JAIL SUICIDE/MENTAL HEALTH UPDATE

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Looking Ahead Toward a Better Understanding of Suicide Prevention in Correctional Facilities

When I was asked last year to make a presentation at your conference today, my first thought was obviously — What should I talk about?[1] The luncheon theme of "Preventing Suicides: It's Everybody's Responsibility," was certainly one we should all embrace, but what is it really about suicide prevention that correctional and healthcare professionals are interested in? Current research? Liability? Hot topics?

During the past month, I've received several inquires regarding what some would consider hot topics? A newspaper reporter called and asked what I thought about the issue of inmate companions (or suicide prevention aides). It seemed a state prison system had a rash of suicides last year, but since they began the companion program, there had not been any suicides reported in the system this year. The mental health director of a large county jail called to ask me who sold the best safety smock on the market? And then I received a call from a technology geek from one of the largest corporations in the country. It seems they have a research technology grant with the U.S. Justice Department and one of areas they are studying is inmate safety. The short version of the conversation was that they were testing pulse sensor devices in cells housing suicidal inmates. If an inmate's heart beat was detected as being outside the normal range and viewed as being in distress, an alarm would go off and presumably an emergency response would be called. He asked me what I thought? I said, "Does Jack Bauer know about this gadget?" He didn't think it was funny (either).

What do these three hot suicide prevention topics have in common? Well, unfortunately, the common thread is that they all seem fixated on keeping inmates safe *while they are on suicide precautions*. Certainly a very worthy topic, but should that be the extent of our suicide prevention efforts? I think not.

More times than not, we do a fine job of safely managing inmates identified as suicidal and placed on suicide precautions. After all, few inmates successfully commit suicide while on suicide watch. If they did, we can surely expect to incur liability.

What we continue to struggle with is the ability to prevent the suicide of an inmate who is *not* on suicide precautions. These are inmates that might not be easily identifiable as being at risk for self-harm. These are inmates that emphatically deny they are suicidal, they may even contract for safety, but their actions and history suggest otherwise. These are inmates with past histories of self-injurious behavior and poor coping skills who find themselves locked down in segregation or recently received bad news during a court hearing, telephone call, or visit. These are inmates who are not currently on suicide precautions, but should be!

Kay Redfield Jamison, a prominent psychologist and author, has best articulated the point by stating that if "*suicidal patients were able or willing to articulate the severity of their suicidal thoughts and plans, little risk would exist.*"[2]

With this in mind, I offer the following 14 principles for better identifying suicidal inmates.

Number 1

The assessment of suicide risk should *not* be viewed as a single event, but as an on-going process. Because an inmate may become suicidal at any point during confinement, suicide prevention should begin at the point of arrest or transfer to your facility and continue until the inmate is released from the facility. So, for example, as the inmate is entering your facility, there should be a formalized process by which your intake staff ask arresting or transporting officers whether they believe the inmate has demonstrated any concerning behavior, including the risk for suicide.

In addition to early stages of confinement, many suicides occur in close proximity to a court hearing. We must begin to devise ways to be more attentive to this risk period. In Albany County, New York, inmates who are on the mental health caseload and/or have a prior history of suicidal behavior, receive a brief mental health status screening after each court hearing. In Santa Clara, California, inmates arrested on charges of murder, domestic violence, or child molestation receive similar scrutiny.

Inside. . .

In addition, once an inmate has been successfully managed on, and discharged from, suicide precautions, they should remain on a mental health caseload and assessed periodically until released from the facility.

Put another way, most suicide prevention policies that I review are heavy on explaining the intake screening process, but light on most of the other critical areas of identification.

Number 2

Screening for suicide risk during the initial booking and intake process should be viewed as something similar to taking one's temperature — it can identify a current fever, but not a future cold. The shelf life of current behavior that is observed and/or self-reported during intake screening is time-limited, and we often place far too much weight upon this initial data collection stage. Following an inmate suicide, it is not unusual for the mortality review process to focus exclusively upon whether the victim threatened suicide during the initial intake stage, a time period that could be far removed from the date of suicide. If the victim had answered in the negative to suicide risk during intake, there is often a sense of relief expressed by participants of the mortality review process, as well as a misguided conclusion that the death was not preventable. Although the intake screening form remains a valuable prevention tool, the more important determination of suicide risk is the *current* behavior expressed and/or displayed by the inmate during their confinement.

Number 3

With that said, however, prior risk of suicide is strongly related to future risk. At a minimum, if an inmate had been placed on suicide precautions during a previous confinement in the facility or agency, such information should be accessible to both correctional and healthcare personnel when determining whether the inmate might be at risk during their current confinement. It's also a common plaintiff strategy in current litigation. Imagine the embarrassment when the plaintiff's attorney has received documentation that the inmate was on suicide precautions during a previous confinement in your facility, but you or your staff did not have access to the information at the time of the initial assessment.

Number 4

We should not rely *exclusively* on the direct statements of an inmate who denies that they are suicidal and/or have a prior history of suicidal behavior, particularly when their behavior, actions and/or history suggest otherwise. Often, despite an inmate's denial of suicidal ideation, their behavior, actions, and/or history speak louder then their words. For example:

> In Washington State, an inmate was booked into a county jail and informed the intake officer that she had a history of mental illness, had attempted suicide two weeks earlier, but "will not hurt herself in jail." Jail records indicated that the inmate threatened suicide during a recent prior confinement in the facility. The inmate attended a court hearing two days later and the escort officer noticed that she appeared despondent, was crying, and appeared worried about her children. She was not referred to mental health staff, nor placed on suicide precautions. The inmate committed suicide the following day.
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> In Michigan, police were called to the home of a man who accidentally shot and killed a friend during a domestic dispute with his estranged wife. Upon arrival of the police, the suspect placed a handgun to his head and clicked the trigger several times. He also encouraged the officers to shoot him. Following five hours of negotiations, the suspect surrendered without incident. He was transported to the county jail and denied being suicidal during the intake screening process. The inmate was not referred to mental health staff, nor placed on suicide precautions. He committed suicide the following day.

It is not all that surprising that these preventable deaths often escape our detection. Take, for example, the booking area of a correctional facility. It is traditionally both chaotic and noisy; an environment where staff feel pressure to process a high number of

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 were distributed in early 2008. Findings from the study should be available in mid-2009. 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

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, interpreting their responses (including gauging the truthfulness of their denial of suicide risk), 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, as well as circumstances that may lend themselves to potential self-injury, are lost.

In yet another example, a suicidal inmate sent to the hospital for an assessment may appear to be stable in front of an emergency room physician, even deny suicide risk, only to be discharged from the hospital and returned to the correctional facility where they again revert to the same self-injurious behavior that prompted the initial referral. Given such a scenario, healthcare and correctional staff should *not* assume that the hospital was cognizant or even appreciative of this cyclical behavior. On the contrary, regardless of what the hospital clinician might have observed and/or recommended, as well as the inmate's denial of risk, whenever healthcare and correctional staff hear an inmate verbalize a desire or intent to commit suicide, observe an inmate engaging in suicidal behavior or otherwise believe an inmate is at risk for suicide, they should take immediate steps to ensure that the inmate's safety.

Number 5

We must provide useful pre-service and annual suicide prevention training to all staff. While implementing suicide precautions for an inmate that verbally threatens suicide requires little training, identifying suicidal behavior of inmates unwilling and/or unable to articulate their feelings, or who deny any ideation, requires both comprehensive pre-service and annual training. Simply stated, correctional staff, as well as medical and mental health personnel, cannot detect, make an assessment, nor prevent a suicide for which they have little, if any, useful training.

All suicide prevention training must be *meaningful*, i.e., timely, long-lasting information that is reflective of our current knowledge base of the problem. Training should not be scheduled to simply comply with an accreditation standard. A workshop that is limited to an antiquated videotape, or recitation of the current policies and procedures, might demonstrate compliance (albeit wrongly) with an accreditation standard, but is not meaningful, nor helpful, to the goal of reducing inmate suicides. Without regular suicide prevention training, staff often make wrong and/or ill-informed decisions, demonstrate inaction, become complacent, or react contrary to standard correctional practice, thereby incurring unnecessary liability.

In reviewing a case file recently, a came across this rather interesting deposition testimony. When asked if he was ever provided with training on how to properly conduct intake screening, the booking officer replied that "I wasn't trained as far as what specific questions to ask them." When questioned whether he would ask an inmate if they were thinking about suicide, the officer replied, "I would not personally….You don't want to turn around to an inmate and say, 'Do you feel like you're suicidal' and give him an idea. You have to, like, judge that person when they come in…. if he's not suicidal and he's just depressed, I'm not going to say, 'are you suicidal,' and give them the idea to kill himself….I don't push the issue for the simple reason I don't want to push it in his mind to do it."

In another case, an officer was asked how he would monitor an inmate for signs of depression (as recommended by the jail nurse) and he responded: "Depression is not a word that means much. You're in jail, you should be a little depressed. That's not an uncommon emotion. Okay, it's not something we get really excited about." In addition, when asked during the deposition whether he ever reviewed an inmate's prior jail record to see if they had previously been identified at risk of suicide, the officer responded: "There's no reason to be looking at the previous record….Should he always be treated as a suicide person for the rest of his life? No."

Number 6

Not all suicides are preventable, but those that are often result from poor communication amongst correctional, medical and mental health staff. Communication problems are often caused by lack of respect, personality conflicts, and other boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides.

Number 7

One size does not fit all and basic decisions regarding the management of a suicidal inmate should be based upon their individual clinical needs, not simply on the resources that are said to be available. For example, if an acutely suicidal inmate requires continuous, uninterrupted observation from staff, they should *not* be monitored by closed circuit television simply because that is the only option the system chooses to offer. A clinician should never feel pressured, however subtle that pressure may be, to downward and/or discharge an inmate from suicide precautions because additional staff resources (such as overtime, post transfer, etc.) are required to maintain the desired level of observation. Although they would never admit it, clinicians have prematurely downgraded, discharged, and/or changed the management plan for a suicidal inmate based upon pressure from correctional officials.

I was in a county jail recently and, while interviewing a mental health clinician, the telephone rang. It was the head nurse. Apparently a female inmate had just arrived into the clinic from booking. During booking, the intake nurse had scored the inmate high on a suicide risk screening form (for loss of relationship, psychiatric history, drug history, displaying signs of depression, anger, incoherent, and inability to focus). Now the head nurse was calling to ask the mental health clinician to assess and *clear* the inmate from the clinic. I followed the clinician to the clinic and came upon a female inmate sitting in a chair surrounded by the head nurse and several officers. She was barely conscious and appeared incoherent. One might ask how she was able to be medically cleared into the facility. Anyway, the clinician tried to talk to the inmate, but it was pointless. She could not respond to any questions and had to be held up from falling off the chair. The clinician clearly could not conduct the assessment and told the

head nurse that the inmate would need to be placed on suicide precautions until such time as she could be interviewed. Given her condition, she would also need to be housed alone and, given the facility policy of requiring constant observation for suicidal inmates housed alone, an officer would need to be reassigned to conduct the supervision.

The clinician and I returned to her office. The interviewed continued until there was a knock on the door. It was the shift supervisor who wondered aloud how long it would take to assess the inmate. In other words, how long do I need to assign an officer to provide constant observation. The clinician calmly responded that the assessment could not be conducted until the inmate became coherent and could understand the questions. The supervisor thought about it for a moment, glanced at me, then departed. The interview continued again for a few minutes until the telephone rang. This time it was the jail commander. I only heard half of the conversation, but it seemed to be of similar content to that of the shift supervisor. Again the clinician responded politely that the assessment would occur only when the inmate was coherent enough to understand the questions. The telephone conversation ended and my interview continued. Well, not really. Another knock on the door. This time it was the head nurse with some evidence. It seemed that, in reviewing the intake screening form, the head nurse noticed that one of the "no" answers had been scratched out and replaced with a "yes" response. Perhaps the intake nurse had made a mistake and the screening form score was really 7, not 8. If so, that would drop the inmate out of the high risk category, thus eliminating the need for constant observation. The clinician remained calm and told the head nurse that, no, the scoring on the form would remain the same. The inmate would remain on constant observation and hopefully be assessed the following day. The nurse reluctantly left and the interview continued without any further distractions.

It turns out that a later review of the inmate's prior records revealed that she had been in the jail approximately six months earlier and placed on suicide precautions following a suicide attempt. The clinician I interviewed had worked at the facility for approximately five years and was obviously experienced and not easily intimidated. There was one other clinician at the facility. He had only started working there the previous week. What if he had been the clinician on duty that day?

Number 8

We must avoid creating barriers that discourage an inmate from accessing mental health services should they feel suicidal. Often, certain management conditions of a facility's suicide prevention policy appear punitive to an inmate (e.g., automatic clothing removal/issuance of safety garment, lockdown, limited visiting, telephone, and shower access, etc), as well as excessive and unrelated to their level of suicide risk. As a result, an inmate who becomes suicidal and/or despondent during confinement may be reluctant to seek out mental health services, and even deny there is a problem, if they know that loss of these and other basic amenities are an automatic outcome.

Take, for example, an inmate who is on suicide precautions in your facility for attempting suicide the previous day. He is naked except for a suicide smock, given finger foods, and on lockdown status. He is housed with another inmate who is also on suicide precautions. Neither has been allowed out of the cell to shower. The mental health clinician approaches the cell and opens the food slot. The foul smell is immediate. The clinician leans down and asks the inmate, within hearing distance of everyone else on the cellblock: "How are you feeling today? Still feeling suicide? Can you contract for safety?"

How will the inmate respond? Will the response be based upon suicidal ideation or be influenced by his current environment? How would each of us respond to the clinician's questions? Most importantly, under these circumstances, how can the clinician be expected to conduct an accurate suicide risk assessment?

Although we must safely manage inmates on suicide precautions, we also need to make better decisions in avoiding what appear to be punitive responses to self-injurious behavior. We often take these measures to discourage inmates we perceive as manipulative from threatening or engaging in self-harm, but at what cost? What if we are also discouraging suicidal inmates from coming forward?

At a minimum, inmates on suicide precautions should receive showers, access to telephone cells, legal and family visits, and other routine privileges we provide to non-suicidal inmates that are commensurate with their classification status. Some would argue that telephone calls and legal and family visits might precipitate a suicide attempt. They might, but what better way to gauge an inmate's reaction to negative news than by monitoring the reaction while on suicide precautions.

Number 9

Few issues challenge us more than that of inmates we perceive to be manipulative. It is not unusual for inmates to call attention to themselves by threatening suicide or even feigning an attempt in order to avoid a court appearance, or bolster an insanity defense; gain cell relocation; transfer to the local hospital; receive preferential staff treatment; or seek compassion from a previously unsympathetic spouse or other family member. Some inmates simply use manipulation as a survival technique.

Although the prevailing theory is that any inmate who would go to the extreme of threatening suicide or even engaging in self-injurious behavior is suffering from at least an emotional imbalance that requires special attention; too often we conclude that the inmate is simply attempting to manipulative their environment and, therefore, such behavior should be ignored and not reinforced through intervention. Too often, however, a feigned suicide attempt goes further than anticipated and results in death. Recent research has warned us that we should *not* assume that inmates who appear manipulative are not also suicidal, i.e., they are not necessarily members of mutually exclusive groups.

Although there are no easy solutions to the management of manipulative inmates who threaten suicide or engage in self-injurious behavior for a perceived secondary gain, *the critical issue is not how we label the behavior, but how we react to it.* The reaction must include a multidisciplinary treatment plan.

Number 10

A disproportionate number of suicides take place in segregation and we must develop better strategies to deal with this problem. One effective prevention strategy is to create more interaction between inmates and correctional, medical and mental health personnel in these housing areas by: increasing rounds of medical and/or mental health staff, requiring regular follow-up assessments of all inmates released from suicide precautions, increasing rounds of correctional staff, providing additional mental health screening to inmates admitted to segregation, and avoiding lockdown due to staff shortages (with the resulting limited access of medical and mental health personnel to the units).

Number 11

A lack of inmates on suicide precautions should *not* be interpreted as meaning there are not any currently suicidal inmates in your facility, nor a barometer of sound suicide prevention practices. Invariably I arrive at a jail or prison on the first day of an assessment to find that all inmates have been cleared from suicide precautions. It's as if the jurisdiction is promoting the idea that the lack of inmates on suicide precautions is indicative of a solid suicide prevention program. It's not. In fact, the opposite is probably true. We cannot make the argument that our correctional systems are increasingly housing more mentally ill and/or other high risk individuals and then state there are not any suicidal inmates in our facility today. Correctional facilities contain suicidal inmates every day; the challenge is to find them. The goal should not be a zero number of inmates on suicide precautions; rather the goal should be more focused on the identification, management and stabilization of suicidal inmates in our custody.

Number 12

As healthcare and correctional professionals, we must avoid using the terms "WATCH CLOSELY" or "KEEP AN EYE ON HIM" when describing an inmate we are concerned about, *but* have not placed on suicide precautions. Have you ever received a telephone call from a family member of an inmate who says, "Please watch my husband or son closely, he might do something stupid." And our response normally is, "Sure, we'll watch him closely" or "We'll keep an eye on him." Yet, such vague terms rarely result in increased observation. If we are concerned that an inmate may be at risk for suicide, they should be on suicide precautions or at least referred to mental health personnel for a thorough assessment.

Number 13

We must create and maintain comprehensive suicide prevention programs that include the following eight (8) essential components: staff training, intake screening/assessment, communication, housing, levels of supervision (including follow-up and treatment planning), intervention, reporting, and morbidity-mortality review.[3]

Number 14

In order for our suicide prevention efforts to be meaningful, we must avoid the obstacles to prevention. Experience has shown that negative attitudes often impede meaningful suicide prevention efforts. These obstacles to prevention often embody a state of mind that unconditionally implies that inmate suicides cannot be prevented. We've heard these slogans before, some from ourselves: "If someone really wants to kill themselves there's generally nothing you can do about it" and/or "We did everything we could to prevent this death, but he showed no signs of suicidal behavior."

There are also some rather subtle (or not so subtle) obstacles that I've run into over the years. One system utilized a fee-for-service program for health care services. That's not unusual, but the Charge Sheet that listed the co-payments for each service was:

Nurse Call — $10.00
Transportation Fee — $25.00
Over-the Counter Medication — $3.00
Physician Evaluation —- $60.00
Pregnancy Test — $20.00
Request Release From Suicide Watch — $10.00

Another example. A nurse once asked an inmate during intake screening if he felt suicidal. When the inmate answered "Yes," the nurse replied, "If you tell me you're suicidal, we're going to have to strip you of all your clothes and house you in a bare cell." "Okay, then I'm not," replied the inmate.

A final example. I was an expert witness in a juvenile suicide case a few years ago. It was a very tragic case. The young man had been committed by the court to a juvenile boot camp, a poor choice given his known history of both mental illness and suicidal behavior. The boot camp program was ill-equipped to handle him and, in fact, had exclusion criteria that should have kept him out of the facility. It lacked adequate intake screening, mental health services, and staff training. The facility had no suicide prevention policy. Within a few weeks of his arrival, the 16-year-old youth sustained a traumatic suicide attempt that left him severely brain damaged. The family sued. Following a three-week trial, the jury returned a $4.6 million jury verdict against the county and several employees. But it was the response from the county administrator that was perhaps the most disturbing. He told a local newspaper reporter after the verdict that there would be no changes made at the boot camp. Why? Because:

> *"Our defense is that we have adequate policies and procedures….I don't really want to give any indication that we would do something that's not consistent with what our defense was."*

There are several ways to overcome these obstacles to prevention and the negative attitudes that drive them. We can speak to the dramatic reduction in the rate of suicide in correctional facilities throughout the country, particularly in jails. We can look at specific model suicide prevention programs that are currently in operation. I once asked a jail commander of one such program how his facility was able to maintain success despite budget pressures that caused low staffing levels, as well as other challenges, and he responded:

> "When you begin to use excuses to justify a bad outcome, whether it be low staffing levels, inadequate funding,

physical plant concerns, etc., issues we struggle with each day, you lack the philosophy that even one death is not acceptable. If you are going to tolerate a few deaths in your jail system, then you've already lost the battle."[4]

Conclusion

Hundreds of inmates continue to commit suicide in jail and prison facilities each year. Despite increased general awareness of the problem, research that has identified precipitating and situational risk factors, emerging correctional standards that advocate increased attention to suicidal inmates and demonstration of effective strategies, prevention remains piecemeal and inmate suicides continue to pose a serious public health problem within correctional facilities throughout the county. Although not all inmate suicides are preventable, many are, and the challenge for those who work in the correctional system is to conceptualize the issue as demanding a continuum of comprehensive suicide prevention services aimed at the collaborative identification, continued assessment, and safe management of inmates at risk for self-harm.

Footnotes

[1]This presentation was made by Lindsay M. Hayes to the American Correctional Association's HealthCare Professionals Luncheon in New Orleans, Louisiana on August 9, 2008.

[2]Jamison, K. R. (1999), *Night Falls Fast: Understanding Suicide*, New York, Knopf, at page 150.

[3]For more information regarding the eight (8) components of a comprehensive suicide prevention program, see www.ncianet.org/suicideprevention or Appendix C of the National Commission on Correctional Health Care (2008)'s *Standards for Health Services in Jails*, Chicago, IL: Author.

[4]Hayes, L. (2005), "Model Suicide Prevention Programs: Part II," *Jail Suicide/Mental Health Update*, 14 (2): 1-6, at page 6. ❑

Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems

by
John Petrila, JD, LLM

Recently, police arrested an individual with a long arrest record. During the arrest, he was injured and police took him to an area hospital for care. When the police came to check on him the next day, he had been released. The hospital spokesperson said that the Health Insurance Portability and Accountability Act (HIPAA) made it impossible for the hospital to communicate with the police regarding the individual's release.

This 2006 newspaper story is notable for two reasons. First, it illustrates one of the many types of interactions between law enforcement officials and health care providers that occur every day across the United States. Second, it illustrates the many misunderstandings regarding HIPAA that continue to exist years after its enactment.

These misunderstandings are sometimes so deeply ingrained that they have assumed the status of myth. These myths have serious negative consequences for persons with mental illness who are justice-involved. They can bring efforts at cross-system collaboration to a halt and they can compromise appropriate clinical care and public safety. In fact, these myths are rarely rooted in the actual HIPAA regulation. HIPAA not only does not create a significant barrier to cross-system collaboration, it provides tools that communities should use in structuring information sharing arrangements.

What is HIPAA?

Congress enacted HIPAA in 1996 to improve the health care system by "encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information."

The HIPAA "Privacy Rule" (which establishes standards for the privacy of information and took effect on April 14, 2003) has received most of the attention from those concerned about the impact of HIPAA. However, as important, the Department of Health and Human Services adopted the Rule on Security Standards in 2003, to govern the security of individually identifiable health information in electronic form. An Enforcement Rule was also adopted, effective March 2006. Most of the myths about HIPAA concern the Privacy Rule, while too often ignoring the potentially more troublesome area of electronic security.

Who Does the HIPAA Privacy Rule Cover?

The Privacy Rule establishes standards for the protection and disclosure of health information. The Privacy Rule only applies to "covered entities," which are health plans (such as a group health plan, or Medicaid); health care clearinghouses (entities that process health information into standard data elements); and health care providers. Other entities may be affected by HIPAA if they are "business associates" (discussed briefly, below).

Contrary to myth, HIPAA-covered entities do not include the courts, court personnel, accrediting agencies such as JCAHO, and law enforcement officials such as police or probation officers. There are special rules for correctional facilities, discussed briefly below.

What Does the Privacy Rule Require Before Disclosure of Protected Health Information?

The Privacy Rule permits disclosure of health information in many circumstances without requiring the individual's consent to the disclosure. These circumstances include the following:

- Disclosures or uses necessary to treatment, payment, or health care operations. This means, for

example, that a care provider may release information to another treatment provider at discharge, because the disclosure is necessary for treatment. In addition, "health care operations" is defined broadly and includes quality improvement, case management, and care coordination among other things.

- HIPAA also permits other disclosures without the individual's consent. Those relevant here include disclosures for public health activities; judicial and administrative proceedings; law enforcement purposes; disclosures necessary to avert a serious threat to health or safety; and disclosures mandated under state abuse and neglect laws.

- In the example provided at the beginning of this fact sheet, the hospital properly could have notified law enforcement of the presence of the arrestee in the hospital under the provision of HIPAA that permits a covered entity to disclose protected health information to a law enforcement official's request for "information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person" (164.512(f) (2). While this section limits the type of information that may be disclosed for this purpose, it is clear that identifying information can be disclosed.

- *In the case of correctional facilities, HIPAA permits health information to be shared with a correctional institution or law enforcement official with custody of the individual, if the information is necessary for the provision of health care to the individual; the health and safety of the inmate, other inmates, or correctional officials and staff; the health and safety of those providing transportation from one correctional setting to another; for law enforcement on the premises of the correctional facility; and for the administration and maintenance of the safety, security, and good order of the facility. This general provision does not apply when the person is released on parole or probation or otherwise released from custody.*

Does This Mean that Consent is Never Required in these Circumstances?

While HIPAA permits disclosure without consent in many situations, it does not mean that unlimited disclosure is permissible or that obtaining consent is unnecessary or inappropriate. First, confidentiality and privacy are important values in health care. Obtaining consent may be a way of demonstrating respect for the individual's autonomy, whether or not it is legally required. Second, other laws may mandate that consent precede disclosure even if HIPAA does not. If a state law provides more stringent protection of privacy than HIPAA, then the state law must be followed. The same is true of the Federal rules on the confidentiality of alcohol and drug abuse patient records (commonly referred to as Part 2). These rules, enacted more than 30 years ago, have strict requirements for the release of information that would identify a person as an abuser of alcohol or drugs. Another example illustrates this point: HIPAA permits disclosure of information in response to judicial and administrative subpoenas that many state laws limit. If state law has more procedural protection for the individual in that circumstance, then state law applies. Finally, HIPAA incorporates the principle that in general disclosures should be limited to the "minimal necessary" to accomplish the purpose for which disclosure is permitted.

Are There Tools That Can be Used in Cross-System Information Sharing?

There are several tools systems can adopt in creating an integrated approach to information sharing.

- *Uniform consent forms*. While HIPAA does not require prior consent to many disclosures, consent may still be necessary for legal (i.e., other state law) reasons, or because it serves important values. One barrier to collaboration is that most agencies use their own consent forms and consent is obtained transaction by transaction. In response, systems can adopt uniform consent forms that comply with Federal and state law requirements.

- Such forms have several features. First, they permit consent to be obtained for disclosure throughout the system at whatever point the individual encounters the system. Second, the forms can be written to include all major entities in the collaborative system; the individual can be given the option to consent to disclosure to each entity in turn, by checking the box next to that entity, or consent can be presumed with the individual given the option of withholding information from a particular entity.

- *Standard judicial orders*. Courts and court officers (state attorneys, public defenders) are not covered entities under HIPAA. However, in some jurisdictions care providers have been reluctant to share health information with the courts, or with probation officers, on the ground that HIPAA prohibits it. In response, some judges have created judicial orders with standard language mandating the sharing of information with certain entities, for example probation officers. Such orders do not concede that courts or court officers are covered by HIPAA; rather they are designed to eliminate mistaken assumptions that care providers may have regarding HIPAA.

- *Business associate agreements*. A "business associate" is a person or entity that is not a covered entity but that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. Examples include the provision of accounting, legal, or accreditation services; claims processing or management; quality assurance; and utilization review. Entities or persons providing these and other services described in the regulation must

sign a business associate agreement with the covered entity for which the services are provided.

HIPAA does not discuss uniform consent forms or standard judicial orders, but it is evident that both will assist in easing sharing of information within and across systems. HIPAA does require the use of business associate agreements in some circumstances, and so knowledge of the requirements for such agreements is important. 42 CFR Part 2, on the confidentiality of alcohol and substance use information, has an analogous though not identical provision permitting the sharing of information with "qualified services organizations."

Will HIPAA Violations Lead to Severe Penalties?

The fear of liability far outstrips the actual risk of liability in providing mental health care. This is true generally, and particularly true with confidentiality, where there have been few lawsuits in the last three decades alleging a breach of confidentiality.

There is also great fear regarding the possibility of punishment for violating HIPAA. Certainly, HIPAA provides for significant penalties, including civil and criminal fines and incarceration. However, there are two reasons that penalties for minor HIPAA violations, in particular, are unlikely. First, if an individual's health information is disclosed inappropriately under HIPAA, that individual cannot bring a lawsuit for the violation. Rather, enforcement of HIPAA is done entirely through regulatory agencies, with primary enforcement the responsibility of the Office of Civil Rights of the Federal Department of Health and Human Services. Second, although, there had been 22,664 complaints received by OCR through September 30, 2006, not a single penalty has been imposed.

In fact, only 5,400 (or 23%) complaints required further investigation, and these were resolved either by informal action (for example, a letter) or no further action. Therefore, the actual, as opposed to perceived, risk for being severely punished for a HIPAA violation is remote.

A Note on the Rule on Security Standards

As noted above, this rule was adopted in 2003 but has received comparatively little attention in discussions of cross-system collaboration. Yet while concerns regarding the Privacy Rule have been exaggerated in many jurisdictions, security issues may sometimes receive too little attention. For example, while protected health information may be shared in most circumstances, if it is done electronically steps must be taken to secure the information, for example by encrypting email exchanges. As systems get beyond the myths regarding sharing of information under HIPAA, it will be important to focus on the requirement of the Security Standards, particularly since the most egregious violations of individual privacy over the last few years have resulted from intrusions into electronic data.

Summary

HIPAA has become the reason many conversations regarding cross-system collaboration have come to a stop. Yet HIPAA provides no significant barrier to sharing information within and across systems. While confidentiality and privacy of health information are important and legally protected values, HIPAA has become subject to myths that have no foundation in the text of the regulation. It is important that all parties involved in efforts to create integrated systems for people with mental illnesses in the criminal justice system put HIPAA aside as a reason these efforts cannot succeed.

Useful Resources

www.hhs.gov/ocr/hipaa This is the home page for the Office of Civil Rights of the US Department of Health and Human Services. OCR has primary enforcement authority for HIPAA. This page has a wealth of information regarding HIPAA — it's the first place to go with questions.

www.hipaa.samhsa.gov/download2/SAMHSAHIPAAComparisonClearedPDFVersion.pdf This page links to a document prepared by SAMHSA that compares Part 2 (the Federal regulations on the confidentiality of substance use and alcohol information) with the HIPAA Privacy Rule.

www.hhs.gov/ocr/combinedregtext.pdf This link provides the full text of the Privacy Rule and Security Standards for the Protection of Electronic Protected Health Information.

www.gainscenter.samhsa.gov/html/resources/presentations.asp This page includes an audio replay and materials from a CMHS TAPA Center for Jail Diversion net/teleconference: HIPAA and Information Sharing. A sample uniform consent form is included.

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News From Around the Country

Offered below are brief stories regarding inmate suicide, offenders with mental illness, and other related topics that have recently occurred and/or been reported throughout the country.

Arkansas

In June 2008, the Baxter County Sheriff's Office and the State Police were investigating the death of an inmate who committed suicide in a holding cell of the Baxter County Detention Center in Mountain Home. According to a jail incident report, 37-year-old Scott Eric Ellis was taken into custody during the early morning of June 1 following reports that he had been walking down a highway carrying firearms and pointing them at passing motorists. According to the report, Mr. Ellis' wife said she feared her husband was going to hurt himself. Upon arrival, police verified that Mr.

Ellis was carrying a rifle and a pistol, and told an arresting officer that he also had three large knives — two attached to his waist and one to his thigh. He then reportedly told the officer several times to "go ahead and shoot," he "wanted to die."

Mr. Ellis was subdued with pepper spray and taken to the 33-bed Baxter County Detention Center and placed in a temporary holding cell near the booking counter. According to Baxter County Sheriff John Montgomery, Mr. Ellis was not placed under a suicide watch. "Once he was brought in he gave no indication that he intended to harm himself," the sheriff told the *Baxter Bulletin*. Mr. Ellis was last seen alive at 5:10am. Approximately an hour later at 6:10am, he was found hanging from the upper bunk in his cell by a pair of socks.

New York

The Center for Urban Community Services (CUCS) has recently teamed with the New York State Office of Mental Health (OMH) and New York State Department of Correctional Services (DOCS) to introduce an evidence-based practice for persons with mental illness, known as Wellness Self Management (WSM), at three state correctional facilities The project is funded by the Jacob and Valeria Langeloth Foundation.

Through this pilot project, CUCS will assist inmates with mental illness to better manage their illness, both during their incarceration and following their release as they transition back into the community. Among the strategies that will be used by CUCS within the prison system:

- Teaching concrete skills and strategies for better managing the inmate's illness;
- Customized Wellness Self Management (WSM) to include concrete skills and strategies for managing life while incarcerated;
- Assisting in transition to the community by customizing WSM to include a concentration of planning for transition to the community;
- Evaluating the extent to which WSM improves participant outcomes in several areas, including increased understanding of mental illness and strategies to manage their illness, reduction in disciplinary actions while incarcerated, and improved rates of successful transition to the community; and
- Provide training to staff working on-site in correctional facilities

CUCS will provide Wellness Self Management programs to a minimum of 126 inmates with mental illness among the three state correctional facilities (Bedford Hills, Fishkill and Sing Sing), as well as train a minimum of 35 OMH and DOCS staff at these facilities. If the program is judged to be successful, wide-scale dissemination of the project would begin so that the project can be implemented in correctional facilities throughout the country.

According to DOCS Commissioner Brian Fischer, "people with mental illness are a growing part of New York's incarcerated population, and we are grateful to the Center for Urban Community Services for bringing this foundation-funded program into our correctional system. In addition to providing critical assistance for mentally ill inmates to cope with life in prison, Wellness Self Management will help them prepare for life in the community afterwards — a transition that is tough even for offenders without mental illness."

Michael F. Hogan, PhD, OMH Commissioner, said that "Wellness self-management has been proven to help individuals with mental illness monitor and manage their own physical and mental health, and to live successfully in community settings. While these skills are important for all people recovering from a psychiatric disability, they can be especially helpful to individuals who are returning to community settings from an institutional environment."

In order to provide new knowledge to the field, a primary aim of this pilot project is to evaluate whether WSM can have other beneficial effects for inmates with mental illness. To advance the use of WSM in the corrections system, CUCS will, for the first time, test whether inmates participating in WSM have lower rates of disciplinary action while incarcerated than mentally ill inmates who do not receive WSM, as well as whether inmates completing WSM have lower rates of recidivism than mentally ill inmates who do not receive WSM.

For more information on Wellness Self Management in the correctional system, contact the Center for Urban Community Services at 198 East 121st Street, New York, New York 10035, (212) 801-3300, www.cucs.org or the New York State Office of Mental Health, 44 Holland Avenue, Albany, New York 12229, (800) 597-8481, www.omh.state.ny.us/omhweb/wellness

Florida

When Enrique Cordero was arrested, he was healthy enough to work, his sister says. But after a year on the Miami-Dade County jail's wing for the mentally ill, the voices in his head had reached such a frenzied pitch, he couldn't even sit quietly in a courtroom as lawyers argued over his future. "Every time I imagine what's happening to him, I leave crying. I don't understand why they've destroyed him like this," she said, asking that her name not be used because she doesn't want their mother in Havana to find out how bad things really are.

Minnie Atwell, of Fort Lauderdale, understands her pain. She has watched her son, Benjamin Franklin Jones, deteriorate emotionally while waiting months for treatment in the same jail's mental health wing. "It's like your worst nightmare," she said, adding that she felt like her son was treated like "somebody that don't even count."

Everyone involved agrees, Cordero, Jones and hundreds of other mentally ill inmates around the state can't get the care they need — and are constitutionally entitled to — in county jails. Miami-Dade Department of Corrections spokeswoman Janelle Hall said she could not comment on conditions on the county jail's ninth floor because of the pending litigation. But courts and the Department of Children and Families have reached a legal impasse.

Judges routinely are ordering state authorities to treat mentally ill inmates within 15 days, yet DCF leaders argue that state legislators didn't allocate enough money to treat convicted or suspected criminals who are mentally ill.

In August, DCF officials decided to ignore orders from judges that certain inmates be immediately transferred to a hospital. Officials say it wouldn't be fair to jump over others on the waiting list that often has more than 300 names statewide. On Friday, Lucy Hadi, the agency's embattled chief, abruptly resigned, a day after a Tampa Bay judge fined her agency $80,000 for repeatedly ignoring orders to take mentally ill jail inmates into DCF psychiatric hospitals for treatment. Attorneys have filed motion after motion — more than 30 alone by the Miami-Dade public defender's office — in an attempt to force DCF to comply with judicial orders. Two inmates have sued in federal court. Nearly forgotten amid the legal wrangling are the families of sick inmates, forced to sit on the sidelines, watching helplessly as their loved ones deteriorate.

Getting Worse in Jail

Cordero and his sister grew up in Cuba. He was hospitalized in Havana once when he refused to bathe, she said. He came to Miami several years ago, she followed in 2004. He worked in landscaping and as a pool lifeguard at a hotel — he even saved a tourist once, she proudly recalls. He had problems sometimes, but he was mostly able to keep his mind clear. Then last year, a neighbor accused him of raping her. His case can't go to trial until he gets well enough to help his attorneys prepare his defense. But in jail, he kept getting worse.

Soon after his arrest, he was transferred to the Cell Block 9C, the suicide wing, where the most seriously mentally ill inmates live without bedding or clothes — they wear paper uniforms. The lights are kept on 24 hours a day, seven days a week. The cells meant for one person have two, three or even four inmates sharing them, with some sleeping on the floor, some drinking out of the toilet, some urinating and defecating on the floor and walls, according to court records.

It took months for attorneys to line up psychiatrists to evaluate Cordero, get their reports in, and schedule a hearing on his competency. His sister went to each hearing, standing when his name was called, even though he often didn't. With only limited English, she had a tough time figuring out what was happening. "How can it take one year to resolve this situation in a developed country? He keeps getting worse," she said after one particularly disturbing hearing.

Her brother, who didn't seem to know her anymore, sat rocking back in forth in the jury box. Then he started screaming "hungry!" in Spanish. He had to be removed from the courtroom so other hearings could proceed. On Aug. 23, Circuit Judge Dava Tunis ordered DCF to hospitalize Cordero; he was put on a waiting list. In early November, Cordero was transferred to a DCF facility. His medications were changed and the fog in his mind began to lift. He calls his sister on the phone now and after two weeks in the hospital, his conversations began to make sense again. "He used to say things that didn't mean anything," she said. "Now, he seems better. He's very depressed. But it seems they treat him well, much better than the jail."

Suicide Attempt

Atwell's son, Benjamin Franklin Jones, ended his first day in the Miami-Dade County Jail this year with a trip to the hospital. Atwell wasn't surprised. Her son had been to the jail before. He had told his mother he feared for his life on the ninth floor. She said other inmates attacked him. Then he tried to kill himself. That attempt this summer wasn't Jones' first.

Jones, 34, diagnosed as being mildly retarded as a child, has been in and out of state institutions since he was 10 years old. In his early teens, the label shifted to severely emotionally disturbed. That's also when the run-ins with police began. His first arrest came when he pushed a lawn mower out the front door of a neighborhood store. "He just forgot the paying part," Atwell said.

In 2000, Jones was convicted of breaking into an ex-girlfriend's home. While serving a five-year prison sentence, he allegedly attacked a guard. That battery charge landed him back in county jail in April 2004, and he quickly landed on the ninth floor. He spent more than a year there before Atwell and her husband used their home as collateral to post his $15,000 bond and get him released. After Hurricane Wilma damaged the property last year, the lien became too heavy a burden. Though Jones hadn't had problems with the law while out on bond, a judge ordered him back into custody. Atwell remembers the emotions that registered on her son's face that day in the courtroom: sadness, horror, dread. "His whole countenance changed," she said. "He just dropped his head." She spoke to her son on the phone sometimes, but wasn't able to visit him, apparently because he didn't understand how to put her on the visitors list.

Cell Fouled By Waste

"I remember this one specific time he said….they put him in a cell that had feces and urine and all this stuff all over the place," she said. "I was afraid for him getting out of there alive." She worried sooner or later he'd succeed in his suicide efforts. One man at the jail did in August, accord ," Atwell said. "Things are gonna turn over now for good. Things are gonna change."

The above article, "System Fails Mentally Ill Inmates, Families," was written by Susannah Nesmith and Dani McClain, staff writers for the ***Miami Herald****, and appeared in the April 4, 2008 edition of the newspaper. Copyright 2008,* ***Miami Herald****. All rights reserved. Used with permission.*

Editor's Note: In April 2008, the Special Litigation Section of the U.S. Justice Department's Civil Rights Division initiated an investigation into conditions of confinement within the Miami-Dade County Corrections and Rehabilitation Department.

Wisconsin

In September 2008, state officials agreed to make wide-ranging improvements in mental health care for women being held at Taycheedah Correctional Institution, a 700-bed women's prison in

Fond du Lac. The agreement between the state and the U.S. Department of Justice's Civil Rights Division is the latest development in a nearly decade-long push for reform of health care inside the prison, where Justice Department investigators and experts found inmates with mental illness left untreated for months.

One such inmate was 18-year-old Angela Enoch, who committed suicide in the facility on June 19, 2005. In May 2006, the Justice Department released its investigative report on the adequacy of mental health treatment in the facility (see ***Jail Suicide/Mental Health Update***, Volume 14, Number 4, Spring 2006, pages 18-20) and specifically recounted Angela's case:

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

In August 2008, the state agreed to pay $635,000 to the young woman's family, but denied any liability for her death.

According to the state Department of Corrections, several improvements in mental health care have already been made at the Taycheedah facility, including adding 33 positions, planning a new 45-bed care wing and creating additional programs. "We have made a lot of progress in care, and there is more progress to be made," stated John Dipko, the DOC spokesman. "Both sides have agreed to try to resolve the matter, allowing more resources to be directed away from litigation and toward improved care."

Under the agreement, the state will hire additional personnel and increase training requirements, revise policies regarding the dispensing of medication, improve mental health treatment, and provide flexible responses to inmates with mental illness facing disciplinary sanctions. The four-year agreement will be overseen by a federal court monitor.

The 20-page findings letter of May 1, 2006 from the Justice Department's *Investigation of the Taycheedah Correctional Institution* can be accessed at the Justice Department's website: www.usdoj.gov/crt/split/documents/taycheedah_findlet_5-1-06.pdf

Tennessee

On January 25, 2008, an intoxicated Gary Robinson was involved in a single-vehicle accident in Sullivan County. The 62-year-old man was then arrested for driving under the influence (DUI) of alcohol and transported to the Sullivan County Jail in Blountville. He was subsequently released on bond. Because the arrest was his fourth for DUI, Mr. Sullivan later accepted a plea bargain to serve a 120-day jail sentence. He was scheduled to arrive at the jail on April 11 to begin his sentence.

Mr. Robinson had seen his primary care physician approximately one month earlier in anticipation of serving the four-month jail sentence. According to his medical records, he suffered from severe mental illness that required him to take a number of psychotropic medications, including Seroquel, Abilify, Trileptal and Lithium. He also suffered from high blood pressure, chronic obstructive pulmonary disease, a deficient thyroid, and asthma. These records, including the name of Mr. Robinson's psychiatrist, was provided to a sheriff's department deputy by his attorney at the sentencing hearing. His companion, Eva Hammond, delivered the prescribed medications to the Sullivan County Jail's medical department on April 11.

During the next week, it appeared that Mr. Robinson had been given little of his prescribed medication and most of it was discarded by medical staff. He did receive Lithium, high blood pressure medication, and "a little red pill," according to the inmate. Mr. Robinson's mother, Vivian, visited her son on April 19 and he appeared to be in a nervous and agitated state, and sweating profusely; a week later he appeared more nervous and agitated.

On May 8, both Vivian Robinson and Eva Hammond called the Sullivan County Jail to complain about Mr. Robinson's medical condition and the fact he was not receiving all the medication as

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.omh.state.ny.us/omhweb/forensic/suicide.htm
www.pbstandards.org/ResourceSection.aspx?id=4

prescribed. They were informed by a jail nurse, Penny Tester, that Mr. Robinson's medication was restricted to "formulary medication" prescribed by the jail physician. Nurse Tester also told Mrs. Robinson that her son was "manipulating" both she and Ms. Hammond.

The following day (May 9), Ms. Hammond received a return telephone call from Lori Fennell, a mental health worker at the jail. Ms. Fennell stated she had visited with Mr. Robinson and recommended that he be moved to an isolation cell in the medical unit "for his own safety" so that he could be better monitored by nursing staff. She had also made a referral to the jail physician, Daniel Paul, MD, for further assessment of his psychotropic medication needs.

Ms. Hammond visited with Mr. Robinson the next day and found him to be hallucinating about his surroundings. He was dirty and disheveled, with fecal material under his fingernails. He also appeared extremely frightened and began to cry. Ms. Hammond talked with Nurse Tester and informed her that Mr. Robinson was "rapidly decomposing," and again begged her to dispense all the medication and that the family would provide any prescribed medication that was not covered in the formulary. The nurse responded that only formulary medication could be used at the jail.

A few days later on May 15, Nurse Tester called Mrs. Robinson to inform her that her son's health was very poor and that Dr. Paul had started him on an unspecified anti-psychotic drug from the formulary. According to the nurse, if Mr. Robinson's condition did not improve within the next two weeks, he would need to be transferred to the state psychiatric hospital. But Mr. Robinson's condition did not improve. When his mother visited him on May 17, he had lost significant weight and appeared delusional.

Nurse Tester later acknowledged his condition was deteriorating on the formulary medication and informed family members on May 22 that they would like to place him on both Seroquel and Abilify (which had been prescribed to him prior to confinement). Ms. Hammond then went to the local pharmacy to fill Mr. Robinson's Seroquel and Abilify prescriptions. She talked with the pharmacist who informed her that nursing staff at the jail had been informed by the pharmacy on May 10 that Mr. Robinson had a "true chemical imbalance" and needed all of his prescribed medication. In addition, according to the jail's medical records, neither Mr. Robinson's primary care physician or psychiatrist had been contacted to verify his medication needs.

Ms. Hammond returned to the jail to deliver the medication, but it was too late. During the early morning hours of May 23, Mr. Robinson was transferred to the Bristol Regional Medical Center by ambulance. Upon the family's arrival at the hospital, they were informed that Mr. Robinson had experienced cardiac arrest and his kidneys had shut down. He had no brain activity. Gary Robinson died a few hours later.

The above summary of alleged facts was taken from a civil complaint filed by the Robinson family against Sullivan County, Frontier Health, Inc. (the jail's contracted health care provider), and several individual medical and mental health personnel. Filed in August 2008, the federal lawsuit alleges that the defendants failed to properly treat Mr. Robinson's serious medical needs, denied or delayed his access to medical care, and intentionally interfered with the treatment that had been prescribed for him. According to the lawsuit, Mr. Robinson's death was a direct and proximate result of the defendants' negligence and deliberate indifference. "This was just an unnecessary and horrible death," family attorney Cheryl Stewart told the *Kingsport Times News*. "The jail and all of the named defendants had ample opportunity to see that this man got proper medical care and he did not. It is just a horrible thing this is happening in our community."

Florida

In August 2008, court deputies twice used a Taser gun on an inmate with mental illness following a court hearing. According to the Broward County Public Defender's Office, 22-year-old David Jones was shackled and handcuffed and did not pose a major threat at the time he was subdued. "He was restrained, already in handcuffs, and was obviously someone with a mental illness," Doug Brawley, chief assistant public defender in charge of the office's mental health division, told the *South Florida Sun-Sentinel*. "It just seems as though tasering was not necessary in this case."

According to witnesses, Mr. Jones asked for a brief break after Judge Geoffrey Cohen ruled that the inmate was mentally incapable to stand trial. The judge ordered that Mr. Jones be transferred to a state psychiatric hospital for further evaluations, stated his attorney, Anne LeMaster, who attended the August 29 hearing. "Two deputies came to take him back to jail, but he told them he needed a breather, that he was feeling very upset," Ms. LeMaster told the newspaper. The deputies told Mr. Jones he had to get up and leave. Ms. LeMaster said they tried to get him to stand up, and when he resisted, one of the deputies punched Mr. Jones in the face. Another deputy said he was going to shock Mr. Jones with the Taser and ordered everyone to clear the area. According to his attorney, Mr. Jones began to gasp for air as soon as the high-voltage prongs hit him.

Mr. Jones was sitting in the jury box and fell in between some chairs; the deputies moved him to the open floor and waited for him to calm down, Ms. LeMaster said. "He told them to remove the prongs and then became very abrasive," she told the *Sun-Sentinel*. "When they didn't, he said 'Why don't you just Tase me again?'" They did.

The public defender's office filed a compliant with the Broward County Sheriff's Office and requested an investigation of the incident. "Any time a Taser is used, it's well documented and we'll look into it," said sheriff's office spokesman Jim Leljedal. "He was known to be violent and he was in jail on a violent felony charge. But obviously we're going to have to investigate the circumstances in the courtroom."

Washington State

The shooting rampage that left six dead Tuesday in Skagit County is the latest tragic incident involving a person with

apparent mental illness who didn't get treatment in time to prevent violence.

Six more names to add to an already grim list: Sierra Club worker Shannon Harps, stabbed to death outside her Capitol Hill apartment last New Year's Eve; Jewish Federation employee Pamela Waechter, gunned down at work; Newport High School coach Mike Robb, shot in his car; firefighter Stan Stevenson, stabbed to death in a crosswalk walking back from a Mariners game; pregnant Kari Osterhaug, shot by her husband.

In each case, a person with severe, untreated mental illness has been charged or convicted in the killing. And in each case, family members or others tried to intervene to get the suspect help before he committed a horrific crime but were stopped by Washington's strict commitment laws and overburdened, ineffective mental health care system.

Now it appears Isaac Zamora, 28, who was arrested after the shooting spree this week, may fit that same profile. His mother, who characterized her son as "increasingly psychotic," said she had tried for years to get him help without success. "The laws are insane," Dennise Zamora said Wednesday. "He needed to be in a facility." Her statements echo those of countless other families who say Washington's mental health system fails those who need it most.

A Seattle P-I analysis found the state is spending $1.8 billion on mental illness. But most is spent in courtrooms, squad cars, jail cells, homeless shelters and emergency rooms, not on prevention or long-term treatment. The biggest price taxpayers pay for mental illness in this state is not the cost of treatment — it's the cost, and consequences, of failure to treat.

Isaac Zamora's lengthy court record contains a sprinkling of references to concerns over his mental health, including a 2003 reference to biting a staff member who was trying to restrain him at North Sound Evaluation and Treatment Center, a mental health clinic in Sedro-Woolley. Zamora also was ordered by a Skagit County Superior Court judge to undergo a mental health evaluation as part of his court-ordered community supervision, said Department of Corrections spokesman Chad Lewis. Zamora was released Aug. 6, but that evaluation had not taken place before the shootings.

This pattern of not getting help soon enough is endemic to Washington's health care system. The P-I's analysis found that of the taxpayer dollars spent on people with severe mental illness each year in this state, about seven of every $10 go to services that don't directly address underlying sickness. Little goes to long-term solutions such as treatment, housing and support for people whose symptoms are otherwise so severe they can't function. Of all the money the state spends dealing with mental illness, $530 million goes specifically to address mental health care.

To figure out where the money goes, the P-I interviewed prison officials, government workers, psychiatrists, families, attorneys, police, social workers, patients and others to put a dollar amount on ways the mentally ill interact with public agencies. In cases where specific dollar figures could not be calculated, the P-I prepared its own estimates based on public records and the views of experts.

With no central source keeping track of the money, the P-I built a database of these numbers. What emerged was a view of a largely disconnected system with multiple bottlenecks that mostly is driven by emergency or short-term care. King County recognizes more needs to be done and has taken some steps toward dealing with the crisis, said Amnon Shoenfeld, director of King County Mental Health. A 0.1 percent sales tax approved last fall will infuse more than $50 million a year into substance abuse recovery and mental health services. The council is expected to take action on the plan later this month.

Families, and even many of those who work within the system, argue that the current crisis-response model doesn't work, makes people sicker and puts the public at risk.

Prison Treatment

There's a case for that argument: The state's second-largest psychiatric treatment center for the severely mentally ill is also a maximum-security prison. At the Monroe Correctional Center's Special Offender Unit, the patients are prisoners first. Their psychiatric facility, originally built for maximum-security incarceration, is embedded within a matrix of cameras and massive steel doors that control and monitor access to their cells. "Anything you see in a state hospital or emergency room or acute setting, you see here," said Eric Harting, who has worked in the mental health field as a counselor and caseworker for 30 years and now supervises 400 beds at Monroe.

Monroe also houses many of the state's designated "dangerous mentally ill offenders," those violent inmates considered to be high risk to the community. Most of the unit's residents — up to 80 percent — have alcohol and drug abuse issues on top of mental and personality disorders. The population of prisoners with mental illness has been rising each decade since the big push during the 1960s to "deinstitutionalize" patients by releasing them from psychiatric hospitals into community care.

But the community care piece of the plan never materialized as social engineers envisioned. President Johnson's "Great Society" plan was to build 2,000 community health centers around the country to provide comprehensive care for people with mental illness who were being sprung from institutional care. Fewer than 500 were built, leaving the severely mentally ill, who were least capable of coordinating their own care, to scavenge for services and fend for themselves.

"The situation is considerably worse than it was 10 years ago,: said E. Fuller Torrey, psychiatrist and author of several benchmark books on the social consequences of the deinstitutionalization of the mentally ill. Funding for community health and hospital beds has been cut back, but the population of people needing those services, if anything, is increasing, he said. "Basically, to get help, you have to get arrested." In an ironic twist, Zamora's alleged rampage took place just down the road from the old Northern State Hospital in Sedro-Woolley — once a psychiatric hospital — that closed in 1973. At its peak, it housed more than 2,000 patients.

Meanwhile, the percentage of state prison inmates diagnosed with serious mental illness has increased from 11 percent of the total inmate population in 2001 to 16 percent last year, said Karen Daniels, assistant secretary for Washington's Department of Corrections. At the national level, the Justice Department estimates about 45 percent of federal inmates have serious mental issues.

Even using the state's more conservative figure that means more than 2,500 of state inmates have serious mental illness. It costs an average of $85 a day to house a regular inmate. It costs $110 a day to house one who is mentally ill, which means an additional $23 million a year. The state now spends $7.2 million a year on psychiatric drugs — 51 percent of its total prescription budget.

The King County Jail spends $8.7 million on inmates with mental disorders, and the Seattle Police Department spends $8.4 million responding to incidents involving people experiencing symptoms of their mental illnesses.

Washington spends more than $100 million a year incarcerating people with mental illness. Yet many of these incidents — the petty thefts, vandalism, assaults, trespassing, public urination — might have been avoided had those who needed it gotten effective treatment and support to begin with, said Torrey, who is now president of the Treatment Advocacy Center, a Virginia-based nonprofit working to eliminate barriers to treatment for people with severe mental illness.

The opinion that treatment can cut down on offenses has been borne out locally. The state's dangerously mentally ill offender program which provides intensive supervision of released felons resulted in a 37 percent reduction in recidivism rates. But only a select group of offenders qualify for this program.

Preventable Tragedies

Treatment might also have prevented some horrific crimes. People with untreated schizophrenia and bipolar disorders committed about 1,000 of the estimated 16,000 homicides in the United States last year, according to figures kept by the Treatment Advocacy Center.

The names of victims are now memorialized in new treatment laws in many states: "Kendra's Law" in New York was named for a young woman who was pushed under a subway by a man with untreated schizophrenia. "Laura's Law" in California is named for a college student who was working at a public mental health clinic and was shot to death by a man who had been refusing treatment. "Nicola's Law," the latest such effort, is named after a young New Orleans police officer who was overpowered by a suspect with paranoid schizophrenia and shot to death with her own gun.

The majority of people with mental illness do not commit crimes, but of those who do, it's frequently when they are not taking medication or sticking to treatment plans. Currently, about 40 percent of the 4.5 million individuals with schizophrenia and bipolar disorder in the United States are not getting treatment, said Torrey.

'Outpatient Commitments'

In this state, more people don't get treatment — or stay in it — for a complex array of reasons: shortages of beds and housing, overextended mental health care workers and no legal means to treat people early on in the progression of their disease. One of the key reasons, however, is that many people with severe mental illness don't believe they are sick and refuse interventions — something Zamora's mother said was true of her son.

To address these issues, a growing number of states are moving toward "outpatient commitments" — which are court orders mandating that people with serious mental health issues get treatment and take medication while out in the community. Sometimes called "assisted outpatient therapy," this approach works, in part, because treatment providers are also accountable to the courts for providing care.

In states that do use outpatient commitment, data show it reduces homelessness, hospitalizations, arrests and violence, said Jon Stanley, lawyer for the Treatment Advocacy Center. In New York, "Kendra's Law," an outpatient commitment law in effect since 1999, reduced arrests of those involved in treatment by 83 percent, and 74 percent less of those in the program ended up homeless.

Technically, Washington's mental health law allows for court-ordered outpatient treatment, but it isn't used much. In 20 years, Dr. Peter Roy-Byrne, head of psychiatry at Harborview Medical Center, recalls it being used only twice.

Noose Around the Neck

In theory, the state's involuntary treatment act allows, or even encourages, the placement of people in a "least restrictive alternative" such as community treatment, but here's the catch: The primary reason people can be ordered to get involuntary treatment is for being in such a state they pose imminent harm to themselves or others. By definition, those are not people who can be released to the community, said Shoenfeld, whose office handles involuntary commitments. "Basically, to get a commitment now, you have to be climbing the telephone pole, with a noose around your neck," said a mother with a mentally ill son, who did not want to be named for fear of jeopardizing her son's current care situation. "You're forced to watch your child spiral out of control."

Many families are desperate to get help sooner rather than later for loved ones who are coping with mental illness. But unlike in more than 40 other states, families in Washington can't petition to get someone into involuntary treatment. Instead they have to go through a gatekeeper called a designated mental health professional — a county worker who gets called in to collect evidence and make that determination. A staff of 28 such workers — the same number there has been for the last decade — is responsible for King County's 1.8 million residents.

This approach means only the sickest get committed for involuntary treatment — and then only to inpatient care, an approach that also

means foregoing the opportunity to intervene sooner when treatment might result in better outcomes.

ER Backups

Even when patients do meet the threshold of being a danger to themselves or others, it doesn't guarantee they will get treated. "The system is dramatically underfunded," said Roy-Byrne of Harborview's psych unit. "We don't have the capacity to see the people needed."

Washington has a severe shortage of beds — about 19 beds per 100,000 residents, said Torrey. The national recommendation is 50 psychiatric beds per 100,000 in population. And the shortage is getting more acute. Budget cuts are forcing the closure of four more wards at Western and Eastern State hospitals by next year — a total loss of 90 beds. Meanwhile, some people put on involuntary holds simply wait them out in emergency rooms that aren't staffed to provide psychiatric care, a practice called "boarding." King County boards three to 19 patients a day in emergency rooms, depending on bed availability, Shoenfeld said.

Boarding patients in the emergency rooms is hazardous for the staff around them, and for the patients themselves, said Matt Goodheart, one of the county workers who has to make those involuntary detainment decisions. "These patients are not receiving any psychiatric care and could go walking out of the ER they are in and hurt themselves or someone else."

A shortage of places to discharge patients also keeps them in the hospital longer than necessary. "Today we have 120 people at Western State who are clinically cleared for discharge — no longer at risk to self or others — but who have significant support needs, and nowhere to go," said Richard Kellogg, head of the mental health division of the state Department of Social and Health Services. "We wouldn't have backups if we had patient flow — if we could get people out in a timely manner," he said. "In the short term, what is significantly lacking is housing alternatives — housing connected to support services, employment and social networks."

Such housing, scarce to begin with, has been disappearing. King County recently closed several group homes with a total of 100 beds because of code violations, licensing and funding issues.

Bottlenecks Impede Care

The bottlenecks in the system keep people from getting better, which keeps them coming back to the emergency room, or jail, in crisis mode, which is where Goodheart sees them. "I detained someone this week who had 19 previous psychiatric hospitalizations," said a weary-looking Goodheart, who spoke recently after coming off a night shift. "Last night I evaluated someone who just came out of West Seattle (psych hospital) four days ago," he said. "People get let loose, and they are still really sick."

The trend is to push patients out the door with no follow-up, said Torrey. "They throw their medication in the garbage on the way out of the hospital."

The above article, "State Pays in Blood for Flawed Mental Health System," was written by Carol Smith and Daniel Lathrop, staff writers for the ***Seattle Post-Intelligencer****, and appeared in the September 4, 2008 edition of the newspaper.*

Texas

On August 25, 2008, Roberto Garcia was arrested for a domestic disturbance and transported to the Nueces County Jail in Corpus Christi. During transport, the 47-year-old arrestee threatened suicide. Following his arrival at the jail, it was learned that Mr. Garcia had a prior history of suicidal behavior and mental illness. The inmate was placed on suicide precaution with observation at 15-minute intervals.

According to family members, they thought Mr. Garcia's arrest would immediately result to transport to a psychiatric hospital, not the county jail. On August 27, they went to court and allegedly obtained a judge's order for a psychiatric evaluation. They then received assurances that Mr. Garcia would be transferred shortly. The following day, however, Mr. Garcia strangled himself with metal restraints which had been placed on him following an unauthorized attempt to leave his cell. Emergency medical services were provided and the inmate was transported to a local hospital, but later died of his injuries on August 31.

As the Texas Rangers were investigating the incident, Nueces County Sheriff Jim Kaelin told the *Corpus Christ Caller-Times* that "It's still baffling to me how he can have his hands and feet in wrist and ankle shackles and be able to contort his position to get (the chains) around his neck as we found him." The sheriff said no jail personnel have been placed on administrative leave because of the incident, and there was no indication that any policies or procedures were violated. "I can't give you a head count but there are lots of people in our jail that are on suicide watch," Sheriff Kaelin told the newspaper. "We have over 900 inmates in that jail and many of them are depressed. This was one individual, like many others in the jail, on a suicide watch."

Several days after his death, the angry family of Roberto Garcia filed a federal court lawsuit against the Nueces County Sheriff's Office and its personnel alleging that the death was preventable and the proximate cause of their negligence and deliberate indifference.

Kentucky

On August 7, 2007, Daniel Trimble tried to slit his wrists with a razor blade shortly after he was booked into the Bourbon County Detention Center (BCDC) in Paris. The 28-year-old was subsequently hospitalization for a psychiatric evaluation. A clinician later wrote to the court that, although now stable, Mr. Trimble would continue to be a high risk for suicide. He had been admitted to the state hospital multiple times, had tried to hang himself at least once, and had paranoid delusions, "believing that guards and police planned to kill him." The evaluation warned that "Jail staff should be aware of the possibility that he would use anything he has in his possession as a weapon against himself." Mr. Trimble was returned to the jail and over the course of the next several months, periodically threatened suicide but apparently was never placed on suicide precautions.

On February 15, 2008, Mr. Trimble was found dead in his cell, hanging from a ventilation grille by a bed sheet. The state police began to investigate the death after Mr. Trimble's family became angry regarding how BCDC officials and staff handled the situation both before and after his death. "When I went out there….for people not even to say 'We're sorry for your loss,' and they just look at you and basically throw stuff in your arms and push you out the door; they don't care, they don't care about anyone in there," Samantha True, the decedent's sister, told the *Lexington Herald-Leader*. "And I know that people think people in jail are bad, but people make mistakes and they are human."

The State Police initially released few details about their investigation, but an affidavit for a warrant to search the BCDC, filed in August 2008, alleged that on the day of Mr. Trimble's death, Head Jailer Tony Horn asked Chief Deputy Jailer Sandy Dotson to delete an e-mail alerting staff to Mr. Trimble's request for mental health services. The affidavit also alleged Ms. Dotson asked another jail deputy to fill out various documents after Mr. Trimble had died. The State Police were also said to be investigating allegations by a former cellmate that the jail could not afford $600 for Mr. Trimble's psychotropic medication and stopped giving it to him. Contacted by the *Lexington Herald-Leader*, Mr. Horn said "I've done nothing wrong, personally."

But in September 2008, a county grand jury indicted the two jailers on a number of charges, including tampering with public records and official misconduct in Mr. Trimble's death. Mr. Horn was charged with two counts of tampering with public records and two counts of first degree official misconduct. Ms. Dotson was charged with two counts of tampering with physical evidence and one count of official misconduct. According to the indictment, Chief Deputy Dotson told investigators that Head Jailer Horn contacted her at home immediately after Mr. Trimble's death and instructed her to come to the jail. Upon arrival, Mr. Horn told Ms. Dotson "to permanently delete an e-mail sent by a correctional officer on the BCDC Jail Tracker system." The e-mail contained information regarding Mr. Trimble's request to see a mental health professional. The indictment stated that Mr. Horn ordered the document's destruction "with the intent to impair the e-mail's availability for use in the official proceeding." He also faxed a fabricated document to the state Department of Corrections "believing that an official proceeding was pending."

Investigators also interviewed former Deputy Adam Vice who stated "he was ordered to fill out a suicide watch report by Chief Deputy Sandy Dotson, after the death of Daniel Trimble. Vice stated he filled it out and Dotson placed it in Trimble's jail file while investigators were still at the BCDC investigating Trimble's death." Another deputy told investigators "that he witnessed Sandy Dotson tell Deputy Adam Vice to fill out a suicide watch report after the death" and that "this was unusual due to the fact that Trimble was already dead and the report should have been filled out while Trimble was alive."

When contacted by the *Lexington Herald-Leader*, Mr. Trimble's mother, Charlene Morris, told the newspaper that the indictments gave her "a sense of relief. That's all I wanted — justice for Daniel," Ms. Morris said, "because it just wasn't right the way he died."

New York

In September 2008, a city police officer was cleared of any criminal wrongdoing in the suicide of a man who hanged himself last year while in custody at the Utica Police Department. However, the city and police department now find themselves facing a civil lawsuit alleging Reinerio Romero's suicide was the result of deliberate indifference and negligence.

Mr. Romero, 42-years-old, was arrested during the evening of June 23, 2007 for a bench warrant involving a previous driving while intoxicated charge. During intake screening, he denied any current suicidal ideation or prior self-injurious behavior. He was placed in his cell at approximately 11:30pm. Several hours later at approximately 2:38am on June 24, Officer Lawrence Cross found Mr. Romero hanging from the cell bars by his shirt. Despite the provision of emergency medical treatment, Mr. Romero was subsequently pronounced dead. The forensic pathologist who performed that autopsy stated that "I believe Mr. Romero had been hanging greater than 20-30 minutes and perhaps even 1-2 hours before being found."

Utica Police Department policy required that detainees be observed at 15-minute intervals. According to an investigation of Mr. Romero's death conducted by the state Commission of Correction (COC), Captain Mark Williams stated he observed Officer Cross after the suicide making written entries in the "remarks" section of the jail log utilized for documenting observation checks. The captain instructed the officer to stop writing and then confiscated the log book. According to COC investigators, the log book time entries made by Officer Cross "were written in advance as 12:15am, 12:30am, 12:45am, 1:00am, 1:15am, with 'lying' written after the incident….The written entries for the times 1:30am, 1:45am, 2:00am, 2:15am, 2:30am, 2:45am were also written in advance without any remarks noted next to them." Officer Cross maintained he observed Mr. Romero every 15 minutes as required, and only filled out the log book after the death because he was asked to do so by his supervisor.

In September 2007, the police department placed Officer Cross on administrative leave without pay pending disciplinary action. Based upon their investigation, the Commission of Correction recommended that the Oneida County District Attorney further investigate whether Officer Cross "should be held criminally liable" for falsification of the observation log.

The district attorney's office presented the case to a grand jury for possible indictment and, based upon insufficient evidence regarding the precise time of Mr. Romero's death, the grand jury voted to not indict Officer Cross. As Oneida County District Attorney Scott McNamara told the *Utica Observer-Dispatch*, "From the very beginning, there was never any indication whatsoever that he was responsible for the man's death. The only allegation was whether or not he was performing his job up to task."

The police department has since installed electronic scanning equipment near the holding cells to better ensure that observations are made as required, and the attorney representing the city and police department declined to comment about the pending civil litigation by the Romero family.

Arizona

April 2007 began the rash of inmate suicides in the Pinal County Adult Detention Center in Florence. On April 1 of last year, 27-year-old George Horner was found hanging from a ventilation grille in his cell by a bed sheet. He was awaiting trial on charges of sexual assault on a minor. On July 8, 2008, Rogelio Canalas, detained in the facility by immigration officials, committed suicide. A week later on July 16, David Neang asphyxiated himself with a bed sheet in his cell. Mr. Neang had been recently indicted for the stabbing death of his girlfriend. After stabbing his girlfriend, he turned the knife on himself, but survived the suicide attempt and confessed to the murder. He was initially placed on suicide precautions at the jail, but removed several days later.

The most recent suicide occurred a month later during the early morning of August 20, 2008 when 45-year-old Ricky Mann was found dead in a handicapped cell. The inmate, who had limited physical mobility, hanged himself by tying a sheet around his neck and then to a medical walker in the cell. Mr. Mann had been previously indicted on multiple counts of sexual contact and molestation of a child.

The Pinal County Sheriff's Office (PCSO) declined to comment on any of the individual four suicides, but Terry Altman, Chief Deputy and jail administrator, told the *Associated Press* that the "PCSO considers the jail safe. When supervising 1,200 individuals who are accused of disobeying the law and have been placed in detention, and are forced to live together, there will be disagreements and some altercations." In late August 2008, all jail staff received a refresher course on suicide prevention. The training was conducted Pinal County Correctional Health's mental health staff.

Missouri

With eyes bulging and fluids dribbling from his mouth, jail inmate Charles Benoit suffered seizures for more than 30 minutes before anyone called an ambulance. For 15 months, the accused killer had been locked up at the Lincoln County Jail, where he awaited trial in the slaying of a Troy, Mo., motel owner.

The day of his death, March 10, Benoit was expected to plead guilty and head to prison for the rest of his life. He had said he was sorry for his actions and dreaded the reality of so many years behind bars. Benoit, 43, had been stashing his medication. The pills, doxepin, were supposed to calm his nerves and help him sleep. Instead, Benoit died from an overdose.

Jail officials acknowledge that jailers did not consistently supervise inmates taking high-risk medication. Jailers also didn't regularly search cells for hidden drugs and lacked suicide training. Officials say they have changed the jail's operations and begun suicide prevention training. "Those are common practices that a good correctional facility will do regardless if it's a small jail or a larger metropolitan jail," said Lindsay Hayes, a consultant with the National Center on Institutions and Alternatives, which researches jail suicides and develops prevention programs.

The Missouri Highway Patrol recently released a 170-page report into Benoit's death that concluded there was no criminal conduct by any of the jail's staff. However, several of the jail's officers told investigators that an ambulance for Benoit should have been called much sooner. By the time inmates found Benoit convulsing, he was beyond being saved by any medical treatment, said Dr. Christopher Long of the St. Louis County medical examiner's office, which performed an autopsy. Long, director of the forensic toxicology lab, said Benoit had taken "enough doxepin to kill a horse." But jail staff didn't know that, and the patrol's report shows Benoit's seizures lasted 34 minutes before anyone summoned an ambulance.

"Maybe we should have acted a little quicker, and I say that with a big emphasis on maybe," said Interim Sheriff Kent Hanshew. Benoit's death "gave us an opportunity to improve some things in the jail," he added.

The patrol's report provides a detailed account of the frenzied night at the jail: At 4:36am inmates playing cards spotted Benoit writhing in his bunk bed. Someone punched the call button for help, and a guard charged into the cell two minutes later. Still shaking, Benoit struggled to breathe and bled from his mouth after biting his tongue. Sgt. Lindell Riffle, the jail's night supervisor, ordered inmates to carry Benoit to an observation room. In interviews with investigators, several inmates said they heard Riffle say he refused to call an ambulance because he didn't want to look "like an idiot."

Sheriff's Department policy prohibits Riffle from commenting.

"We kept telling them, 'This dude's going to die if you don't do anything,'" said inmate Dustin Hollingsworth, 22, of Elsberry, who helped carry Benoit from his bunk to the booking room where he died. An ambulance was called at 5:10am only after Benoit had begun turning blue, stopped breathing and lacked a pulse. Paramedics arrived in four minutes and began CPR, but they could not revive him. Inmate Kurt P. Murphy, 35, of St. Louis, believes corrections officers should have moved faster to help Benoit. "Until he quit breathing, they would not call an ambulance," he said. "It was just really wild."

Benoit's death has prompted the jail to make several key policy changes. They include:

- Providing suicide prevention training to all corrections officers.
- Conducting daily, random inspections of jail cells for prohibited items like drugs.
- Requiring a nurse to dispense high-risk medication and observe inmates to ensure they take it.
- Appointing a second commander to supervise inmate welfare.
- Issuing new portable radios to improve communication.

Jail administrator Larry Doyle, the Republican candidate for sheriff in November, said his staff lacked formal training to identify signs of depression or suicide. But he insisted they followed the jail's old policies properly by contacting the jail nurse for instruction before providing Benoit medical treatment. The nurse told jailers to observe Benoit's condition.

Hanshew and Doyle say the changes should help prevent future incidents. "I think the changes that we implemented since that time have, if they've done nothing else, given us a better understanding of what we need to look for," Doyle said.

Hanshew, who requested that the Highway Patrol investigate Benoit's death to avoid any conflict of interest, said the jail needs to improve. "Now we know we need to be aware of people that have been sentenced or are going to be sentenced," Hanshew said. "We have to do a little better job in just about everything when it comes to taking care of inmates."

Though Benoit's death was not ruled a suicide, jail officials don't believe it was an accidental overdose.

Jail suicide rates have declined over the last two decades, but suicide remains the second-leading cause of death in county and municipal jails, behind natural causes, according to a 2005 report by the U.S. Department of Justice.

Any jail lacking basic suicide training for its staff would make the facility "inconsistent with national practices," said Hayes, the consultant with the National Center on Institutions and Alternatives. In particular, jailers should pay closer attention to inmates when they are facing potentially life-changing court hearings. "There's a high correlation between the receipt of that (new) information and the suicide attempt," he said. Hayes said drug overdoses represent a small fraction of jail suicides; nine of 10 suicides are hangings.

Benoit, a high school dropout, was charged nearly two years ago with first-degree murder in the killing of Saunak Kapadia, 56, of Troy. Kapadia was found beaten and strangled in an SUV parked in a commuter lot at the Budget Inn and Suites at 14 Frenchman Bluff Road. Benoit had lived at the motel and performed odd jobs there.

His two teenage sons visited Benoit regularly at the jail. Benoit often complained of insomnia and frequent headaches. A psychologist diagnosed him with depression and an anxiety disorder in January and recommended antidepressant medication to treat him.

Three weeks before his death, he wrote a letter to his sister saying he was ready to accept punishment for the killing. "I put enough shame on our family, I won't put more," he wrote. "I love you all very much, but I did this alone. I should face it alone."

Benoit's sister and father declined to comment for this story.

As officers cleaned out Benoit's bunk the day he died, they found a handwritten poem: "I'm so tired I don't even try. There's a time to live, theirs [sic] a time to die. Time for wonder and I wonder why. There is a reason."

The above article, "A Delay in Call for Help is Cited in Jail Death," was written by Joel Currier, staff writer for the ***St. Louis Post-Dispatch****, and appeared in the September 8, 2008 edition of the newspaper. Copyright 2008,* ***St. Louis Post-Dispatch****. All rights reserved. Used with permission.*

Louisiana

Billy Ayer's first involvement with the juvenile justice system was when he was charged with resisting arrest and battery on a Shreveport Police Department officer on March 27, 1999. The 14-year-old was transported to the Caddo Parish Juvenile Detention Center. Upon intake screening at the facility, Billy acknowledged having a history of suicidal behavior, stating that he "thought about it, lately, all of his life," and that his younger brother had twice attempted suicide. He was assessed as having Conduct Disorder. Several days later on March 31, the charges against him were dropped, and Billy was released from the facility to the custody of his mother.

Billy remained at home for the next few months, but his continued unruly and delinquent behavior resulted in a boot camp placement. However, on August 25, 1999, Billy was hospitalized for suicidal behavior. Specifically, his presenting problem was stated as follows: "anger — easily angered — goes into rages — yells, screams — makes suicidal statements — going on all his life — since age 5." As a result of this assessment, Billy's initial diagnosis was Impulsive Conduct Disorder. An assessment referral for psychotropic medication was made, as well as out-patient mental health treatment.

On October 10, 1999, Billy was arrested by the Shreveport Police Department and charged with aggravated incest (upon his 12-year-old sister). He was again transported to the Caddo Parish Juvenile Detention Center where he remained for approximately two months. During this time, Billy was interviewed by his probation officer and received a court-ordered psychological evaluation. According to the probation department report, "Billy and his mother stated that he has been treated with medication in the past to control his anger outbursts and fits of rage. However, he is not presently taking any medication….Billy did indicate that he has had suicidal thoughts in the past. He indicated that they were prevalent while he was in boot camp." According to the psychological evaluation, "Billy is a bright, but angry and impulsive adolescent. He presents as having narcissistic characteristics and fits the diagnostic criteria for Oppositional Defiant Disorder." The report recommended that Billy receive an evaluation for medication for impulsive and angry behavior, sex offender counseling, as well as individual and family therapy. A similar recommendation was made in Billy's probation report.

On December 9, 1999, a juvenile court judge committed Billy to the Office of Juvenile Services within the state Department of Public Safety and Corrections "until his twenty-first birthday with recommendations that said child be placed in the Sexual Perpetrators Program. Further that he be evaluated for medication for his impulsive, angry outbursts; that he receive individual therapy and monitored group therapy, as well as sexual offenders' counseling." Billy was then remanded back juvenile detention facility to await transfer to state juvenile training school.

A few weeks later on December 21, 1999, Billy was transferred to the Office of Juvenile Services' Jetson Correctional Center for Youth (JCCY) in Baton Rouge. Pertinent records regarding his suicidal and mental health histories, as well as need for an evaluation of psychotropic medication, were forwarded to the JCCY. Upon admission to the facility, Billy was seen by a nurse who administered an intake health screening form that noted he had an "impulsive control problem." He was recommended for general population housing. Billy was also assessed by an institutional counselor. When asked by the counselor "Do you think about killing yourself?" the youth replied "Sometimes, usually when I'm in a rage…3-4 months ago was last rage." He was apparently ***not*** asked whether he was currently suicidal.

Billy also acknowledged that a family member (his brother) had recently attempted suicide. The counselor's progress notes mentioned his previous diagnosis of Impulsive Conduct Disorder, but there was no reference to a referral evaluation of psychotropic medication. The "treatment plan" for Billy consisted of group counseling, indoor/outdoor recreation, and family visitation. Precautions listed on the treatment plan included "monitor for escape, monitor for inappropriate sexually active behavior." Two days later on December 23, 1999, Billy was seen again by medical staff and a "Physical Examination and Clinical Evaluation" was completed. The only noteworthy entry on the form was that a psychiatric evaluation was not recommended.

According to a disciplinary report dated December 30, 1999, Billy "got out of bed and started walking toward the security desk. When ordered to stop, offender refused. Offender stated f—-you nig—-. I am going to the motherf——— restroom." As a result of this outburst, Billy was charged with "Defiance" and escorted to the administrative segregation unit by the captain of security. (Although the captain later denied that Billy ever threatened suicide, according to the statements of several youth, Billy allegedly threatened suicide as he entered the lockdown unit on the morning of December 30.) Per JCCY policy, an administration segregation card was completed for Billy upon his entry into the unit and the box labeled "mental health concerns" was marked "none."

Several hours later at approximately 12:15pm, a sergeant entered the lockdown unit with another officer to distribute lunch trays. When he arrived at Billy's cell, the sergeant observed the youth to be sitting on the floor with a sheet tied around his neck and attached to the faucet on the sink. He called out to the other officer for assistance, entered the cell, and cut the sheet from Billy's neck. The sergeant then attempted to call for back-up support using both his beeper and radio. When no response was received, he ran to the front desk and called the control center via telephone. Shortly thereafter, back-up correctional and medical personnel arrived. Cardiopulmonary resuscitation was initiated by JCCY staff and continued until the arrival of emergency medical services personnel. The 14-year-old youth was then transported to a local hospital and subsequently pronounced dead.

Following Billy's death, his family filed a lawsuit against the state alleging that his suicide was preventable and that staff displayed both negligence and deliberate indifference, the proximate result of which was his death. The defense denied any wrongdoing and argued that Billy's death was not preventable. An expert hired by the state would later opine "that the policies and procedures at Jetson Correctional Center for Youth conformed to 1999 juvenile correctional industry standards" and his death was not preventable.

During the ensuring discovery process, the plaintiff, bolstered by its own expert, provided evidence that: 1) Billy had a recent history of suicidal behavior, mental illness, and need for a psychotropic medication assessment, and that this information was known to, and ignored by, various personnel; 2) Billy was inappropriately placed in the lockdown unit on December 30, 1999, a placement that was contrary to JCCY policy and precipitated his suicide; and 3) there was disputed evidence regarding whether Billy threatened suicide to JCCY personnel, as well as whether he was observed at required 15-minute intervals while confined in the lockdown unit on December 30, 1999.

History of Suicidal Behavior, Mental Illness, and Need for Psychotropic Medication Assessment

Billy had self-reported suicidal ideation throughout his life and was most recently hospitalized for suicidal behavior in August 1999. He also self-reported a history of suicidal ideation during both his admission into the juvenile detention center and JCCY. Despite this history, JCCY staff ignored this information and Billy's treatment plan did not include any reference to suicidal behavior. In addition, Billy had been diagnosed with suffering Impulsive Conduct Disorder and Oppositional Defiant Disorder prior to his JCCY commitment. Despite this history, JCCY staff ignored this information and Billy's treatment plan did not include any reference to these mental health diagnoses. Further, Billy had previously been prescribed psychotropic medication to control his mental illness. As a result of his most recent court-ordered psychological evaluation, a recommendation was made by both the psychologist and probation officer for Billy to receive an assessment for psychotropic medication in an attempt to control his impulsive and angry behavior. The committing judge also ordered that "he be evaluated for medication for his impulsive, angry outbursts," as well as receive sex offender treatment.

Despite this court order, JCCY staff ignored this information and Billy's treatment plan did not include any reference to individual therapy and sex offender treatment, and the youth was never evaluated for psychotropic medication. In fact, during a physical examination of Billy on December 23, medical staff noted on the form that a psychiatric evaluation was not recommended, and the youth's administrative segregation card indicated that he did not have any mental health issues.

Inappropriate Placement in Lockdown Precipitated Suicide

During the early morning of December 30, Billy ignored a staff directive to ask permission before using the restroom and left his room and walked toward the restroom. When directed to stop, Billy became angry, belligerent and shouted racial slurs at the staff member. He was then placed on administrative segregation status in the lockdown unit. This staff response was in direct violation of a JCCY's administrative segregation policy which states that "Administrative Segregation shall be utilized *only when no less restrictive measure is sufficient* (emphasis added) to protect the safety of the facility, the persons residing or employed therein, or the safety of the public at large." There was no evidence to suggest that JCCY personnel ever considered a less restrictive measure for Billy's behavior during the early morning hours of December 30.

Further, JCCY personnel violated other administrative segregation directives in Billy's case. For example, one policy allowed for youth to be "released after a cool down period of one (1) hour" and required either the shift supervisor or area major to assess the child and review the case *each* hour of confinement. The directive required that "offenders will be released from Administrative Segregation immediately after review *unless* the offender continues to be engaged in: 1) Repeated failure to follow orders, where the failure to comply is destabilizing; 2) Repeated interference with staff or other offenders' duties; 3) Improper sexual behaviors; 4)

Fighting; 5) Substantial destruction of property; and 6) Violent conduct that creates and imminent danger to other juveniles or staff."

There was no evidence to suggest that JCCY personnel ever considered releasing Billy from administrative segregation after a one-hour cool down period, nor was there any evidence that Billy engaged in any of the above behaviors during his lockdown confinement that would justify continued administrative segregation status.

JCCY personnel were aware that Billy had a recent history of suicidal behavior that was precipitated by angry, raging and impulsive behavior. His placement in the lockdown unit was the result of angry and belligerent behavior toward staff. It was, therefore, reasonable to assume that Billy could become suicidal following his placement on administrative segregation status, as well as reasonable to assume that a mental status assessment by mental health staff could have revealed that lockdown was contraindicated in his case. The failure of mental health staff to assess Billy while he was in the lockdown unit was a contributing factor to his death.

Disputed Evidence Regarding Suicide Threat and Required Observation of Billy Ayer

There was disputed evidence regarding whether Billy threatened suicide to JCCY personnel, as well as whether he was observed at required 15-minute intervals while confined in the lockdown unit. First, according to the statements of several youth, Billy Ayer had threatened suicide for several days leading up to the morning of December 30. These youth stated that Billy's threats were not heard by any JCCY personnel. However, these youth also stated that in the early morning of December 30, Billy threatened suicide as he was escorted to his cell by the captain of security, and that the captain heard and seemingly ignored the youth's threat. The captain denied this allegation.

In addition, there was disputed evidence as to whether Billy was observed at required 15-minute intervals while confined in the lockdown unit. According to the officer assigned to the unit, rounds were performed at regular 15-minute intervals and Billy was last observed to be alive at 12:00pm before being found hanging in his room at 12:15pm. However, a review of the housing unit log for that day indicated that the officer's log notation were at exact intervals of 11:00am, 11:15am, 11:30am, 11:45am, and 12:00pm, and these checks were in a different styled handwriting than the 12:15pm check. The 12:15pm notation was suspicious in that the writing appeared scribbled or rushed. The officer later stated that he noted the 12:15pm check and wrote "10-38" (which means satisfactory or normal) *before* he actually performed the round — a clear violation of policy. In addition, several emergency medical personnel stated that, based upon the condition of Billy's body (asystole, jaw beginning to stiffen, etc.) when they arrived on the scene, it appeared that the youth had been hanging for much longer than 15 minutes.

Conclusion

In conclusion, the plaintiffs argued that the actions and inactions of the Jetson Correctional Center for Youth personnel were inconsistent with national juvenile correctional standards and standard correctional practice, as well as the proximate causes of Billy's death. Finally, more than eight years after his death, this protracted litigation ended prior to trial in October 2008 when both parties settled the case for an undisclosed sum. ❑

JAIL SUICIDE/MENTAL HEALTH UPDATE

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

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

AVAILABLE JAIL/PRISON/JUVENILE SUICIDE PREVENTION MATERIALS

And Darkness Closes In...National Study of Jail Suicides (1981)
National Study of Jail Suicides: Seven Years Later (1988)
Training Curriculum on Suicide Detection and Prevention in Jails and Lockups—Second Edition (1995)
Curriculum Transparencies—Second Edition (1995)
Prison Suicide: An Overview and Guide to Prevention (1995)
Juvenile Suicide in Confinement: A National Survey (2004)
Jail Suicide/Mental Health Update (Volumes 1-16)

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

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