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)

Summer 2007 **Volume 16 • Number 1**

SUICIDE RISK DESPITE DENIAL

(OR WHEN ACTIONS SPEAK LOUDER THAN WORDS)

Joseph Scott Rehrig, a 31-year-old carnival worker from Hazelton, Pennsylvania, committed suicide in the Wake County Jail in Raleigh, North Carolina on October 19, 2000. His body was found suspended from an air vent by a bed sheet in his isolation cell. Arrested several days earlier and charged with kidnapping and sexually assaulting a 13-year-old boy in a rest room at the North Carolina State Fair, Mr. Rehrig had been held on a $1 million bond and housed in the protective custody section of the facility for his own safety.

When arrested and interrogated by police, Mr. Rehrig had appeared downcast and embarrassed. "He was just sitting there, head hanging down during questioning," Lieutenant W.J. Weaver of the State Capital Police told a reporter from the *News and Observer*. "He said, 'I know what I did was wrong. I knew it was a young kid.' And he said he had made a mistake." Although he did not have a prior record, Mr. Rehrig refused to talk about his background. "There were things he didn't want to talk about," Lieutenant Weaver recalled. "When we asked him if he had done something like this before he said, 'Nothing like this'."

Wake County Sheriff John Baker ordered a routine investigation into the suicide of Joseph Rehrig. The inquiry found only that there had been a problem with cell checks. Three jail officers were briefly suspended without pay for failing to make required 30-minute checks on the night the inmate died. When asked by a reporter if Joseph Rehrig had been on suicide watch, Sheriff Baker reacted with indignation — "He gave no indication that he was suicidal. *If he had threatened suicide*, we would have put him on suicide watch."

Not unlike his brethren around the country, Sheriff Baker seems to take the simple, direct approach to suicide prevention — if an inmate does not threaten suicide or denies being suicidal, then they must not be suicidal, now or at any time while they're in my facility! In the Fall 2000 issue of the ***Jail Suicide/Mental Health Update*** (Volume 10, Number 1), we spoke about the critical need for identification of suicide risk despite an inmate's denial of such risk. As we revisit this topic, several more recent examples abound.

Michael Simpson[1]

According to available records, 49-year-old Michael Simpson was arrested by the Ellis County Sheriff's Office on October 4, 2006 and charged with "defrauding a secured creditor and concealment or removal of secured property." The arrest was based upon on an out-of-state warrant. He was booked into the county jail and apparently responded "no" to two questions regarding prior and current risk for suicide. Because Mr. Simpson worked as a sergeant at the nearby state prison, he was placed in a single cell in the jail.

During the afternoon of October 4, his wife (Peggy) and brother-in-law (Bill Tompkins) visited with Mr. Simpson in the jail. According to both individuals, Mr. Simpson appeared distraught, confused and, as a correctional officer, feared for his safety. Most importantly, he also threatened suicide, stating to his wife and brother-in-law that he would be found "hanging in his cell." Mrs. Simpson and Mr. Tompkins immediately informed Ellis County Jail staff, specifically Officer Keith Sheppard, of the suicide threat. When told of the suicide threat, Officer Sheppard told them "Don't worry. I'll take care of it and I promise we won't let anything happen to Mike." The officer subsequently informed Sheriff Gil Pyle of the threat and they both went to talk with Mr. Simpson, who denied making a suicide threat. Apart from a brief notification in the Jail Officer's Daily Log on October 4 that read "Received word to watch Simpson," no other action was apparently taken in response to Mr. Simpson's potential risk of suicide.

Throughout his week of confinement at the Ellis County Jail, Mr. Simpson displayed disturbing behavior to jail staff. According to various officers, he was observed as being "very stressed," "quiet," "distraught," "crying," "pacing the cell," and "acting very peculiar." Mr. Simpson was particularly concerned about his impending out-of-state extradition in a transportation vehicle containing other inmates who might recognize him from his job at the prison. During the evening of October 7, Dispatcher Rodney Tanner, who had previously worked with Mr. Simpson at the prison, went back into the cell block area and

[1]In order to ensure complete confidentiality, certain identifying information regarding the victim, facility, staff and dates have baeen changed. No other factual modifications have been made.

INSIDE. . .

briefly conversed with the inmate. According to the dispatcher, Mr. Simpson "was pacing a lot in the cell, and he just looked like very stressed. He was going through a hard time." Mr. Tanner later wrote in an incident report that during their conversation "I also told Mike I hope you are not going to do anything stupid, like suicide, Mike replied, 'no I am not'….Then I told Mike I needed to get back to dispatch, if he needed anything let someone know, I also informed him I was watching him in the camera."

During the evening of October 10, both jail and family members (during a visit) observed Mr. Simpson to be very distraught and crying regarding his impending extradition, thought to be scheduled for the following day. According to Officer Jack Turner, Mr. Simpson was "quiet and distraught" following the visit with his wife and "Mike looked like he had been crying and acted like he wanted to cry as he was walking but was trying to keep from showing emotions."

Both Officer Paula Hanson and Dispatcher Tanner worked the overnight shift of October 10-11, 2006. Both individuals noticed that Mr. Simpson appeared agitated during the shift. According to Officer Hanson, Mr. Simpson appeared distraught and was crying. According to Dispatcher Tanner, he "was constantly watching the window in his cell door," pacing the cell, and "acting very peculiar." Both agreed to "just keep an eye on him" through making regular rounds of the cellblock area and observing Mr. Simpson's cell via closed circuit television monitoring (CCTV).

During the early morning shift change on October 11, both Officer Hansen and Dispatcher Tanner informed in-coming Officer Sheppard of their observations and concerns regarding Mr. Simpson. According to the dispatcher, "When Keith Sheppard came to work Paula and I informed him the way he'd been behaving and they needed to keep an eye on him 'cause he wasn't acting right at all…I don't recall the exact words, but I said, Mike's not acting right, something's wrong, you know, something may be wrong with him, you know, he may do something, stupid, I don't know, and that he needed to be watched and Paula addressed her concern to him also." When they informed Officer Sheppard of their concerns regarding Mr. Simpson, Officer Sheppard "just basically shrugged his shoulders and said, oh, well, you know, it's like it's another day." Mr. Tanner also informed the in-coming dispatcher, Ron Hart, of their concerns. Mr. Hart apparently did not give any verbal reply, however, he later stated that it was not his responsibility to monitor inmates via the CCTV equipment.

During the morning of October 11, 2006, Officer Matt Wilson was conducting a round of the cellblock area and observed Mr. Simpson to be sitting on his bed. Approximately one hour later, he conducted another round and observed a blanket tied around the door of Mr. Simpson's cell, and the inmate could not be observed. Officer Wilson went up to the control booth and told Dispatcher Hart to turn on the CCTV monitor for Mr. Simpson's cell and try to locate the inmate. With the monitor turned on, the inmate could not be located. Officers Wilson and Sheppard then ran to Mr. Simpson's cell and initially had difficulty gaining entry because a blanket was tied around the door and soap had been jammed into the key hole. Upon entering the cell, the inmate was discovered hanging from the shower knob by a bed sheet. His body was cut down and laid on the cell floor. Emergency medical services (EMS) personnel arrived, examined the victim, and decided not to initiate cardiopulmonary resuscitation. According to EMS personnel, Mr. Simpson's body had lividity, an indication that he had been dead for a considerable period of time. Michael Simpson was later pronounced dead.

Donald Dugan

According to available records, 40-year-old Donald Dugan was arrested by Leicester Police Department (LPD) officers during the late evening of September 21, 2006 and charged with first degree assault for the allegedly brutal beating of his roommate. Following initial processing at the LPD, he was transported to the Leicester County Jail (LCJ), arriving during the early morning of September 22. According to intake screening records, Mr. Dugan denied any suicidal ideation, as well as any prior histories of suicidal behavior or mental illness. However, shortly after his booking into the LCJ, jail staff received a telephone call from LPD Lieutenant Claire Pace stating that the police department had received information the previous day that Mr. Dugan had threatened to commit suicide. Specifically, the information was derived from a LPD Broadcast which described the alleged assault and then stated that Mr. Dugan had made "suicidal

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.

Phase 1 surveys were distributed in 2007. Phase 2 surveys will be distributed in early 2008. 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

statements to his girlfriend. His mental well-being should be evaluated." As a result of this information, Mr. Dugan was re-housed in a holding cell in the booking area and placed on "behavior observation" status by Sergeant Mitch Kennedy at approximately 2:00am. A referral to a "corrections specialist," a non-mental health counseling position, was also made. According to a notation entered into Mr. Dugan's Behavior Observation Log by Sergeant Kennedy: "LPD Pace called and stated Dugan made suicide statement yesterday. Has suicidal history. When I spoke with Donald he stated he was not feeling suicidal and would be okay."

During the morning of September 22, Steven Cooker, a "Corrections Specialist I" (CSI) arrived at the LCJ. According to CSI Cooker, he interviewed Mr. Dugan and reviewed both the "Referral to CSI" form and Behavior Observation Log. CSI Cooker then wrote the following in the LCJ's pass-down log: "I/M denied any mental health issues or suicidal history, and said that he has been here before and knows what to expect but had no thoughts of wanting to hurt himself. After I/M contracted to notify staff of any problems, he was recommended for lodge." As a result of CSI Cooker's encounter, Mr. Dugan was removed from behavior observation status and re-housed in another unit.

Mr. Dugan's comment to CSI Cooker that he had "been here before" was a reference to his 2000 confinement in the Leicester County Jail in which he received psychotropic medication for "delusional" and "depressed" behavior. Mr. Dugan had then been arrested for violation of a protective order regarding his girlfriend. He later told officers that he had planned to kill his girlfriend and then commit suicide. As a result, an involuntary emergency commitment order was issued and resulted in Mr. Dugan's treatment in the Leicester County Crisis Center. This information was available in the LCJ's medical records and Crisis Center file, and resulted in a red "flag" alert on the LCJ computer screen when Mr. Dugan was booked into the county jail in September 2006. This information, however, was apparently not reviewed by any personnel, including Mr. Cooker.

Two days later at approximately 11:44pm on September 24, 2006, a correctional officer was conducting rounds of Mr. Dugan's housing unit and found the inmate hanging from the ventilation grate in his cell by a bed sheet. The officer called for back-up personnel and several correctional staff arrived shortly thereafter. The ligature was removed, Mr. Dugan was lowered to the floor, and several officers initiated cardiopulmonary resuscitation. Donald Dugan was subsequently transported to a local hospital and pronounced dead.

Anthony Conway

According to available records, Anthony Conway was arrested by officers from the Harrison Police Department on November 13, 2006 and charged with domestic assault on, and false imprisonment of, his girlfriend. He was subsequently transported to the McKinley County Jail. During the booking process, Mr. Conway answered "no" to all questions regarding medical and mental health problems. He also answered in the negative to questions regarding both current and prior suicidal ideation.

During the afternoon of November 15, Officer Larry Kenney walked past Mr. Conway's cell and noticed what appeared to be blood on the wall that spelled out the words "I love Anthony." Officer Kenney called out for assistance and another officer responded to the scene. According to both officers, Mr. Conway appeared teary-eyed and very depressed. It was subsequently discovered that Mr. Conway had repeatedly stabbed himself in the left wrist and forearm with a pencil, banged his forehead several times against both the cell wall and desk, and reportedly ingested cleaning solution. He had used the blood from his self-inflicted wounds to write on the cell wall.

Mr. Conway was transported to the emergency room of Glenn Ridge Medical Center (GRMC) for treatment. Following examination and treatment at the emergency room, the physician determined that, based upon the suicide attempt, as well as a history of suicidal behavior (including ingestion of caustic substances and swallowing pills), Mr. Conway was in need of a psychiatric evaluation at the Wilson Regional Treatment Center. According to the GRMC physician's recommendations as recorded in the medical record of the McKinley County Jail, "72-hr. hold for psychological evaluation. Patient states plans to harm himself with history of same. I believe patient has potential and/or thought pattern to commit suicide."

Mr. Conway was subsequently transported to the Wilson Regional Treatment Center (WRTC) a few hours later on November 15. According to WRTC records, Mr. Conway reported a current and prior history of suicidal ideation and self-injurious behavior, depression, anxiety, and recent weight loss. He was diagnosed with an "adjustment disorder, with mixed, emotional features; poly-substance abuse." The following day, however, Mr. Conway informed hospital staff that he was no longer depressed or suicidal. According to the examining psychiatrist, "I feel he has some continuous anxiety in regards to current legal social situation with girlfriend. I feel that he is currently adjusting to his new life situation with jail. Does have the capacity to act out in jail and may need close supervision….Patient is psychiatrically stable for discharge to jail at this time." As such, Mr. Conway was transported back to the McKinley County Jail on November 16.

Upon return to the jail, Mr. Conway was placed in a regular cell and observed under normal supervision. He was not provided with any "close supervision," as instructed by the WRTC psychiatrist, nor seen by any medical or mental health personnel at the McKinley County Jail.

During the morning of December 3, Mr. Conway informed a jail officer that he had again ingested cleaning solution and stabbed himself with a pencil. He was again transported to the GRMC emergency room. Following examination and treatment at the emergency room, the physician determined that, based upon the "suicide gestures," Mr. Conway continued to be an imminent risk of self-harm and was again in need of a psychiatric evaluation at the Wilson Regional Treatment Center. According to the GRMC physician's request for commitment, "This is the second 'cry for help' in 2-3 weeks. I feel he needs more than a 24-hour stay at Wilson. Please admit him and do the appropriate work up this time."

Mr. Conway was subsequently transported to the WRTC. He reported a recent prior history of suicidal ideation and self-injurious behavior, but denied any current ideation. The psychiatrist noted that his self-injurious behavior appeared related to stress over the relationship with his mother, as well as his court hearings. His diagnosis was slightly revised from the earlier hospital stay to state "adjustment

HOW JAIL ENVIRONMENTS INFLUENCE SUICIDAL BEHAVIOR

The rate of suicide in a correctional facility is higher than in the community. Why? Because certain unique characteristics of correctional facilities make the environment more susceptible to suicidal behavior:

Authoritarian Environment: Persons not familiar with regimentation can encounter traumatic difficulty in the jail setting;

No Apparent Control over the Future, Including Fear and Uncertainty Over the Legal Process: Following incarceration, many jail inmates experience feelings of helplessness and hopelessness. They feel powerless and overwhelmed.

Isolation From Family, Friends and Community: For incarcerated individuals, support from family and friends may seem far away, especially with restricted visiting and telephone privileges.

Shame of Incarceration: Feelings of shame (often found in misdemeanants) are often inversely proportionate to the gravity of the offenses committed. Frequently, such feelings develop in those persons who have never been arrested before or who have a limited arrest history. It is not uncommon for jail suicides to be committed by intoxicated persons held under "protective custody" until sober, or by individuals arrested for traffic violations, disturbing the peace or other minor offenses.

Dehumanizing Aspects of Incarceration: Viewed from the inmate's perspective, confinement in even the best of jail facilities is dehumanizing. Lack of privacy, association with acting-out individuals, inability to make your own choices in the regulation of your life, and strange noises and odors can all have a devastating effect. Many facilities are old, with a substandard environment. General overcrowding creates stress.

Fears: Based on stereotypes of jails seen on television and in movies, and stories carried by various media, fears heighten anxieties on the part of some individuals about other inmates and, sometimes, about staff.

Officer Insensitivity to the Arrest and Incarceration Phenomenon: Most professionals working in the criminal justice field have never personally experienced the trauma of arrest and incarceration. Experience has shown that, in many instances, the longer people work in the corrections field, the more insensitive they can become to the emotional effects of arrest and incarceration, particularly for the first-time arrestee.

Reaction to "Special Housing" Assignment: Most suicides occur in isolation cells. A disproportionate number of suicides occur in segregation or "special housing" units. Inmates housed in isolation and/or special housing are often locked down in their cells 23 or more hours per day with few privileges. Under these conditions, an inmate may react with frustration, panic, despair or rage. The reaction can also include self-injurious behavior or suicide.

disorder, mixed, emotional features of anxiety and depressed mood; malingering; poly-substance abuse." Upon discharge from the WRTC the following day, the examining psychiatrist prescribed psychotropic medication for Mr. Conway's anxiety and "For safety: would highly recommend no sharps to patient in jail and to make cleaning solution unavailable to incarcerated individual. Would recommend close monitoring; patient may manipulate system in order to get out of jail in future, as he has recently demonstrated." During the late afternoon of December 4, Mr. Conway was transported back to the McKinley County Jail by Officer Janice Lee. The officer had a copy of Mr. Conway's discharge summary report and recommendations, as well as a prescription for anti-anxiety medication.

Upon return to the jail, Mr. Conway was again placed under normal supervision, not suicide precautions. He was, however, isolated and placed on lockdown status to prevent him from gaining access to both cleaning solution and pencils. The following morning, Mr. Conway became agitated over the conditions of the lockdown status and threw a food tray on the floor. For this behavior, he received a disciplinary sanction from Officer Lee, i.e., he received written notice that his lockdown status would be extended an additional 23 hours as punishment for his behavior. Despite his agitated condition, Mr. Conway was not given his anti-anxiety medication. Approximately an hour later on December 5, 2006, Mr. Conway was observed by an officer to be hanging by a sheet tied to the ceiling ventilation grate in his cell. The officer radioed for back-up support and, upon arrival of other staff, entered the cell and removed Mr. Conway from the ligature. The victim was moved out of the cell, other officers arrived, and cardiopulmonary resuscitation was initiated. Anthony Conway was subsequently transported to the GRMC emergency room and, although surviving the critical suicide attempt, sustained a catastrophic brain injury that requires around-the-clock nursing care.

Bruce McGill

According to available records, 37-year-old Bruce McGill was an 18-year veteran of the United States Army who had recently returned from Iraq. On September 13, 2006, he was arrested by deputies from the Canton County Sheriff's Office, charged with maiming (in a domestic dispute with a neighbor) and transported to the Canton County Jail (CCJ). During the booking process, Mr. McGill expressed suicidal ideation and was referred to the facility's medical department for further screening. According to his CCJ medical records, Mr. McGill was "unstable, crying, rocking back and forth, rubbing hands through hair, holding his head tightly…He continues to state he just doesn't know what he's going to do, he has nothing to live for, his family is now ruined because of his wife." Based upon this screening and his behavior, Mr. McGill was placed on suicide precautions and a referral was made to the local community mental health agency.

Mr. McGill was assessed later that day by a mental health clinician and appeared "very agitated, not making sense. Voiced concerns for safety. Lost mother and younger brother over last 3 years….On Zoloft for 2 years. No history of suicide. Thought about killing self Saturday (fall on knife)." Mr. McGill remained on suicide precautions until the following day (September 14) when he was released from custody on bond.

Several days later on September 20, Canton County Sheriff's Office deputies were again called to the McGill home in response to another

POTENTIAL PRECIPITATING FACTORS

When examining the records of inmates who committed suicide, certain precipitating factors are usually found. For example:

Prior History of Suicidal Behavior: Any individual with a history of one or more prior suicide attempts is at much greater risk for suicide than those who have never made a suicide attempt. Although all prior history is important, the more *recent* the history, the more significant the risk. Absent an actual prior suicide attempt, an inmate can still be at risk for suicide based upon a history of suicidal ideation, threats, and/or gestures.

Use of Alcohol and/or Drugs: The depressive effects of alcohol and certain drugs increases the risk for suicide. The "disinhibiting" (or lack of restraint) effects of alcohol and drugs may also increase the risk. Alcohol and drugs are closely associated with criminal behavior. Alcoholism also increases disruption of interpersonal relationships and social supports. Even if the individual is not an alcoholic, use of alcohol at the time of suicidal ideation may increase the probability of poor judgment, lack of control, and mood changes.

Separation/Loss of Relationship: The incarceration of an inmate brings obvious separation from family members and significant others. This separation often results in increased levels of stress and anxiety for the inmate. It can also result in the possible loss of a relationship, thereby precipitating suicidal behavior. During confinement, an inmate may also threaten, feign, or even attempt suicide in order to gain sympathy from family members and significant others who had appeared unsupportive of the inmate's plight.

Severe Guilt or Shame Over the Offense: While some inmates involved in violent crimes commit suicide, many who commit suicide in jail are charged with non-violent offenses. For many suicidal inmates, therefore, the guilt or shame may well be inversely proportionate to the seriousness of the offense. In addition, persons either accused and/or convicted of a particular heinous crime, such as child molestation, sexual assault, murder(s) of family member(s), could be especially prone to suicidal behavior during their confinement.

Sexual and/or Physical Assault or Threat of Such: In interviews with inmates who were prevented from committing suicide, some of them said that they had been raped or leaned on heavily for sexual favors.

Mental Illness: Many inmates who commit suicide have a mental disorder, usually one of the mood disorders (e.g., Major Depression, Bipolar Disorder), personality disorders (e.g., Borderline Personality Disorder), and/or conduct disorder. Suicide risk is also high among individuals with schizophrenia and those suffering from delusions/hallucinations, with command voices telling them what to do.

Poor Health or Terminal Illness: While mainly a problem of the elderly, persons of all ages suffer from varying degrees of depression when confronted with a serious illness, e.g., AIDS.

Approaching an Emotional Breaking Point: Each of us has our breaking point, although that point differs within each of us, according to duration of stress, time and situation. One clinician (Bonner, 1992) has offered the *stress vulnerability model*, the theory that suicide should be viewed in the context of a process by which an inmate is (or becomes) ill-equipped to handle the common stresses of confinement. As the inmate reaches an emotional breaking point, the result can be suicidal ideation, attempt, or completion. During initial confinement in a jail, these stressors can be limited to fear of the unknown and isolation from family, but over time (including stays in prison) may become exacerbated and include loss of outside relationships, conflicts within the institution, victimization, further legal frustration, physical and emotional breakdown, and problems of coping within the correctional environment.

domestic dispute in which Mr. McGill was described by his wife as "disorderly and suicidal." The deputies arrived to find that he had already left the residence. Mr. McGill was later found at a local hotel and described as intoxicated, very agitated, and suicidal. Through the intervention of several U.S. Army personnel and officials, he was admitted into the in-patient psychiatric unit at a Naval hospital. Mr. McGill remained at the psychiatric hospital until September 27.

On the afternoon of October 8, Melanie McGill submitted a criminal complaint stating that her husband had assaulted her the day before and had been behaving erratically and "when I came out of my room this morning he was holding a knife to himself. This behavior have (sic) been going on for a while, this is not new." A warrant was issued for his arrest on a charge of assault and battery, and Mr. McGill was again taken into custody by Canton County Sheriff's Office deputies and transported to the Canton County Jail.

Upon entry into the CCJ, Mr. McGill was first seen by a magistrate who determined that he should be held without bond. He was then escorted into the intake area and presented to Brice Taney, a booking officer. The commitment papers given to Officer Taney included Mr. McGill's Commitment Order and Checklist for Bail Determinations from the magistrate, as well as the aforementioned Criminal Complaint from his wife. The Commitment Order stated the following conditions: "No abusive contact or communication with Melanie McGill at all pending outcome of trial. Accused should be evaluated and is a danger to self and others. Was recently in psychiatric hospital." The magistrate's Checklist for Bail Determinations stated that "accused should be evaluated and is a danger to self and others and seems to be a bit confused."

According to Officer Taney and various jail records, Mr. McGill "was very drunk" and "pretty much out of it" during the booking process. Officer Taney completed a Booking Observation Report on Mr. McGill, a 37-item intake screening questionnaire. According the questionnaire, Mr. McGill answered "yes" to only one question, i.e., "influence of drugs/alcohol," while answering "no" to the remaining 36 questions, including the following: "ever try to hurt yourself," "recent hospitalization," "prescriptions," "mental," "ever tried to commit suicide," and "do you feel like committing suicide."

In addition to these 37 questions, the computerized Booking Observation Report contained an "Inmate Alert" drop-down box that read "Alert Code: Suicidal," with the comment of "last time in" — a reference to the fact that Mr. McGill was placed on suicide precautions during his previous CCJ confinement three weeks earlier. According to Officer Taney, as a result of this information, he asked Mr. McGill several times on October 8 whether he was presently experiencing suicidal ideation and the inmate repeatedly denied feeling suicidal and simply stated that "just want to lay down and go to sleep." The computerized booking process also contained a two-page Inmate Commitment Summary Report in which Officer Taney typed the following under "Special Concerns" — "physical handicaps, medical alert information, drug addict, alcohol addiction, and mental illness."

Pursuant to CCJ policy, Mr. McGill was seen later that evening by Beth Hildebrandt, a jail nurse, for additional medical screening. Mr. McGill completed a self-administered form in which he wrote that he had been in the CCJ a "couple of weeks ago" and had received treatment "a couple of weeks ago for depression." A Physical Assessment Sheet, which recorded Mr. McGill's vital signs and indicated that he took psychotropic medication and declined any medical, dental, or mental health services, was incomplete and unsigned by Nurse Hildebrandt. Mr. McGill was then escorted to a cell.

Several hours later on October 9, 2006, a jail officer found Mr. McGill hanging from a sheet that was anchored to a metal wall shelf in his cell. An emergency code was called and several other officers and a nurse responded to the cell. Emergency medical services was notified. Mr. McGill's body was taken down and laid on the cell floor. Cardiopulmonary resuscitation was initiated. EMS personnel subsequently arrived, continued life-saving efforts without success, and Mr. McGill was pronounced dead at the scene.

Charles Nixon

According to available records, 31-year-old Charles Nixon was confined in the Southwick County Jail on January 28, 2007 on charges of carrying a concealed weapon and menacing by stalking. His arrest followed an incident on January 20 in which he arrived at his wife's place of employment with a loaded gun and threatened to kill himself and wanted her to witness his suicide. Mr. Nixon was subsequently admitted to the local hospital for in-patient psychiatric treatment. On January 28, he was transferred from the hospital to the county jail. According to the Booking System Medical Evaluation form, Mr. Nixon denied any current suicidal ideation, but admitted to attempting suicide a few days earlier with a gun. The inmate also admitted that he had made two previous suicide attempts, and that his uncle had committed suicide. Mr. Nixon also told the booking officer that he was taking psychotropic medication for depression and bi-polar disorder.

Following the booking process, Mr. Nixon was housed in a holding cell. During the next few days, he was described by jail staff as being "anxious and worried" about his up-coming court hearing, and "seemed overwhelmingly concerned about his wife and their young son's welfare." Following a visit with her son during the evening of January 28, Gloria Nixon asked jail staff to "keep an eye on him." She was assured by jail staff that he was being carefully observed.

HIGH RISK PERIODS

Experience has shown that there are certain high risk periods which correlate to phases of an inmate's incarceration or steps in the criminal justice process. Some of these high risk periods include:

The First 24 Hours of Confinement: More suicides occur within the first 24 hours of confinement than any other 24-hour period.

Intoxication/Withdrawal: As previously discussed, alcohol and drugs are closely associated with suicide. Although initially acting as a stimulant, the euphoric effect of intoxication from alcohol and/or drugs is limited, and it soon acts as a depressant, particularly when the inmate sobers up and/or goes through withdrawal.

Court or Other Legal Hearing: The anticipation of a scheduled hearing and uncertainty of the result creates a high degree of anxiety. Further, receipt of unexpected or unanticipated news (denied bail reduction, longer sentence, parole set-off, etc.) from the hearing could have a devastating impact upon an inmate. Many suicides occur in close proximity to a court hearing, parole hearing, or institutional (disciplinary) hearing.

Significant Dates to the Date: Although holidays are not normally associated with an increased risk for suicide, the occurrence of a suicide might be more closely related to a significant date in an inmate's life, e.g., court or other legal hearing, anniversary date (of birth, death, marriage, divorce), etc. We should remain vigilant throughout the year.

Darkness/Decreased Staff Supervision: Since suicide is a very private act, the hours of darkness (with an accompanied decreased staff support) account for many inmate suicides. Unfortunately, the decreased number of staff and lack of inmate movement during these shifts may result in the tendency of correctional staff to relax their supervision responsibilities and miss regularly scheduled rounds of the housing unit. A number of suicides may also occur during shift change when staff are distracted and/or less attentive.

Receipt of Bad News: With few support mechanisms available, it is both difficult and frustrating to cope with receiving bad news while confined in a correctional facility. Over time, prolonged incarceration creates more opportunity for bad things to happen.

Impending Release/Transfer: This phase catches many people by surprise because we would like to think that release from incarceration would be something to look forward to. For some inmates, particularly those inmates who have become "institutionalized" following many long years of confinement, the correctional facility has become their community, and they lack any real ties to the outside world. As such, their impending release becomes a traumatic event. Jail inmates may also be at higher risk for suicide in close proximity to their impending transfer to the state prison system.

On the morning of January 31, Mr. Nixon attended a court hearing in which his bond was set at $500,000 and a temporary protection order was issued that prohibited him from contacting his wife and son. The hearing included a discussion on expediting his placement into a mental health treatment program. Shortly after his return to the jail from court, Mr. Nixon was observed to be crying by jail staff. He also appeared to be confused about the court hearing's outcome, as well as worried about the prospect of receiving a prison sentence. Mr. Nixon was subsequently placed on "special needs watch status" because, according to the log, "prisoner is bi-poplar and emotionally unstable – received high bond – facing long jail sentence - states he sometimes has "thoughts" at night" — an apparent reference to suicidal ideation. According to jail staff, special watch inmates were observed at 20-to-30 minute intervals. According to the jail commander, "Mr. Nixon was not placed on a suicide watch due to him being released from the hospital the previous days and, if he was suicidal, one would believe the doctor would have kept him and not released him to us."

During the afternoon of January 31, Mr. Nixon was permitted to place a telephone call to his mother. Following the call, he was observed to be "stressed out," embarrassed, and crying. At one point he informed the officer that "I feel like I just want to die." Several hours later, Mr. Nixon's mother arrived at the jail to visit her son. Following their visit, Gloria Nixon told an officer she did not believe that "he was going to try anything, but that we should keep an eye on him and talk with him every now and then." She also expressed concern that her son needed a higher dosage of psychotropic medication.

Sometime after 6:00pm on February 1, 2007, and at least 45 minutes after the last observation, an officer found Mr. Nixon hanging from the outside bars of his cell by a bed sheet. The officer called for assistance and then tried to lift the victim up in order to relieve pressure from the ligature. Other officers responded to the scene, cut the ligature, placed Mr. Nixon on the floor, and initiated cardiopulmonary resuscitation. EMS personnel subsequently arrived and continued life-saving measures. Charles Nixon was then transported to the hospital and pronounced dead.

Screening, Assessment, and Reassessment

The cases of Joseph Rehrig and the other victims summarized above highlight a disturbing trend by both jail and health care (medical and mental health) staff to often ignore either subtle or even obvious signs of potentially suicidal behavior simply because the inmate did not verbalize a threat or offered an unconvincing denial during the booking process. It certainly is not unusual to hear a sheriff tell a local newspaper reporter following an inmate suicide — "We screened him at booking and, by his denial, he gave us no indication that he was suicidal." Further, in many of these cases, despite obvious warning signs, the inmates were not even referred to mental health personnel because they denied suicidal ideation at booking.

Yet the booking area of a jail facility is traditionally both chaotic and noisy; an environment where staff feel pressure to process a high number of arrestees in a short period of time. Two key ingredients for identifying suicidal behavior — time and privacy — are at a minimum. The ability to carefully assess the potential for suicide by asking the inmate a series of questions, recording their responses, and observing their behavior is greatly compromised by an impersonal environment that lends itself to something quite the opposite. As a result, the clearly suicidal behavior of many arrestees or circumstances that may lend themselves to potential self-injury is missed.

In fact, identification of suicide risk at intake continues to be limited to a single inquiry in some jails throughout the country — "Does the inmate appear suicidal or assaultive?" This single inquiry, a throw-back to the original receiving screening form developed by the American Medical Association during the late 1970s, is not only extremely limited, but a "yes" answer would surely create uncertainty as to whether the arrestee was either suicidal *or* assaultive. Even a more direct inquiry — "Are you thinking of killing yourself?" is not only limited, but a response might be dictated by the degree of interest, if any, shown by the screener and/or how the question was literally interpreted by the arrestee (e.g., "Do you mean, 'Am I going to try to kill myself right now or at some point in the near future'?").

Although an inmate can attempt suicide at any point during incarceration, beginning immediately following intake and continuing through a stressful aspect of confinement, approximately 50 percent of jail suicides occur during the first 24 hours of incarceration (Hayes, 1989). A comprehensive intake screening process to identify suicidal behavior is critical to a correctional facility's suicide prevention efforts. And although the psychiatric and medical communities disagree about which factors should be used to predict suicide in general, there is little disagreement as to the value of screening and assessment to the increased likelihood of preventing suicide (Hughes, 1995).

The precipitating factors of suicidal behavior in jail are well established. From the inmate's perspective, certain features of the jail environment enhance suicidal behavior: fear of the unknown, distrust of authoritarian environment, lack of apparent control over the future, isolation from family and significant others, shame of incarceration, and the dehumanizing aspects of incarceration. In addition, certain factors are prevalent among inmates facing a crisis situation that could predispose them to suicide: recent excessive drinking and/or use of drugs, recent loss of stabilizing resources, severe guilt or shame over the alleged offense, current mental illness, prior history of suicidal behavior, and approaching court date. Some inmates simply are (or become) ill-equipped to handle the common stressors of confinement. As the inmate reaches an emotional breaking point, the result can be suicidal ideation, attempt, or completion. During initial confinement in a jail, this stress can be limited to fear of the unknown and isolation from family, but over time (including stays in prison) may become exacerbated and include loss of outside relationships, conflicts within the institution, victimization, further legal frustration, physical and emotional breakdown, and problems of coping within the institutional environment (Bonner, 2000; Bonner 1992). Therefore, one or two-line questioning at intake will not suffice.

Another theme running through some of the above case examples is that the inmates (e.g., Anthony Conway, Bruce McGill, and Charles Nixon) had been released from a psychiatric hospital to the jail where personnel wrongly assumed that hospital officials would not have released them had they continued to be at risk for

SIGNS AND SYMPTOMS

Experience has shown that certain signs and symptoms exhibited by the inmate often foretell a possible suicide and, if detected, can often prevent a death. What the individual says and does at the time of arrest, during transport to the jail, at booking/intake, and during confinement in either a jail or prison are vital in detecting suicidal behavior. The following signs and symptoms of suicidal behavior can either be exhibited upon initial confinement or periodically throughout an inmate's incarceration:

- Depression.
- Expresses or evidences strong guilt and/or shame over offense.
- Talks about or threatens suicide; makes statements that are death-related and/or speak to finality, e.g. "I've had it. I can't take it anymore."
- Under influence of alcohol/drugs.
- Severe agitation and/or aggressiveness.
- Projects hopelessness and/or helplessness; no sense of future.
- Expresses *unusual* or *great* concern over what will happen to them, i.e., "What will my wife say?" and "What will my kids think?" There may be extreme anxiety.
- Noticeable mood and/or behavior changes. (Once the decision to commit suicide has been made, a once agitated and/or despondent inmate now feels a sense of relief and may display a sense of calm.)
- Speaks unrealistically about getting out of jail.
- Has increasing difficulty relating to others.
- Does not effectively deal with present, is preoccupied with the past.
- Begins packing belongings; starts giving away possessions.
- Engages in non-fatal, self-injurious behavior; "attention-seeking" gestures; self-mutilation. (All incidents of self-injurious behavior, regardless of intent or motivation, must be taken seriously.)
- Delusions or hallucinations; visions and/or voices instructing the inmate to commit suicide.

Absent a threat or attempt, ***depression*** is the single best indicator of potentially suicidal behavior. Approximately 70 to 80 percent of all suicides are committed by persons who are severely depressed. The following are common signs and symptoms of depression:

- Feelings of inability to go on; expressing hopelessness or helplessness.
- Extreme sadness and crying.
- Withdrawal or silence.
- Anxiety.
- Loss or increase of appetite and/or weight.
- Pessimistic attitudes about future.
- Insomnia or awakening early; excessive sleeping.
- Mood and/or behavior variations.
- Tenseness.
- Lethargy, fatigue or loss of energy.
- Loss of self-esteem.
- Loss of interest in people, appearance or activities.
- Excessive self-blaming.
- Strong guilt feelings.
- Difficulty concentrating or thinking.
- Recurring thoughts of death (including suicide).

suicide. Of course, this assumption ignores the fact that much of the suicidal behavior displayed by these inmates occurred *subsequent* to their hospital release, therefore outside the eyes of hospital evaluators, as well as ignoring the commonly known fact that individuals are at greater risk for future suicidal behavior following a recent suicide attempt and/or ideation.

Comprehensive inquiry for suicide risk at intake may be contained within the medical screening form or on a separate form, but should include, at a *minimum*, the following questions:

- "Was the inmate a medical, mental health or suicide risk during any prior contact and/or confinement within this facility? (Requires either a manual or computerized record review.) If yes, explain."
- "Does the arresting and/or transporting officer have any information (e.g., from observed behavior, notification/ documentation from the transporting agency/facility, family member, etc.) that indicates the inmate is a medical, mental health or suicide risk now? If yes, explain."
- "Have you ever attempted suicide? If yes, when, why, and how?"
- "Have you ever considered suicide? If yes, when and why?"
- "Are you now or have you ever been treated for mental health or emotional problems? If yes, when and where?"
- "Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)? If yes, explain."
- "Has a family member/close friend ever attempted or committed suicide? If yes, explain."
- "Do you feel there is nothing to look forward to in the immediate future (inmate expressing helplessness and/or hopelessness)? If yes, explain."
- "Are you thinking of hurting and/or killing yourself? If yes, explain."

While affirmative responses to some of the above questions will not necessarily indicate that the arrestee is suicidal, an affirmative response to any of these questions should prompt the screener to initiate a referral to health care staff for further assessment.

Most importantly, regardless of the inmate's responses, the screener should always initiate a referral if the arrestee's behavior and/or demeanor are *even* suggestive of potential self-harm.

Ultimately, the identification of potentially suicidal behavior at intake is critical to suicide prevention measures because if an arrestee denies that they are suicidal and/or not identified as potentially suicidal based on either current or past behavior during the intake screening process, the likelihood of being identified as potentially suicidal at any time during confinement is greatly reduced.

Of course, not all potentially suicidal behavior is manifested at the point of admission, and while over 50 percent of all jail suicides occur within the first 24 hours of incarceration, almost half take place during other stages of confinement. As emphasized by national correctional standards: "While inmates may become suicidal at any point during their stay, high-risk periods include the time immediately upon admission to the facility, following new legal problems (e.g., new charges, additional sentences, institutional proceedings), after the receipt of bad news regarding self or family (e.g., serious illness, the loss of a loved one), and after suffering some type of humiliation (e.g., sexual assault) or rejection. Inmates in specialized single-cell housing are also at increased risk of suicide. In addition, inmates who are in the early stages of recovery from severe depression may be at risk" (National Commission on Correctional Health Care, 2003).

Research has consistently reported that at least two thirds of all suicide victims communicate their intent some time before death and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt (Clark & Horton-Deutsch, 1992). As such, certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and communicated to others, can prevent a suicide. There are essentially three levels of communication in preventing inmate suicides: 1) between the arresting/transporting officer and correctional staff; 2) between and among facility staff (including medical and mental health personnel); and 3) between facility staff and the suicidal inmate.

In many ways, suicide prevention begins at the point of arrest. What an individual says and *how they behave* during arrest, transport the jail, and at booking are crucial to detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the arrestee. Arresting officers should pay close attention to the arrestee during this time; suicidal behavior may be manifested, and previous behavior can be confirmed by onlookers such as family and friends. As previously offered, any pertinent information regarding the arrestee's well-being must be communicated by the arresting/transporting officer to correctional staff during the booking process.

In addition, effective management of suicidal inmates often comes down to communication among correctional officers and other professional staff. Because inmates can become suicidal at any point during incarceration, correctional officers must maintain awareness, share information and make appropriate referrals to mental health and medical staff. Further, correctional staff must use various communication skills with the suicidal inmate, including active listening, staying with the inmate if they are in immediate danger, and maintaining contact through conversation, eye contact, and body language. Poor communication between and among correctional, medical, and mental health personnel, as well as outside entities (e.g., arresting or referral agencies, family members) is a common factor found in the reviews of many preventable inmate suicides. Communication problems are often caused by lack of respect, personality conflicts and boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides.

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:

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Correctional staff should also trust their own judgment and avoid being misled by others (including mental health staff) into ignoring signs of suicidal behavior. It is not unusual for a suicidal inmate to appear stable in front of a mental health clinician (or hospital evaluator) only to be discharged from suicide precautions, returned to their original housing unit, and revert to the same self-injurious behavior that prompted the initial referral to health care staff. Given such a scenario, correctional staff should not assume that the clinician was cognizant of this behavior. On the contrary, regardless of what the clinician might have observed and/or recommended, whenever correctional staff hear an inmate verbalize a desire or intent to commit suicide, observe an inmate making a suicidal gesture, or otherwise believe an inmate is at risk for suicide, they should take immediate steps to ensure that the inmate is continuously observed until appropriate medical, mental health, and/or supervisory assistance is obtained.

And while observing an inmate engaging in self-injurious behavior, as well as asking an inmate directly whether they are suicidal, are certainly critical pieces to suicide prevention, the identification of potentially suicidal behavior does not end there. Many inmates have great difficulty verbalizing their thoughts and feelings. As offered in the sidebar boxes, both correctional and health care staff should be sensitive to other, often non-verbal, indicators of suicidal behavior, including precipitating factors, high risk periods, signs and symptoms, and how jail environments influence suicidal behavior (Hayes, forthcoming, 2008).

Finally, the reassessment of suicide risk is as important, if not more important, then the initial identification of risk. Far too many suicides occur shortly after inmates have been prematurely discharged from suicide precautions. Premature discharge can occur for a variety of reasons, including poor assessment from the clinician, subtle pressure from correctional officials to "clear" the watch in order to lessen staff resources (e.g., overtime, post transfer, etc.), and deceit from the inmate and over-reliance on risk denial. Inmates may simply deny they are suicidal and desire to be removed from suicide precautions because the conditions of the precautions appear punitive. Take, for example, the case of an inmate who is on suicide precautions for attempting suicide the previous day. He is now housed naked, except for a suicide smock, given finger foods, and on lockdown status. The mental health clinician approaches the cell and asks the inmate through the food slot (within hearing distance of others on the cellblock): "How are you feeling today? Still feeling suicide? Can you contract for safety?" Will this inmate's response be influenced by his current predicament? Of course it will, wouldn't ours?

The most important question to answer in the reassessment of suicide risk is — *What changes, if any, have occurred in this inmate's behavior since the previous assessment?* For example, an inmate might have been placed on suicide precautions because of a suicidal threat or ideation expressed during an intoxicated state at intake. The inmate is now sober, but many of the stressors in their life remain (e.g., estrangement from family, uncertain legal future, possible conflicts with other inmates, etc.). The inmate may deny any current suicidal ideation, but what has really changed in the past 24 hours to better equip them to cope with these stressors of confinement? In addition to a brief mental status examination, to answer the question (what has changed?), each time an inmate is reassessed, the following questions should be asked:[2]

- *What are your current feelings and thoughts?* (Look for feelings of depression, i.e., decrease in energy or appetite, increase in helplessness, hopelessness, or sadness.)
- *Do you have any thoughts or feelings about hurting yourself? If so, how would you harm/kill yourself?*
- *How have your feelings and thoughts changed over the last 24 hours?* (Look for changes in thoughts process or patterns of thinking.)
- *Do you feel that things are going to get better or does it seem they will stay the same or get worse?* (This will indicate whether the inmate has hope or is helpless, and the seriousness of their thinking.)
- *What are some of the things you have done to deal with these thoughts and feelings?* (This will indicate the inmate's current coping ability.)
- *What has worked in the past to help you cope when these feelings have come up?* (This will assist them in drawing from what they already know and may help give them ideas of what they can do now.)
- *Do you think you are capable of coming to staff if your thoughts increase or if you feel less in control?* (This should not be confused with contracting for safety. No-harm contracts do ***not*** provide any assurance against suicide, and should not be utilized to assess suicide risk.)

Conclusion

Because Joseph Scott Rehrig never actually threatened suicide, he was never considered a risk for self-injury in the Wake County Jail. Yet he was clearly a potential risk for suicide. Arrested for sexually assaulting a 13-year-old boy and facing the possibility of spending the remainder of his life in prison, Joseph Rehrig had appeared embarrassed and despondent during police questioning. At a minimum, he should have been referred to mental health staff for assessment.

Suicide prevention does not begin and end at booking, nor does it begin and end with the denial of suicide, however convincing the denial may appear. If suicidal individuals were either willing or able to articulate the severity of their suicidal thoughts and plans, little risk would exist (Jamison, 1999). As such, both correctional and health care personnel share a responsibility for observing the non-verbal suicidal behavior and actions of inmates. An inmate's

[2]Adapted from the Risk Assessment Questions form utilized by the North American Family Institute, Touchstone Program, in Connecticut.

denial of self-injury, or a non-threat of suicide in the face of behavior or actions that suggest otherwise, should not end the inquiry; on the contrary, the process has just begun and continues throughout the individual's confinement.

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Program Keeps Mentally Ill out of Hopsital, Jail

Cheryla Shaw is giddy and smiling as she greets her caseworker and a visitor with a plate of homemade treats. "You look great. I'm so proud of you," caseworker Nina Allen said. Smiling is not always easy for Shaw. The 58-year-old Edgewater woman has been taking medication for depression since she was 18. Shaw has mood-altering bipolar disorder and has been committed to psychiatric care several times over the years. But with the help of Allen, she's adjusting well in her own apartment and coping with life's ups and downs — her mother died last year — better than before.

Allen is part of the Florida Assertive Community Treatment, or FACT Team, which helps people with severe and persistent mental illnesses run their day-to-day lives. The team, operated by Act Corp. through state and federal funding, takes 100 people who have had problems functioning in society and teaches them everyday tasks from grocery shopping to learning how to live on their own. Caseworkers help clients get into a routine of taking their medication, delivering it weekly or even daily while watching to make sure the client takes it. Most of the clients have been hospitalized multiple times and other conventional methods have not worked. Some, like Mark Urbanski, escape the spiral of homelessness. Others, like Alfred Hastings, mentor younger clients.

The daily or weekly support by the team, including nurses and a psychiatrist, has decreased returns to the hospital or crisis unit or jail, program officials said. "I don't know what I'd do without them," said Shaw, who five years ago needed to be checked daily by FACT Team case workers to ensure she was taking her medicines that keep her from slipping into periods of depression. Now Shaw takes them on her own after Allen double-checks every week that the 12 bottles of medicine are sorted correctly into a pill box. Shaw has become so faithful taking her medication, she hasn't been confined to a hospital since 2002 when she joined the FACT Team.

Life Lessons

This past week, Shaw went inside the bank by herself and cashed her Social Security disability check while her case manager sat in the car. The two then went to Winn-Dixie where Allen is teaching Shaw not only how to buy healthy, but wisely. Caseworkers often take clients on errands; to their doctor appointments or to relax in the park. The team helps pay for the client's rent, bus passes, medication and other needs. In under 15 minutes, Shaw picked up groceries for the next several days, only putting back a couple of items like cherries that Allen helped her realize were not within her budget. What may seem like a simple thing, FACT team members said, can be a big deal to someone with a mental illness. "We get to know the clients — what their stressors are and things they are good at and what they are interested in," said Patty Shevlin, FACT Team leader. "We are almost like a pseudo family."

Homeless to Independent

Surrounded by furniture donated by the FACT Team or his brother, Mark Urbanski feels comfortable in his Daytona Beach apartment. He even has a special foam cover on his bed to help his back as he goes through kidney dialysis. It's a far cry from falling asleep at night on the streets and being woken up by police for trespassing, he said. The 51-year-old, who has bipolar disorder and was the FACT Team Client of the Year last year, lived on the streets for 11 months and was in substance abuse treatment. When he ran out of medicine and couldn't afford more, he went back to drinking.

Now sober and living on his own, he's looking into getting a driver's license with the help of his FACT Team worker. He also held down a dishwashing job for more than a year until he recently had to stop because of kidney dialysis. The FACT Team has gone to doctor's appointments with him and are looking into a kidney transplant. "They try to understand you rather than put you into

a category and maintain you," said Urbanski, who has been on the team for four years. "You're allowed to make your own choices. It helps your mental health because you don't have to depend on somebody to make decisions for you. They don't push you around and try to hospitalize you." Urbanski said society has misconceptions about people with mental illnesses. They expect to see "you dress up as a spy," he said, or "spend your pension on fairy dust." "They don't think of you as a well-intentioned person who wants to work," he said.

With sometimes sporadic funding for such programs and cuts in previous Act case managers, clients have been worried how long the FACT Team will last. But state officials say the program is well-funded and there is no talk of cuts. "It's one of the plus programs in mental health," said Angela Jackson, local substance abuse and mental health program administrator for DCF. But with a waiting list of more than 50 it doesn't seem likely the money will be there for a second team, Jackson said. The need is great to help get people out of state hospitals. Sixty local residents take up beds at one of the state mental health hospitals in Macclenny, Jackson said, even though the bed space for Volusia and Flagler counties is only for 41. The only time there is an opening on the FACT Team is when someone moves or dies.

Clients Helping Clients

Justin Wright, 26, whose illness with schizophrenia and bipolar disorder began when he was 19, is one of the newest members of the team after a slot opened in May. He's used to taking Votran around New Smyrna Beach, but not Daytona Beach. Trying something new, even taking a new bus route, can be "scary," FACT Team officials said, especially for someone dealing with paranoia.

But he's getting help. Alfred Hastings, 46, who is a client of the FACT Team, has done so well in the program over the past five years, he now is a peer specialist helping other clients adjust to getting around town on public transportation. Hastings said since he also was diagnosed with schizophrenia when he was 18, he can relate better and help people.

It hasn't always been easy for Hastings, who now lives in an apartment with a roommate. He's been in and out of the crisis unit about 10 times after hearing voices and trying to hurt himself. The last time he was hospitalized was 2½ years ago. He said it's up to the individual to decide to stay on their medication. The sound of hospital doors locking behind him is what keeps him on track with his pills. "It's a little scary," Hastings said. "I look back from where I came from and I don't want to go back down that road again."

Wright, who enjoys painting and skateboarding, hopes to one day also volunteer helping others. But his illness is still causing him to hear voices, even though he said the medicine he's on now is better than before, when he also hallucinated. Recently at his house where he lives with his parents, Wright's caseworker, also Nina Allen, helped him sort his medication. He was distracted because before Allen arrived he was saying a prayer in his room and said demons were telling him to say "666 and bad things" and interrupting the prayer. "I think I said 'Amen,' but they are trying to make me think that I didn't," Wright said as Allen tries to get him to focus on organizing his pills for the week. "I feel like I need to run into my room and get on my knees and say the rest of the prayer. It's a long-term battle. I have it gnawing in my head." He ended up finishing the prayer at the kitchen table and then was able to continue with his pills.

His mom, Sherree Wright, said some days the voices make him fixate on something and he can't stop thinking about it all day. But she said having Allen visit and go over his medication has been a blessing. Before, she said, she and her husband had little support. "It's improved his life so much," Wright said. "When he has issues, there is someone there who is knowledgeable and can help him."

Dealing with Stress

The topic is common to many — learning to deal with stress, anger and life's other obstacles. Surrounded by eight people with chronic mental illnesses, Nina Allen, a clinician with Florida Assertive Community Treatment, or FACT Team, asked what problems group members were having. Zandra Johnson, 48, said she had a hard time controlling her anger over a recent dispute with her mom and sister. "It was hard to pull myself out of the anger," Johnson said. "I was trying to just be regular again. I was huffing and puffing and being bullheaded. It took me a long time to get over it." She joked about how her hair is getting gray, but two of the men in the group said she looks good for her age.

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
www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
www.cimh.org/publications/publications.cfm
www.omh.state.ny.us/omhweb/forensic/suicide.htm
www.pbstandards.org/ResourceSection.aspx?id=4

Allen, whose organization works with mentally ill people to learn skills for everyday life, also told Johnson not to dwell on the negatives, and to learn to be forgiving. She said writing things down in a journal is helpful to know what may trigger the anger and how to avoid certain situations. Coping strategies such as going for a walk or exercise are also helpful. "We work on one problem at a time. There's always room for improvement. That's real life," Allen said.

After three years in an assisted living facility and being hospitalized "too many times to count," Kim Kirkwood, 38, recently started living on her own with the help of her best friend and neighbor, Rachel Ponds, 33, also a FACT Team client. They live in a Daytona Beach apartment community with several other clients. Kirkwood said she deals with depression and loneliness. The FACT Team is looking at letting the two be roommates so they can better help each other.

Carolyn Boston, 43, wants to be more independent so "I can be happy and have friends." On the FACT Team for five years, she lives with her parents. The team is working toward Boston living on her own. She's also taking remedial classes at Daytona Beach Community College. Her goal is to get her GED — and to stay out of the hospital. Boston insists it's not the medication keeping her out. "It's my own will."

FACT Team Facts

Florida Assertive Community Treatment, or FACT Team, which has been in existence locally since 2001, works with people with severe and persistent mental illness, helping them live and work in the community. Act Corp. operates the program through $1.2 million annually in state and federal funding.

- Statewide, there are 32 teams made up of the clients and 10 staff, including psychiatrists, nurses and mental health workers.
- There are 100 clients on the team in Volusia and Flagler counties who are helped with everything from subsidizing their rent to getting their medications. · Locally, there are 56 men and 44 women.
- The average age is 46.
- About 51 percent locally live on their own with the remainder in assisted living facilities or with their families.
- A study from several years ago looking at 64 local clients, showed they were hospitalized a combined total of 264 times prior to joining the team. A year after being on the team, hospitalizations for the group dropped to 60.

The above article, "Program Keeps Mentally Ill Out of Hospital, Jail," was written by Deborah Circelli, a staff writer for the ***Daytona Beach News-Journal****, and appeared in the August 13, 2007edition of the newspaper. Copyright 2007,* ***Daytona Beach News-Journal****. All rights reserved. Used with permission.* ❑

Assertive Community Treatment
(National Alliance on Mental Illness)

Assertive Community Treatment (ACT) is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses. Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers. ACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. The ACT team provides these necessary services 24 hours a day, seven days a week, 365 days a year.

How Did ACT Begin?

Now in its 26th year, the ACT model evolved out of work led by Arnold Marx, M.D., Leonard Stein, M.D., and Mary Ann Test, Ph.D., on an inpatient research unit of Mendota State Hospital, Madison, Wisconsin, in the late 1960s. Noting that the gains made by clients in the hospital were often lost when they moved back into the community, they hypothesized that the hospital's round-the-clock care helped alleviate clients' symptoms and that this ongoing support and treatment was just as important - if not more so - following discharge. In 1972, the researchers moved hospital-ward treatment staff into the community to test their assumption and, thus, launched ACT.

What are the Primary Goals of ACT?

ACT strives to lessen or eliminate the debilitating symptoms of mental illness each individual client experiences and to minimize or prevent recurrent acute episodes of the illness, to meet basic needs and enhance quality of life, to improve functioning in adult social and employment roles, to enhance an individual's ability to live independently in his or her own community, and to lessen the family's burden of providing care.

What are the Key Features of ACT?

Treatment:

- psychopharmacologic treatment, including new atypical antipsychotic and antidepressant medications
- individual supportive therapy
- mobile crisis intervention
- hospitalization

- substance abuse treatment, including group therapy (for clients with a dual diagnosis of substance abuse and mental illness)

Rehabilitation:

- behaviorally oriented skill teaching (supportive and cognitive-behavioral therapy), including structuring time and handling activities of daily living
- supported employment, both paid and volunteer work
- support for resuming education

Support services:

- support, education, and skill-teaching to family members
- collaboration with families and assistance to clients with children
- direct support to help clients obtain legal and advocacy services, financial support, supported housing, money-management services, and transportation

Who Benefits from the ACT Model?

The ACT model is indicated for individuals in their late teens to their elderly years who have a severe and persistent mental illness causing symptoms and impairments that produce distress and major disability in adult functioning (e.g., employment, self-care, and social and interpersonal relationships). ACT participants usually are people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder (manic-depressive illness); those who experience significant disability from other mental illnesses and are not helped by traditional outpatient models; those who have difficulty getting to appointments on their own as in the traditional model of case management; those who have had bad experiences in the traditional system; or those who have limited understanding of their need for help.

What is the Difference between ACT and Traditional Care?

Most individuals with severe mental illnesses who are in treatment are involved in a linkage or brokerage case-management program that connects them to services provided by multiple mental health, housing, or rehabilitation agencies or programs in the community. Under this traditional system of care, a person with a mental illness is treated by a group of individual case managers who operate in the context of a case-management program and have primary responsibility only for their own caseloads. In contrast, the ACT multidisciplinary staff work as a team. The ACT team works collaboratively to deliver the majority of treatment, rehabilitation, and support services required by each client to live in the community. A psychiatrist is a member of, not a consultant to, the team. The consumer is a client of the team, not of an individual staff member. Individuals with the most severe mental illnesses are typically not served well by the traditional outpatient model that directs patients to various services that they then must navigate on their own. ACT goes to the consumer whenever and wherever needed. The consumer is not required to adapt to or follow prescriptive rules of a treatment program.

Is There a Difference Between ACT and PACT?

There is no difference between the PACT (Program of Assertive Community Treatment) model and the ACT (Assertive Community Treatment) model. Not only does NAMI use ACT and PACT interchangeably, but ACT or PACT is also known by other names across the country. For example, in Wisconsin, ACT programs are called Community Support Programs, or CSP. In Florida, ACT programs are called FACT (Florida Assertive Community Treatment); in Rhode Island and Delaware ACT programs are called Mobile Treatment Teams (MTT), while Virginia uses PACT for its assertive community treatment teams.

While the official name that a state, county, or locality uses for ACT varies widely, there is only one set of standards that NAMI sets forth for all programs of assertive community treatment.

How do ACT Clients Compare with Those Receiving Hospital Treatment?

ACT clients spend significantly less time in hospitals and more time in independent living situations, have less time unemployed, earn more income from competitive employment, experience more positive social relationships, express greater satisfaction with life, and are less symptomatic. In one study, only 18 percent of ACT clients were hospitalized the first year compared to 89 percent of the non-ACT treatment group. For those ACT clients that were rehospitalized, stays were significantly shorter than stays of the non-ACT group. ACT clients also spend more time in the community, resulting in less burden on family. Additionally, the ACT model has shown a small economic advantage over institutional care. However, this finding does not factor in the significant societal costs of lack of access to adequate treatment (i.e., hospitalizations, suicide, unemployment, incarceration, homelessness, etc.).

How Available are ACT Programs?

Despite the documented treatment success of ACT, only a fraction of those with the greatest needs have access to this uniquely effective program. Only six states (DE, ID, MI, RI, TX, WI) currently have statewide ACT programs. Nineteen states have at least one or more ACT pilot programs in their state. In the United States, adults with severe and persistent mental illnesses constitute one-half to one percent of the adult population. It is estimated that 20 percent to 40 percent of this group could be helped by the ACT model if it were available.

For more information on Assertive Community Treatment, contact the National Alliance on Mental Illness, Colonial Place Three, 2107 Wilson Boulevard, Arlington, VA 22201, (703) 524-7600, www.nami.org ❑

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.

New York

In 2002, Disability Advocates, Inc., the Legal Aid Society's Prisoners' Rights Project, Prisoners' Legal Services, as well as the law firm of Davis, Polk & Wardwell filed *Disability Advocates, Inc. v. New York State Office of Mental Health and Department of Correctional Services, et al.*, [Civil No. 02-CV 4002 (GEL)]. The lawsuit alleged that inmates with mental illness throughout New York did not get adequate mental health treatment in violation of the Eighth Amendment. The lack of treatment resulted in many inmates with mental illness being punished with lengthy terms of solitary confinement in "Special Housing Units" (SHU) or Keeplock, where they were confined for 23 hours each day, had severe restrictions on property and visitation, and no access to out-of-cell programming. Suffering from the isolation and idleness, these inmates often experienced severe psychiatric deterioration, including acts of self-mutilation and even suicide.

Following five years of litigation and two weeks of trial, the state Department of Correctional Services and state Office of Mental Health agreed to a "private settlement" which is projected to establish major improvements in psychiatric treatment for state inmates with mental illness. The settlement agreement was approved by Judge Lynch of the United States District Court for the Southern District of New York on April 27, 2007. At the settlement conference hearing, Judge Lynch stated that SHU confinement was "almost guaranteed to worsen the mental condition of just about anyone but certainly those with vulnerable psyches."

The plaintiffs envision that the settlement will improve mental health care for all inmates with serious mental illness throughout the New York State prison system, including all the SHU and Keeplock units. Unlike similar cases in other states, relief for inmates was not limited to "supermax" prisons. The settlement will require creation of new mental health treatment programs for inmates with serious mental illness who have SHU and Keeplock sanctions, and requires the state to provide at least two hours a day of out-of-cell treatment and programming to all inmates with serious mental illness remaining in SHU. It also requires reviews of disciplinary sentences for inmates with serious mental illness in consideration of sanction reduction and diversion from SHU. It will require improved mental health assessments for inmates when they first arrive in state custody, and increase the numbers of residential mental health treatment beds. Improved screening, assessment, and treatment is expected to enable more inmates with mental illness to avoid SHU and Keeplock sanctions.

The settlement agreement can be found at the Disability Advocates, Inc. website: http://www.disabilityadvocates.info/complaints/DAIvOMHSettlement.pdf

Illinois

When police arrived at his mother's house on June 28, 2007, 20-year-old Victor Flores fled to the roof of a neighbor's garage. As officers surrounded the area, he allegedly threatened to commit suicide by jumping. A few hours later, he carried out the threat, hanging himself in a district holding cell of the Chicago Police Department. Mr. Flores' family said they had warned police that he was a danger to himself and needed to be monitored. "As soon as they were trying to arrest him, I told the officer that he has bipolar disorder and that he's suicidal and that this isn't the first time he tried to kill himself," Mr. Flores' mother, Janell Salgado, told the *Chicago Tribune*. "I told them to watch him." According to family members, the young man had a history of suicide attempts, the most recent of which occurred two months earlier when he was briefly hospitalized.

But Monique Bond, spokeswoman for the Chicago Police Department, told the *Tribune* that "There's nothing in the [police] report to indicate that he was suicidal, but that's not to say the matter won't be investigated thoroughly." The department's Office of Professional Standards would look into the death, she told the newspaper.

Mississippi

In July 2007, several civil rights groups filed a lawsuit asking a federal judge to impose injunctive relief to end the "horrendous" physical and sexual abuse of six girls confined at the state Division of Youth Services' Columbia Training School. The lawsuit also asked the court to order that the state provide federally required mental health and rehabilitative treatment to girls confined in the facility.

The Mississippi Youth Justice Project, a project of the Southern Poverty Law Center, Mississippi Protection and Advocacy, Inc, the Bazelon Center for Mental Health Law, and Robert B. McDuff, a civil rights attorney in Jackson, filed the lawsuit on behalf of six girls ranging in age from 13 to 17. All the girls experience mental illness and each was committed to the facility for non-violent offenses. Most are victims of past histories of physical or sexual abuse.

Filed in the United States District Court for the Southern District of Mississippi, the lawsuit (*J.A. v. Barbour, et al*) alleges that:

- In an apparent response to unsubstantiated allegations that they planned to escape, five of the plaintiffs were shackled around their ankles for 12 hours a day for periods ranging from eight days to a month. They had to eat, attend school, use the bathroom, participate in recreational activities and visit with their families while wearing the painful shackles.

- One girl was sexually assaulted by a male employee of the facility while she was confined in a segregated area. She reported the assault, but was never informed of the results of an investigation, and never received counseling to help her deal with the trauma.

- Three of the girls cut themselves while on suicide precautions. None of the youth received any psychological help during their isolation. No attempt was made to stabilize their moods, and staff members failed to perform periodic checks to ensure their safety. One girl was placed in a cell alone for 14 hours, during which time she carved the words "HATE ME" into her forearm. Another girl sliced her wrists with glass, while a third girl sliced her wrists on the edge of the concrete bunk.

According to a study commissioned by the state Department of Public Safety, between 66 percent and 85 percent of incarcerated Mississippi youth have at least one diagnosable mental disorder, and the vast majority of girls were sent to Columbia for non-violent offenses such as drug charges and shoplifting. The lawsuit alleges that most of these youth could be treated far more effectively — and at half the cost — in community-based programs that focus on rehabilitation and mental health treatment. The state spends approximately $5 million a year to house an average of 60 girls at the Columbia Training School.

Although the state Department of Human Services declined to comment on the lawsuit, Representative George Flaggs, chairman of the juvenile justice committee in the state legislature, reacted to allegations in the lawsuit by telling *The New York Times*: "It's indefensible, it's embarrassing to the state of Mississippi, and it's unnecessary. Shackles should never be used unless they are being transported. It's clearly stupidity."

The state entered into a settlement agreement with the U.S. Justice Department's Civil Rights Division in 2005 following the discovery of widespread problems in the care and treatment of youth at both the Columbia Training School and the Oakley Training School for boys (see ***Jail Suicide/Mental Health Update***, Spring 2006, Volume 14, Number 4, pages 17-18).

Arizona

Maricopa County will pay $2 million to the family and estate of a man who died after being placed in a restraint chair in Phoenix's Maricopa County Jail in 2005. The settlement agreement was approved in June 2007 by the county board of supervisors. In December 2005, 33-year-old Clint Yarbrough walked into a convenience store in Phoenix and asked the clerk to call 911 because he was feeling ill. When police were called to the scene, an altercation ensued and Mr. Yarbrough was arrested and transported to the county jail. At the jail, he continued to resist the officers and was placed in a restraint chair. He died shortly thereafter.

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

Under terms of the settlement, the Yarbrough family and their attorney, Michael Manning, agreed not to further discuss the case.

It is the third such case that Mr. Manning has won since 1999 involving Maricopa County Jail inmates who died after being strapped into a restraint chair. In 2006, a federal jury awarded $9 million to the family of Charles Agster, III, who died in 2001. In 1999, the county agreed to pay $8.25 million to the family of Scott Norberg, who died in 1996. All of the victims were under the influence of methamphetamines at the time of their arrests. The use of restraint chairs in the Maricopa County Jail system has since been discontinued.

Texas

In December 2006, the Civil Rights Division (Special Litigation Section) of the U.S. Department of Justice released an investigative report regarding grossly inadequate medical and mental health care at the Dallas County Jail (DCJ). According to the report, "jail staff frequently mismanage inmates' acute medical needs, thereby significantly delaying appropriate medical care…..Most seriously, we found numerous instances where DCJ's mismanagement contributed to preventable deaths, hospitalizations and unnecessary harm." The report was based on on-site inspections at the jail in February and March 2006, as well as review of hundreds of documents (including policies and procedures, grievances, and medical and mental health files).

In November 2007, the Department of Justice and Dallas County entered into a settlement agreement to improve medical and mental health care within the jail system. Filed in the United States District Court for the Northern District of Texas, the "Agreed Order" in *United States v. Dallas County et al* (Civil No. 307 CV 1559-N) contains the following mental health and suicide prevention requirements:

1) Timely and Appropriate Evaluation

- Defendants shall provide develop and implement policies and procedures to appropriately assess inmates with mental illness, and evaluate inmates' mental health needs.

- Defendants shall ensure that the intake evaluation process includes a mental health screening, which shall be incorporated into the corresponding inmate's medical records. Defendants shall ensure timely access to a qualified mental health professional when presenting symptoms of mental illness require such care.

- Defendants shall ensure that the mental health screening process includes inquiry regarding: (1) past suicidal ideation and/or attempts, (2) current ideation, threat, or plan, (3) prior mental health treatment or hospitalization, (4) recent significant loss, such as the death of a family member or close friend, (5) history of suicidal behavior by family members and close friends, (6) suicide risk during any prior confinement, and (7) any observations of the transporting officer, court, transferring agency, or similar individuals regarding the inmate's potential suicide risk.

- Defendants shall ensure adequate and timely treatment for inmates whose assessments reveal serious mental illness, including timely and appropriate referrals for specialty care and regularly scheduled visits with qualified mental health professionals.

- Defendants shall ensure an adequate array of crisis services to appropriately manage the psychiatric emergencies that occur among inmates. Crisis services shall not be limited to administrative segregation or observation status. Inmates shall have access to appropriate licensed in-patient psychiatric care when clinically appropriate.

2) Assessment and Treatment

- Defendants shall ensure that treatment plans adequately address inmates' serious mental health needs and that the plans contain interventions specifically tailored to the inmates' diagnoses.

- Defendants shall provide for an inmate's reasonable privacy in medical and mental health care, and maintain confidentiality of inmates' medical and mental health status, subject to legitimate security concerns and emergency situations.

- Defendants shall provide adequate on-site psychiatric coverage for inmates' serious mental health needs and ensure that psychiatrists see inmates in a timely manner.

- Defendants shall ensure that disciplinary charges against inmates are reviewed by a qualified mental health professional to determine the extent to which the charge was related to serious mental illness, to ensure that inmates who commit infractions resulting from a serious mental illness are not punished for behavior caused by mental illness, and to ensure that an inmate's serious mental illness is used as a mitigating factor, as appropriate, when punishment is imposed on inmates with a serious mental illness.

- Defendants shall ensure that mentally ill inmates in segregation receive timely and appropriate treatment, including completion and documentation of regular rounds in the segregation units at least once per week by adequately trained qualified mental health professionals in order to assess the serious mental health needs of inmates in segregation. Inmates with serious mental illness who are placed in segregation shall be immediately and regularly evaluated by a qualified mental health professional

to determine the inmate's mental health status, which shall include an assessment of the potential effect of segregation on the inmate's mental health. During these regular evaluations, Defendants shall evaluate whether continued segregation is appropriate for that inmate, considering the assessment of the qualified mental health professional, or whether the inmate would be appropriate for graduated alternatives.

3) Psychotherapeutic Medication Administration

- Defendants shall ensure that psychotherapeutic medication administration is provided in accordance with generally accepted professional mental health care standards.

- Defendants shall ensure that psychotropic medication orders are reviewed by a psychiatrist on a regular, timely basis for appropriateness or adjustment.

- Defendants shall ensure timely implementation of physician orders for medication and laboratory tests. Defendants shall ensure that inmates who are being treated with psychotropic medications are seen regularly by a physician to monitor responses and potential reactions to those medications, in accordance with generally accepted correctional mental health care standards.

4) Suicide Prevention

- Defendants shall develop policies and procedures to ensure the appropriate management of suicidal inmates, and shall establish a suicide prevention program in accordance with generally accepted professional standards of care.

- Defendants shall ensure that suicide prevention procedures include provisions for constant direct supervision of actively suicidal inmates and close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks). Officers shall document their checks. Suicide prevention policies shall include procedures to ensure the safe housing and supervision of inmates based on the acuity of their mental health needs. Cells for suicidal inmates shall be retrofitted to render them suicide-resistant (e.g., elimination of protrusive shower heads, exposed bars, unshielded lighting or electrical sockets).

- Defendants shall ensure that all staff are trained on suicide response, prevention, and detection. Staff posts will be equipped with 911 rescue tools.

- Defendants shall ensure adequate administrative mortality and morbidity review of custodial suicides and serious suicide attempts review following a custodial suicide or suicide attempt. At a minimum, the review shall include: (1) critical review of the circumstances surrounding the incident; (2) critical review of procedures relevant to the incident; (3) synopsis of all relevant training received by involved staff; (4) pertinent medical and mental health services/reports involving the victim; (5) possible precipitating factors leading to the suicide or attempt; and (6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.

The complete "Agreed Order" in *United States v. Dallas County et al* (Civil No. 307 CV 1559-N) can be found at: http://www.usdoj.gov/crt/split/documents/dallas_county_order_11-06-07.pdf

Oklahoma

The parents of a young man found dead in the Cherokee County Detention Center in Tahlequah believe the state jail inspector's investigative report released in late September 2007 raised more questions than answers. The report stated that Aaron Colby Riddle, 22-years-old, had been dead several hours before jail staff found him hanging with a sheet tied around his neck on September 6. Margaret Riddle said losing her son was the worst thing she had experienced, and questioned the ever-changing accounts that have been given with regard to his death. "They gave me all kinds of stories," Mrs. Riddle told the *Muskogee Phoenix*. "First they said he hung himself with a belt, then it was a rope. Now it's a T-shirt or a sheet."

Completed by Cal Kester, an investigator with the state Department of Health's Jail Inspection Division, the report lists the absence of documented cell checks as the most troubling aspect of the investigation. Mr. Kester said jail staff told him they were too busy to conduct hourly sight checks. Mr. Riddle was last seen alive at 7:45pm before being found hanging at 10:55pm. "If they were actually that busy, then why did one staff member leave the facility to pick up food?" Mr. Kester wrote in his report.

Opened in January 2007, the 150-bed Cherokee County Detention Center is operated by a trust authority created by the county commissioners. Don Garrison, supervisor of the state Jail Inspection Division, said the jail was cited as being deficient with regard to the failure to comply with a state law that requires hourly sight checks for all inmates. "They had policy and procedures in place, and the employees had been properly trained," Mr. Garrison said. "This is just a situation where the jail employees didn't do what they are supposed to be doing."

In addition to the lack of documented cell checks, the investigative report also revealed other discrepancies in jail staff accounts of what took place during the night of September 6. One of those involves the time of death. The report states that one jailer told a supervisor that emergency medical services (EMS) personnel estimated Mr. Riddle had been dead approximately 15 to 25 minutes before he was found hanging.

However, the EMS report actually stated that Mr. Riddle "had been deceased for several hours" before he was found by a detention officer who entered the cell to "change out clothing."

There are other discrepancies in the case. Mr. Riddle had been arrested on September 4 and charged with several burglaries in the area. According to the victim's father, Eugene Riddle, his son had been treated for depression prior to his arrest and jail staff were notified of his condition. Mr. Riddle told the *Muskogee Phoenix* that he was informed that his son was being closely observed by staff at the jail. In fact, Cherokee County Undersheriff Jason Chennault told the *Muskogee Phoenix* that he was originally told that Aaron Riddle was on suicide precautions for two days before being transferred to a different cell where "he was locked down by himself."

But Loyd Bickel, administrator of the 150-bed facility, denied that Mr. Riddle had been on suicide precautions. "He was in the front for a while where we could watch him," Mr. Bickel told the newspaper. "We had no indicators (of suicidal tendencies), and he (Riddle) said he wasn't suicidal," although the inmate had self-reported a suicide attempt 18 months earlier. Mr. Bickel also stated that he had taken unspecified disciplinary action against four jail staff who were on duty when Mr. Riddle committed suicide. "This was poor judgment on their part," Mr. Bickel told the *Tahequah Daily Press*. "They've been through jail training, and they all know our policy on sight checks."

On October 17, 2007, the Cherokee County Governmental Building Authority, which oversees the county jail, received notice of a tort claim against the county and its jail staff for the death of Aaron Riddle.

Florida

Robert C. Burrell, 41-years-old, with mental retardation and physical disabilities, sat in the Hillsborough County Jail for 432 days with no criminal charges but nowhere more suitable to go. On July 20, 2007, however, the non-profit Gulf Coast Community Care agency in Clearwater accomplished in days what four government agencies could not in 13 months when it secured placement for him at a skilled nursing home. "Better late than never, I guess," Assistant Public Defender John Skye, whose office represented Mr. Burrell, told the *St. Petersburg Times*.

Mr. Burrell was originally arrested for breaking into an automobile in South Tampa and was later found incompetent to stand trial. He then spent two years at a state program for defendants with mental retardation. When his condition did not improve, a judge dropped the criminal charge in June 2006. But Mr. Burrell stayed at the county jail awaiting transfer to a facility equipped to handle an adult who could not talk, required a wheelchair, and needed assistance for using the toilet.

Both jail and public defender's office officials stated they thought the state Agency for Persons with Disabilities was responsible for arranging long-term care for Mr. Burrell. But that agency said that task was the responsibility of the jail and the state Department of Elder Affairs. In mid-July, a judge ended the deadlock by ordering Mr. Burrell released from the jail and involuntarily committed to a psychiatric hospital for evaluation.

Kim Tennant, behavioral health administrator for Gulf Coast Community Care, read about Mr. Burrell's plight in the *St. Petersburg Times*. She called one of the agency's forensic specialists to schedule a meeting with Mr. Burrell the next day. "It was just a shame we had to read about it in the newspaper for a man who needed services so desperately," she told the newspaper. "The system is definitely breaking down."

Gulf Coast Community Care has served Tampa Bay area residents with medical and psychiatric needs for more than 40 years and runs a program specifically designed to prevent such people from languishing in jail, Ms. Tennant said. The agencies previously involved with the case said Mr. Burrell's medical and mental condition, plus his lack of family and birth certificate, made for a difficult placement. But Ms. Tennant disagreed. "We have cases that make this case look easy," she said. Robert Burrell will be provided with a full array of services at the nursing home that will be paid for by Gulf Coast Community Care until Medicaid or Medicare funding can be secured.

For more information on Gulf Coast Community Care, contact the agency at 14041 Icot Boulevard, Clearwater, FL 33760, (727) 538-7460, website: www.gulfcoastcommunitycare.org/svc-mental.htm

New Mexico

In November 2007, two civil rights groups and two private attorneys filed a lawsuit suit against the Dona Ana County Detention Center in Las Cruces, alleging the county is negligent in providing mental health services to inmates. The American Civil Liberties Union of New Mexico and Protection and Advocacy System, Inc. filed the complaint in the state's Third Judicial District Court in Las Cruces. Four inmates currently or previously in the detention center were named as plaintiffs in the lawsuit, which seeks class-action certification.

The lawsuit alleges that 30 to 40 percent of the 800 to 900 inmates at the county jail "have a mental disability requiring some form of therapeutic service or support," but the county does not provide adequate mental health services, monitoring and care, in violation of the federal Americans with Disabilities Act and the Rehabilitation Act. The suit seeks an injunction that will order county officials to comply with the law, as well as unspecified damages. It also seeks implementation of policies that would prohibit unnecessary confinement for those individuals with mental health problems and provide reasonable accommodations to those that are incarcerated, including adequate mental health screening and assessment.

The lawsuit cites the case of one inmate who, in spite of repeated suicide attempts, had not received a mental health assessment. According to the complaint, the defendants "chronically engage in acts or omissions that are discriminatory and negligent, and which manifest deliberate indifference to plaintiffs' serious mental health needs." In December 2006, a jail conditions expert (who was hired by the Protection and Advocacy System, Inc.) inspected the facility and recommended changes to establish adequate mental health screening, but county officials allegedly ignored the recommendations. "By ignoring inmates' mental health problems,

the county has created a lose-lose situation," ACLU of New Mexico Executive Director Peter Simonson said in a statement reported in the *Las Cruces Sun-News*. "The inmates suffer. The jail suffers, because it faces possible suicides and violence within the facility. And ultimately the citizens of Dona Ana County lose because eventually some of these inmates will return to society in worse mental states than when they entered the jail. It's high time the situation is resolved for all concerned." The county declined to comment on the lawsuit.

Virginia

Jails contain more people with mental illness than all the state and private hospitals in Virginia, a legislative study found. While the study concluded that the number of available psychiatric beds is generally adequate, hospital beds for the mentally ill and services do not exist in vast areas of the state. The findings were contained in a draft 158-page report released in October 2007 by the General Assembly's Joint Legislative Audit and Review Commission (JLARC). Among the conclusions:

- Of the 6,350 people with mental illness in hospitals or jails on a single day two years ago, 60 percent were in jails.
- 43 percent of jails responding to a state survey said regional mental health agencies do not provide mental health services.
- In 1936, only one person with mental illness was in jail for every six in state hospitals. In 2005, that ratio had gone to five people in jail for every two in a hospital.
- Seven of the state's localities have more than half the roughly 1,500 psychiatrists in the state. Forty-seven localities have none.

The JLARC study found that hospital care accounts for only a fraction of the needs of the state's estimated 400,000 adults and children with serious mental illness. Although the number of beds statewide is up to state Department of Health standards, the beds tend to be concentrated in certain geographic areas. The western part of the state, for instance, is underserved. The report also found vast disparities in the quality of care from one jurisdiction to another and a failure by state agencies and local mental health agencies to follow state laws mandating how patients are to be assessed and identified for care. A state law dating back a decade requires public hearings and regulations to set payment rates for temporary detentions, but it has never been implemented. The rates are set unilaterally by the state Department of Medical Assistance Services. The report said clear data on services, needs and disabilities are lacking and hospitals are losing millions of dollars in caring for the mentally ill.

The report, "Availability and Cost of Licensed Psychiatric Services in Virginia," also raises questions about unclear agreements among partnerships of regional mental-health agencies. It is available at: http://jlarc.state.va.us/Meetings/October07/PsychRpt.pdf ❑

Jail Suicide/Mental Health Update

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

This publication is supported by Cooperative Agreement Award Number 06HI02GJM7 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 1-15)

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

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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

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