suicide was preventable. For example, although identified as a high risk for suicide, he was placed on observation at 15-minute intervals, not constant observation. In addition, although required to also be monitored by CCTV, there were not any staff assigned to monitor the CCTV equipment. Although issued a paper gown, Mr. Sisk was permitted to retain a blanket. Contrary to policy, he was housed in a cell that was not "protrusion-free." Finally, evidence was presented that disputed the testimony of officers that 15-minute observation rounds were conducted as required. Notations on the observation sheet were highly suspicious, with times and inmate behavior crossed out and rewritten around the time Mr. Sisk was found hanging. A nurse testified that she did not observe any officers in the medical unit for well over an hour between 10:30 and 11:30pm on July 6, 1999.

On April 22, 2003, following six days of testimony, the federal jury found that four correctional staff were negligent for the death of Scotty Sisk and awarded $10 million to his family. The judge later reduced the award to $250,000, citing a state law that capped awards arising from negligence verdicts. Several months later in October 2003, another inmate committed suicide in the Shawnee County Adult Detention Center — bringing the total to five deaths in five years at the450-bed facility.

Why do some jail systems experience an inordinate number of inmate suicides or deaths attributed to obvious deficiencies while others of comparable size are spared the tragedy? Some observers would call it good fortune, while others believe that "attitude" and comprehensive policies and procedures are the keys to suicide prevention in correctional facilities (Hayes, 2005). The ***Update*** *has continually stressed that negative attitudes (e.g., "If someone really wants to kill themselves, there's generally nothing you can do about it") impede meaningful jail suicide prevention efforts.*

Our most loyal readers will recall that the ***Update*** *profiled model jail suicide prevention programs in both 1998 and 2005. Continuing with this issue, we will be periodically revisiting the topic by examining model suicide prevention programs operating in jail systems of varying sizes throughout the country. Programs will be evaluated (and on-site case studies conducted) according to the following criteria:*

- *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.*

We continue our special series by highlighting the suicide prevention program currently operating within the Shawnee County Adult Detention Center in Topeka, Kansas, site of the Scotty Sisk suicide.

NATIONAL STUDY OF JAIL SUICIDES

Through a cooperative agreement with the National Institute of Corrections (NIC), U.S. Justice Department, the National Center on Institutions and Alternatives (NCIA) is currently conducting a national study on jail suicides. The 18-month project, representing the third such national study conducted by NCIA for NIC (e.g., see *And Darkness Closes: A National Study of Jail Suicides* in 1981 and the *National Study of Jail Suicides: Seven Years Later* in 1988), will determine the extent and distribution of jail suicides (i.e., city, county, and police department facilities) during 2005 and 2006, and gather descriptive data on demographic characteristics of each victim, characteristics of the incident, and characteristics of the jail facility which sustained the suicide. NCIA will then develop a report of the findings to be utilized as a resource tool for both jail personnel in expanding their knowledge base, and correctional (as well as mental health and medical) administrators in creating and/or revising policies and training curricula on suicide prevention.

Data provided by individual agencies/facilities will be coded and held in the strictest confidence. Results of the study will be presented in summary fashion, thus preventing the linkage of any data to the particular agency/facility from which the information originated.

Initial surveys will be distributed in early 2007. Both NIC and NCIA would greatly appreciate the cooperation of all agencies/facilities receiving the initial survey request. For further information on the project, please contact Lindsay M. Hayes, Project Director, NCIA, 40 Lantern Lane, Mansfield., MA 02048, (508/337-8806), e-mail: lhayesta@msn.com

Shawnee County Department of Corrections

Built in 1987 and expanded in 1998, the Shawnee County Adult Detention Center (SCADC) in Topeka, Kansas is a direct supervision facility with a 557-bed capacity. Its average daily population is between 450 and 460 inmates. Until Scotty Sisk's 1999 suicide, the last suicide in the facility occurred in 1990. As can be seen by Table 1, the Sisk death was followed by four other suicides in consecutive years. The department of corrections was also plagued with other serious problems, including inmate escapes and sexual harassment of both staff and inmates from other staff. By August 2000, the county commissioners had had enough and sought a new management team for the facility. They chose Elizabeth Gillespie, former warden of Larned Correctional Mental Health Facility within the state department of corrections, as the new jail director.

Average Daily Population and Inmate Suicides 1997-2006*

Year	Average Daily Population	Suicides	Rate
1997	246	0	0
1998	298	0	0
1999	334	1	299.4
2000	372	1	268.8
2001	374	1	267.3
2002	381	1	262.4
2003	448	1	223.2
2004	422	0	0
2005	450	0	0
2006	460	0	0
1997-2006	**3,775**	**5**	**132.4**

Attitude Changes

A 32-year veteran of prison systems, Ms. Gillespie had limited experienced working in a jail environment. But she was hired as a change agent and wasted little time in addressing inadequate suicide prevention practices. First, she assigned an officer to the third (overnight) shift in the medical unit where Mr. Sisk had died. She then assigned an officer to a permanent post of observing inmates on suicide precautions. Two modules were identified for housing suicidal inmates and retrofitted to ensure they were "protrusion-free."

The Shawnee County Community Mental Health Center (SCCMHC), which previously had little involvement with the local jail system, began providing both mental health and suicide prevention training to correctional staff. SCCMHC was then asked to develop a new suicide prevention policy for the facility. The revised policy included an additional level of observation at four (4)-minute intervals for high risk suicidal inmates, as well as a requirement that inmates would be downgraded and discharged from suicide precautions *only* by a qualified mental health professional (QMHP). The only problem — the Shawnee County Adult Detention Center did not have any QMHP staff at the time.

Several months later in April 2001, a social worker was hired from the local county health agency. Another masters-level clinician came on board several months later from a vacated deputy director position. A third clinical position was filled when a corrections counselor at the facility became certified as a QMHP. In June 2004, county commissioners funded a fourth position. Thus, in the span of four years, Director Gillespie created a four-member mental health team within the Department of Corrections. Currently, three clinicians are assigned to the Adult Detention Center and one to the adjoining 70-bed Juvenile Detention Center.

Yet perhaps the most important change in the Shawnee County Adult Detention Center was the attitude. Remember the reaction to Scotty Sisk's suicide in July 1999 by then Jail Director Thomas Merkel: "Policies and procedures that we have in place are appropriate….Upon review of this situation, the conduct (of jail staff) certainly was reasonable. Sort of what we've done, I don't know what you can do." Upon her arrival, Elizabeth Gillespie created a "zero tolerance for offender suicides within the Department of Corrections" which was written into policy. The policy actually instructs that "Staff shall *never* make statements such as 'If an inmate truly wants to commit suicide, there is nothing we can do to prevent it' or 'If a person wants to kill himself, he will eventually succeed.'"

Beyond the written policy statement, Director Gillespie deeply believes in suicide prevention and offers her brethren around the country the following:

> "A sheriff or jail administrator that is truly determined to prevent all suicides will find ways to do so. The determined administrator will ask for help from the experts, step back to analyze, and find a way to make it happen. The resolution may not look like anything done before. It may be an adaptation of another detention center's policy. The most important part is the administrator's drive or desire to succeed and how well he/she motivates staff to believe in and share the same goal.
>
> And it doesn't stop there! The sheriff or jail administrator must convince the governing body to authorize funding for more staffing, equipment, and physical plant improvements as necessary. A skilled administrator recognizes the value of honest communication and cooperative working relationships with the members of the governing body and will obtain their support for suicide prevention needs. The administrator can never be deterred in the challenge to win!"

The Suicide Prevention Program

With the assistance of a consultant, Director Gillespie completely revamped the SCADC's suicide prevention program. The 17-page written policy is divided into the following procedural sections: observation of suicide risk factors, screening for risk of suicide, intervention to prevent suicide, suicide watch status, close observation status, removal from suicide watch and

close observation status, response to attempted suicides/medical emergencies, and follow-up evaluation. The real strengths of the SCADC program — intake screening/assessment and observation levels — are highlighted below.

Intake Screening/Assessment

Upon admission to the Shawnee County Adult Detention Center, all inmates are screened by booking, medical, and classification personnel. During booking, inmates are asked if they have "attempted suicide" in the past and "are considering it now?" Regardless of the responses to these questions, any inmate who was on suicide precautions in the SCADC during the previous 12-months is referred to the shift supervisor for further screening. In addition to the initial intake screening by booking staff, a *Receiving Screening Form* is completed by medical personnel from Prison Health Services, the facility's medical contractor. In addition to medical and mental health questions, intake nursing staff makes the following inquiry regarding suicide risk:

Have you ever considered or attempted suicide?
Do you feel there is nothing to look forward to in the future?
Have you recently thought about hurting or killing yourself?
Do you have plans now to hurt yourself?

All inmates are also assessed by classification staff. Questions related to suicide risk and mental illness on the *Initial Classification Listing* form includes the following:

Ever attempted suicide?
Had thoughts of hurting yourself?
Thinking of hurting yourself now?
How would you attempt suicide?
Do you have the means to do so now?
Recent loss/death of loved one?
Diagnosis of mental illness?
Taking psychotropic medication?
Past in-patient mental health care?

As a result of a suicide involving miscommunication between the local police department and SCADC booking staff regarding an inmate's threats of suicide made during arrest, the department developed a *Law Enforcement Referral of Possible Suicide Risk* form (see page 5). The form is completed by the arresting officer or other referring source when the arrestee/inmate's mood, behavior, and/or situational risk factors are indicative of possible suicide risk. Inmates with positive responses on the form are referred to the shift supervisor for further screening.

Following the initial booking process, any positive responses from screening provided by booking, classification, or medical personnel, as well as outside agencies, are reported to the shift supervisor who then directs a line supervisor or other certified screener to complete a *Suicide Risk Screening Form* on the referred inmate. The form, modeled after the well recognized New York State's *Suicide Prevention Screening Guidelines* form (see ***Jail Suicide/Mental Health Update***, Volume 14, Number 1, Summer 2005, page 6), contains 21 lines of inquiry regarding suicide risk. Affirmative responses to the following questions result in placement on suicide precautions:

- Information has been received from an outside source (i.e., family, friend, attorney) that the inmate might be suicidal.
- Arresting or transporting officer believes that the inmate may be suicidal risk based upon the completed law enforcement referral form.
- Is the alleged crime shocking in nature and/or domestic and was the inmate arrested within the past 72 hours?
- Does the inmate hold a position of respect within the community (professional, public official) and was the inmate arrested within the past 72 hours?
- Have you attempted to commit suicide within the past 5 years?
- Are you now thinking about killing yourself?
- Does the inmate feel that there is nothing to look forward to (expresses feelings of hopelessness)?
- Does the inmate appear to be unusually embarrassed or ashamed?
- Is the inmate's present state of mood excessively sad or unhappy (extremely quiet, withdrawn, unresponsive, cry uncontrollably)?
- Has a suicide note, a noose, or other physical evidence of suicide intent been discovered recently?
- Have you been hospitalized within the past year for psychiatric care and treatment or are you currently taking any psychiatric medications?

The SCADC maintains a low threshold for placement of inmates on suicide precautions. For example, approximately 1,200 new arrestees are admitted into the facility each month, with an average of 160 inmates (roughly 13 percent) initially placed on suicide precautions from the screening process. All *Suicide Risk Screening Forms* are reviewed for accuracy by David Coleman, one of three QMHP staff at the facility and considered the Lead Social Worker.

A review of various forms indicates that many inmates are not placed on suicide precautions because they threatened suicide, but because of other concerning behavior. In fact, it is not unusual to find inmates on suicide precautions that had denied any suicidal ideation. For example, inmate K.P denied any suicidal ideation at booking, but was placed on suicide precautions after staff were informed that he attempted suicide two months earlier, was expressing some feelings of hopelessness, and had banged his head on the patrol car window several times following arrest. Inmate E.G. denied any current or prior suicide ideation, but was placed on suicide precautions because he was intoxicated and booking staff determined he had been on suicide precautions during a recent prior confinement in the SCADC. Inmate T.T. denied any

Shawnee County
Department of Corrections
501 SE 8TH Street – Topeka, Kansas 66607 – (785) 291-5100 / (785) 233-7765 fax

Law Enforcement Referral of Possible Suicide Risk

Subject Name: _____ Booking # _____ Agency Case # _____

Due to personal observation and/or information provided, the undersigned requests that the above-named subject be evaluated for risk of suicide. The factors marked below constitute all of what was observed and/or provided, and are the sole basis for this request:

[NOTE: This is not an assessment tool, but a form to provide information to the Department of Corrections]

Source of Information: For each marked box under Section A or B below, identify the source of the information, using the numeric code from the list to the right (e.g., #1=arresting officer). Provide the name and contact number for each source in the narrative section to facilitate follow-up.

Source Codes
1. Arresting officer
2. Subject's spouse, friend, or other family member
3. Subject's probation or parole officer
4. Official(s) of other law enforcement or corrections agency
5. Other arrested person or co-defendant
6. Victim or victim's spouse, friend or other family member
7. Other: _____

A: Mood/Behavior:	Source Code	Narrative:
☐ Withdrawn/non-responsive/depressed		
☐ "Hyper" or "manic"		
☐ Highly agitated or upset		
☐ Sudden mood change (agitated-calm)		
☐ Behavior bizarre or "out-of-touch with reality"		
☐ Self destructive/suicidal behavior or comments		
☐ Other: _____		

B: Situational Risk Factors:	Source Code	Narrative:
☐ Recent severe life crisis (e.g., divorce, health)		
☐ First time offender (if known)		
☐ Arrested for murder or other violent crime		
☐ Person with high standing in community		
☐ Alcohol or drug withdrawal		
☐ Victim/possible victim of same-sex rape		
☐ Arrested for "crime of passion"		
☐ Arrested for crime against child		
☐ Past suicide attempt(s) (if known)		
☐ Other: _____		

Officer Name:	ID Number:	Agency:	Signature:	Date:

suicidal ideation at booking, but was placed on suicide precautions for several reasons — he was intoxicated, reported his mother had committed suicide, and was overly concerned about making bond, began crying, and stated he "wouldn't make through the night." Finally, although inmate M.C. answered "no" to every intake screening question, he was placed on suicide precautions after being observed acting in a strange manner, smiling inappropriately, and mumbling to himself during the booking process.

Following placement on suicide precautions, each inmate is assessed daily by mental health staff. A *Suicide Risk Assessment Form* is utilized when an inmate is downgraded and/or discharged from suicide precautions. The form contains numerous areas of inquiry, including reason for assessment, physical appearance and behavioral observation during interview, personal and family history, history of drug and alcohol abuse, current legal status, support systems, past history and current suicidal behavior, psychiatric and physical health, intelligence/orientation, evaluation of risks/strengths, and treatment plan. Following the assessment, the clinician discusses the findings informally with a "team" comprised of other clinicians, housing unit officers, correctional supervisors, and medical staff. Although all decisions regarding downgrading, discharging, or maintaining an inmate on suicide precautions rests with mental health staff, input is always solicited from, and received by, both correctional and medical personnel.

Increased Supervision

Given the inadequate system of observing suicidal inmates at the time of Scotty Sisk's death, the SCADC suicide prevention policy was revised to include two levels of observation:

Suicide Watch: Continuous supervision provided to an inmate who is considered to be at imminent risk for suicide. The inmate shall be assigned to a multi-bed cell (8 beds maximum) with or without other inmates on suicide watch. An officer shall be assigned to provide continuous, uninterrupted supervision of all inmates assigned to the cell. When the shift supervisor or mental health professional determines that the inmate must be housed in a single-cell, the inmate shall be assigned to a protrusion-free cell. The officer assigned to suicide watch duties for a maximum of four (4) inmates in protrusion-free cells shall observe the inmate(s) frequently, at least every four (4) minutes. When all protrusion-free cells are occupied or other circumstances provide the need for alternate housing, the inmate shall be placed in a single-cell with one officer assigned to observe the inmate on a continuous, one-on-one basis.

Close Observation: Close monitoring and supervision of an inmate who is not considered imminently suicide but who possesses one or more suicide risk factors. One male and one female living unit shall be designated for the assignment of inmates to Close Observation status. Staff shall observe these inmates with greater frequency than the general population, but at a minimum, shall conduct 15-minute health and well-being checks of inmates on this status.

Although most suicidal inmates can be safely housed in either K Module (a male unit housing six 8-bed cells) or Y Module (a female unit housing 2-bed and 4-bed cells), inmates that need single-cell housing can relocated to the medical and segregation units. Inmates on suicide precautions are *not* on lock-down status or managed as segregated inmates unless they receive a disciplinary sanction for unrelated behavior. As such, inmates on suicide precautions are permitted out of their cells and into the dayroom area up to 10 hours per day and allowed such routine privileges as commissary, newspapers and other reading materials, writing materials, visits, telephone calls, and showers. Inmates on Suicide Watch are prohibited from having any property *inside* their cells. Meals are served in the dayroom area. Commented on officer who was assigned to the K module on a two-hour rotation, "These inmates are a lot better when they're out of their cells."

On any given day, there can be approximately 25 inmates on Close Observation and Suicide Watch. Although length of stay statistics are not kept, inmates may remain on suicide precautions between 24 hours and several weeks. When asked if there was pressure to move inmates quickly through the process, Mr. Coleman responded — "never." He stressed that "without pressure from the administration to move inmates out of suicide prevention beds, mental health staff can work with individuals as long as it takes. We do not have to take unnecessary risks with them. We are able to intervene before an inmate becomes imminently suicidal rather than waiting for a suicidal act or threat to take place. Actual attempts at suicide have been reduced with this pro-active, wide-net approach."

In addition, given the strong relationship between suicide and isolation, as well as a disproportionate number of suicides occurring in "special housing units" in jails throughout the country, Director Gillespie increased the frequency of cell checks in segregation, medical, and classification units to 15-minute intervals, while requiring all other housing units to be patroled at 30-minute intervals. In addition, all inmates taking psychotropic medication are placed on Close Observation status. In 2005, a hand-held computerized Guard Tour system was instituted to ensure better reliability of officers' rounds in the facility.

A Case Study

Perhaps the story of Gary Thornton best illustrates SCADC's suicide prevention efforts. Mr. Thornton (a pseudonym), 59-years-old, was booked into the SCADC on April 29, 2005 after his bond was revoked pertaining to a Driving Under the Influence (DUI) arrest in which his girlfriend was killed. Prior to the arrest, Mr. Thornton, had been hospitalized for a broken shoulder and back injuries sustained during the accident. He had several prior arrests for DUI and other less serious offenses.

Mr. Thornton was married to a woman who was bedridden following two strokes. She was also a severe alcoholic. Following the arrest, he was unable to contact her because of a block on the telephone. Mr. Thornton was also a veteran who had served three tours of duty in Vietnam. Following his military duty, he started a lengthy career in the aerospace industry. Mr. Thornton periodically struggled with depression and post traumatic stress disorder. During the past few years, his

alcoholism worsened, he lost his job, and was collecting disability.

Upon booking on April 29, the arresting officers completed a *Law Enforcement Referral of Possible Suicide Risk Form* on which the officer relayed to SCADC staff that Mr. Thornton had been involved in an automobile accident in which his girlfriend was killed. He had told hospital staff that he wanted to kill himself because his passenger died. That statement resulted in a *Suicide Risk Screening* by a SCADC supervisor and subsequent placement on Suicide Watch, the facility's highest level of observation. Mr. Thornton was escorted to the Medical Unit, housed in a single cell due to injuries sustained in the accident, and observed by an officer on a continuous, uninterrupted basis.

Mr. Thornton was subsequently assessed by the "lead social worker" of the mental health team and continued to express suicidal ideation. He remained on this status for several weeks as he continued to struggle with various legal and personal issues. Mr. Thornton realized he could be sentenced to prison, as well as face a civil lawsuit from the victim's family. He was frustrated regarding the limited contact with his attorney, and depressed over the loss of his girlfriend. He continued to complain of pain from his broken shoulder and back injuries. Mr. Thornton was subsequently assessed by the facility psychiatrist and prescribed psychotropic medication for his depression.

By June 2005, Mr. Thornton began denying continued suicidal ideation and requested to be removed from suicide precautions. He had grown tired and bored of the isolation within the Medical Unit and was looking forward to a visit and possible reconciliation with his wife. Following a *Suicide Risk Assessment* by the lead social worker on June 8 and subsequent discussion with the clinical team, Mr. Thornton status was downgraded from Suicide Watch to Close Observation and he was re-housed in K Module. Under this status, he was seen on a regular basis by mental health staff, including the psychiatrist, required to remain in the unit's dayroom when not sleeping at night, and encouraged to interact with other inmates.

> Many inmates are not placed on suicide precautions because they threatened suicide, but because of other concerning behavior.

During his stay in K Module on Close Observation status, Mr. Thornton continued to struggle with his legal and personal issues. He awoke one morning and read in the newspaper that the district attorney had filed new charges against him for the death of his passenger (girlfriend). He was facing at least a minimum 10-year prison sentence. Mr. Thornton was upset that he had not first learned the information from his attorney. He was very anxious regarding his upcoming court hearing and angry at his attorney's infrequent visits. He also struggled to get along with his cellmate, a known antisocial individual. Throughout this period, however, he was able to process these issues with mental health staff on a regular basis.

In July 2005, Mr. Thornton's suicidal ideation finally ended and he was removed from Close Observation status. At the recommendation of mental health staff, however, he remained housed in K Module as a general population inmate. This housing assignment provided a calmer environment with regular access to mental health staff. In December 2005, Mr. Thornton completed a five-week alcohol/drug treatment program at the facility. He was subsequently released on bond from the SCADC on April 26, 2006.

Mr. Thornton returned to the SCADC a week later on May 3, 2006 when his bond was revoked after his trial ended with a deadlocked jury verdict. During the intake process, the booking officer recognized him from the prior confinement and a referral was made for *Suicide Risk Screening* by the supervisor. He was subsequently housed in general population. Mr. Thornton was again released on bond with strict conditions (of house arrest and abstinence from alcohol and drugs) on July 27. The bond was again revoked a week later on August 2 when he was found guilty of involuntary manslaughter. Upon his return to the SCADC, Mr. Thornton was placed on Close Observation status for one day. On September 22, he was sentenced to over 13 years in prison. Upon his return from court that day, Mr. Thornton was again assessed by mental health staff. Found to be stable, he was again housed in the general population section of K Module. On October 26, 2006, Mr. Thornton was transferred to the state department of corrections. SCADC staff provided prison officials with information regarding his history of suicidal ideation and mental illness.

Conclusion

In February 2007, Elizabeth Gillespie resigned her position as SCADC Director to take a similar position in a neighboring county. Among her proudest accomplishments was the development of the facility's comprehensive suicide prevention program. Although her leadership in this area will be missed, the extraordinary commitment to suicide prevention within the Shawnee County Department of Corrections lives on. In summarizing the program, Lead Social Worker David Coleman stated that "our suicide prevention program is holistic in the sense that we are going to look at all of the issues that influence a person's potential for self harm. It is part of a commitment to our zero tolerance policy towards suicide and sends the message that suicide prevention is extremely important. Suicide prevention is not an activity that we engage in only when we have to or when it is impossible to ignore. It is an activity for which we are pro-active with every inmate every day. In order to do that, we cast a wide net from intake and throughout each inmate's stay here. We teach *all* staff to recognize the signs of depression and to be attentive to more than what is said. Officers and other staff are encouraged to request screens for suicide risk. There is a sense of pride in our record of suicide prevention, and it is communicated to all staff that suicide prevention is one of the most important activities that we engage in."

For more information on suicide prevention efforts at the Shawnee County Adult Detention Center, contact Richard C. Kline, Deputy Director, Shawnee County Department of Corrections, 501 SE 8th Street, Topeka, Kansas 66607, (785/291-5000) or e-mail: richard.kline@snco.us; or David Coleman, Lead Social Worker, Shawnee County Department of Corrections, 501 SE 8th Street, Topeka, Kansas 66607, (785/291-5000) or e-mail: david.coleman@snco.us ❑

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.

Pennsylvania

On October 19, 2006, Jeremy Shane Corbin was placed in a Blair County Courthouse holding cell awaiting a court appearance. He was crying and threatening suicide. He was charged with violating a protection-from-abuse order. "He said it a bunch of times. He wanted to kill himself," Deputy John Higgins told the *Altoona Mirror*. Deputy John Miller, who also escorted Mr. Corbin to court, said the inmate threatened to kill himself "a couple of times." The sheriff's deputies reported the suicide threats to facility personnel when Mr. Corbin was returned to the Blair County Prison in Hollidaysburg.

Mr. Corbin was found dead in his cell with a bed sheet around his neck the following afternoon. Prison Warden Donald Ott insisted all procedures were followed. Mr. Corbin first was placed in a cell where he was checked every 15 minutes, according to the warden. He was then evaluated by the prison's mental health worker after the court appearance and then placed in general population. Charles Bellon, one of the victim's cellmates, found Mr. Corbin hanging in the cell. In a letter to the *Altoona Mirror*, Mr. Bellon said he warned Blair County Prison officials of a possible suicide attempt. "They didn't listen. It still haunts me. You don't see a dead body every day in the cell you still sleep in," he wrote. Warden Ott stated he would meet further with PrimeCare, the facility's medical provider.

Florida

For years, circuit judges here have ordered state officials to obey Florida law and promptly transfer severely mentally ill inmates from jails to state hospitals. But with few hospital beds available, Governor Jeb Bush's administration began flouting those court orders in August. Now, in a growing standoff between the government of Florida and its judges, the state is being threatened with steep daily fines if it does not comply. And at least one judge has raised the possibility that the secretary of the Florida Department of Children and Families could go to jail for contempt of court. "This type of arrogant activity cannot be tolerated in an orderly society," Judge Crockett Farnell of Pinellas-Pasco Circuit Court wrote in an October 11 ruling.

State law requires that inmates found incompetent to stand trial be moved from county jails to psychiatric hospitals within 15 days of the state's receiving the commitment orders. Florida has broken that law for years, provoking some public defenders to seek court orders forcing swift compliance. With the state now rebuffing even those orders, a rising number of mentally ill inmates, now more than 300, have been left without treatment in crowded jails because the state's 1,416 psychiatric beds are full.

Two mentally ill inmates in the Escambia County Jail in Pensacola died over the last year and a half after being subdued by guards, according to news reports. And in the Pinellas County Jail in Clearwater, a schizophrenic inmate gouged out his eye after waiting weeks for a hospital bed, his lawyer said.

Public defenders in Miami-Dade County describe psychotic clients who have hallucinated, mutilated themselves and attempted suicide while awaiting transfer to hospitals. The state says that shortages of beds and financing have made compliance impossible, and that court orders forcing the transfer of certain inmates are unfair to those who have waited longer.

Most judges have responded skeptically, asking why the Department of Children and Families has not sought more state money as the number of committed inmates has soared. The agency cut its budget by $53 million this year, which public defenders say makes no sense given the inmate crisis and the state's $8 billion budget surplus.

In one of the toughest rulings to date on the subject, Judge Farnell said last month that he would start fining the department $1,000 a day for each mentally ill inmate who stayed in the Pinellas County Jail longer than 15 days. The judge, based in Clearwater, expressed outrage about the agency's "conscious decision" to ignore court orders.

Judges in Broward, Hillsborough and Miami-Dade Counties are also weighing motions to force the department to comply with the law or to hold it in contempt for letting the mentally ill pile up in unsuitable jails. The department appealed after three state judges in Miami ordered it to take custody of several inmates last month, but a panel of the Third District Court of Appeal indicated last week that it might rule against the department and its secretary, Lucy D. Hadi. "It strikes me that ultimately you've got contempt issues," Judge Frank A. Shepherd said during oral arguments, "and Ms. Hadi may be going to jail."

The problem is not unique to Florida, although it is especially severe in Miami-Dade County, which has one of the nation's largest percentages of mentally ill residents, according to the National Alliance for the Mentally Ill, an advocacy group.

A Justice Department study released in September found that 64 percent of inmates in county jails around the nation reported mental health problems within the last year. Many are arrested for petty crimes, advocates say, yet remain in jail an inordinately long time because there is nowhere else for them to go.

Only 40,000 beds remain in state psychiatric hospitals around the nation, down from 69,000 in 1995. Advocates for the mentally ill say that community-based treatment programs, which were supposed to replace psychiatric hospitals after the deinstitutionalization movement of the '60s and '70s, have not begun to make up for the loss.

Long waits for beds are especially common in the nation's urban areas. Last week, 307 mentally ill inmates were waiting for one of Florida's 1,416 psychiatric beds, and 72 percent had waited longer than 15 days. The state has three psychiatric hospitals with secure

beds. "This is a national problem, and it's a direct reflection of the lack of adequate beds and coordination between the criminal justice and mental health systems," said Ronald S. Honberg, legal director of the National Alliance for the Mentally Ill.

In Miami, an average of 25 to 40 acutely psychotic people live in a unit of the main county jail that a lawyer for Human Rights Watch, Jennifer Daskal, described as squalid after visiting last month. Seventeen such inmates are currently waiting for state hospital beds, said Valerie Jonas, a county public defender, adding that the number has been as high as 30 in recent weeks. Ms. Daskal said that some of the unit's 14 "suicide cells" — dim, bare and designed for one inmate — were holding two or three at a time, and that the inmates were kept in their cells 24 hours a day except to shower. None of the mentally ill inmates receive group or individual therapy, she said in an affidavit.

Officials with the Department of Children and Families have argued that the agency cannot be held in contempt when it simply has no more beds, and that it could not have anticipated this year's sharp rise in commitments. In June 2005, they said, only 125 inmates were waiting for hospital beds, of which 38 percent had waited longer than 15 days. "We are at the moment on a daily basis trying to find a short-term solution to the bed shortage," said Al Zimmerman, a spokesman for the department. "We are trying to find ways to pay for additional space, pay for additional beds." The department requested and received money for about two dozen new secure beds this year, and it has asked for 38 next year. Each bed costs $100,000 a year, Mr. Zimmerman said.

Ms. Jonas, the public defender, said it was unconscionable that the department would not ask for more. "Given they've got a wait list of over 300 and they're running all over the state claiming inability to comply," she said, "where do they get off requesting only 38 new beds?"

Yet Mr. Honberg said that putting more mentally ill inmates in state hospitals should not be the ultimate goal. The treatment they get there often skims the surface, he said, and many end up deteriorating when they return to jail, only to end up on the wait list for a hospital bed again. "You have large numbers of people sent to state hospitals not for therapeutic purposes, but for purposes of making them competent to proceed to trial," Mr. Honberg said. "We're not going to solve these problems until we invest adequate resources into services that work for people before they get to jail."

The above article, "Officials Clash Over Mentally Ill in Florida Jails," was written by Abby Goodnough, a staff writer for ***The New York Times****, and appeared in the November 16, 2006 edition of the newspaper. Copyright 2006,* ***The New York Times Company****. All rights reserved. Used with permission.*

Editor's Note: *In January 2007, the Florida Legislative Budget Commission, a special panel authorized to allocate money outside of legislative sessions, approved spending $16.6 million to add more than 370 new psychiatric hospital beds for mentally ill inmates currently housed in county jails. The money, slated to be transferred from state Agency for Health Care Administration surplus funds, will provide for 373 beds, including 233 beds in high-security facilities and 140 lower-security beds. "It won't happen all at once, but we'll fast-track it," Robert Butterworth, Secretary of the state Department of Children & Families (DCF) told* ***The Florida Times-Union.*** *"We know judges are frustrated." In May 2007, DCF officials announced that the list of inmates waiting beyond the 15-day limit had almost been eliminated.*

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 1997 thru 2006 to:

Lindsay M. Hayes, Project Director
Jail Suicide/Mental Health Update
40 Lantern Lane
Mansfield, MA 02048
(508) 337-8806
Lhayesta@msn.com

Texas

In a case strikingly similar to Florida, a recently filed lawsuit alleges that the state of Texas routinely violates the constitutional rights of people with mental illnesses who have been accused of crimes by keeping them in jail longer than necessary. The lawsuit from Austin-based Advocacy Inc. claims that approximately 100 defendants with mental illnesses across the state have been declared incompetent to stand trial but are awaiting admission to a state psychiatric hospital. That delay clogs local jails, slows the legal system and violates inmates' right to due process, said Beth Mitchell of Advocacy Inc. Her agency wants a Travis County court-at-law judge to force the state to take custody of the inmates and help them become competent to stand trial by sending them to a state hospital or a community treatment program. "They can't just hold these people indefinitely, Ms. Mitchell told the *Austin American-Statesman* in February 2007.

The lawsuit comes as state psychiatric hospitals struggle to deal with a growing number of forensic patients. Accused of offenses that range from public intoxication to murder, the patients are considered incompetent to stand trial, so they remain in the hospital until they are able to participate in their defense. Even though the number of forensic beds statewide grew from 399 in 2001 to 738 in 2006, there are still an inadequate number of available beds. So, until hospital beds are available, defendants sit in local jails. Many people are in jail for 60 to 75 days before being transferred to a state hospital. In one case cited in the lawsuit, a man was held in jail for more than four months waiting for a bed. "Jails are a punitive setting, are significantly more restrictive than a state mental health facility, and do not have the resources or ability to provide the treatment necessary to restore the competency of a person" found incompetent to stand trial, the lawsuit claims.

Indiana

In January 2007, the American Civil Liberties Union (ACLU)'s National Prison Project and the ACLU of Indiana announced that, as a result of a lawsuit, the state Department of Correction (DOC) had agreed to move all mentally ill prisoners out of the Secured Housing Unit (SHU), a "supermax" unit where prisoners are forced to live in extreme isolation and sensory deprivation for months or even years. In signing the agreement, prison officials promised to avoid housing seriously mentally ill prisoners in long-term isolation and to provide additional mental health services for all prisoners housed in the SHU. "The department implemented changes in housing seriously mentally ill offenders because the transfers were an appropriate response to public safety and the mental health needs of our offender population," DOC Commissioner J. David Donahue said in a prepared statement.

"No one should be subjected to the brutal conditions of these isolation units, but for the mentally ill to live in them is truly a form of domestic torture," said Kenneth J. Falk, Legal Director of the ACLU of Indiana. "We are pleased that the Indiana Department of Correction has made the right decision to remove mentally ill prisoners from the SHU." Mr. Falk and David C. Fathi, senior staff counsel of the ACLU National Prison Project, represented the prisoners in the lawsuit.

The "supermax" unit, located at Wabash Valley Correctional Facility in Carlisle, is used to house prisoners in disciplinary or administrative segregation. Every prisoner in the unit is forced to live in solitary confinement where cells remain illuminated throughout the day and night and prisoners are only allowed to leave the cells for showers once a day and for solitary recreation, weather permitting. While housed in the unit, prisoners have had very limited contact with the outside world. Calls and visits with family and friends have been restricted, and there have also been limitations on prisoners' ability to keep personal items in their cells, such as family photographs, letters from loved ones, newspapers, or books. Prisoners may spend years under these conditions.

In February 2005, the ACLU challenged the constitutionality of housing mentally ill prisoners in the SHU after a series of four suicides and numerous self-mutilations took place there in a two-year span. In the lawsuit, *Mast v. Donahue*, the ACLU cited research by mental health experts showing that prisoners who are forced to live in extreme isolation are likely to experience intense pain, suffering, and mental deterioration. According to experts, the impact on mentally ill prisoners is even more severe, often leading to self-mutilation or suicide.

Until the ACLU lawsuit, little had changed at the "supermax" unit since 1997, when Human Rights Watch and a team of psychiatrists inspected the facility, finding that severely mentally ill and psychotic prisoners were held under conditions that exacerbated their conditions. In its report, *Cold Storage: Super-Maximum Security Confinement in Indiana*, Human Rights Watch stated that, "in some cases, the suffering that results are so great that the treatment must be condemned as torture."

The ACLU also raised concerns about the high number of mentally ill prisoners who end up in the secure unit because of behavioral problems frequently related to their mental illness. A recent Bureau of Justice Statistics study looked at the rates of disciplinary charges against mentally ill prisoners compared to those against other prisoners. The September 2006 report revealed that of those state prisoners charged with violating prison policy, 58 percent had mental health problems.

"A disproportionate number of mentally ill prisoners are sent to the 'supermax' unit for disciplinary reasons that are often directly related to their illnesses," said Mr. Fathi. "We expect that our recent settlement agreement will eliminate the practice of simply punishing mentally ill prisoners for their illness and will bring needed treatment to these prisoners instead."

The *Mast v. Donahue* settlement agreement can be found online at: www.aclu.org/prison/mentalhealth/28160lgl20070130.html

Nebraska

In September 2006, a Dodge County Grand Jury released a report containing several recommendations regarding the suicide of Troy Sampson a month earlier in the Dodge County Jail, a 42-bed facility located in Fremont. Mr. Sampson, 37-year-old, was found hanging in his cell by a sheet tied to a ventilation grille on August 10. Several days earlier, the inmate, with a history of mental illness,

had requested to be sent to a psychiatric hospital for treatment. He was on suicide precautions at the time of his death.

In light of the fact that Mr. Sampson was identified as suicidal, the grand jury report recommended that jail officials review policies and procedures regarding suicide precautions. Jail Administrator Doug Campbell responded to the recommendation by telling the *Fremont Tribune* that "after the incident, I sat down with all the shift supervisors and critiqued the incident to see if anything needed to be changed." No major problems were identified, he said. "In August, we had a jail standards inspection and that found us in total compliance."

The grand jury also recommended that jail officials consider changing the type of ventilation grilles in the cells. Mr. Campbell said he would look into alternative covers, but "the cells are pretty sparse" and designed to make it difficult to commit suicide. Mr. Sampson's death was the third suicide in the facility since 2001. With regard to the grand jury recommendation of increased staffing, particularly to provided observation of suicidal inmates, Mr. Campbell responded by telling the *Fremont Tribune* that "I can't dedicate one staff member to watch one individual."

Mr. Campbell said he would consider a grand jury recommendation of increased suicide prevention training for his officers, but added that the jail was already in compliance with state jail standards for training.

A month later on October 20, Corey Beerbohm, 37-years-old, was found hanging in his Dodge County Jail cell by a sheet tied to a ventilation grille. He was not on suicide precautions at the time of his death, but was facing 20 years to life in prison for the murder of his girlfriend.

Finally, in December 2006, the Dodge County Board of Supervisors had seen enough and agreed to hire an outside consultant to review suicide prevention practices within the jail. In a report release in April 2007, the consultant found that the Dodge County Jail "lacks adequate and appropriate space for serious mental health and special management inmates" and that expansion was necessary in order to "provide appropriate housing for inmates with special needs and/or suicidal tendencies." Other recommendations focused on revising suicide prevention protocols, increased mental health services, internal review procedures for inmate deaths, and providing protrusion-free housing for suicidal and other at-risk inmates.

Delaware

In December 2006, the Special Litigation Section of the U.S. Department of Justice's Civil Rights Division announced a settlement agreement with the state regarding conditions of confinement at five prison facilities. The agreement follows the Justice Department's investigation of the facilities, which found substantial civil rights violations at four prisons: Delores J. Baylor Women's Correctional Institution, Delaware Correctional Center, Howard R. Young Correctional Institution, and Sussex Correctional Institution.

The investigation uncovered inadequate intake screening and health assessments to identify acute and chronic health needs of inmates, inadequate treatment of inmates with infectious diseases, inadequate treatment of inmates with serious mental illness, and deficiencies in suicide prevention practices. "I appreciate Delaware's cooperation during our investigation and commend them for their commitment to improve their correctional facilities," Wan J. Kim, Assistant Attorney General for the Civil Rights Division, stated in a press release dated December 29, 2006.

With regarding to suicide prevention, the Justice Department investigation found that the state Department of Correction's practices "substantially depart from generally accepted professional standards and expose inmates to significant risk of harm. Our investigation uncovered a system in which inmates at risk for suicide are not adequately identified, housed and supervised." The consultant/expert hired by the Justice Department to assess suicide prevention practices found that the state failed to adequately assess and identify inmates at risk for suicide. For example, although the initial intake screening form was found to be adequate, medical personnel conducting the assessment lacked appropriate training and experience with issues related to mental health and suicide prevention. Further, although inmates routinely signed release of information forms so that the state could access outside medical and mental health records, such records were not consistently obtained. Post-intake mental health assessments, which should be conducted within 14 days of admissions, were not being done.

Although Correctional Medical Services, the state's provider of medical and mental health services, conducted training of its employees on suicide prevention, it had not implemented its training curricula as policy or standard operating procedure. Similarly, correctional staff received insufficient training in the area of suicide prevention. Training at the state academy was only two or three hours, and annual refresher training methods were inadequate.

In addition, inmates placed on suicide precautions were not always placed in "protrusion-free" cells, instead, they could be housed in cells that contained dangerous window bars, ventilation grilles, and sprinkler heads. Suicidal inmates were sometimes observed at 30-minute intervals. Correctional staff at one facility reported conflicting requirements for observation checks, highlighting the confusion regarding the appropriate interval contained in the departmental policy. Rounds by mental health staff for inmates held in segregation and other special units were not regularly done. Segregation rounds were not documented by correctional staff, and personnel at some facilities incorrectly suggested that the various undocumented incidental contacts with at-risk inmates throughout the day, such as dispensing medication or picking up sick call slips, sufficed as a periodic check for inmate safety.

The *Memorandum of Agreement Between the United States Department of Justice and the State of Delaware Regarding the Delores J. Baylor Women's Correctional Institution, Delaware Correctional Center, Howard R. Young Correctional Institution, and Sussex Correctional Institution* contains the following suicide prevention requirements:

Suicide Prevention Policy: The State shall review and, to the extent necessary, revise its suicide prevention policy to ensure

that it includes the following provisions: 1) training; 2) intake screening/assessment; 3) communication; 4) housing; 5) observation; 6) intervention; and 7) mortality and morbidity review.

Suicide Prevention Training Curriculum: The State shall review and, to the extent necessary, revise its suicide prevention training curriculum, which shall include the following topics: 1) the suicide prevention policy as revised consistent with this Agreement; 2) why facility environments may contribute to suicidal behavior; 3) potential predisposing factors to suicide; 4) high risk suicide periods; 5) warning signs and symptoms of suicidal behavior; 6) case studies of recent suicides and serious suicide attempts; 7) mock demonstrations regarding the proper response to a suicide attempt; and 8) the proper use of emergency equipment.

Staff Training: Within 12 months of the effective date of this Agreement, the State shall ensure that all existing and newly hired correctional, medical, and mental health staff receive an initial eight-hour training on suicide prevention curriculum described above. Following completion of the initial training, the State shall ensure that a minimum of two hours of refresher training on the curriculum are completed by all correctional care, medical, and mental health staff each year.

Intake Screening/Assessment: The State shall develop and implement policies and procedures pertaining to intake screening in order to identify newly arrived inmates who may be at risk for suicide. The screening process shall include inquiry regarding: 1) past suicidal ideation and/or attempts; 2) current ideation, threat, plan; 3) prior mental health treatment/ hospitalization; 4) recent significant loss (job, relationship, death of family member/close friend, etc.); 5) history of suicidal behavior by family member/close friend; 6) suicide risk during prior confinement in a state facility; and 7) arresting/ transporting officer(s) belief that the inmate is currently at risk.

Mental Health Records: Upon admission, the State shall immediately request all pertinent mental health records regarding the inmate's prior hospitalization, court-ordered evaluations, medication, and other treatment. DOJ acknowledges that the State's ability to obtain such records depends on the inmate's consent to the release of such records.

Identification of Inmates at Risk of Suicide: Inmates at risk for suicide shall be placed on suicide precautions until they can be assessed by qualified mental health personnel. Inmates at risk of suicide include those who are actively suicidal, either threatening or engaging in self-injurious behavior; inmates who are not actively suicidal, but express suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or have a recent prior history of self-destructive behavior; and inmates who deny suicidal ideation or do not threaten suicide, but demonstrate other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury.

Suicide Risk Assessment: The State shall ensure that a formalized suicide risk assessment by a qualified mental health professional is performed within an appropriate time not to exceed 24 hours of the initiation of suicide precautions. The assessment of suicide risk by qualified mental health professionals shall include, but not be limited to, the following: description of the antecedent events and precipitating factors; suicidal indicators; mental status examination; previous psychiatric and suicide risk history, level of lethality; current medication and diagnosis; and recommendations/treatment plan. Findings from the assessment shall be documented on both the assessment form and health care record.

Communication: The State shall ensure that any staff member who places an inmate on suicide precautions shall document the initiation of the precautions, level of observation, housing location, and conditions of the precautions. The State shall develop and implement policies and procedures to ensure that the documentation described above is provided to mental health staff and that in-person contact is made with mental health staff to alert them of the placement of an inmate on suicide precautions. The State shall ensure that mental health staff thoroughly review an inmate's health care record for documentation of any prior suicidal behavior. The State shall promulgate a policy requiring mental health staff to utilize progress notes to document each interaction and/or assessment of a suicidal inmate. The decision to upgrade, downgrade, discharge, or maintain an inmate on suicide precautions shall be fully justified in each progress note. An inmate shall not be downgraded or discharged from suicide precautions until the responsible mental health staff has thoroughly reviewed the inmate's health care record, as well

UPDATE
ON THE INTERNET

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

www.ncianet.org/suicideprevention

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

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

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

as conferred with correctional personnel regarding the inmate's stability. Multidisciplinary case management team meetings (to include facility officials and available medical and mental health personnel) shall occur on a weekly basis to discuss the status of inmates on suicide precautions.

Housing: The State shall ensure that all inmates placed on suicide precautions are housed in suicide-resistant cells (i.e., cells without protrusions that would enable inmates to hang themselves). The location of the cells shall provide full visibility to staff. At the time of placement on suicide precautions, medical or mental health staff shall write orders setting forth the conditions of the observation, including but not limited to allowable clothing, property, and utensils, and orders addressing continuation of privileges, such as showers, telephone, visiting, recreation, etc., commensurate with the inmate's security level. Removal of an inmate's prison jumpsuit (excluding belts and shoelaces) and the use of any restraints shall be avoided whenever possible, and used only as a last resort when the inmate is engaging in self-destructive behavior. The Parties recognize that security and mental health staff are working towards the common goal of protecting inmates from self-injury and from harm inflicted by other inmates. Such orders must therefore take into account all relevant security concerns, which can include issues relating to the commingling of certain prison populations and the smuggling of contraband. Mental health staff shall give due consideration to such factors when setting forth the conditions of the observation, and any disputes over the privileges that are appropriate shall be resolved by the Warden or his or her designee. Scheduled court hearings shall not be cancelled because an inmate is on suicide precautions.

Observation: The State shall develop and implement policies and procedures pertaining to observation of suicidal inmates, whereby an inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior, or an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, shall be placed under close observation status and observed by staff at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes). An inmate who is actively suicidal, either threatening or engaging in self-injurious behavior, shall be placed on constant observation status and observed by staff on a continuous, uninterrupted basis. Mental health staff shall assess and interact with (not just observe) inmates on suicide precautions on a daily basis.

Step-Down Observation: The State shall develop and implement a "step-down" level of observation whereby inmates on suicide precaution are released gradually from more restrictive levels of supervision to less restrictive levels for an appropriate period of time prior to their discharge from suicide precautions. The State shall ensure that all inmates discharged from suicide precautions continue to receive follow-up assessment in accordance with a treatment plan developed by a qualified mental health professional.

Intervention: The State shall develop and implement an intervention policy to ensure that all staff who come into contact with inmates are trained in standard first aid and cardiopulmonary resuscitation; all staff who come into contact with inmates participate in annual "mock drill" training to ensure a prompt emergency response to all suicide attempts; and shall ensure that an emergency response bag that includes appropriate equipment, including a first aid kit and emergency rescue tool, shall be in close proximity to all housing units. All staff who come into regular contact with inmates shall know the location of this emergency response bag and be trained in its use.

Mortality and Morbidity Review: The State shall develop and implement policies, procedures, and practices to ensure that a multidisciplinary review is established to review all suicides and serious suicide attempts (e.g., those incidents requiring hospitalization for medical treatment). At a minimum, the review shall comprise an inquiry of: a) circumstances surrounding the incident; b) facility procedures relevant to the incident; c) all relevant training received by involved staff; d) pertinent medical and mental health services/reports involving the victim; e) possible precipitating factors leading to the suicide; and f) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. When appropriate, the review team shall develop a written plan (and timetable) to address areas that require corrective action.

The Department of Justice's investigative findings letter regarding conditions of confinement within the Delaware Department of Correction can be found at: http://www.usdoj.gov/crt/split/documents/delaware_prisons_findlet_12-29-06.pdf, and the *Memorandum of Agreement* can be found at: http://www.usdoj.gov/crt/splitdocuments/delaware_prisons_moa_12-29-06.pdf

Virginia

In December 2006, Portsmouth City Attorney Tim Oksman requested a federal civil rights investigation into Joseph Combs' death several months earlier in the city jail. On June 22, 2006, Mr. Combs' wife, Granada, called 911 because she needed help taking him to the Hampton Veterans Administration Medical Center, where the Vietnam veteran had previously been hospitalized for mental illness. Mrs. Combs had a magistrate's temporary detention order (TDO) authorizing her husband's hospitalization. When police arrived at the residence, Mr. Combs was waving a knife and hallucinating about imaginary figures. He had not slept or eaten for several days. The officers transported Mr. Combs to the VA hospital, but he was rejected for admission because of a hospital policy of not accepting patients who have a TDO. Police tried three other hospitals, each of whom failed to admit Mr. Combs, and they then reluctantly brought him to the Portsmouth City Jail on an assault charge "with the understanding that the jail would arrange for medical and mental treatment as needed."

On June 26, an employee from the state Department of Behavioral Health Services examined Mr. Combs at the jail. The examiner found that he was not a candidate for a temporary detention order or involuntary treatment because Mr. Combs did not say he wanted

to kill himself and did not appear to be in imminent danger. According to the medical examiner's investigation, however, Mr. Combs began smearing himself with feces and was placed in isolation. He was examined by a jail physician the following day. The physician wrote that Mr. Combs was naked in his cell with a bare mattress on the floor. He answered in short phrases that did not convey logical information. Mr. Combs "did say he wanted water," the doctor's notes continued. "He also said, 'I'm dying.'"

On June 28, 57-year-old Joseph Combs was dead, found lying naked on the floor of his cell. The medical examiner concluded that he died of severe dehydration and acute pneumonia, with bipolar disorder contributing to his death.

City Attorney Oksman began to look into the case after being contacted by Granada Combs. She told *The Virginian-Pilot* that "This should not have happened. His death could have been avoided had they taken him to a hospital." When a newspaper reporter contacted the office of Portsmouth City Sheriff Bill Watson, they were told to contact Prison Health Services (PHS) Inc., the jail's medical provider. "His position right now is that PHS needs to handle that," a sheriff's spokesman told *The Virginian-Pilot*. "It was their thing." Emma Floyd, director of nursing for PHS at Portsmouth City Jail, stated "I don't know why he would ask you to contact me." Asked about Mr. Combs, the nursing director remembered the case but declined to comment on it. She suggested that the reporter contact PHS corporate office in Tennessee. When contacted, PHS spokeswoman Susan Morgenster stated that "our mission is to provide quality health care to all the patients we serve. Anytime a patient dies, we are deeply saddened, and extend our heartfelt sympathy to the patient's family and friends." Citing confidentiality laws, Ms. Morgenster would not comment on Mr. Combs' case, but said PHS would fully cooperate with any investigation.

In early January 2007, both the U.S. Department of Justice and the Federal Bureau of Investigation informed City Attorney Oksman that they would not be opening an investigation into Mr. Combs' death. Mr. Oksman then established a task force comprised by police and mental health officials to examine alternatives to incarceration for the mentally ill. The lack of treatment and disproportionate number of mentally ill individuals in jail led the Virginia Supreme Court to create a Commission on Mental Health Law Reform last year. Richard Bonnie, the Commission's chair, said it will give serious consideration to the issues Mr. Oksman raised with the Combs case. "I share Tim Oksman's view that this tragic case highlights the need for reforming the Commonwealth's laws and procedures governing involuntary treatment," he told *The Virginian-Pilot*.

Indiana

In a case as tragic as was found above in Virginia, parents of an inmate who died from dehydration and malnourishment in the Elkhart County Jail have filed a lawsuit against the county. Nicholas Rice, 22-years-old, was diagnosed as schizophrenic and held in the county jail for more than a year on an attempted bank robbery charge while doctors and court officials argued about whether he was competent to stand trial. Mr. Rice was found dead in his jail cell on December 18, 2004.

The lawsuit contends that officials allowed Mr. Rice to starve himself, withheld his medication, and failed to protect him from abuse of other inmates. During his 15 months of confinement, Mr. Rice was assaulted by another inmate with a broomstick, and received medical treatment after attempting suicide by slicing his neck with a razor blade. He was often observed to be naked in his cell, and refused to eat or bath regularly. At the time of his death, Mr. Rice had lost 50 pounds.

Family members told the *South Bend Tribune* that they tried unsuccessfully to convince court officials how sick Mr. Rice was, enlisting outside help and medical records. Mr. Rice was eventually taken to a hospital emergency room after a judge issued a 72-hour civil commitment order for psychiatric assessment. "Patient is dying of malnourishment, a jail psychiatrist wrote in Mr. Rice's application for emergency detention. A judge finally committed Mr. Rice to a state mental hospital, but he died in jail waiting for a room to become available.

Missouri

In March 2007, the city of Arnold agreed to pay the family of Kurt Hartzell the sum of $950,000 to settle a pending lawsuit regarding his death by suicide in the city jail. Mr. Hartzell, 29-years-old, died in the Arnold City Jail on June 30, 2005. Family members contended that Arnold Police Department staff had failed to monitor Mr. Hartzell even though they knew he was despondent and at risk for suicide. He had been held at the jail in connection with unpaid traffic tickets.

Arnold Police Chief Robert Shockey subsequently fired two dispatchers and disciplined several other employees because they did not follow proper procedures relating to the suicide. Four officers were demoted, six officers were suspended without pay for one to five days, and two officers were reprimanded. Two officers resigned [see ***Jail Suicide/Mental Health Update*** (Fall 2005), 14 (2): 13-14].

Although the city refused to discuss any specifics regarding the case, an official report on the death noted that: 1) Kurt Hartzell had complained to police officers about his mental state and unsuccessfully requested medical attention; 2) Staff meant to place Mr. Hartzell on suicide precautions, but they failed to follow proper procedures; and 3) Dispatchers did not observe the closed-circuit television monitor which showed the inmate making a ligature from a bed sheet and hanging himself.

Kentucky

Suicides in county jails in Kentucky — viewed as alarmingly high just five years ago — now appear to be significantly declining, and numerous officials credit an innovative mental-health program set up by state lawmakers in 2004.

During a 30-month stretch in 2004-2006, the nine suicides in Kentucky's 83 county jails occurred at roughly half the rate as they did during a comparable period in 1999-2001, when there

were 17 suicides, state records reviewed by *The Courier-Journal* show. In addition, among just the 74 jails that now use the innovative program called the Kentucky Jail Mental Health Crisis Network, inmate suicides have been running at one-fifth the earlier rate — a drop that, if sustained, would amount to a wholesale turnaround from 1999-2001. "I know it's saved some lives," said Woodford County jailer Gary Gilkison, president of the Kentucky Jailers' Association, whose members were initially skeptical of the program.

The Crisis Network's designers and other experts believe the program offers a unique approach to a problem that has long bedeviled jails nationwide: It provides a round-the-clock telephone "triage" line, which a jail may call for advice from mental-health professionals about troubled inmates. In the most serious cases, the Crisis Network can dispatch a specialist from a community mental-health agency to evaluate an inmate within three hours — even in the middle of the night, in the far reaches of the state.

The program puts a great deal of attention on each inmate's mental condition just after arrest, a period of high risk for suicide. By providing face-to-face emergency evaluations, the program also fills a gap that once left many inmates in peril, particularly in rural counties. And it all costs the jails nothing. The $2.1 million per year used to run the program is raised through a $5 increase in court costs paid by criminal defendants in circuit and district courts statewide.

Lindsay M. Hayes of Mansfield, Massachusetts, a leading authority on suicides in jails, said evidence suggests that suicide rates have fallen nationally over the last two decades as awareness and prevention measures have increased. He said he believes more time probably is needed to assess connections between the new Kentucky program and the suicide decline — but "those numbers sound very encouraging."

Kentucky's program already has drawn considerable national attention. Three mental-health officials flew to Phoenix a few weeks ago to accept an "Innovations Award" from the Council of State Governments. And more than 10 states have asked for briefings on the program from its architects, Ray Sabbatine, former director of the jail in Lexington, and Connie Milligan, who oversees the Crisis Network as director of intake and emergency services for the Bluegrass Regional Mental Health-Mental Retardation Board in Lexington.

The Bluegrass agency provides the service under a contract with the state. Milligan describes the work of the jails, the triage line and the local mental-health agencies as being "like a relay race. A baton keeps getting passed to the next person to do the next phase of work."

The Crisis Network's effectiveness may have been seen from its very beginning. After the full program was launched in October 2004, Kentucky's county jails, which have 16,387 beds, did not have a suicide for 10 months, state records show. And there has not been a suicide in any Kentucky jail since June 15, more than six months ago. "Any time the suicides are decreasing, it sounds like something is working," said Judy Devine of Danville — whose 52-year-old brother, Edgar Martin "Junie' Strevels, hanged himself on July 4, 2000, in the Marion County Detention Center, where he had been held for nearly four months on a sentence for fourth-offense drunken driving. But Devine also said she believes more still could be done, including closer checks on inmates put in cells by themselves.

And not everyone has embraced the program. In Bowling Green, for example, city police and other officers decline to answer screening questions that jail officers pose about prisoners' behavior prior to arrival at the jail. That's because of liability fears from judgments officers might be making, according to city attorney Eugene Harmon — fears Sabbatine say are misplaced. Milligan and Sabbatine also say that some jails are not calling the triage line as often as they should. And some jailers and mental-health workers worry that Kentucky still has no hospital beds for many jail inmates with serious mental illnesses, mainly those charged with violent crimes.

Nevertheless, state mental-health officials are elated over the Crisis Network's results. Rita Ruggles, a program administrator for the state Department for Mental Health and Mental Retardation Services, said she believes the current lower level of inmate suicide can be maintained. "The real key is the partnership between the jails and the mental-health provider," she said — a partnership that was nonexistent in some jails before 2004.

The Courier-Journal published a series of articles in early 2002 titled "Locked in Suffering," reporting that 17 inmates killed themselves in 14 county jails between January 1, 1999, and June 30, 2001. That was roughly one suicide every 53 days. Many of the 17 inmates had drug and alcohol problems and were in jail for nonviolent or minor offenses. The 2002 General Assembly reacted by setting up a $550,000 program to train jail officers in identifying suicidal tendencies. The state also began requiring that jails report suicides and serious attempts to the state Department of Corrections.

The 2004 General Assembly went further, adopting Sabbatine's idea for the Crisis Network and a related "Telephonic Triage." It also provided funding through the court cost increase. Under the system, a participating jail can call the triage line to discuss an inmate's condition with a mental-health professional. Sometimes, the mental-health specialist will speak directly with the inmate. The mental-health worker will then designate a level of risk for the inmate — critical, high, moderate or low. That will guide the jail in how to place and monitor the inmate.

For example, inmates deemed at "critical" risk are typically put on either frequent or constant observation by jail staff, and might be strapped into a confining device called a restraint chair. At the same time, the triage line will arrange for the state-supported mental-health agency serving that jail's community to send a worker to evaluate the inmate.

By the end of 2005, the network had signed up 65 jails. By next month, the number will top 75 — leaving only a handful of jails not participating.

Initially, the program provided annual payments to each mental-health agency equaling $121 for each bed in each participating jail in its region. This year, however, the payment dropped to $86 per

jail bed because income from the $5 court cost fee has been running about $500,000 a year less than projected.

In the state's largest jails, in Louisville and Lexington — which have their own mental-health staffs under contract — the network money is being used to expand mental-health services. In Louisville, for example, the jail and Seven Counties Services are developing a pilot project to increase services to mentally ill inmates once they leave the jail.

In a review of state records this month, *The Courier-Journal* found that Kentucky jails reported nine suicides from January 1, 2004, to June 30, 2006. That is one suicide every 101 days — nearly 50 percent lower than the 17 during a comparable period in 1999-2001. The numbers are even more dramatic when reviewing the jails participating in the Crisis Network. Those jails have seen only three suicides in the almost 27 months the phone line has been operating statewide. That's one suicide every 271 days. And Milligan and Sabbatine said that only one of those three jails called the line for help with the inmate who later committed suicide. In other words, of more than 15,000 calls the line has taken from jails in the past 27 months, only one inmate who was "triaged" and evaluated went on to commit suicide. That inmate was in Daviess County, in Owensboro.

Milligan said the program has provided valuable insights into jail suicide. For example, of the 10,135 triage line calls in the year ending Oct. 31: just over one-third of the inmates triaged had been in a psychiatric hospital in the previous six months — confirming that many inmates simply rotate between the justice and treatment systems; one-third of the inmates reported a substance abuse problem — confirming the frequent co-existence of alcohol and drug abuse with mental illness, and two-fifths of inmates were deemed to be at high or critical risk for suicide.

Milligan said the program also has found that an inmate's stress or shame over the charge he is facing is "one of the most critical….variables" in assessing suicide risk. "And that had not been in the literature," she said.

The above article, "Jail Suicides Declining: Crisis Network in Kentucky Is Saving Lives at Little Cost," was written by Jim Adams, a staff writer for ***The Courier-Journal*** *in Louisville, Kentucky, and appeared in the December 24, 2006 edition of the newspaper. Copyright 2006,* ***The Courier-Journal****. All rights reserved. Used with permission.*

Editor's Note*: For more information regarding the Kentucky Jail Mental Health Crisis Network, see "Innovations to Reduce Jail Suicide — A Kentucky Initiative," by Connie Milligan and Ray Sabbatine,* ***Jail Suicide/Mental Health Update*** *(Spring 2004), 12 (4): 1-7.*

Oklahoma

In December 2006, the Special Litigation Section of the U.S. Department of Justice's Civil Rights Division filed a federal lawsuit challenging the conditions of confinement at the L.E. Rader Center, a juvenile facility in Sand Springs. The complaint alleges that conditions at the facility, which houses 215 boys up to 19-

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) 995-6423, or visit their website at: www.nicic.org

years-old, routinely and systemically deprive youth of federally protected civil rights in violation of the Violent Crime Control and Law Enforcement Act of 1994. This statute allows the federal government to identify and root out systemic abuses such as those allegedly discovered at the Rader Center.

The lawsuit, filed in United States District Court for the Northern District of Oklahoma, follows an investigation of two and a half years, the findings of which were detailed in a letter sent to Oklahoma Governor Brad Henry in June 2005. That findings letter documented evidence of numerous alleged civil rights violations, including youth-on-youth violence, staff-on-youth violence, youth-on-staff violence, sexual misconduct between youths and staff, sexual misconduct among youths, inadequate psychotropic medication administration, and an inadequate system to prevent suicides and self-injurious behavior. The lawsuit was filed after settlement negotiations collapsed in the case.

The Department of Justice's investigative findings letter regarding conditions of confinement within the L.E. Rader Center can be found at: http://www.usdoj.gov/crt/split/documents/split_rader_findlet_6-15-05.pdf

Michigan

In November 2006, a federal judge ordered sweeping changes in the provision of mental health care at the state's Department of Corrections (DOC) to prevent the further mistreatment and death of inmates. In his written opinion, Senior United States District Judge Richard Alan Enslen suggested a prayer be said for those who have already died in custody. "Any earthly help comes far too late for them," he wrote in a scathing opinion in which he chastised both prison officials and health-care providers.

Judge Enslen is enforcing federal oversight under *Hadix v. Caruso*, a class-action lawsuit brought by inmates in 1980 to remedy conditions of confinement at several state prisons in Jackson. The lawsuit ultimately led to a consent judgment. "This is an extraordinarily important decision," Elizabeth Alexander, director of the American Civil Liberties Union (ACLU)'s National Prison Project, told the *Detroit Free Press*.

The federal court order addresses use of restraints and care for inmates with mental illnesses. In placing severe restrictions on the use of mechanical restraints at correctional facilities in Jackson, Judge Enslen wrote:

> "What legitimate uses of mechanical restraints will be permitted in *Hadix* facilities? The use of in-cell restraints for punitive reasons, correction, to prevent in cell 'disruption,' in cell 'destruction of property,' or 'observation other than by physicians or psychiatrists' is prohibited. Restraints may still be used for transportation of prisoners, for movement of prisoners between secure locations, for the safe provision of services to prisoners, and for temporary emergency reasons such as to quell a riot or to provide emergency officer or prisoner safety. Restraints may be used to arrest prisoners engaged in escape or other crime, such as assault. Restraints may also be used by medical and psychiatric staff to prevent self-harm, injury to staff, and interference with treatment, provided that the medical staff supervises the use of the restraints by daily physician orders and monitors the conditions of patients regularly and around the clock to ensure that patient health is not unduly compromised."

Judge Enslen issued the latest order following an investigative series of *Detroit Free Press* articles that examined the worsening state of care in the state's prisons, including the death of a 21-year-old inmate who was mentally ill and had been left strapped naked to a concrete bed for most of five days without medical or mental health care before he died. The ACLU said it was the first time a judge anywhere in the nation had banned such restraints.

The judge also ordered state prison officials to develop a staffing plan to ensure there are enough psychiatrists and psychologists to care for prisoners with mental disabilities at the four state prisons in Jackson. Judge Enslen said psychiatrists and psychologists must begin to make daily rounds in isolation units to ensure that prisoners receive adequate care. He also ordered corrections officials to develop a plan to improve coordination between mental health and medical staff at the prisons and to provide better training for employees.

Referring to Timothy Joe Souders, a 21-year-old inmate who died in a segregation cell in August 2006 as "T.S.," Judge Enslen: "God bless T.S. and the others." Their lives "were short, but their legacies may be long." Theresa Vaughn, Mr. Souders' mother, said she was pleased with the decision, but said Judge Enslen should have banned restraints even if they are ordered by medical or psychological staff for the inmates' protection. "This is a good starting point, but it's nowhere near where we need to be as far as training for people who have care and control of people in prison," she told the *Detroit Free Press*.

Mr. Souders, who had a history of mental illness, was sentenced to prison for pulling a knife on security staff at a store after stealing two paintball guns. In March 2006, four months into his sentence, Mr. Souders was sent to Jackson Medical Facility (within the Southern Michigan Correctional Facility) and put in isolation on July 31, 2006 for disobeying orders from correctional staff. Two days later on August 2, he was strapped to his concrete bed after flooding his sink and kept there for most of five days despite hot and humid conditions. He was naked and laid in his urine for most of time in restraints. He was also taking medication that causes dehydration. On August 6, with his restraints were temporarily removed, Mr. Souders collapsed in his cell and was later pronounced dead at a local hospital. The DOC Medical Director was quoted in Judge Enslen's opinion as stating that "I think there were opportunities for all the disciplines to have taken a more active role in advocating for the welfare of Mr. T.S. and unfortunately that did not happen…..I think in looking at the tapes in particular it was very apparent in the tapes that T.S. was having, number one, mental deterioration, and number two, physical deterioration. I thought that there was ample opportunity for custody officers, for mental health professionals and for nursing to have intervened and brought in a psychiatrist, brought in a medical doctor, or just done something to intervene. And that was not done."

In 2001, Judge Enslen had dismissed the portion of the *Hadix* suit dealing with mental health care after the prison officials assured him that they were providing inmates with adequate care. Plaintiff attorneys asked the court to reopen the issue in September 2006 after a number of prisoner deaths due to delays or inadequate mental health care. In his November 13, 2006 ruling in *Hadix v. Caruso* (461 F. Supp. 2d 574), Judge Enslen was particularly incensed with officials from both the DOC and Correctional Medical Services (CMS), the state's health care provider. He wrote:

> "Here is the basic message: You are valuable providers of life-saving services and medicines. You are not coatracks who collect government paychecks while your work is taken to the sexton for burial. If a patient does not receive necessary medical or psychological services, including medicines and specialty care, it is not his problem, it is your problem, a problem that must be solved at lunch, nights or weekends, if necessary. If someone in the bureaucracy, including CMS, is stopping you from providing necessary services in a timely way, or stopping the patient from obtaining necessary specialist care or medicine, you should pester the malefactors until they respond and the services are provided. If they still won't relent, you are to relay their names, including correct spellings and addresses at which they may be arrested, to the medical monitor so those persons may be held in contempt and jailed, if necessary. The days of deadwood in the Department of Corrections are over, as are the days of CMS intentionally delaying referrals and care for craven profit motives."

Washington State

In February 2007, the four children of a man who committed suicide in the Yakama Tribal Detention Center near Toppenish nearly three years ago were awarded $700,000 in settlement of a wrongful-death lawsuit against the federal government. Ricky Owens Sampson, 40-years-old, was found hanging from a towel tied to a broken light fixture in June 2004.

The lawsuit against the Bureau of Indian Affairs (BIA) argued that poor jail conditions led to Mr. Sampson's suicide. The death was noted extensively in a national report issued by the United States Department of Interior that labeled the 50-bed jail a "national disgrace" [see ***Jail Suicide/Mental Health Update*** (Summer 2004), 13 (1): 11-14]. The report revealed that 53 suicide attempts were reported there within three years, accounting for about one-fifth of all attempts in tribal jails nationally. Approximately six months after Mr. Sampson's death, the BIA shut down the facility, citing safety reasons after a 17-year-old boy attempted to hang himself there. The jail remains closed.

The settlement "closes a tragic chapter at the jail," Terry Abeyta, the Sampson family told the *Yakima Herald-Republic*. "The recognition of the poor condition of the jail which led to Sampson's death will at least lead to some positive benefit to his four children and one grandchild," he said.

Mr. Sampson was housed alone in a cell when he stood on a mop bucket to hang himself. A wall blocked the view of a surveillance camera. Only one dispatcher was on duty that night, the same individual who was working alone when the jail's previous suicide occurred in 1996. An investigation revealed that Mr. Sampson had expressed suicidal ideation and was placed in an isolation cell without any cell checks for approximately eight hours. His body was not found until breakfast was being served the following morning. The Yakama Tribal Detention Center lacked any suicide prevention procedures, nor did it even have a jail operations manual. "The facts were really horrendous," Mr. Abeyta said.

Florida

A Jackson County Jail officer was fired in late January 2007 after an investigation found that he had falsified log entries to indicate proper housing unit checks. Surveillance tapes of the housing unit showed that inmate Roy L. Conrad made a ligature out of his pants and hanged himself from the bunk in his cell at approximately 2:00am on January 23. The officer, Kenneth Anderson, did not find Mr. Conrad until almost 4:45am, although he recorded hourly checks during the night in the log. Mr. Anderson, a former state correctional officer, was working at the booking desk at the 300-bed jail in Marianna. The surveillance tapes indicated that Officer Anderson did not leave the booking desk that night. When interviewed by investigators, Mr. Anderson admitted he falsified the log.

Wisconsin

A lawsuit, filed in April 2007, blames poor mental health care and a slow response from staff members as contributing factors in the suicide of an young inmate with mental illness at Taycheedah Correctional Institution, the state's largest prison for women located in Fond du Lac. The suit was filed on behalf of the estate and relatives of 18-year-old Angela Enoch, who died in June 2005 when she used a seam ripped from a pillow to strangle herself in an observation cell within the prison's segregation unit.

Angela Enoch entered the state's juvenile court system at age 12 and was charged with her first adult crime at age 14. She had a history of assaults, as well as self-destructive and suicidal behavior. Angela had previously been diagnosed with bipolar disorder, personality disorder, mood disorder and attention deficit hyperactivity disorder. She had been in and out of institutions and foster care her entire young life, said James Gende, an attorney who filed the lawsuit for the estate. "I think the system turned her into a throw-away child," he told the *Appleton Post-Crescent*. "The treatment she received while incarcerated by the Department of Corrections was a substantial cause of the deterioration of her mental health status, which resulted in her successful suicide."

The Department of Corrections reserved comment on the lawsuit, but spokesman John Dipko stated "we take any suicide that occurs in our prison system very seriously and we re-evaluate our practices and policies in each instance to see if there are any actions that could have prevented the death and if there are any changes that need to be made."

The Taycheedah Correctional Institution houses approximately 730 female inmates, of whom two thirds have mental health treatment needs — the highest such ratio among the state's 19 prisons. A pending class-action lawsuit by the American Civil Liberties Union (ACLU) and a separate United States Department of Justice investigation have both alleged that medical and mental health care at Taycheedah is grossly inadequate. Angela's death was cited in both the ACLU lawsuit and Justice Department investigation.

According to the family's lawsuit, Angela's mental illness caused her to be placed in solitary confinement where her condition deteriorated. It also alleges the Taycheedah staff was lax in administering Angela's prescribed medications in the days before her death, and it took staff members six to eight minutes to get in her cell after she was observed strangling herself.

Further, the lawsuit also claims that prison officials showed gender-based disparities in treatment. Female inmates are not afforded the same level of mental health care available to male inmates at the Wisconsin Resource Center, a specialized mental health facility located in Winnebago and operated by the state Department of Health and Family Services through a partnership with the Department of Corrections. "If Angela had been a man, she never would have been in that segregation unit," Mr. Gende claims. "She'd have been in a mental health facility."

In Governor Doyle's recently proposed two-year budget, the state Building Commission has approved an $11 million proposal for a 45-bed female inmate treatment facility at the Wisconsin Resource Center. The budget also includes a $2.7 million request for 33 additional permanent positions for medical and mental health care at the prison.

The Department of Justice's investigative findings letter regarding conditions of confinement at the Taycheedah Correctional Institution can be found at: http://www.usdoj.gov/crt/split/documents/taycheedah_findlet_5-1-06.pdf

New York

A class-action lawsuit involving the treatment needs of inmates with serious mental illness who are placed in disciplinary confinement was settled in April 2007. Disability Advocates, Inc. (DAI) and several other inmate advocacy groups (including the Legal Aid Society and Prisoners' Legal Services of New York) sued both the state Office of Mental Health (OMH) and state Department of Correctional Services (DOCS) alleging grossly inadequate care of mentally ill inmates housed in segregation. The suit had been filed in the United States District Court for the Southern District of New York.

Although the settlement agreement in *DAI v. Office of Mental Health et al* (No. 02-CV-4002) does not prohibit the use of segregation for inmates with serious mental illness, it requires better screening, assessment, and treatment services, as well as justification for such placement. The agreement contains, but is not limited to, the following:

- Requires a heightened level of mental health care for almost all inmates with a serious mental illness who are confined in segregation, commonly referred to as a Special Housing Unit (SHU). The increased level of care will be provided as soon as necessary beds and programs are established. Out-of-cell treatment programming lasting from two to four hours each day, at least five days each week, will also be provided.

- Greatly expands mental health services available to all prison inmates, and establishes new residential treatment programs which will provide care to inmates who cannot be housed in the general prison population. New programs are to include 215 new Transitional Intermediate Care Program beds to provide enhanced mental health services and programming for inmate-patients housed in general population, 90 additional Intermediate Care Program beds for inmates with mental illness who cannot tolerate general population, a 100-bed Residential Mental Health Unit (RMHU) which will provide four hours per day of out-of-cell programming for prisoners with serious mental illness who would otherwise be housed in the SHU, and an additional 20 in-patient psychiatric beds for inmates in need of acute care. (The above number of new beds are in addition to 310 residential mental health program beds which the state instituted after the litigation commenced in 2002.)

- Establishes an on-going process to reconsider disciplinary actions involving inmates with serious mental illness by DOCS superintendents and OMH clinicians. These reviews are intended to offer a heightened level of programming and mental health care for inmates with a serious mental illness.

- Establishes an on-going process whereby staff from both OMH and the DOCS will help identify inmates in various types of disciplinary housing who can be treated and housed safely in less restrictive settings within the prison.

- Limits the use of punitive "restricted diet" loafs as a punishment for misconduct by inmates with serious mental illness; and

- Provides improved suicide prevention measures, including better mental health screening for all inmates who enter the DOCS reception centers, better suicide risk assessments for inmates designated to the SHU, enhancement of treatment services and physical plant modifications provided to suicidal inmates confined in observation cells, and prohibits the punishment of inmates with mental illness who hurt themselves because of their illness.

According to Michael F. Hogan, OMH Commissioner, "This is an historic settlement. The mental health services now provided in

New York prisons are already stronger than in most states. With the additional resources that Governor Spitzer proposed and that the Legislature provided in the 2007-8 budget, and the protocols for care agreed to in this settlement, New York will have the strongest prison mental health care system in the nation. Now, we have work to do to ensure that people with a mental illness in our communities get the services needed to avoid unnecessary involvement with the law." Brian Fischer, DOCS Commissioner, stated that "The treatment programs outlined in the settlement agreement will enhance existing programs, and provide for a more comprehensive approach to the mental health needs of each inmate."

Nina Loewenstein, attorney for DAI, stated "This settlement will greatly enhance the care and treatment of every prisoner with serious mental illness in New York prisons and, once the treatment beds promised in the settlement are completed, significant numbers of prisoners with serious mental illness will be diverted from SHU into programs providing treatment and programming up to four hours a day." Cliff Zucker, DAI Executive Director, said "This landmark settlement will insure that prisoners with serious mental illness receive needed treatment and are not confined under inhumane conditions. Moreover, mental health staff, correctional officers, prisoners and the public will benefit from the increased safety and stability provided by making mental health treatment available to those in need."

Governor Eliot Spitzer and lawmakers set aside more than $50 million for construction of the new mental health beds this year and approximately $4 million more to hire additional OMH and DOCS staff. Funds for new OMH staffing will grow to $9 million when construction is completed. "Through a considerable investment of state resources in the budget this year, the Spitzer administration has committed to providing significant improvements to the services and housing available for mentally ill inmates," said Christine Pritchard, a spokesperson for the governor's office.

"We see the settlement as a step in the right direction because it provides additional resources and services for treating the mentally ill in prison," Robert Gangi, executive director of the Correctional Association of New York, told *The New York Times*. "But it falls far short of the policy changes that are needed to ensure humane and appropriate treatment for all the mentally ill people in prison."

Yet plaintiff attorneys in the case and national prisoner rights advocates believe the *DAI* settlement is unique in covering <u>all</u> inmates with mental illness — from the time they enter the system until they leave — whereas other states have merely focused on stopping inmates with major mental illnesses from being designated to segregation.

"The proof of the pudding is in the eating," David C. Fathi, senior staff counsel with the American Civil Liberties Union's National Prison Project, told *The New York Times*. "We will have to see how this is implemented. But on paper, it is very significant, a victory and a step forward." He added, "Now we can point to New York and say, if New York can do it, why can't you do it?" ❑

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.

This publication is supported by Cooperative Agreement Award Number 05J41GJH5 from the National Institute of Corrections (NIC), U.S. Department of Justice. Points of view or opinions stated in this document do not necessarily represent the official position or policies of the U.S. Department of Justice.

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:

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

or

NIC Information Center
791 North Chambers Road
Aurora, Colorado 80011
(800) 877-1461 • (303) 682-0558 (fax)
Web Site: www.nicic.org