

JAIL SUICIDE/MENTAL HEALTH UPDATE

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

Fall 2000

Volume 10 • Number 1

SUICIDE RISK DESPITE DENIAL (OR WHEN ACTIONS SPEAK LOUDER THAN WORDS)

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

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

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

Not unlike his brethren around the country, Sheriff Baker seems to take the simple, direct approach to suicide prevention — if an inmate does not threaten suicide or denies being suicidal, then they must not be suicidal, now or at any time while they're in my facility! There are many recent examples of such tunnel logic.

In the state of Washington, 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 stated that she "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 was despondent, 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.

In Virginia, police became involved in a high-speed pursuit of a man who had allegedly fired a gun at a bail bondsman. The suspect's vehicle was eventually stopped after being disabled from ramming into several police cruisers. When officers approached the suspect, he placed a handgun to his head and threatened suicide. An officer talked with the suspect for several hours and was eventually able to convince the man to surrender. He was transported to the county jail, refused medical treatment, and placed in a cell. The inmate was not referred to mental health staff, nor placed on suicide precautions. He committed suicide several hours later.

In Wisconsin, a man was arrested on a contempt of court warrant and transported to the county jail. During the booking process, he was described by jail personnel as intoxicated, yet cooperative, even "happy." When asked if he had ever attempted suicide, the inmate smiled and answered "yes, about 3 days ago but I'm okay now." He also admitted to having a history of mental illness and was prescribed psychotropic medication. Jail records revealed that the inmate had been confined in the county jail on nine previous occasions, and had documented histories of suicidal behavior and mental illness. The inmate was not referred to mental health staff, nor placed on suicide precautions. He committed suicide the following day.

In Colorado, police arrested a man on charges of assault, resisting arrest, and obstruction. He was transported to the county jail and described as agitated, belligerent, intoxicated, uncooperative, and

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SIGNS AND SYMPTOMS

Experience has shown that certain signs and symptoms exhibited by the inmate often foretell a possible suicide and, if detected, can prevent a death. They may include:

- “ *Depression*: The single best indicator of potential suicide because approximately 70 to 80 percent of all suicides are committed by persons who are severely depressed. The following are common signs and symptoms of depression:
 - Inability to go on (expressing hopelessness/helplessness)
 - Extreme sadness and crying
 - Withdrawal or silence
 - Loss or increase of appetite and/or weight
 - Pessimistic attitude (or no sense) of future
 - Insomnia or awakening early; excessive sleeping
 - Mood variations
 - Tenseness
 - Lethargy (slowing of movements or non reactive)
 - Loss of self-esteem
 - Loss of interest in people, appearance or activities
 - Excessive self-blaming
 - Strong guilt feelings
 - Difficulty concentrating or thinking
 - Agitation (including high level of tension, extreme anxiety, strong feelings of guilt, rage, or wish for revenge)
- “ *Expression and/or evidence of strong guilt/shame over offense*
- “ *Talking about or threatening suicide*
- “ *Intoxication/Withdrawal*
- “ *Previous suicide attempts and/or history of mental illness*
- “ *Severe agitation or aggressiveness*
- “ *Noticeable mood or behavior changes*
- “ *Speaking unrealistically about getting out of jail*
- “ *Having increased difficulty relating to others*
- “ *Does not effectively deal with present, is preoccupied with past*
- “ *Begins to pack belongings, giving away possessions when release is not imminent*
- “ *Paranoid delusions or hallucinations*
- “ *Engaging in non-lethal self-injury (regardless of lethality, behavior is dangerous and often leads to actual suicide attempt)*

using profane language. According to the arresting officer, the suspect also verbalized suicidal behavior because he “had been acting very erratic, and had screamed out several times during arrest ‘kill me, just kill me! Put your gun to my head and kill me!’” The suspect also told jail staff during the intake screening process that he had attempted suicide three months earlier, but was not currently thinking of hurting himself.

During the next 30 days, the inmate wrote numerous letters to family members and friends. Many, if not, all of these letters were intercepted by jail staff prior to mailing. The letters spoke of his frustration, lack of patience, and depression of not being able to make bond and be reunited with his family. Many of the letters also spoke of giving up and committing suicide. One concerned officer reading the letters referred the inmate to classification staff. A classification officer interviewed the inmate and then wrote a notation in a jail log that the inmate “appears depressed, although denies being suicidal.” The inmate was never referred to mental health staff, nor placed on suicide precautions. He eventually committed suicide in the jail after finding out that the money previously posted for bond was insufficient to gain his release.

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 their arrival, 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 negotiation, the suspect surrendered without incident. He was transported to the county jail and denied being suicidal during the intake screening process. “If he had checked the box, he would automatically have gone on suicide watch,” recalled the sheriff. The inmate was not referred to mental health staff, nor placed on suicide precautions. He committed suicide the following day.

In Pennsylvania, a man was arrested for public drunkenness and transported to the local police lockup for safekeeping. He was placed in a cell that was monitored by closed circuit television (CCTV). A short time later, the dispatcher looked at the CCTV monitor and noticed that the inmate was tying his clothes to the cell bars. The dispatcher notified an officer who proceeded to the cell area. When the officer approached the cell, he asked the inmate what he was doing. The inmate did not respond. The officer then requested and received the clothing from the inmate and departed the cell area. The inmate was never referred to mental health staff, nor placed on suicide precautions. A short time later, the dispatcher looked at the CCTV monitor and could not observe the inmate, but assumed he was using the toilet which was outside of monitoring range. The dispatcher eventually became suspicious and notified an officer who again proceeded to walk back to the cell area. The inmate was found hanging by his underwear and died a short time later.

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

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

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

Although an inmate can attempt suicide at any point during incarceration, beginning immediately following intake and continuing through a stressful aspect of confinement, over 50 percent of jail suicides occur during the first 24 hours of incarceration (Hayes, 1989). A comprehensive intake screening process to identify suicidal behavior is critical to a correctional facility’s suicide prevention efforts. And although the psychiatric and medical communities disagree about which factors should be used to predict suicide in general, there is little disagreement as to the value of screening and assessment to the increased likelihood of preventing suicide (Hughes, 1995). In addition to current and past suicidal ideation, research in the area of jail and prison suicide has identified a number of characteristics that are strongly related to suicide, including intoxication, emotional state, family history of suicide, recent significant loss, limited prior incarceration, lack of social support system, psychiatric history and various “stressors of confinement” (Bonner, 1992). Therefore, one-line questioning will not suffice.

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

“Was the inmate a medical, mental health or suicide risk during any prior contact and/or confinement within this facility? (Requires either a manual or computerized record review.) If yes, explain.”

“Does the arresting and/or transporting officer have any information (e.g., from observed behavior, notification/ documentation from the sending agency/ facility, family member, etc.) that indicates inmate is a medical, mental health or suicide risk now? If yes, explain.”

“Have you ever attempted suicide? If yes, when, why, and how?”

“Have you ever considered suicide? If yes, when and why?”

“Are you now or have you ever been treated for mental health or emotional problems? If yes, when and where?”

“Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)? If yes, explain.”

“Has a family member/close friend ever attempted or committed suicide? If yes, explain.”

“Do you feel there is nothing to look forward to in the immediate future (inmate expressing helplessness and/or hopelessness)? If yes, explain.”

“Are you thinking of hurting and/or killing yourself? If yes, explain.”

While affirmative responses to any of the above questions will not necessarily indicate that the arrestee is suicidal, an affirmative response to any of these questions should prompt the screener to initiate a referral to health care staff for further assessment. Most importantly, regardless of the inmate’s responses, the screener should always initiate a referral if the arrestee’s behavior and/or demeanor are suggestive of potential self-harm.

SITUATIONAL RISK FACTORS

The following are some of the situational factors which affect jail suicides:

- “ Arrestee with little or insignificant criminal history
- “ Juvenile (anyone under 18, whether or not waived to adult court)
- “ Persons with high status in community
- “ Prior suicide by close family member or loved one
- “ Previously imprisoned and facing new serious charges and long prison term
- “ Recent suicide attempt by another inmate (“copycat”)
- “ Harsh, condemning, rejecting attitudes of officers, e.g., “We’ll give you the rope whenever you’re ready”
- “ Prior experience with the pain and suffering of alcohol/drug withdrawal and reluctance to undergo the ordeal again

JAIL ENVIRONMENTS INFLUENCING SUICIDAL BEHAVIOR

The following unique characteristics of jail environments can make them conducive to suicidal behavior:

- “ *Authoritarian Environment*: Persons not familiar with regimentation can encounter traumatic difficulty in the jail setting;
- “ *No Apparent Control over the Future, Including Fear and Uncertainty Over the Legal Process*: Following incarceration, many jail inmates experience feelings of helplessness and hopelessness. They feel powerless and overwhelmed.
- “ *Isolation From Family, Friends and Community*: For incarcerated individuals, support from family and friends may seem far away, especially with restricted visiting and telephone privileges.
- “ *Shame of Incarceration*: Feelings of shame (often found in misdemeanants) are often inversely proportionate to the gravity of the offenses committed. Frequently, such feelings develop in those persons who have never been arrested before or who have a limited arrest history.
- “ *Dehumanizing Aspects of Incarceration*: Viewed from the inmate’s perspective, confinement in even the best of jail facilities is dehumanizing. Lack of privacy, association with acting-out individuals, inability to make choices in the regulation of your life, and strange noises and odors can all have a devastating effect. Many facilities are old, with a substandard environment. Common overcrowding creates stress.
- “ *Fears*: Based on stereotypes of jails seen on television and in movies, and stories carried by various media, fears heighten anxieties on the part of some individuals about other inmates and, sometimes, about staff.
- “ *Officer Insensitivity to the Arrest and Incarceration Phenomenon*: Most professionals working in the criminal justice field have never personally experienced the trauma of arrest and incarceration. Experience has shown that, in many instances, the longer people work in the criminal justice field, the more insensitive they can become to the emotional effects of arrest and incarceration, particularly for the first-time arrestee.

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

Of course, not all potentially suicidal behavior is manifested at the point of admission and while over 50 percent of all jail suicides occur within the first 24 hours of incarceration, almost half take place during other stages of confinement. As emphasized by national correctional standards: “While inmates may become suicidal at any point during their stay, high-risk periods include the time immediately upon admission to a facility (especially if inmates are intoxicated from alcohol or other drugs); after adjudication, when the inmate is returned to a facility from court; following receipt of bad news regarding self or family (such as serious illness or the loss of a loved one); and after suffering some type of humiliation or rejection. Individuals who are in the early stages of recovery from severe depression may be at risk as well” (National Commission on Correctional Health Care, 1996).

Research has consistently reported that at least two thirds of all suicide victims communicate their intent some time before death and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt (Clark & Horton-Deutsch, 1992). As such, certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and

communicated to others, can prevent a suicide. There are essentially three levels of communication in preventing inmate suicides: 1) between the arresting/transporting officer and correctional staff; 2) between and among facility staff (including medical and mental health personnel); and 3) between facility staff and the suicidal inmate.

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

In addition, effective management of suicidal inmates often comes down to communication among correctional officers and other professional staff. Because inmates can become suicidal at any point during incarceration, correctional officers must maintain awareness, share information and make appropriate referrals to mental health and medical staff. Further, correctional staff must use various communication skills with the suicidal inmate, including active listening, staying with the inmate if they are in immediate danger, and maintaining contact through conversation, eye contact, and body language.

HIGH RISK PERIODS

Experience has demonstrated that there are certain high risk periods for the inmate which correlate with phases of their incarceration or steps in the criminal justice process. Some of these periods include:

- “ *The First 24 Hours of Incarceration:* As shown through national research, many suicides occur during the initial period of confinement, particularly the first few hours.
- “ *Intoxication/Withdrawal:* Depression frequently sets in when the inmate sobers up. Although alcohol is initially a stimulant, its effect is limited, and it soon becomes a depressant for many people, particularly those who drink to mask their problems.
- “ *Waiting for Trial/Sentencing:* The agony of the unknown, or just plain waiting, produces great anxiety and pressure for many people. The time period immediately before and after sentencing, particularly when awaiting or responding to a sentence just imposed, constitutes the breaking point for some inmates. Included in this group is the serious repeat offender who knows what kind of future to expect in prison and cannot bear the thought of returning.
- “ *Impending Release:* Although unusual, release from jail is not always something to look forward to for some inmates who either have no place to go or face unsympathetic family members, friends, employer, etc.
- “ *Special Days:* Holidays are associated with festive times for families, yet only separation and loneliness for inmates. Anniversary dates (including birthday, wedding, divorce, etc.) can be difficult for many inmates.
- “ *Darkness:* Since suicide is a very private act, the hours of darkness (often accompanied by decreased staff support) produce many suicides.
- “ *Decreased Staff Supervision:* Many jails have less correctional and health care staff on duty during weekends, nights and holidays. Fewer programs and activities also affect the jail atmosphere.
- “ *Bad News of Any Kind:* A suicide attempt may be triggered by any assortment of disturbing news, including the issuance of a restraining order, job termination, notice of foreclosure on a home, a death notice, divorce proceedings, visits or lack of visits, block on telephone from family members, etc.

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

And while observing an inmate engaging in self-injurious behavior, as well as asking an inmate directly whether they are suicidal, are certainly critical pieces to suicide prevention, the identification of potentially suicidal behavior does not end there. Many inmates have great difficulty verbalizing their thoughts and feelings. As offered in the sidebar boxes, both correctional and health care staff should be sensitive to other, often non-verbal, indicators of suicidal behavior, including pre-disposing factors, high risk periods, situational risk factors, signs and symptoms, and jail environments influencing suicidal behavior (Rowan & Hayes, 1995).

Conclusion

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

Suicide prevention does not begin and end at booking, nor does it begin and end with the denial of suicide, however convincing the denial may appear. If suicidal individuals were either willing or able to articulate the severity of their suicidal thoughts and plans, little risk would exist (Jamison, 1999). As such, both correctional and health care personnel share a responsibility for observing the non-verbal suicidal behavior and actions of inmates. An inmate's denial of self-injury, or a non-threat of suicide in the face of behavior or actions that suggest otherwise, should not end the inquiry; on the contrary, the process has just begun and continues throughout the individual's confinement.

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NEW FEDERAL LAWS: THE REPORTING OF DEATHS IN CUSTODY AND MENTAL HEALTH COURTS

Deaths in Custody Reporting Act

It took more than six legislative years and the perseverance of many individuals, including a prison advocacy group and two Arkansas brothers, but a new federal law now requires all deaths occurring in both state and local correctional facilities to be reported to the federal government.

In 1994, U.S. Representative Robert C. Scott wrote an amendment to the federal crime bill that would have required all deaths in custody to be reported regularly to the U.S. Attorney General's Office. "Since we couldn't document the extent of cell deaths, I decided not to introduce that amendment," Representative Scott told the *Asbury Park Press* in 1995. "It's a problem we just didn't have a good handle on. I still feel a simple, one-page report would at least give us accurate numbers."

In February 1995, the *Asbury Park Press* ran a four-part investigative series on deaths in custody by Mike Masterson, who commented at the time that the "*Press* spent five months attempting to count custodial deaths nationwide, but was unsuccessful because of incomplete data and lack of cooperation from public servants in a number of states." Mr. Masterson had been former editor of the *Northwest Arkansas Times* newspaper and his investigative series, as well as periodic national studies by the National Center on Institutions and Alternatives, caught the eye of then U.S. Representative (now Senator) Tim Hutchinson from Arkansas. Together with Representative Scott, legislation was initially introduced in 1995 to require the reporting of deaths in custody. The bill was later watered down to only direct the U.S. Justice Department (Bureau of Justice Statistics) to study the feasibility of requiring states to collect such statistics. Commented Representative Scott at the time — "Of course, I would hate to think that there are any jurisdictions with so many deaths in custody that it would not be feasible to report them." In March 1998, the Bureau of Justice Statistics reported back to Congress that the reporting of deaths in custody was indeed achievable by the agency.

Tim Hutchinson moved on to the Senate in 1996, but his brother, U.S. Representative Asa Hutchinson, continued to carry the gauntlet of legislation. In addition, Charles Sullivan, founder and co-director of Citizens United for Rehabilitation of Errants, a prison advocacy group, almost single-handedly kept the issue alive over the years by persistently lobbying various members of Congress. Finally, on May 13, 1999, Representative Asa Hutchinson became the lead sponsor and introduced the "Deaths in Custody Reporting Act (H.R. 1800)." The bill, again co-sponsored by Representative Scott, required that each state receiving prison construction funding under the federal truth-in-sentencing grant program were to:

report, on a quarterly basis, information regarding the death of any person who is in the process of arrest, is en route to be incarcerated, or is incarcerated at a municipal

Clark, D.C. & Horton-Deutsch, S.L. (1992). Assessment in *absentia*: The value of the psychological autopsy method for studying antecedents of suicide and predicting future suicides. In Maris, R., Berman, A.L., Maltzberger, J.T. et al (Eds), *Assessment and Prediction of Suicide*, New York, NY: The Guilford Press.

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POTENTIAL PRE-DISPOSING FACTORS

Each of us has a "breaking point." Many jail suicides would never have occurred an hour, day, week or month later, had not one or more of the following predisposing stress factors entered into that person's life:

- *Recent Excessive Drinking and/or Use of Drugs:* In many instances, when intoxicated persons sober up, depression sets in. However, a number of persons with blood-alcohol levels in excess of the legal limit commit suicide while still intoxicated. For some individuals, even a small amount of alcohol/drugs can influence suicidal behavior.
- *Severe Guilt or Shame Over the Offense:* Look no further than the case of Joseph Scott Rehrig.
- *Same-Sex Rape or Threat of It:* In interviews with inmates who were prevented from committing suicide, many of them said that they had been raped or leaned on heavily for sexual favors.
- *Current Mental Illness:* Persons who are depressed or suffer from delusions/hallucinations, with voices telling them what to do, are prime candidates for suicide.
- *Poor Health or Terminal Illness:* While mainly a problem of the elderly, persons of all ages succumb to the depression of serious illness. Persons suffering from AIDS are known to have high rates of suicide.

or county jail, state prison, or other local or state correctional facility (including any juvenile facility) that, at a minimum, includes:

- (a) the name, gender race, ethnicity, and age of the deceased;
- (b) the date, time, and location of death, and
- (c) a brief description of the circumstances surrounding the death.

The legislation worked its way through Congress for more than a year before it was finally passed. Commented Rep. Hutchinson, "In any other atmosphere, unnatural deaths under questionable circumstances would not only be reported but would raise serious concerns. State and local jails and lockups should be no different." The Death in Custody Reporting Act of 2000 became Public Law No. 106-297 when it was signed by President Clinton on October 13, 2000.

Mental Health Courts

The popular, yet still unproven, concept of mental health courts received a giant boost recently when the U.S. Congress passed legislation (Senate Bill 1865) to provide up to \$10 million a year for expansion of the program concept throughout the country. Entitled "America's Law Enforcement and Mental Health Project," the legislation was initially introduced in 1999 by two Ohio politicians (U.S. Senator Mike DeWine and U.S. Representative Ted Strickland) and became Public Law No. 106-515 when it was signed by President Clinton on November 13, 2000. The new law, which authorizes funding for up to 100 mental health courts during the next four years, is designed to provide early identification, diversion and treatment services of certain mentally ill offenders.

"As a prosecutor in my home of Greene County, Ohio, I learned that our state and local penal facilities have become way stations for far too many of our nation's mentally ill," said Senator DeWine. "Law enforcement agencies and corrections institutions designed to fight crime have had to spend valuable time and scarce resources attempting to provide mental health services to prisoners. Certainly, some mentally ill offenders must be incarcerated because of the severity of their crimes. But many others could receive appropriate care early on, reducing recidivism and unnecessary burdens on our police and corrections officials, as well as the mentally ill offender."

Similar to drug courts, mental health courts would maintain separate dockets, specialized judges, prosecutors, defense attorneys, and community service liaisons. Each mental health court (MHC) program would coordinate with existing community resources to provide access to: 1) specialized training of law enforcement and MHC judicial personnel to address the special needs and challenges of mentally ill offenders; 2) centralized case management for cases involving qualified offenders who are mentally ill and/or developmentally disabled; 3) voluntary assignment of qualified offenders to outpatient or inpatient mental health treatments; 4) life skills training, job placement, and education for mentally ill participants; and 5) continued judicial monitoring of offenders participation in a treatment plan.

America's Law Enforcement and Mental Health Project will significantly expand mental health courts currently existing in selected jurisdictions of Florida, Washington State, California, New York, Oregon, Alaska, Indiana, and Ohio.

"As a psychologist who has worked in a maximum security prison, I have personally treated individuals who will live out the rest of their lives behind bars because they have committed crimes that they most likely would not have committed had they been able to receive adequate mental health treatment," said Representative Strickland, the legislation's co-sponsor. "I have seen the ravaging effect that a prison environment has on the mentally ill, and the destabilizing effect that the mentally ill have on the prison environment. Inmates, families, correctional officers, judges, prosecutors and police are in agreement that our broken system of the seriously mentally ill into the criminal justice system must be fixed." □

ELLIS V. WASHINGTON COUNTY ET AL: A DIVIDED DEFENSE VERDICT

*On November 30, 1999, a divided panel from the United States Court of Appeals for the 6th Circuit ruled 2-to-1 that Washington County and Johnson City, Tennessee, as well as several individual defendants, did not act with deliberate indifference in the jail suicide of Craig W. Lanthorn. The case, **Ellis v. Washington County et al** (No. 98-6178/6228), is reprinted below.*

Before: MERRITT, KENNEDY, and DAUGHTREY,
Circuit Judges.
MERRITT, Circuit Judge:

In this wrongful death action, plaintiffs, Nancy Ellis, individually, as the mother of Craig Lanthorn, now deceased and as next friend of Catherine E. Lanthorn, and Catherine Lanthorn, individually, minor child of deceased, Craig Lanthorn, sued the defendants, Johnson City and Washington County, Tennessee, a city and the county in which it is located. Plaintiffs also sued three jailers: Sam Garland, employed by the Johnson City Jail; and R. D. Jamerson and Billy Mitchell, employed by Washington County Jail. Plaintiffs brought suit under 42 U.S.C. §1983 for the suicide of Craig Lanthorn while incarcerated at the Washington County Jail on August 3, 1994, three hours after being transferred there from the Johnson City Jail. The primary issue we deal with in this opinion is whether the actions or policies of the defendants, or any of them, was the proximate cause of the suicide. We conclude as to all defendants, except Jamerson, that the plaintiffs have failed to establish proximate causation and therefore affirm the summary judgment entered below as to Washington County and Johnson City. We affirm the District Court's grant of summary judgment on grounds of qualified immunity to jailers Garland and Mitchell. We conclude that we lack interlocutory appellate jurisdiction as to the defendant Jamerson's claim that the District Court erred in refusing to grant him qualified immunity.

I. Washington County's Liability for Failure to Train Its Jailers to Prevent Suicide

The case proceeded in the court below on the theory that Craig Lanthorn committed suicide in “cell block B-4” of the Washington County Jail by hanging himself at approximately 1:55 p.m. on August 3, 1994. This cell had a monitor camera at one end. It was not designed as a suicide prevention cell. Plaintiffs claim that Lanthorn should have been placed in a suicide prevention cell and that all sheets and clothing useful in committing suicide should have been removed. They also claim that the County did not give the jailers adequate training in suicide prevention.

On the afternoon of August 2, 1994, Craig Lanthorn was arrested at the residence of Dr. and Mrs. James Turnbull, following a 911 call from the Turnbull's daughter, Sara, reporting that Lanthorn, her boyfriend, was attempting to break into the house. She left the residence and hid in a neighbor's yard after Lanthorn broke a window to gain access through the back door. Dr. Turnbull, a psychiatrist, testified that Lanthorn was “delirious or delusional,” and he attributed this to “Lanthorn's drug use,” not to suicidal tendencies or a mental illness. Arresting officer Hensley believed that Lanthorn was drunk. He was “dazed or disoriented,” “unsteady on his feet” but “cooperative.” Hensley carried Lanthorn to the Johnson City Jail and charged him with public intoxication and criminal trespass. He was held overnight in the Johnson City Jail. After he was arraigned in court the next morning, where he was represented by counsel, the Johnson City police carried him to the Washington County Jail to await trial.

During the period from 11:00 a.m. in the morning when Lanthorn arrived at the Washington County Jail until his suicide three hours later, nothing occurred that would put reasonable jailers on notice of a possible suicide attempt. Jailer Robertson talked to Lanthorn about suicide when Lanthorn arrived, and Lanthorn said that he was not a suicide risk and “loved life.” A few minutes later Jailer Mitchell, who had gone to high school with Lanthorn, came on duty. He was concerned about Lanthorn's mental health and so advised his superior, who told him to determine if Lanthorn was a suicide possibility. Mitchell found Lanthorn on the second floor of the jail talking to his mother. He seemed to be crying. After the phone call, Mitchell engaged him in conversation. Mitchell asked Lanthorn, “Craig, are you suicidal?” Lanthorn said, “Hell no, I've got a baby on the way that I've got to take care of.”

Finally, and most important of all, plaintiff in this case, Nancy Ellis, Lanthorn's mother, is an experienced, practicing, licensed, clinical psychologist with a Ph.D. She stated two months after the death of her son in a letter that “he was not suicidal at 11:30 when I talked to him [on the phone],” and he “knew he was getting out [of jail]”:

Craig had everything to live for, a family who adored him, a child on the way, numerous friends and, a positive future. He was immensely likable. Although he had had some painful experiences, he was dealing with this in therapy and was very enthusiastic about treatment. One of the things we talked about in our last conversation was his next session with Ted (his psychologist). He was eager to get there. (App. 474.)

Based on these facts — particularly in view of his mother's expert opinion two months later and jailer Mitchell's conversation about suicide — there is no evidence from which a reasonable jailer would have foreseen suicide. No deliberately indifferent policy was a proximate cause of the death. When an experienced expert in the field of psychology, like decedent's mother, plaintiff, Nancy Ellis, was unable to predict suicide, and did not think it was necessary to warn her son's jailers of such a possibility, it is unreasonable to attribute fault to the County or its jailers for failing to predict suicide. The County was under no legal obligation to isolate Lanthorn in a suicide cell or take other extraordinary steps in anticipation of suicide. Whatever the county may have failed to do in training its jailers about suicide, its training program was not a proximate cause of the injury here. Its conduct was no more a proximate cause of the suicide than was the failure of plaintiff Ellis herself — an expert in the field — to foresee the result.

The same reasoning applies to jailer Mitchell, the jailer who was in high school with Lanthorn. Mitchell recognized that Lanthorn was mentally unstable and interrogated him about suicide. After the interview, Mitchell made a mistake in assessing Lanthorn's suicidal tendencies — just as did Lanthorn's mother — but he certainly was not deliberately indifferent toward Lanthorn and exhibited a genuine concern for his welfare while in jail. The District Court did not err in granting summary judgment for Mitchell.

II. Liability of Johnson City and its Jailers for Lanthorn's Suicide

Although Lanthorn's suicide occurred in the Washington County Jail after his transfer, not in the Johnson City Jail, plaintiffs also seek to blame Johnson City and its jailers for the death of Lanthorn on grounds that Johnson City did not properly train its jailers in suicide prevention, which in turn led the jailers to fail to anticipate, and remain deliberately indifferent to, the possibility of Lanthorn's suicide. For reasons similar to those expressed above, we conclude that the actions and policies of Johnson City and its jailers did not proximately cause the suicide of Craig Lanthorn. There is no evidence to support a conclusion that the City or its employees should be held legally responsible for the suicide.

During the less-than-24-hour period Lanthorn was in the Johnson City Jail, he talked to his mother, plaintiff Nancy Ellis, four times by phone. He talked to his father, Dr. Lanthorn, also a clinical psychologist. His uncle, Tom Cowan, a local lawyer, came to see him in jail. Lanthorn also talked to his grandmother. Two family friends, the Farthings, also came to see him in the jail. None of these relatives or family friends posted the \$100 bond necessary to release him from jail because his mother and father both wanted him to stay in jail until he agreed to enter a drug treatment program. The record is clear on this point. Neither the mother — the plaintiff in this case — nor the father, nor any of the relatives or family friends, warned the jailers that Craig Lanthorn might be suicidal, nor did they provide the jailers with any information that would put them on notice that this young man might try to take his own life. Moreover, both of the two psychiatrists who had treated Lanthorn, Dr. Fenley and Dr. Patel, testified that Lanthorn's

behavior in jail did not indicate suicide. From their testimony it is clear that they would not have predicted or anticipated suicide.

Under these circumstances — with experts in the field, (including his mother and father and the two psychiatrists who had treated him) failing to recognize or anticipate suicide — counsel’s argument for the plaintiffs that the City and its jailers should be held blameworthy for similar mistakes under federal constitutional law is wholly without merit. The City and its jailers may or may not have been properly trained in suicide prevention — we reserve judgment on that question — but that did not proximately cause the injury here. In this case the evidence in the record before us would not support a finding that the defendants should be held legally responsible in damages because they failed to anticipate and prevent Lanthorn’s suicide.

The questions discussed above are relatively easy, and reflection after a review of the record can lead to only one conclusion. Defendant Jamerson’s cross-appeal from the denial of his motion for summary judgment on qualified immunity presents a more difficult problem.

III. Jamerson’s Cross-Appeal

In *Johnson v. Jones*, 515 U.S. 304, 319-20 (1995), Justice Breyer wrote for a unanimous court, “a defendant, entitled to invoke a qualified immunity defense, may not appeal a district court’s summary judgment order insofar as that order determines whether or not the pretrial record sets forth a ‘genuine’ issue of fact for trial.” Here, the District Court determined that there was a genuine issue of fact for trial regarding Jamerson and denied his motion for summary judgment. We have held that in order for an interlocutory appeal based on qualified immunity to lie, “the defendant must be prepared to overlook any factual dispute and to concede an interpretation of the facts in the light most favorable to the plaintiff’s case.” *Berryman v. Rieger*, 150 F.3d 561 (6th Cir. 1998).

The factual dispute here arises from plaintiffs’ claim that Jamerson saw Lanthorn tie the noose around the bar at 1:45 p.m., but did not call an emergency medical team until 1:56 p.m. Plaintiffs further contend that Jamerson did not notify other jailers of the problem until 1:55 p.m. As evidence that Jamerson saw Lanthorn tie the noose at 1:45, plaintiffs rely on the following hearsay statements Sheriff Ron England made to the press on the day of Lanthorn’s death:

Our sergeant Jamerson was watching the monitors and seen [sic] him when he tried to place the loop on the bars and summonsed [sic] an upstairs jailer - they went in and one inmate helped hold him up and the jailers and the inmates took the noose from around his neck.

In a separate statement, Sheriff England said:

[Lanthorn] was a Johnson City police department prisoner and...they transported him down here at 11:00 a.m....[H]e was booked in, placed in a cell with four other inmates, and like I said at 1:45 while watching the monitor, sergeant Jamerson seen [sic] him put the sheet around his neck which was fashioned as a rope.

On appeal, Jamerson disputes these facts which might, if true, give rise to a finding of deliberate indifference. This sort of factual dispute is precisely what the Supreme Court has instructed appellate courts to avoid on an appeal of a denial of qualified immunity, except for one thing: The statement is unreliable hearsay. It is an out-of-court declaration, offered for the truth of the matter asserted, by a declarant, who subsequently testified by deposition that he has no personal knowledge about the event and does not know now why he made the statement or what it was based on.

The question then comes down to this: In a qualified immunity appeal by a state official, should the court of appeals look behind a *Johnson v. Jones* type factual dispute to determine if the factual dispute is based only on uncorroborated hearsay that will not be admissible at trial. We would prefer to avoid these kinds of evidentiary issues when ruling on our jurisdiction to decide qualified immunity under *Johnson v. Jones* because the issue of qualified immunity cannot be “decided with reference only to undisputed facts,” the requirement for appellate jurisdiction set out by the Supreme Court at 515 U.S. at 313. To decide on interlocutory appeal all of the possible fact related evidence questions present in the case would, as the Supreme Court observed, “consume inordinate amounts of appellate time” and “require a reading of a vast pretrial record” and even “greater delay” in bringing cases to a conclusion. 515 U.S. at 316.

The court below declined to grant Jamerson’s motion for summary judgment because, and only because, of Sheriff England’s hearsay statements. The summary judgment rule, Rule 56(e) is clear that such rulings may be based only on statements “made on personal knowledge” or statements otherwise “admissible in evidence” by a witness “competent to testify to the matters stated.” Plaintiffs argue that the Sheriff’s statement is an admission. But the Sheriff’s admissions are not admissible in the case against Jamerson, which is against him personally.

Thus the only factual dispute in this case arises from the rankest type of inadmissible hearsay. Based on the Sheriff’s deposition, the statement to the press was unreliable and inadmissible in evidence. No exception to the hearsay rule would let it in. Nonetheless, restrained as we are by *Johnson*, we must dismiss Jamerson’s appeal because a factual dispute remains.

The judgment of the District Court is therefore affirmed as to all parties.

CONCURRING IN PART, DISSENTING IN PART

MARTHA CRAIG DAUGHTREY, Circuit Judge, concurring in part and dissenting in part. Despite the “relative[] eas[e]” with which the majority is able to dispense with plaintiffs’ claims against defendants Washington County, Johnson City, Sam Garland, and Billy Mitchell, my review of the record in this matter reveals genuine issues of material fact that remain to be resolved concerning actions and inactions by those defendants. Consequently, while I concur in the majority’s conclusion that we have no jurisdiction over defendant Jamerson’s appeal at this time, I respectfully dissent from the remainder of the majority opinion.

JUVENILE SUICIDE IN CONFINEMENT: A NATIONAL SURVEY

Beginning in August 1999, the National Center on Institutions and Alternatives (NCIA) initiated a project to conduct the *first* national study of juvenile suicide in confinement. The project, funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), will determine the extent and distribution of suicide during a five-year period (1995 - 1999) in all public and private juvenile facilities throughout the country. NCIA is being assisted on the project by both the National Juvenile Detention Association and Council of Juvenile Correctional Administrators.

During Phase 1, a one-page survey instrument was mailed to facility directors. The survey asked these directors if their facility experienced a juvenile suicide(s) between 1995 and 1999. In order to more accurately account for the total number of juvenile suicides in confinement during the survey years, NCIA supplemented the verification process by contacting various secondary sources, including each state department of juvenile corrections. Once facilities experiencing suicides during the five-year study period have been identified, Phase 2 of the survey process will begin with dissemination of an in-depth survey instrument to facility directors that experienced suicides during 1995 and 1999. The survey instrument will collect data on the 1) demographic characteristics of each victim; 2) characteristics of the incident; and 3) characteristics of the juvenile facility sustaining the suicide. During Phase 3, NCIA will collect, analyze, and describe the findings from the national survey in a comprehensive report to OJJDP. At a minimum, descriptive statistics will be offered regarding the extent and distribution of juvenile suicide in confinement, as well as descriptive data on victims, the incidents, and the facilities sustaining the suicides. If appropriate, conclusions and policy recommendations will be offered.

All public and private juvenile facilities sustaining a suicide during the five-year period of 1995 through 1999 are strongly encouraged to participate in the study. Data provided will be coded and held in the strictest confidence. Results of the study will be presented in summary fashion, therefore, victim and facility names will *not* appear in any report.

For more information on the **Juvenile Suicide in Confinement Project**, contact Lindsay M. Hayes, Project Director, National Center on Institutions and Alternatives, 40 Lantern Lane, Mansfield, MA 02048, (508) 337-8806 (office), e-mail: Lhayesta@aol.com, or (508) 337-3083 (fax).

Without question, the now-familiar 1986 trilogy of cases, *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574 (1986); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986); and *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986), “ushered in a ‘new era’ in the standards of review for a summary judgment motion” by lowering the movant’s burden in such proceedings. See *Barnhart v. Pickrel, Schaeffer & Ebeling Co.*, 12 F.3d 1382, 1388 (6th Cir. 1993). Despite that relaxation, however, summary judgment remains improper unless *no* genuine issue of material fact exists in the case. Should such a dispute remain, faith in the jury system that undergirds American jurisprudence requires that the finders of fact be allowed to resolve the disagreement after hearing all relevant evidence.

In this case, the majority highlights selected facts from the record before us and, at one point in its analysis, concludes that “[b]ased on these facts . . . there is no evidence from which a reasonable jailer would have foreseen suicide.” (Emphasis added.) With that statement, I cannot disagree. With the benefit of additional evidence included in the record but not mentioned in the majority opinion, however, I believe a reasonable jury *could* find in favor of the plaintiffs on the excessive force, deliberate indifference, and failure-to-train claims. Viewing the facts in the record and the inferences to be drawn from them in the light most favorable to the plaintiffs, as we are required to do, see, e.g., *American Council of Certified Podiatric Physicians and Surgeons v. American Bd. of Podiatric Surgery, Inc.*, 185 F.3d 606, 619 (6th Cir. 1999), I believe reasonable jurors could conclude that the

individual defendants had knowledge of Craig Lanthorn’s need for medical treatment but were deliberately indifferent to that need. Moreover, evidence adduced by the plaintiffs was sufficient to enable a reasonable jury to question the adequacy of the defendant municipalities’ training programs and to find that Officer Garland used excessive force in handling Lanthorn in the Johnson City jail.

I. Deliberate Indifference Claim

We have recently reiterated that “summary judgment is inappropriate when there are issues of fact as to whether [a defendant in a § 1983/Eighth Amendment case] was aware of facts from which the inference could be drawn that a substantial risk of serious harm exist[ed] and whether he actually dr[e]w the inference.” *Woods v. Lecureux*, 110 F.3d 1215, 1224 (6th Cir. 1997) (quoting *Street v. Corrections Corp. of Am.*, 102 F.3d 810, 816 (6th Cir. 1996)) (internal quotation marks and citations omitted). In this matter, almost from the inception of the defendants’ contacts with Lanthorn shortly before his suicide, disturbing facts and occurrences presented themselves that could, in the estimation of a reasonable jury, support the plaintiffs’ claims of obvious, imminent harm. After Lanthorn’s arrest, for example, Officer Tim Hensley of the Johnson City Police Department noted that Lanthorn was foaming at the mouth.

Similarly, at the arrest scene, Dr. James Turnbull, the father of Sarah Lee, also noted that Lanthorn was foaming at the mouth and that Craig had mistakenly called Turnbull “Dr. Fenley,” one

of Lanthorn's physicians. Although Turnbull attributed Lanthorn's condition to drug use, he admits informing the police that the young man "obviously needs some medical attention." No such attention was forthcoming.

At the Johnson City jail, Lara Bolton processed Lanthorn's paperwork and noted that he suffered from anxiety and seizures and that he was taking the prescription drug Klonopin. Despite those danger signals, however, Bolton did not inquire further into Lanthorn's need for medical treatment. A few hours later, Lanthorn began screaming and kicking at his cell door. Officer Garland responded to the disturbance and observed Lanthorn flailing on his back, complaining that he was having a seizure, and requesting transport to the hospital. That request was denied, however, and a rescue team was summoned. Although the paramedics did not deem Lanthorn's condition serious enough to require transport, a member of the team did write that Garland should contact Lanthorn's physician for additional instructions about medication. Garland did not do so.

The day following Lanthorn's arrest, the pretrial detainee was transferred to the Washington County jail for court proceedings. Officer Hensley again transported Lanthorn and, because of a conversation between the young man and other prisoners, he asked Lanthorn if he was contemplating suicide. Hensley testified that he made the inquiry based upon a feeling and Lanthorn's "high level of anxiety and upsetness." Because Lanthorn denied such thoughts, Hensley chose not to mention to Washington County jail officials the suicide talk, the bizarre behavior, the summoning of the rescue team, or Lanthorn's request for medical treatment.

Upon arriving at the Washington County facility, Lanthorn did explain to booking clerk Wanda Robertson that he was presently on medication for panic attacks, nerves, and seizures. Given that history and the prisoner's disoriented appearance, Robertson initially assigned Lanthorn to one of the county's suicide prevention cells. Lanthorn twice insisted, however, that he was not suicidal. Even though Robertson also overheard Lanthorn promise his mother that, upon his release, he would check into a psychiatric hospital, Robertson did not become overly concerned and, in fact, testified that she thought only that the prisoner had a drug or alcohol problem.

Before Lanthorn could be placed in the suicide watch cell, Officer Billy Mitchell heard Lanthorn's name being mentioned and recognized the prisoner as the individual Mitchell had transported to a Knoxville psychiatric hospital approximately one month earlier. Realizing that Lanthorn had required hospitalization on that prior occasion, Mitchell, at the direction of R.D. Jamerson, his immediate superior, engaged Lanthorn in conversation and later related that the prisoner claimed that he loved life and was preparing to care for an infant who would be born soon. Based upon that discussion, despite having seen Lanthorn distraught while speaking with his mother on the telephone, without reviewing an assessment of Lanthorn's condition and complaints, and without consulting the booking card, Mitchell recommended that Lanthorn be transferred from the previously-assigned suicide prevention cell to a less-frequently monitored cell.

Based upon *these* facts alone, a reasonable jury could conclude that Garland and Mitchell were deliberately indifferent to

Lanthorn's need for medical treatment. Consequently, summary judgment should not have been granted to the defendants on this claim.

II. Failure To Train Claim

Despite the shocking nature of the individual defendants' inattention to warning signs and the outright disregard of requests by Lanthorn for medical care, such inaction is understandable when presented with evidence from which a jury could find that the municipal defendants unconstitutionally failed to train their employees adequately to spot such dangerous situations. In fact, defendant Garland intimated during his deposition testimony that although his personnel file indicates that he received the required number of hours in suicide prevention training, Johnson City actually falsified those reports so as to permit certification without the requisite instruction. Additionally, although both Johnson City and Washington County maintained suicide prevention guidelines in their jail manuals, defendant Mitchell testified unequivocally that he had never seen the county's manual, despite employment in the jail facility.

Such evidence, if believed by a jury, would enable a plaintiff to establish a failure-to-train claim under the circumstances presented in this matter. The refusal of the district court and of the majority to permit examination of that evidence by a fact-finder thus justifies reversal of the summary judgment granted to the municipal defendants on plaintiffs' allegations.

III. Excessive Force Claim

Similarly, the plaintiffs adduced proof that, if believed, would justify a jury in concluding that defendant Garland utilized excessive force in dealing with Lanthorn while Lanthorn claimed to be suffering from a seizure in the Johnson City jail. Deposition testimony established that while the pretrial detainee was flailing on the floor of a jail cell, Garland, who then weighed approximately 380 pounds, came into the cell and physically restrained the prisoner. Although Garland insists that he only placed his foot lightly on Lanthorn's leg between the ankle and shin in order to stop the thrashing, Lanthorn later claimed he had been beaten by Garland. Also, Dr. Cleland Blake testified in his deposition that his autopsy of the body of Craig Lanthorn revealed some bruising *in the buttocks area* "consistent" with a shoe print. Such divergent testimony again demands resolution, not in a ruling on a motion for summary judgment, but rather by a jury selected by the litigants to sift through the conflicting evidence.

IV.

In upholding the district court's grant of summary judgment to the defendants in this case, the majority gives credence to the evidence adduced by the city and county employees. Furthermore, in concluding that no reasonable person could have envisioned Lanthorn's need for medical treatment, the majority relies heavily upon statements made by Lanthorn's mother, without a personal visitation of her incarcerated son, in a letter she wrote seeking assistance in contacting a psychic to aid her in unraveling the events of Craig's final hours. A jury, presented with all relevant information in this case, might well concur in

the result reached by the majority. Other evidence, however, supports a determination that the plaintiffs' allegations are well-founded. In our judicial system, it is only the appointed finders of fact that should be allowed to make the necessary credibility findings and analyses necessary to sort through such conflicting testimony. Out of respect for that system, I dissent from that part of the majority's decision removing the jury from its pre-eminent fact-finding role.

□

NEWS FROM AROUND THE COUNTRY

Continuing with this issue, the *Update* will periodically present brief stories regarding jail suicide, mental health services, and other related topics that have recently occurred throughout the country.

Nebraska

In October 2000, a 17-year-old boy was found hanging in his cell at the Hall County Jail in Grand Island. Joshua J. Treichler had been arrested for burglary the previous day after he and his 15-year-old girlfriend broke into a home and stole some food and blankets. His mother, Donna Carter, was allegedly told by jail officials that her son was supposed to be on a suicide watch. She

was also told that Joshua was last seen alive at approximately 7:00 p.m., and his body was found at 10:15 p.m. "He hadn't been checked for over three hours, and that's what really upsets me," Mrs. Carter told the *Grand Island Independent*. "I just miss him. Someone let my boy die because they didn't do their job."

According to Mrs. Carter, her son had a history of mental illness and suicidal behavior. Joshua had spent some time in a mental hospital in Indiana, but the family did not have money or insurance for extended treatment. "They were a couple of scared teenagers," she said. "He was a good kid who had some problems."

Pursuant to state law, a grand jury was impaneled to investigate the death. In December, the grand jury released its findings and cleared jail officials and staff of any criminal wrongdoing. Although not providing any further insight into the details of Joshua's death, the grand jury did make several recommendations, including 1) uniform training for all jail personnel; 2) clearly stated policies with true accountability when procedures are violated; 3) mandatory pre-shift briefings for staff; 4) mandatory use of audio and video equipment, with constant monitoring of all juveniles and other inmates on suicide watch; and 5) a more balanced disbursement of experienced personnel.

Maryland

National surveys suggest that as many as 10 percent of emergency calls to local police departments involve persons suspected of having mental disorders. Police officers in Montgomery County have recently taken part in a unique training course that simulates the everyday lives of the mentally ill. The officers are asked to perform routine tasks while wearing a headset that fills their heads with screaming voices. The goal is to teach police how to better handle emergency calls involving mentally ill citizens and reduce the use of deadly force.

The Montgomery County Police Department is the first local law enforcement agency in the Washington, D.C. area, and one of a small number nationwide, to offer a week-long course and create a crisis intervention team of trained officers to handle the calls. In the course, officers are assigned tasks such as buying a newspaper, reading a story or reciting a list of words — while listening to voices. The course also introduces officers to mental health service providers such as the county crisis center, reviews basic symptoms of illnesses, and teaches negotiation techniques. It also includes a visit with patients at Springfield Hospital Center in Sykesville, who critique the police techniques.

Esther Kaleko-Kravitz, executive director of the local chapter of the National Alliance for the Mentally Ill, said the extra training is overdue. The program "allows people with mental illness to be handled by people who are more informed and aware," she told the *Associated Press* in December 2000. "They need to have people who do not have a stigma about mental illness."

California

There are more than 1.5 million citizens who need mental health services, but they are not getting treatment, mainly because the state lacks "a clear commitment to provide mental health

UPDATE ON THE INTERNET

Recent issues of the *Jail Suicide/Mental Health Update* are now available on the Internet at <http://www.igc.org/ncia/suicide.html>

Check us out on the Web!
<http://www.igc.org/ncia/suicide.html>

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

<http://www.hpub.com/journals/crisis/1997>
<http://www.nicic.org/inst/jail-mental.htm>
<http://www.nicic.org/pubs/jails.htm>
http://www.ncjrs.org/html/ojjdp/jjnl_2000_4/sui.html
<http://www.performance-standards.org/resguide.htm>
<http://www.prainc.com/gains/webpub.htm>

services to people who need assistance,” according to a report released in November 2000 by the Little Hoover Commission. The report, entitled *Being There: Making a Commitment to Mental Health*, examined how the state handles services to the mentally ill and concluded that the government needed to invest more money in helping communities provide housing, employment, counseling and other services to the mentally ill. Currently, the state “ration[s] care to only the most severely disabled. And even then we often turn people away because adequate resources have not been budgeted,” said Richard Terzian, chairman of the Commission.

The Little Hoover Commission, an independent oversight board made up of elected officials and private citizens, recommended that lawmakers take immediate steps to ensure anyone who needs mental health services gets treated. “The question is, are we going to continue to muster the political will to build the system that was promised a generation ago?” Assemblyman Darrell Steinberg, the author of several bills on community-based mental health systems, told the *Associated Press*. “The history is clear. About 30 years ago when the decision was made to close the state hospitals, there was a promise to pay for the community programs where people could live with dignity. It hasn’t been done,” he said.

Counties are responsible for providing services, but only to the extent that they have the money to pay for it. Until the state makes more money available, the public will “continue to be frustrated with a fragmented, crisis-driven system where cost-inefficiencies mount and fewer people recover,” Assemblywoman Helen Thomson, a former nurse, told the *Associated Press*.

According to the report, the state should also invest more funds in community-based programs that use integrated service programs. Those programs, such as Project HOPE in Sacramento, provide a gateway to every service that the client needs — medical, counseling, drug rehabilitation, housing, food and clothing. “The goal is to have these integrated services in every county in California,” Mr. Steinberg said. “And not just the homeless. The same model of integrated services and outreach can apply to people who are living with their families.” Assemblyman Steinberg also stated that in its first year of operation, Project HOPE and the other pilot programs in Stanislaus and Los Angeles counties cost the state \$10 million, but saved \$20 million by not taking mentally ill persons to jail or to emergency rooms. The state is paying \$55 million to expand those programs this year.

The report also recommended that the Governor establish a temporary commission that would conduct a public education campaign to overcome the stigma of mental illness, study what programs work and what is needed, and assess the costs of failing to provide appropriate care. The Commission also suggested that the Governor establish the California Council on Offenders with Special Needs, an agency which would investigate approaches to treating the long-term needs of mentally ill inmates.

For a copy of *Being There: Making a Commitment to Mental Health*, contact the Little Hoover Commission, 925 L Street, Suite 805, Sacramento, California 95814, (916/445-2125). The report can also be downloaded from the agency’s website: www.lhc.ca.gov

Florida

An arbitrator rejected an attempt by Sheriff Nat Glover to fire a corrections sergeant and demote a police lieutenant in the choke-hold death of a mentally ill inmate in 1999 at the Duval County Jail in Jacksonville. Arbitrator Steward Savage ruled in December that Sergeant David Haskett should not lose his job and that Lieutenant Beverly Frazier should not be demoted, although he found the neck restraint on Demetrius Brown should not have been used and that the inmate had been improperly placed in a restraint chair.

Police union officials praised the decision, saying the punishment recommended by the sheriff was too harsh. “I’m afraid the publicity affecting this case caused the Sheriff’s Office to look for somebody to blame,” Tad Delegal, attorney for the Fraternal Order of Police, told the *Associated Press*. “There was no reason to discipline these officers. They did what they were taught.”

Sheriff Glover, who has banned the use of the neck restraint, said he was disappointed by the ruling. A police board had previously recommended that Sergeant Haskett and Lieutenant Frazier be disciplined in the October 1999 death of 20-year-old Demetrius Brown. More than a dozen officers responded to reports that Mr. Brown was acting wildly in his cell. The inmate was eventually handcuffed and placed in a restraint chair, where several officers used the neck restraint to control him. According to the autopsy report, Mr. Brown died after suffering a heart attack caused by the neck restraint. The board said the use of force was unnecessary. The arbitrator felt otherwise.

Oklahoma

A woman in jail claims she has been raped and beaten by a jailer. She also complained about being able to see a parade in Bricktown in Downtown Oklahoma City from her cell window. She says people in the parade are having sex. Outside, there was no parade. Inside the cell, the glass block windows do not allow a view of the outside world.

The woman is one of at least 360 inmates — out of about 2,250 a day — in the Oklahoma County Jail who suffer from mental illness. Two psychiatrists are responsible for evaluating each inmate three days a week.

Her claims of being raped and beaten by a jailer were investigated recently, Sheriff John Whetsel said. There was no evidence of the rape, he said. There was evidence she suffers from hallucinations. Whetsel said the jail houses the state’s largest population of inmates who used prescription drugs to treat mental illness. Mental health advocates say too many people are in jail when they may need to be elsewhere for treatment.

The most common mental illnesses in jail are bipolar disorder and schizophrenia. The jail is working to address the problem, said Captain Cliff Uranga of the Oklahoma County Sheriff’s Office. “Jails are often the places where people who need mental health care end up because they have had an incident with the law,” he said. “We house a large population of people who probably need to be somewhere else.” On one August day, the

jail housed more than 400 people on psychiatric medications, he said.

Many people suffering from mental illness end up at the Jesus House after being released from jail, said Robyn Singleton-Szuba, the homeless shelter's development director. She said she doesn't think the Oklahoma County Jail has the resources to handle the problems of mental illness. Homeless people with mental problems often are picked up for vagrancy or other minor complaints, she said.

Something like this happened to Jesus House kitchen worker Gary Fisk, 46. Fisk said he has been medicated for hearing voices since his 8-month-old daughter Tabitha died July 14. He often hears the little girl's voice in his head. One recent night he heard her. "It sounded just like her talking to me. So I decided I was going to go out walking around. We'd already cleaned up the kitchen," he said. "I was contemplating dying, killing myself," Fisk said. About 11:30 p.m. on September 12, Fisk called 911 from a convenience store pay telephone to ask for help. He said police officers arrived and arrested him. Police took him to the Oklahoma County Jail because he had an outstanding public intoxication warrant. "The next thing I knew, there were three officers trying to handcuff me. I fought them, being mad and emotionally disturbed," Fisk said. Fisk said he was left naked on a suicide watch for 12 hours in a cell before he was released. "The solution would have been to take me to a hospital instead of locking me up, or to a crisis center. Any hospital in town has a psychiatric unit," Fisk said.

There is always room for more care for the mentally ill in jail, said Don Bowen, superintendent of Griffin Memorial Hospital. He used to work for the Oklahoma County Crisis Center. Bowen said conditions have improved at the jail, but they could be better. "I don't think there has ever been a time when mental health was addressed enough in the jails," Bowen said. He said there needs to be a closer relationship between the state Mental Health Department and jails, he said. "We need to be able to have more continuity of care in jail," he said.

Anna McBride, president of the local chapter of the National Alliance for Mental Illness, has been trying to come up with ways to keep the mentally ill out of jail. McBride said she thinks one way to help is if police had more training or more crisis intervention teams were available. One psychologist, Dr. Edith King, visits the jail to assess mentally ill inmates at the request of the courts. McBride said King recently was able to get a suicidal person, jailed on a public drunkenness complaint, into a crisis center for treatment. "That's how things are supposed to work," McBride said.

Another idea is offering mentally ill people a chance to check into a treatment program instead of serving jail time for minor offenses, much like is done for first-time drug offenders, McBride said. It's a difficult issue because "nobody wants to release someone who is a danger or risk to society," she said.

A plan for such a "mental health court," is in the works, said Captain Ricky Barrow, Sheriff's Department spokesman. The plan would give some first-time offenders the option of checking into

a mental health program, Barrow said. The jail is also taking extra steps to make sure inmates get medications the county must provide, Barrow said. The county spends \$24,000 a month for prescription psychiatric drugs for inmates — or 64 percent of the \$37,500 it spends each month on all prescription drugs for inmates.

Paul Bouffard, director of the Oklahoma County Crisis Intervention Center, said more resources are needed to care for the mentally ill in jails. His crisis center evaluates people after they are arrested, while they are in jail and after release. "I don't think there are enough resources in the general population to treat mental illnesses anyway," Bouffard said. He said local law officers do a good job bringing the mentally ill to the crisis center instead of jail.

Sheriff Whetsel said an extra psychiatric nurse was hired over the summer, and the jail now has two such nurses. He said he thinks the idea of a "mental health court" should keep some of the mentally ill from jail. His staff is working on a written proposal to be reviewed by the courts and then presented to lawmakers in February. "It's going to take legislation for us to provide this for the mentally ill," Whetsel said.

(Reprinted from *The Oklahoman*, October 30, 2000, "Jail Strives to Cope With Mentally Ill," by Robert Medley, Staff Writer.)

Wisconsin

State legislators want to form a new committee of medical experts and Department of Corrections staff to review every death in the state prison system after an investigative series detailing dozens of questionable inmate deaths appeared in the *Milwaukee Journal Sentinel* newspaper last fall. The deaths include suicides, as well as fatalities resulting from various treatable medical conditions such as appendicitis and asthma. Criticism was also raised in regard to the thoroughness of the review process currently utilized by the Department of Corrections following each inmate death.

Representatives Sheldon Wasserman and Scott Walker stated in December 2000 that they will soon introduce a plan to create a "mortality oversight committee." The proposed 11-member committee would include four faculty members each from the Medical College of Wisconsin and University of Wisconsin Medical School, and three employees of the Department of Corrections. All inmate deaths would have to be reported to the group within 72 hours. The committee would meet quarterly to investigate inmate deaths, make recommendations, if appropriate, to the Department of Corrections, and file complaints, if necessary, against negligent health care professionals with the Department of Regulation and Licensing.

Corrections Secretary Jon Litscher countered that, despite the lawmakers' plan, he will develop his own panel of experts. The Secretary's panel would include both experts from inside and outside the Department of Corrections. "This will happen faster than what the Legislature will do," he recently stated. But Representative Wasserman said the Legislature must step in — "This is the only thing that will have credibility in the eyes of the public."

Ohio

The city of Akron is opening the state's first mental health court, seeking to dole out more treatment than punishment to the mentally ill. As of January 2001, defendants with a documented history of mental illness who are arrested for minor offenses may forgo contesting charges against them in favor of entering a two-year treatment program. The charges would be dropped upon program completion.

"Jail is not meant to be a treatment setting and is not the ideal place for the mentally ill," Dr. Mark Munetz, a psychiatrist with the Alcohol, Drug Addiction and Mental Health Services Board, told the *Associated Press*.

The goal of the program will be to divert 100 mentally ill offenders from the court system this year. With a start-up cost of \$300,000, the new court "will move mentally people out of jail more quickly and reduce costs throughout the system with a more appropriate treatment," stated Akron Municipal Court Judge Elinore Marsh Stormer. "This specialty court is a significant step in enhancing public safety and realistically dealing with the repeat offender whose 'major crime' is untreated mental illness."

The Northeast Ohio Coalition for the Homeless recently stated that Cuyahoga County officials are discussing developing a similar court to serve homeless people who suffer from mental illness and live on the streets of Cleveland.

Texas

Two former correctional officers at the Nueces County Jail in Corpus Christi, fired for allegedly not performing regular cell checks immediately prior to an inmate suicide, were reinstated in January 2001 by the county's Civil Service Commission. In reinstating the officers, the Commission reduced their punishment to a 90-day suspension, but did not award them back pay for the other nine months they were not at work. "The facts didn't even support a suspension," one of the officers told the *Corpus Christi Caller-Times*. "I thought we were going to get some kind of compensation," said the other officer.

Lucio Mendez committed suicide in the Nueces County Jail in September 1999. Jail policy required that correctional staff perform cell checks at 30-minute intervals. Mr. Mendez was allegedly found hanging in his cell more than 60 minutes after the previous cell check.

Walter Bryan, chief of litigation for the county attorney's office, said the county was forced to abide by the Commission's decision. But, he said, the fact that the Commission did not award back pay indicated they agreed the officers had violated jail policy. "That right there would tell you that (the Commission) didn't believe they didn't do it, but just that the punishment was too harsh," he said. Christopher Gale, an attorney representing the Mendez family, said he disagreed with the reinstatement. "They didn't perform their key checks and because of that, at least in part, Mr. Mendez died," he said. "That should be a big concern."

Washington, D.C.

According to a recently released report on mentally ill juveniles, "we too often lock away children with mental health problems, rather than providing them with effective treatment. Arrest and sentencing have become key points of entry into the arena of mental health services for tens of thousands of youth. Yet juvenile detention facilities and staff are rarely equipped to provide appropriate and adequate care — and youth are simply warehoused."

These strong words come from Robert Pence, National Chair of the Coalition for Juvenile Justice, in the preface to the agency's 2000 annual report — *Handle With Care: Serving the Mental Health Needs of Young Offenders*. A national, non-profit organization, the Coalition for Juvenile Justice provides annual reports to the President and Congress. According to Mr. Pence, "It is our purpose to raise awareness throughout the nation of the seriousness of unattended mental health problems among youth in America — links to self-destructive and delinquent behavior — and steps we can take to create greater health and safety for young people, families and communities."

The report reviews varying types of mental illness in children, statistics on the estimated prevalence of mental illness in the juvenile justice system, as well as several case studies to highlight systemic inadequacies in dealing with the problem. The report also reflects optimism by showcasing two community-based programs (Youth Villages in Memphis, Tennessee and Wraparound in Milwaukee, Wisconsin) that offer hope in servicing juveniles who suffer from mental illness. The report offers recommendations to the President, Congress, Office of Juvenile Justice and Delinquency Prevention, and other groups and individuals involved in the juvenile justice system. Several recommendations are specifically directed to juvenile justice facilities:

- 1) Administrators should create a safe, secure and rehabilitative atmosphere for youth. This can be achieved, in part, by maintaining appropriate staff ratios and providing ongoing staff training on mental health issues, discipline and safety procedures.
- 2) Staff should receive specific mental health training in cultural, racial, gender, sexual orientation and developmental issues.
- 3) Staff should also be adequately trained in the proper use of medication. It must be used only to treat illness, not as a substitute for safe and humane behavior control and meaningful mental health care. Administrators should be more diligent in ensuring adequate supervision of the use of medications.
- 4) Administrators should make certain that facilities conform to suicide prevention standards. Every suicide and serious suicide attempt should be examined through an established review process that includes recommendations for changes in policy, training, mental health services, etc.

- 5) Administrators should make certain that every youth entering a facility is screened and assessed for mental illness in a manner that is timely and sensitive to race, gender, culture and sexual orientation.
- 6) Administrators should not allow youth to be victimized by either other youth or staff. There must be discipline and safety alternatives to the pervasive overuse of restraints and long periods of isolation. No youth should be overmedicated for behavior control or neglectfully under-medicated.
- 7) Administrators should be willing to look beyond traditional punishment-oriented juvenile justice models by participating in the cross-pollination of ideas between institutions. They should be open to trying new, innovative programs, such as substance abuse treatment and life skills training that empower youth and help them succeed when released into their communities.
- 8) To initiate such programs, administrators must form new partnerships and draw on the untapped resources of community organizations, faith groups and volunteers.

To receive a copy of *Handle With Care: Serving the Mental Health Needs of Young Offenders*, contact the Coalition for Juvenile Justice, 1211 Connecticut Avenue, NW, Suite 414, Washington, D.C. 20036, (202/467-0864; 202/887-0738-Fax) or e-mail: info@juvjustice.org. The report can also be downloaded through the agency's website: www.juvjustice.org.

JAILING THE MENTALLY ILL¹

by
John Biewen and Stephen Smith

Introduction

In the early 1840's, crusading prison reformer Dorothea Dix wrote a scathing report to the Massachusetts legislature:

I proceed, Gentlemen, briefly to call your attention to the state of Insane Persons confined within this Commonwealth, in cages, closets, cellars, stalls, pens: Chained, naked, beaten with rods, and lashed into obedience!

Dix argued that the many insane people in Massachusetts jails and almshouses did not belong there; they should be placed in more humane institutions designed just for them. Massachusetts and other states responded. Dix's campaign led to the construction

of some 30 new mental institutions. Forty years after she started her campaign, the 1880 United States Census said 99 percent of the nation's "insane persons" lived at home or in asylums. Only a few hundred were in jail. That was the practice in the United States for the next century: mentally ill people who couldn't cope on their own were confined in mental hospitals. Most never had the chance to live freely in society—or to get in trouble there.

That has changed. Last year the U.S. Justice Department reported that 280,000 people with serious mental illnesses were in jail or prison — more than four times the number in state mental hospitals.

A Visit to Jail

His name is Steven, county officials tell us — the lean young man who sits alone on the floor, cross-legged and naked. We can't hear him; he's enclosed in a cell of thick plexiglass. But his lips move. He gestures vigorously and talks as if to the ceiling.

"The other day he was banging on the windows and basically....having an outburst," says Sergeant Ron Riordan, our guide on a tour of the Hennepin County Jail in Minneapolis. Steven is "not somebody that could be out in any sort of general population environment because the other inmates would pick on him."

Steven also tried to hang himself. That explains his nakedness. "We restrict the inmate's clothing because he was tying it around his neck," Riordan explains.

At the Hennepin County Jail, as at most others in the country, large and small, coping with mental illness has become routine. Sergeant Riordan oversees the intake process, where new inmates — 51,000 a year, on average — are searched and signed in. "During that time [we] also ask the inmate a bunch of medical questions: Have any history of psychological problems? Ever tried to harm or kill yourself? Taken any psychiatric medications? Those types of things."

The jail has nurses on staff 24 hours a day. Psychologists visit several times a week. The special set of isolation cells where Steven is being held is for inmates who've behaved aggressively or "shown a potential to be highly suicidal," Riordan explains.

Steven was arrested for trespassing, we learn later. That's a charge that usually leads to little or no jail time. In Steven's case, his attorneys argue he's incompetent to stand trial, so he'll spend six weeks in jail waiting for a hearing. (Eventually he'll be declared incompetent and released.)

The Justice Department says mentally ill inmates generally serve longer sentences than those without mental disorders because they're more likely to break rules or get in fights.

As in early 19th-Century America, jails and prisons now function as the nation's asylums. The Justice Department estimates one in

¹This program originally aired on American RadioWorks in July 2000 and is reprinted with the permission of Minnesota Public Radio.

six inmates across the country has a severe mental illness. Most are locked up for relatively minor offenses. Many cycle in and out of jail repeatedly.

Locked Up and Psychotic

A man we'll call Mike has been to jail several times. He hopes never to go back. Mike is a plumber in his mid-40's, a compactly-built man with a mustache and a firm handshake. His apartment overlooks Main Street in a small town outside Minneapolis. At 8 o'clock in the evening Mike looks at his watch and goes to his medicine cabinet.

"Gotta take two of these babies," he says, pulling out a small bottle of prescription medicine with a satisfied smile. "They're ten milligrams apiece."

Two little pills that make all the difference in Mike's life. He says the antipsychotic medication, Olanzapine, tames the symptoms of his schizophrenia and makes him feel — almost — normal. "I have the same feelings....I feel and see things pretty much the way everybody else does."

The trouble is, Mike hasn't always taken his meds regularly. As a result, he's been arrested and locked up three times — twice for stalking and once for assault.

"Well, he's just hyper! I mean, ready to jump out of his skin." That's how Mike's father, a retired plumber who lives in a Minneapolis suburb, describes Mike's demeanor when he's unmedicated and psychotic. "Like he told me, he says, 'Dad....you don't know all the voices you hear and the things telling you what to do.' And he says it goes on and on and on and on."

Mike's mother adds: "He can be talking to you and all of a sudden he can be staring, like [there's] nobody home, you know. And he'll just stare a hole right through you. And he's got the kind of eyes that look kind of wicked when he does that. And that is what has scared these so-called stalking victims."

In 1995 a woman called police after being scared by Mike's psychotic gaze. He was sentenced to three months in the Hennepin County Workhouse. A similar incident with a different woman put him back in jail for several months in 1998. Between those two arrests, Mike did another two-month term in a rural county jail for assaulting a deputy sheriff. When the deputy pulled Mike over on a traffic stop, he argued belligerently with the officer. The confrontation turned into a chase and a struggle and a deputy with a bloody nose.

Mike's parents blame his illness. "If you put [a schizophrenic] in a corner, he'll fight back just like a cornered tiger," says Mike's father. "That's the paranoia," his mother says. "They think that everybody is out to get'em. Everybody."

So Mike landed in jail. Then, on the inside and still unmedicated, he got into more trouble. In one incident at the Hennepin County Workhouse, an officer told Mike to reach through the bars so he could be handcuffed. Mike refused.

"They maced me and they dragged me off to the isolation cell," he recalls, "and they put me in one with no bed, just a mattress on the cement floor and a TV camera so they could watch me. And I stayed there for the duration of the time."

Mike spent much of his jail time in solitary confinement. Even a couple of years later, remembering the humiliation and frustration makes him weep.

"I didn't get to tell anybody, I didn't get to talk to anybody, I didn't get to tell my side of the story. And when I would try....they wouldn't believe me. But they don't have to wake up in the middle of the night soaking with sweat and staring at the wall and not be able to think of things, either. I go through that all the time."

From the Street to Jail, and Back

Eventually, Mike escaped the revolving door in and out of jail. After his last stalking arrest two years ago, a court found him incompetent to stand trial and committed him to a state mental hospital. There, drugs and treatment stabilized him and reduced his psychosis.

Mike's parents are angry at how police and jailers handled their son, but Mike's mother admits his miserable experiences in jail motivated him to finally start taking his antipsychotic drugs every day. That's something he wasn't doing before.

"He was in and out of Abbott Northwestern [hospital], their psychiatric unit, three or four times. But there again, they'd get him straightened out and then he'd go off the medication." The repeat stalking charges, though, prompted a judge to commit Mike to an extended hospital stay — "which was good," his mother says, "because he wasn't getting anywhere the way he was going."

But a lot of mentally ill people who get in criminal trouble never get plugged into treatment. Most don't get medication in jail unless their psychosis makes them a nuisance to jailers. And in most places mentally ill inmates leaving jail are not directed to mental health programs. They're simply let go.

On any given day in any American city, you'll find some of them wandering the streets and sleeping on heat grates.

"We deal with a lot of [homeless]," says officer David Shotley, who walks a downtown Minneapolis beat. "We've got quite a few homeless shelters. How many of them are mentally ill, it's hard to say."

Shotley and his partner, James Stetson, point out a young man in blond dreadlocks walking across the street, lugging all of his belongings in a backpack. The officers say the young man shows symptoms of bipolar disorder — what used to be called manic depression. They've arrested him for trespassing many times; he has a penchant for walking into lunch-counters, grabbing handfuls of food and walking out.

Then there's a middle-aged, nervous-looking man with gray hair. He stands at the corner of 8th and Hennepin smoking a cigarette. The police call him John-John.

“He’s got a parka on, got all his gear with him,” Shotley points out. “He just stands out there and minds his own business. Some people, you know, they call [us about] him and say he’s barking at people.... You can see his head right now is shaking where he’s, like, talking to himself.”

John-John doesn’t cause trouble; the officers say they’ve never had to arrest him. But they vent frustration about other mentally ill people they’ve arrested dozens of times for nuisance crimes like panhandling and public urination.

“What are you thinking,” Stetson says, “to stand right on the sidewalk here by a restaurant, pull out your unit and urinate right on the ground where people are trying to eat dinner?” The street people creating such disturbing sites may have “some type of a mental disability,” Stetson says, “but we don’t know. We’re not professionals. So we just enforce the crime part of it.”

What to Do?

Many police officers and jailers agree with psychologists that jails don’t make good mental hospitals. But like it or not, jails have inherited that role. The modern trend started in the 1970’s, when most of the nation’s state mental hospitals were emptied and closed down.

“Closing state hospitals was very important because we had drugs at that point that worked so well that people no longer had to be in such restrictive environments,” says psychologist Linda Teplin of Northwestern University. “The problem, though, is that at the same time we didn’t provide the community-based alternatives.”

Alternatives like group homes and outreach for the homeless mentally ill. During the Reagan Administration’s budget-cutting drive in the 1980’s, the federal government slashed funding for such programs, Teplin points out. “In 1975 it was around ten dollars per capita — and these figures are in constant dollars. By 1992 that dropped to just over five dollars per capita. Now, theoretically, state governments were supposed to pick up the slack but in reality they simply have not.”

In Hennepin County, as in most every other city, treatment is in short supply. Mental health officials say they’d need five times their current staff of case managers to serve everyone in the county who has a serious mental illness. Then again, those potential clients aren’t lining up for help. Which brings up another important change in recent decades: Starting in the late 1960’s, courts declared that people with mental illnesses can choose not to get treatment so long as they’re not a proven threat to themselves or others.

The man we’re calling Mike, the schizophrenic plumber, got arrested when he wasn’t taking his Olanzapine. His mother contends Mike should have been forced to take his drugs before he got in trouble.

“These people are not mentally competent to decide for themselves whether or not they need treatment. And how are they ever going to improve? How is society ever going to be able to live with them unless they are treated? In other illnesses, well, I guess if they want to take chances with their health, they have that right. But in mental illness there’s too much at stake. Too much at stake.”

JAIL MENTAL HEALTH SERVICES INITIATIVE FROM THE NATIONAL INSTITUTE OF CORRECTIONS (JAILS DIVISION)

Nearly 6 to 8 percent of the more than 10 million annual commitments to jails are individuals with severe mental illnesses. Many sheriffs and jail administrators view the challenge of responding to the needs of this population as one of the major issues in jail management. In response, the National Institute of Corrections (NIC) has worked collaboratively with the National Institute of Mental Health for the past several years, and more recently, with the Substance Abuse and Mental Health Services Administration’s Center for Mental Health Services to increase and improve these services. As a result of these collaborations, the NIC Jails Division has developed a mental health initiative for jails.

An important component of the initiative is the offering of regional workshops conducted in collaboration with state, regional, and local jurisdictions. The 21-hour regional workshops will be provided upon request to help small and medium-sized jails enhance mental health services and service delivery for inmates. Several jurisdictions in a region can each send a three-person team consisting of a jail administrator, a representative of the jail’s community mental health provider, and the person who coordinates mental health services for inmates. Each workshop will include: overview of the problem, planning principles, contract development, leadership and managing change, implementation strategies, staffing and cross-training, and coalition building. The workshops are conducted at the request of a host agency, which is responsible for furnishing the training rooms and equipment. The NIC Jails Division provides two trainers, the curriculum and training materials. Participants are responsible for their own expenses.

In addition to the workshops, the NIC Jails Division’s mental health initiative includes the following services:

- ◆ **On-site Technical Assistance:** This assistance usually consists of an assessment of a jail system’s mental health needs, *but also can be targeted at suicide prevention issues in the jail;*
- ◆ **Newsletter:** The NIC Jails Division funds the *Jail Suicide/Mental Health Update*, a newsletter which is distributed free of charge on a quarterly basis;
- ◆ **Information Resources:** The NIC Information Center has compiled a jail mental health information resource order form that contains 22 items. The form is available at the mental health workshops held in Longmont, Colorado and at regional sites. It can also be obtained by calling the Information Center at (800) 877-1461.

For more information on the NIC Jails Division’s mental health initiative, on-site technical assistance, and the mental health workshops, contact the agency at (800) 995-6429, or visit their website at: www.nicic.org/inst/jail-mental.htm

It's not clear how society could force mentally ill people to take medication outside of institutions. Anyway, civil libertarians would object to forcing treatment on anyone who isn't proven to be dangerous. To do so would be an ominous step backward, they say.

"Keep in mind that we criticized the Soviet Union for defining dissent as a mental illness and confining people who were anti-Communist, as it were, to mental institutions," says Warren Maas, a Minneapolis defense attorney and psychologist.

Maas represents mentally ill people whom prosecutors, judges or relatives are seeking to commit to mental hospitals. Sure, Maas says, mentally ill people who are genuinely dangerous should be confined. But the behaviors that prompt commitment attempts often "aren't danger-based, they simply are annoying and people want them off the street and out of their home or something of that nature."

Most groups representing the mentally ill don't want a return to forced treatment or confinement in hospitals. What's needed instead, they say, is more and better voluntary treatment. That might prevent more of the mentally ill from doing jail time.

And for those who inevitably do run afoul of the law? Almost everyone interviewed for this story agrees: jails and mental health programs need to work together more effectively and creatively. So people who break the law because of a mental disease get help for their illness — either after, or instead of, punishment. □

BLENDING FUNDS TO PAY FOR CRIMINAL JUSTICE DIVERSION PROGRAMS FOR PEOPLE WITH CO-OCCURRING DISORDERS

by
David Wertheimer

Categorical and rigid federal and state funding streams present some of the greatest barriers to the essential integration of services for persons with co-occurring mental health and substance use disorders involved in the criminal justice system. Categorical funding targets dollars to specific populations, providers and services. Conversely, an integrated approach to providing and funding services is necessary for persons with co-occurring disorders being diverted from incarceration.

It is largely futile, however, to change categorical state and federal funding practices from a local setting. Instead, as a number of U.S. communities have proven, it is more productive to devise ways to blend the various funding streams at the local program level. King County, Washington State (Seattle) is one community that has been able to blend funds from five distinct state and local funding streams to support integrated services for criminal justice diversion programming. It offers a special example of how this can be done.

Finding Support for Diversion Initiatives

The current human service environment is hardly conducive to funding expensive jail diversion and systems integration projects. Typically, taxpayer sentiment has supported increased

expenditures of limited public resources to build and fill more jails rather than to provide community-based treatment and supports for people who otherwise could be safely maintained in the community. A further complication is the emergence of managed behavioral health care in the public sector.

No single system can pay for the array of diversion services needed to effectively interrupt the cycle of repeated arrest and incarceration for persons with co-occurring disorders. When one or another system is pressured to identify diversion resources on its own, each system usually pleads poverty to its sister systems, and the game of bureaucratic ping-pong begins. To develop the necessary range of services for the diversion programming, each system must bring to the table the resources they can make available for shared efforts. "Resources" are not limited to actual dollars, but also include staff time, space and the commitment to change policies and practices that prevent integration and effective diversion programs.

Blending Funds in King County (Seattle)

In King County, the necessary array of pre-booking diversion services for individuals with mental illness and substance use disorders was mobilized only after multiple public funding streams were brought together to support a coherent model for crisis services. A subgroup of the county's Systems Integration Advisory Council (SIAC), the local stakeholder group promoting systems integration, adopted the model for a Crisis Triage Unit (CTU) based on some existing programs across the United States. The mission statement developed by the SIAC for these crisis triage services prioritized the diversion of nonviolent misdemeanants with mental illness and substance abuse issues from booking in the county jail to treatment services in the community. Systems integration/boundary spanning staff assertively marketed this crisis triage program and its goal to funders in five different local systems.

As a result, all five systems committed resources toward the development of a pilot Crisis Triage Unit. Harborview Medical Center (the county hospital) provided space for the CTU within the hospital's Emergency Services Department. Although located in a locked area within the Emergency Room, the CTU was placed under the jurisdiction of the hospital's community mental health program. Twenty-four hour psychiatric coverage is provided and augmented by nursing, social work, and triage staff.

The county mental health and substance abuse systems provided funds to support a large portion of the CTU staff enhancement, as well as an array of "back door" support services, including service linkage staff, crisis respite beds, dedicated capacity at the detoxification unit, fast track access to substance abuse residential treatment, and next day appointments for mental health and substance abuse services. The developmental disabilities systems provided part-time "back door" support staff and the City of Seattle Human Services Department provided funds for emergency respite bed supports that target individuals who appear eligible but are not yet enrolled in the county's mental health managed care system.

When collectively pooled, these resources created a synergy that produced integrated services well beyond the scope of what any

single system could have hoped to mobilize on its own. The total package of funds totaled \$2.4 million, with no single player contributing more than approximately \$800,000. Where necessary, budget documents were prepared to demonstrate that categorical funds were being expended only within required parameters. Yet, the blending of these resources created a holistic service continuum that transcended the categorical restrictions carried by many of the funds provided.

At times, keeping funders comfortable about the blending of resources was a challenge. The restaurant soup metaphor helped to soothe more than a few anxious bureaucrats: *If you go to a seafood restaurant for a \$5.95 bowl of clam chowder, do you ask which of your pennies paid for the clams, the potatoes, the cream, etc.? Hopefully not. Rather, you enjoy the rich melding of flavors that unite the various ingredients to provide a dining experience that is worth what you've paid.*

Overcoming the limitations imposed by categorical funding streams was essential to the mobilization of the Crisis Triage Unit diversion program. The nature of the populations involved and the many diverse needs and services they use, combined with the reality that no one local funding source could have possibly supported the array of services required, meant that an effective response was impossible without blended funding. When dollars are forced to follow bureaucratic guidelines rather than consumer needs, the result can be a service system that makes it difficult to develop programming that comprehensively addresses the needs of individuals with complex problems that cross multiple systems.

Managers of the public dollar — and the public trust — will succeed in their integration efforts only as far as they are able to shift their thinking from a paradigm of “my funds” vs. “your funds” and “my customers” vs. “your customers” to a collective understanding and appreciation of “our funds” and “our customers.”

With the support of the Systems Integration Advisory Council and many local stakeholders and advocates, King County has been able to blend funds and resources from five systems to support pre-booking criminal justice diversion programming for individuals with co-occurring mental health and substance use disorders. It is but one example of a general concept that demands the attention of concerned communities across the United States.

For more information about the King County program, contact David Wertheimer, Systems Integration Administrator for the King County Department of Community and Human Services, at (206) 205-1354 or by e-mail at David.Wertheimer@METROKC.GOV. For further information on the Crisis Triage Unit at the Harborview Medical Center in Seattle, contact Ed Dwyer-O'Connor at (206) 731-5846.

This article was drafted by David Wertheimer. The GAINS for People with Co-Occurring Disorders in the Justice System Center provided editing and design support. For more information on the programs and services of the National GAINS Center, contact the Center at 345 Delaware Avenue, Delmar, New York 12054, (800/311-4246; 518/439-7612-Fax), or e-mail at gains@prainc.com □

JAIL SUICIDE/MENTAL HEALTH UPDATE

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

This publication is supported by Cooperative Agreement Award Number 00J04GIM2 from the National Institute of Corrections (NIC), U.S. Department of Justice. Points of view or opinions stated in this document do not necessarily represent the official position or policies of the U.S. Department of Justice.

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

AVAILABLE JAIL/PRISON 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)
Jail Suicide/Mental Health Update (Volumes 1, 2, 3, 4, 5, 6, 7, 8 and 9)

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

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Web Site: <http://www.nicic.org/inst/jail-mental.htm>