

JAIL SUICIDE/MENTAL HEALTH UPDATE

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SUICIDE PREVENTION INITIATIVES IN A LARGE STATEWIDE DEPARTMENT OF CORRECTIONS: A FULL-COURT PRESS TO SAVE LIVES

by

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Suicide remains the third leading cause of death in prisons throughout the country, following natural causes and AIDS (Metzner, et. al., 1998). For the 10-year period of 1984 and 1993, the rate of suicide was 20.6 deaths per 100,000 inmates, approximately 1.5 times higher than in the general population (Hayes, 1995). The Pennsylvania Department of Corrections (DOC) houses approximately 36,000 inmates in 24 facilities, 22 prisons for male offenders and 2 prisons for female offenders. Between 1991 and 1994, the DOC averaged four inmate suicides per year. Alarming, as summarized in Table 1, there were 14 inmate suicides in 1995 and 11 in 1998. The suicide rate in the DOC between 1995 and 1998 fluctuated between a low of 22.9 to a high of 43.2 deaths per 100,000 inmates.

Department staff speculated that several external factors, including political climate, might have contributed to the increase in both the number and rate of inmate suicides. For example, between 1989 and 1999, the DOC population grew from approximately 21,000 inmates to over 36,000 inmates, an approximate 42 percent increase! In addition, in 1995 and 1996, several dramatic events occurred that sent shock waves across the Pennsylvania political landscape. Two inmates released from the state prison system (one through commutation of his life sentence by the previous Governor and the other via parole) committed out-of-state homicides. Subsequently, the number of inmates paroled from the system was dramatically reduced, and the number of inmates receiving commutation of their sentences by the Governor dropped off from approximately five per year to zero. Finally, in 1995, concurrent to the external crises, the Department began conducting executions for the first time since 1992. To date, three executions have taken place. All of these factors, the "drying up" of commutation, the reduction in parole, and the resumption of executions might be expected to engender stress in the inmate population.

Appointment of a Suicide Prevention Task Force

Although external factors might be related to the dramatic increase in the number of suicides, staff also suspected that some internal factors, such as the placement of inmates with mental illness in administrative custody, might also be related to the fatalities. In response to this crisis, the Secretary of Corrections

appointed a Suicide Prevention Task Force composed of key Central Office (Chief of Psychological Services, Chief of Psychiatry, Assistant Chief Psychologist, Director of the Bureau of Inmate Services, and Assistant Chief of Security); Training Academy (Curriculum Development Supervisor and the Operations Supervisors and Training Lieutenant); and Institutional (Deputy Superintendent for Centralized Services, Chief Psychologists from two facilities, Inmate Program Manager, and line psychologist from one prison) personnel from the mental health, treatment, and custody divisions. The primary mission of the Task Force was to review inmate suicides and suicide attempts within the DOC in order to:

- 1) Identify possible internal factors related to the suicides and determine which inmates are most at risk for self-harm;
- 2) Analyze institutional and DOC responses to the crises to identify where procedural changes should be implemented; and
- 3) Propose recommendations for changes in DOC policies, procedures, and training.

Analysis of Clinical Review Reports

DOC policy mandates that prison superintendents shall appoint a multidisciplinary Clinical Review Committee to analyze each suicide fatality and serious suicide attempt to determine what

INSIDE . . .

- ◆ Suicide Prevention Initiatives in a Large Statewide Department of Corrections: A Full-Court Press to Save Lives
- ◆ Juvenile Suicide in Confinement: A National Survey
- ◆ *Jacobs v. West Feliciana Sheriff's Department*: A Plaintiff Verdict
- ◆ Jail Mental Health Services Initiative from the National Institute of Corrections (Jails Division)
- ◆ News From Around the Country
- ◆ The Massachusetts Forensic Transition Program for Mentally Ill Offenders Re-Entering the Community
- ◆ Model Law for Assisted Treatment

TABLE 1
INMATE SUICIDES AND AVERAGE DAILY POPULATION
WITHIN THE PENNSYLVANIA PRISON SYSTEM
1989 thru 1999

Year	Average Daily Population	Suicides	Rate
1989	20,490	8	39.0
1990	22,325	7	31.3
1991	23,405	3	12.8
1992	24,990	4	16.0
1993	26,060	3	11.5
1994	28,302	6	21.2
1995	32,410	14	43.2
1996	34,537	10*	28.9
1997	34,964	8*	22.9
1998	36,377	11	30.2
1999	36,384	8*	21.9
1989-1999	320,244	82	25.6

*In each of these years, an inmate on furlough status committed suicide by gun at a Community Corrections Center. These incidents are not included above.

SOURCE: Pennsylvania Department of Corrections.

happened in the case under review and what can be learned to reduce the likelihood of future incidents. The Deputy Superintendent for Centralized Services chairs the Committee, which is composed of at least the Deputy for Facilities Management, Chief Psychologist, Correctional Health Care Administrator, Unit Manager, attending physician, and any staff who responded to the suicide, or had been providing services to the victim. Suicide gestures do not require analysis by the Clinical Review Team and the Superintendent previously carried the sole responsibility to rate a non-fatal event as either a “serious attempt” or a “gesture.” Recent policy modifications (as described later) now provide the prison administrator with more guidance regarding when to appoint a Clinical Review Committee.

The multidisciplinary team prepares a Clinical Review Report and submits it to the superintendent for review. The report is subsequently forwarded to DOC Central Office where health care staff provide further analysis. In order to identify themes and patterns that might need to be addressed through modification of DOC policies and procedures or additional training, the Suicide Prevention Task Force analyzed all Clinical Review Reports of inmate suicides occurring between 1997 and 1999. As summarized below, in-depth analysis of these deaths identified several clusters of inmates who appeared to be at greater risk of self-harm. Obviously, these were not discrete clusters; in fact, there was considerable overlap, with victims falling into several different risk groups:

- **Males** – Male inmates accounted for all but one suicide during the past three years. In fact, there have only been two female suicides since 1992, and female inmates compose only 4 percent of the DOC population.
- **Caucasians** – White inmates accounted for 89 percent of the suicides in 1997 and 54 percent in 1998. In 1999, 50 percent of the fatalities were Caucasians. It is noteworthy that White inmates compose 34 percent of the DOC population.

- **Inmates With Mental Illness** – Approximately 56 percent of the suicides in 1997 and 64 percent of those in 1998 were committed by inmates on the DOC’s Mental Health/Mental Retardation Roster. However, these inmates compose only approximately 15 percent of the DOC population. Individuals in this special population are at greater risk of being victimized and manipulated by more predatory inmates. These special needs individuals are less likely to understand and comply with institutional rules and routines and, before recent policy reforms, were more likely to make their way into administrative segregation for longer periods of time. Even now, inmates with mental illness experience greater difficulty obtaining parole and being released from prison.

- **Inmates, Particularly Individuals with Mental Illness, Placed in Administrative Segregation** – In past years, inmates placed on administrative segregation status in Restricted Housing Units (RHUs) were at special risk of suicide. In 1995, for example, 7 out of 14 DOC suicides involved inmates housed in RHUs — two of whom were mentally ill. The Department developed policies and procedures to: (a) divert special needs inmates from RHU placement, if at all possible, or (b) provide enhanced mental health services to those special needs individuals who could not be diverted. In 1997, there was only one suicide in the RHUs, and that individual was not mentally ill. In 1998, however, two inmates committed suicide in the Special Management Units (SMUs), the “maxi-max” area where the mental health precautions had not been implemented. In 1999, although there were no suicides in the SMUs, the DOC experienced three suicides in the RTUs. All three victims were newly admitted male inmates with histories of mental illness.

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).

- “ **Drug and Alcohol Abusers** – Although over 70 percent of the suicide victims and inmates who attempted suicide had histories of substance abuse, most of the DOC inmate population display a background of drug and/or alcohol abuse.
- “ **Sex Offenders** – With respect to offense history, inmates committed to the DOC for sex offenses appear to be a population at particular risk of self-harm. Staff members speculate that this is related to the difficulty that these inmates are experiencing obtaining parole.
- “ **Lifers and Long-Term Offenders** – Inmates committed to life sentences compose approximately 17 percent of the DOC inmate population, yet accounted for 37 percent of the suicides in 1998, as well as 44 percent of the suicides in 1999. With fewer sentences being commuted, anecdotal reports from staff members and other inmates suggest that some of these victims appeared to have lost hope of ever leaving prison. Indeed, two of the lifers took their lives following denial of their final court appeals.
- “ **Elderly Offenders** – The drying-up of parole, coupled with the impact of mandatory sentencing, has resulted in the “graying” of the DOC inmate population. Elderly inmates appear to be becoming greater suicide risks. One of the DOC’s most recent suicides was a 79-year-old sex offender, returned to prison following a parole violation, who learned that he had been denied parole for at least another 2-½ years.
- “ **Parole Violators** – Inmates being returned to prison from the community following failures on parole accounted for an alarming proportion of the fatalities (11 percent in 1997, 18 percent in 1998, and 33 percent in 1999). Committee members speculated that these individuals may have panicked when they realized that their likelihood of being re-paroled in the present political climate might be remote. Additionally, parolees are returned to the facility closest to their site of violation. In the case of violations related to substance abuse, individuals have occasionally been returned to prison while still “high” and/or intoxicated.
- “ **Violent Offenders Committing Violent Acts of Suicide** – In 1998, two inmates committed suicide by cutting in separate incidents that entailed horrific and graphic death scenes. The Committee noted that both of the victims had been incarcerated for extraordinarily violent homicides. Several committee members speculated that these victims had turned their aggression inwardly toward themselves.

SUICIDE RISK INDICATORS CHECKLIST FOR RHU/SMU

INMATE NAME: _____ DOC #: _____

RHU/SMU Officer Completing Form (print): _____ Date: _____ Time: _____

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 1. Escorting officer has information that inmate may be a suicidal risk. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 2. Inmate is expressing suicidal thoughts/making threats to harm self. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 3. Inmate shows signs of depression (crying, withdrawn, passive). |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 4. Inmate is acting/talking in a strange manner (hearing/seeing things that aren't there). |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 5. Inmate appears to be under the influence of drugs/alcohol. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 6. Inmate has recent family change (e.g., death of child/spouse/parent or "Dear John letter"). |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 7. Inmate has recent legal status change (e.g., parole violation or new detainer). |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 8. Inmate states this is his/her first placement in RHU/SMU. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 9. Inmate has been assaulted (physically or sexually) by another inmate. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 10. Inmate shows anger, hostility, and threats. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 11. Inmate appears anxious, afraid (pacing, wringing hands). |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 12. Inmate displays signs of self-neglect or abuse (e.g., poor hygiene or cuts and bruises). |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 13. Inmate states that he/she is taking psychiatric medication. |

Comments: _____

Instructions: The ranking CO present shall ensure that this form is completed when an inmate is brought to the RHU/SMU. The escorting officer will be asked (a) why the inmate is being brought in and (b) whether there is any information that the inmate may be self-destructive. The inmate will be asked (a) if this is his/her first time in the RHU/SMU, (b) if he/she has any special problems or needs of which staff should be aware, (c) if he/she is on any medication, and (d) whether he/she has any recent legal status changes (e.g., parole violation or detainer). The officer will also note any special physical/behavioral characteristics (e.g., crying, poor hygiene, & cuts and bruises) or if the inmate is uncooperative.

If any of items 1 through 8 are checked "Yes," the RHU/SMU officer shall immediately phone the following staff:

- Between 8:00 am and 4:30 pm, nursing and Chief Psychologist or MHC. Psychologist will immediately visit the RHU/SMU to review the checklist, assess the inmate, and discuss the case with RHU/SMU staff. Time of assessment will be recorded on form.
- After hours, or on weekends, the nursing staff and Shift Commander. Nurse will immediately visit RHU/SMU to review checklist, assess the inmate, and discuss case with RHU/SMU staff. Time of assessment will be recorded on form.
- At any time the inmate appears in immediate danger of harming him/herself or somebody else, the RHU/SMU staff shall also contact the Shift Commander, as well as nursing staff and Chief Psychologist or MHC to request an immediate assessment.

If any of items 9 through 13 are checked, the form will be submitted to the nurse and/or psychologist the next time they visit the RHU/SMU, but within 24 hours. The nurse or psychologist will assess the inmate and note the date and time of assessment. The completed form will remain in the Cumulative Adjustment Record until reviewed by PRC. Copies to Medical Record & DC-14.

Clinical Staff Action: _____

Date: _____ Time: _____

Name of Clinical Staff (printed): _____ Title: _____

Implementation of Key Suicide Prevention Measures

The data summarized above and a series of recommendations were presented to the Secretary of Corrections and his Executive Board in a 1999 report (Couturier and Maue, 1999). Based on the findings of the Suicide Prevention Task Force, the Department implemented a number of new procedures and policies, as well as expanded a variety of others.

1) Expand and Enhance DOC Suicide Prevention Policies and Procedures. The Department already had two existing comprehensive policies relating to suicide prevention (“Procedures for Dealing with Potentially Suicidal Inmates and Inmates Who Attempt Suicide” from Chapter IX of the Mental Health Services Delivery Manual, and “Clinical Review of Inmate Deaths and Attempted Suicides.”) In fact, these policies had previously been highlighted in a U.S. Justice Department, National Institute of Corrections monograph on prison suicide prevention (Hayes, 1995). Nonetheless, the Task Force determined that both policies required revision. The primary suicide prevention policy was refined to improve suicide watch procedures, mandate that watches be conducted outside of administrative segregation areas, require that inmates be provided with anti-suicide smocks, and include a Suicide Risk Indicators Checklist. In addition, the policy modification now requires that all staff members (i.e., officers, nurses, mental health counselors, etc.) and inmates participate in critical incident stress debriefings to reduce the impact of the trauma. These changes are more fully described in the sections below.

The Clinical Review policy was modified to reduce the prison superintendent’s prerogative in determining which incidents were suicide attempts and which were merely “gestures,” the latter of which does not require the submission of a Clinical Review Report to Central Office. The policy now requires that institutional staff complete an “Evaluation of Inmate Self-Injury” Form, a protocol that assesses various factors that might indicate the need for a clinical review, including the victim’s mental health history, any previous attempts, evident motive and intent, potential lethality of the attempt, and timing and concealment of the act.

2) Expand the Continuum of Mental Health Treatment Services for Inmates with Mental Illness. The full court press to prevent suicides is part of a larger departmental effort to enhance the continuum of mental health services delivered to all inmates. The Department increased the number of Psychiatric Observation Cells in prison infirmaries to cope with short-term emergencies, and streamlined procedures for committing inmates in psychiatric crises into inpatient treatment so that an individual in any facility can be hospitalized within several hours. The DOC also increased to 21 the number of Special Needs Units (SNUs) -- specialized housing areas and blocks where inmates with handicaps can receive additional services and protection — thereby dramatically increasing the number of unlicensed beds for special needs offenders to nearly 1,700. In addition, the Department enhanced the continuity of care for inmates with mental illness returning to the community and/or moving from one facility to another. Mentally ill inmates experiencing or anticipating dramatic environmental and social changes are at particular risk of emotional distress, and the DOC is seeking to do a better job of supporting them during their life transitions and helping them to manage those changes.

3) Enhance Services for Inmates with Mental Illness and Divert Them From Placement in Administrative Segregation. Existing Restricted Housing Unit (RHU) and Special Management Unit (SMU) policies were modified to increase diversion of inmates with mental illness from these housing areas. The policies now mandate that a psychologist and/or psychiatrist conduct special assessments of mentally ill inmates when they are committed to either a RHU or SMU to determine: (a) whether the misconduct was related to the individual’s mental illness, and (b) what impact close custody might have upon his/her treatment progress. Based upon the assessment findings, prison administrators are encouraged to reduce the disciplinary time that special needs inmates would receive for misconduct infractions, and provide enhanced mental health services and tracking for those inmates with mental illness who must be placed in administrative segregation. In addition, a psychologist and/or psychiatrist now visits the RHUs and SMUs on a daily basis.

4) Monitor Suicidal Inmates via Placement on the Mental Health/Mental Retardation Automated Tracking System. In 1994, the DOC established an automated mental health tracking system to follow special needs offenders and ensure that they did not “fall between the cracks” in the mental health service delivery system. As a result, the system has allowed the DOC to develop more long-term and short-term inpatient psychiatric beds while streamlining psychiatric commitment procedures so those inmates in crisis can obtain inpatient hospital treatment within hours of referral.

5) Expand and Enhance the DOC Staff Suicide Prevention Training. The “Suicide Prevention” and “Signs and Symptoms of Mental Illness” workshops presented to all new employees at the DOC Training Academy were updated and expanded. The Department also increased the suicide prevention refresher training provided annually to institutional line staff from 1 to 2 hours. DOC employees had previously complained that the annual refresher classes tended to present the same information year after year. Accordingly, the Training Academy purchased an 8-hour New York State prison suicide prevention training curriculum (New York State Office of Mental Health, et al, 1995) and different segments of the curriculum are now integrated into the refresher training each year. The annual workshops are “team taught” by clinical and custody staff members who have completed a “train-the-trainer” course at the Academy. Team teaching has resulted in more interesting classes and models the team approach to suicide prevention that the DOC is trying to promote. In addition to the basic training and annual refresher classes that are presented to all contact staff, the Department developed specialized suicide prevention and mental health curricula for specific employee groups (e.g., correctional officers who work in RHUs and other special blocks, superintendents, and nurses).

6) Develop a “Suicide Risk Indicators Checklist for RHU/SMUs” That Can Be Administered to All Inmates Entering Administrative Segregation. In large institutions with an abundant number of mentally ill inmates, there is a danger of emotionally distressed individuals being placed in administrative segregation without the awareness of the mental health staff. The “Suicide Risk Indicators Checklist for RHU/SMU,” which is reprinted on page 4, lists 13 suicide danger signals (e.g., “Inmate shows signs of depression (crying, withdrawn, passive”) and “Inmate appears to be under the influence of drugs/alcohol.”

Correctional officers assigned to either a RHU or SMU complete the checklist for every inmate who enters the unit. “Yes” responses (or “hits”) on any of the 13 risk indicators require that the inmate be assessed by either nursing or psychology staff. In addition, “yes” responses to any of the first 8 items require that the psychologist or nurse immediately visit the RHU/SMU to assess the inmate. Hits on items 9 through 13 require that the clinical staff member assess the inmate during their next visit to the RHU/SMU, but within 24 hours of the inmate’s arrival.

In the past, the DOC has observed that custody staff tend to be unfamiliar with treatment-related policies and procedures, and treatment staff are even more unaware of custody policies and procedures. This problem is not specific to the Pennsylvania Department of Corrections, as a recent statewide suicide prevention training workshop revealed that staff unfamiliarity with policies outside their own professional disciplines, or worse, discrepancies between mental health and custody policies, are potential sources for legal liability in departments of correction throughout the country (Hayes, 1999). Accordingly, the Suicide Risk Indicators Checklist is attached to several DOC directives, including the “Administration of the Restricted Housing Units,” “Administration of the Special Management Units,” and “Delivery of Mental Health Services.”

7) Develop a Suicide Prevention Brochure (“Living Through It: Suicide Prevention for People in Prison”) That is Presented to Every Inmate Entering the DOC or Moving From One Facility to Another. The Department obtained and slightly modified a suicide prevention brochure originally developed by the New York State Department of Correctional Services. The one-page pamphlet describes signs and symptoms of depression and suicidality, and advises the inmate where to go for help in the institution if they experience any of these symptoms, or if they observe any other inmates experiencing this type of distress. The brochure is written in both English and Spanish.

8) Prepare Suicide Prevention Videotapes That Are Presented to All Inmates Via the Institutions’ Closed-Circuit Television Networks. The videotapes present information similar to that in the suicide prevention brochure. Inmates are advised where to obtain help in the facility if they are experiencing emotional distress. Moreover, they are encouraged to watch out for the welfare of other inmates and advised to make referrals to mental health staff if they observe some of the symptoms of depression and other mental health problems.

9) Increase Both the Frequency and Comprehensiveness of the Clinical Reviews That Are Conducted Following All Suicides and Serious Suicide Attempts. The policies guiding Clinical Reviews have been modified to reduce the superintendent’s discretion to rate inmate acts of self-harm as either “suicide gestures” (which do not require an investigation and a report) or “serious suicide attempts” (which do require an investigation and a report). The new policies provide the administrators with guidelines and a checklist concerning when to order a Clinical Review.

In addition to the local Clinical Reviews conducted by institutional staff members, Central Office psychology and/or psychiatry staff are now required to conduct site visits and follow-up reviews

following any suicide. These “off-the-record” meetings are conducted with members of the institutional Clinical Review Team several weeks after the institution has submitted its formal Clinical Review Team Report. The objective of the meeting is to obtain any potentially useful information that might not have been included in the report or might have surfaced in the interim. In most cases, old information is rehashed in the second review. Occasionally, however, new and significant information is unearthed; for example, in one case newly obtained information led the team to conclude that a fatal overdose was probably a homicide rather than a suicide.

10) Mandate That All Facilities Purchase and Employ Anti-Suicide Smocks and Blankets for Inmates Placed On Psychiatric Observation. The previous suicide prevention policy required that patients placed on suicide watch be provided with paper gowns rather than being stripped naked. The Department now mandates the use of anti-suicide smocks and blankets that afford privacy, dignity, and warmth to patients.

11) Enhance Services For “Lifers” and Long-Term Offenders. The Department plans to enrich the treatment and support services provided to lifers and long-term offenders. The DOC has always provided a broad range of family support services to the inmate population. In 1999, the DOC sought to enrich the fatherhood and family support programs in all facilities through a \$500,000 grant, and is now also conducting victim-offender mediation sessions. In addition, the Secretary of Corrections appointed a committee to search the literature and examine practices from other departments of correction in order to identify additional programs and support groups that might be offered to both lifers and long-term offenders. The committee is considering strategies to improve the quality of life for long-term offenders (e.g., providing them with single cells and special privileges, as well as advocating for commutation of sentences for particularly deserving “lifers”). In addition, a survey is presently being sent to long-term offenders to determine what quality of life improvements might make prison existence more tolerable.

12) Mandate Use of “Emergency Rescue Tools” in All Facilities. In the past, several Task Force members had observed corrections officers respond to a hanging attempt in which they burned through the noose with a cigarette lighter, as well as several other incidents in which the officers cut victims down with pocket knives, only to be later disciplined for carrying a weapon inside the prison. As a result, emergency rescue tools or knives, commonly found in correctional facilities throughout the country, are now utilized in the institutions. With their hooked shape, the tools allow for rapid insertion between the ligature device used in a hanging attempt and the skin, with no risk to cutting the victim. The tool can quickly cut through all fibrous material found in an inmate’s cell, including blankets, sheets, clothing, belts, and shoelaces. Because the blade is located inside the frame of the tool, it can not be utilized as a life-threatening weapon in the hands of an inmate.

13) Mandate That Critical Incident Stress Management (CISM) Debriefings and Defusings Be Conducted With All Staff Members and Inmates Involved in Fatal Events. While the purpose of this “full court press” is to save inmate lives, the Department is also concerned about the emotional welfare of its

employees. Cutting down a hanging victim, conducting CPR on an individual presumed to be dead, or trying to rescue a victim who is profusely bleeding, are likely to be traumatic experiences for the staff members and/or inmates involved in the situation. Noting that “responding to and/or observing a suicide in progress can be extremely stressful for staff and inmates,” the National Commission on Correctional Health Care (NCCHC) recently included “critical incident stress debriefing” in the suicide prevention section of its correctional standards (NCCHC, 1997).

In 1989, the Department developed a Critical Incident Stress Management (CISM) policy that mandated debriefings and defusings to DOC employees who are exposed to traumatic events in the workplace. Although the original policy writers envisioned events such as witnessing homicides, being taken hostage, or experiencing a riot as appropriate traumatic events necessitating CISM debriefing, the DOC is now expanding that policy to ensure that similar debriefings are conducted for all employees and inmates who are involved in, or witness, a suicide or attempt. Since correctional staff are often initially reluctant to acknowledge stress or anxiety, the confidential debriefings are now mandatory; however, when required to participate, correctional personnel almost invariably describe the experience as beneficial.

Discussion

It is still too early to assess the overall impact of our suicide prevention campaign. There were eight suicides in the DOC during 1999. The suicide rate is slightly down from the previous year, and substantially below 1995. However, our experience tells us that these situations can change quickly; dramatic events can be related to a flurry of impulsive acts among a volatile inmate population. There does, however, appear to be several positive signs. Suicide prevention now appears to be a prominent target on the “radar scopes” in all of our facilities, and staff at all levels seem to be more sensitized to the issue. For example, staff members in a number of prisons are now competing to produce the most effective suicide prevention video (and we have dubbed the informal contest as the “Bastille Film Festival”).

Given the fact that the DOC sustained three suicides in the RTUs during 1999 involving newly committed mentally ill inmates, we remain concerned about housing assignments for this vulnerable inmate population. We fervently hope that a better mechanism for assessing, treating, and monitoring newly committed inmates with mental illness has been established. In October 1999, the DOC opened a Special Observation Unit (SOU) in our Diagnostic and Classification Center at Camp Hill. The SOU is a 19-bed non-licensed area where newly committed inmates with mental health histories and/or suspected mental health problems can be housed while receiving enhanced psychiatric evaluations, closer observation, and extra protection. Mental health staff assigned to the SOU place inmates on the DOC’s automated MH/MR tracking system and assist clients to develop an Individual Treatment Plan (which is updated every 120 days after the inmate is transferred from the sending institution). If a newly received inmate is acutely ill, he or she is committed to one of the DOC’s inpatient psychiatric units.

Unfortunately, given the nature of the correctional environment, there is probably a limit to the effectiveness our suicide prevention measures. We can make changes around the edge, provide more services, improve the quality of life, and make the atmosphere more humane. Prisons, however, are still depressing environments for men and women who are separated from their families and communities, often for many years. In suicide prevention training workshops, we frequently ask our employees to indicate, by a show of hands, how many of them could imagine completing a life sentence without attempting to harm themselves. When few hands go up, we ask how many could complete a 10- to 20- year sentence, and we get a few more hands. And so on.

Deland (1999) recently cautioned that:

In the real world, jail and prison officials can reduce the risk of suicide, often dramatically, but cannot anticipate every suicide risk or predict every suicide attempt. Even when the risk of suicide is known, there is no guarantee that officials using constitutionally permissible procedures can counter each and every strategy employed by a prisoner who is determined to kill himself or herself (at page 1).

Nonetheless, while there are no guarantees that we can foil the most determined attempts at self-harm, we remain optimistic that we can save some lives with the full court press to prevent suicides. Although our endeavors to encourage hundreds of custody officers, treatment staff members, and administrators to work together on this common goal has been as difficult as herding dogs, cats, and dinosaurs in one direction, there has been a dramatic pay-off. Staff from all levels and professional areas of the DOC are calling in to request updated statistics and inquire about mental health services, as well as the best strategies to protect vulnerable, at-risk inmates. We hope that “constitutionally permissible procedures” are becoming the base upon which we build our services, rather than the objective towards which we are working.

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JACOBS V. WEST FELICIANA SHERIFF'S DEPARTMENT: A PLAINTIFF VERDICT

On September 13, 2000, the United States Court of Appeals for the 5th Circuit ruled that the family of a woman that committed suicide in the West Feliciana Parish Jail in St. Francisville, Louisiana in 1996 had sufficient grounds to sue then-Sheriff Bill Daniel and a deputy. Noting that the death was the third suicide in the tiny jail during the sheriff's tenure, the three-judge panel ruled that "Sheriff Daniel was fully aware that (Sheila) Jacobs had actually attempted suicide once before, regarded her as a suicide risk at all times during her detention, and yet still placed her in the detox cell and ordered loose bedding to be given to her.... We would find it difficult to say that this behavior could not support a jury finding that Sheriff Daniel acted with deliberate indifference, and likewise we find it even more difficult to say that this conduct was objectively reasonable."

*The case, **Jacobs v. West Feliciana Sheriff's Department, et al** (No. 99-30185), is reprinted below.*

Before KING, Chief Judge, and GARWOOD and DeMOSS, Circuit Judges.
DeMOSS, Circuit Judge:

In this section 1983 claim brought by the sons of a woman who committed suicide as a pretrial detainee in a Louisiana jail, Defendants-Appellants, West Feliciana Sheriff Bill Daniel, Deputy Earl Reech, and Deputy Wayne Rabalais have filed this interlocutory appeal from the denial of their motion for summary judgment based on qualified immunity. For the reasons discussed below, we dismiss this appeal as it relates to claims against Sheriff Daniel in his official capacity, we affirm the denial of qualified immunity for Sheriff Daniel and Deputy Reech, and we reverse the denial of qualified immunity for Deputy Rabalais.

On August 21, 1996, Sheila Jacobs was arrested for the attempted, second-degree murder, by shooting, of her uncle. Jacobs had become enraged at her uncle when she learned that he had allegedly sexually molested one of her sons years before. The arresting state troopers informed an investigator for the West Feliciana Sheriff's Department that Jacobs told them shortly after her arrest that, after shooting her uncle, she had tried to kill herself by placing a loaded gun in her mouth and pulling the trigger, but the gun had jammed. The investigator conveyed this information to Sheriff Daniel.

Sheriff Daniel and Deputy Rabalais both testified that they were, indeed, told that Jacobs had attempted suicide shortly before her arrest. After processing Jacobs, the officers at the West Feliciana Parish Prison placed Jacobs in a "detox" cell, which is used to house inmates who are intoxicated, who need to be isolated for safety reasons, or who are designated for placement on a suicide watch. According to Deputy Rabalais's deposition testimony, when Jacobs was placed in the detox cell, the officers had her on suicide watch and had placed a note to that effect in the control center. The various defendants testified that the detox cell could be constantly observed from the jail's control room through a window, but that a substantial portion of the cell, including the bunk area, fell into a "blind spot," and was not visible from the control room. This cell could be completely observed only if an officer viewed it from the hallway. The cell also had several "tie-off" points (bars and light fixtures from which a makeshift rope could be suspended), despite Sheriff Daniel's acknowledgment that a suicide prevention cell should not have such tie off points and despite the fact that another inmate, James Halley, had previously committed suicide in the very same cell by hanging himself with a sheet from one of these tie-off points. To the best of Deputy Rabalais's knowledge, and pursuant to Sheriff Daniel's directive, Jacobs was not given sheets on the first night of her detention, August 21.

On the morning of August 22, Jacobs appeared before a Louisiana state district judge, who appointed attorney Clayton Perkins to represent her. The next morning, Friday, August 23, Perkins visited Jacobs at the jail. Perkins requested that Sheriff Daniel leave Jacobs in the detox cell, and perhaps provide her with a blanket and towel. Sheriff Daniel instructed one of his deputies to give these items to Jacobs, but the record reflects only that Jacobs received a sheet (which she eventually used to kill herself), and there is no evidence that she received either a towel or a blanket. In his report, Sheriff Daniel stated that he had been thinking about moving Jacobs to another cell with other female detainees, but decided to leave her in the detox cell after she asked him not to move her because she was afraid the other women would hurt her. He also noted that Jacobs had asked for her hepatitis medication and had given no other indications that she was planning to attempt suicide or to harm herself.

Deputies Reech and Rabalais were on duty at the West Feliciana jail facility from 11:30 p.m. the night of August 23, until 7:30 a.m. the next morning, August 24. The record reveals that the defendants still regarded Jacobs as a suicide risk during that time. Indeed, Sheriff Daniel testified that Jacobs was on a

“precautionary,” though not a “straight” suicide watch. Our review of the record reveals few discernible differences between these two types of suicide watches. When an inmate was on “strict” suicide watch, the informal policy at the jail was to have the inmate checked on every fifteen minutes. Deputy Reech testified that he and Deputy Rabalais made periodic checks on Jacobs; however, it is unclear exactly how often the deputies checked on Jacobs while she was under the “precautionary” suicide watch. What is clear is that as many as 45 minutes elapsed from the time a deputy last checked on Jacobs to the time she was discovered hanging from the light fixture in the detox cell.

Specifically, the record reveals that, after having observed Jacobs in the detox cell at 12:22 a.m. and 1:00 a.m., Deputy Reech checked on Jacobs at 1:22 a.m., and he observed her lying awake in her bunk. At 2:00 a.m., Deputy Rabalais went to investigate some loud music down the hall, and on his way back to the control station, he observed Jacobs lying awake in her bunk. Deputy Rabalais testified that both he and Deputy Reech checked on Jacobs sometime between 2:00 and 2:44 a.m., and that Jacobs was still awake in her bunk. After this last check, Deputy Reech returned to the jail lobby to read his newspaper. At approximately 2:44 a.m., Deputy Rabalais looked into the detox cell from the control room and saw what appeared to be part of an arm hanging from the ceiling. Concerned, he went to find Deputy Reech, who was still reading the newspaper, to help him get into the detox cell. When the deputies arrived at the cell, they found Jacobs hanging from a sheet that had been tied around the caging surrounding a ceiling light fixture. Deputy Rabalais found a knife and enlisted the assistance of another inmate in cutting the sheet and lowering Jacobs onto the floor. By all indications, Jacobs had torn a small string from the bunk mattress and wrapped that string around the sheet to form a make-shift rope. The paramedics

who arrived only moments later were unable to resuscitate Jacobs. Jacobs’s suicide was the third suicide at the jail during Sheriff Daniel’s tenure there. As noted above, James Halley’s suicide had occurred in the same cell where Jacobs killed herself. The third suicide had occurred in a cell down the hallway from the detox cell.

On July 8, 1997, Anthony LaForte commenced this action in the Eastern District of Louisiana. The case was transferred to the Middle District, which includes the Parish of West Feliciana. On April 6, 1998, Jacobs’ other son, Christopher LoForte (1), was added as a plaintiff. The plaintiffs’ amended complaint alleged a violation of section 1983 by the Parish of West Feliciana, the West Feliciana Parish Sheriff’s Department, Sheriff Daniel, in his individual and official capacities, and Deputies Reech and Rabalais, in their individual capacities. The plaintiffs asserted that the individual defendants violated Jacobs’s rights under the Fourteenth Amendment by exhibiting deliberate indifference to her obvious suicidal tendencies and failing to protect her from self-inflicted harm. They also contended that Sheriff Daniel in his official capacity, violated Jacobs’ Fourteenth Amendment rights by failing to implement a suitable policy for accommodating the medical and psychiatric needs of pretrial detainees like Jacobs. On January 26, 1998, the case was transferred to a magistrate judge and the parties consented to disposition by a magistrate judge pursuant to 28 U.S.C. § 636(c). On August 31, 1998, Sheriff Daniel, Deputy Reech, and Deputy Rabalais, moved for summary judgment, claiming qualified immunity with respect to the claims asserted against them in their individual capacity. Additionally the defendants claimed that the medical/psychiatric accommodation policy for pretrial detainees was constitutionally sufficient to defeat the claim asserted against Sheriff Daniel in his official capacity. The Magistrate Judge conducted a hearing on October 16, 1998, and on January 19, 1999, denied the motion. The individual defendants have now timely filed this interlocutory appeal from the denial of summary judgment on grounds of qualified immunity.

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

II. DISCUSSION

A. Jurisdiction

As a preliminary matter, we must consider whether we have jurisdiction to hear this appeal. “Normally, we do not have appellate jurisdiction to review a district court’s denial of a motion for summary judgment because such [an order] is not a final one within the meaning of 28 U.S.C. § 1291.” *Lemoine v. New Horizons Ranch and Center, Inc.*, 174 F.3d 629, 633 (5th Cir. 1999). There is an exception to this rule, however, when a summary judgment motion is based on an official’s claim of absolute or qualified immunity and the district court’s disposition is premised upon a legal conclusion, and not simply a dispute with regard to the sufficiency of the evidence. *See id.* (citing *Mitchell v. Forsythe*, 105 S. Ct. 2806 (1985)). The district court’s order in this case states that the defendants’ conduct was not objectively reasonable in light of the applicable legal standard of deliberate indifference. Accordingly, we have interlocutory appellate jurisdiction to review the denial of the defendants’ motion for summary judgment, but only insofar as the denial considered the viability of the defendants’ qualified immunity

defense, which defense is applicable only to the claims against Sheriff Daniel, Deputy Reech, and Deputy Rabalais in their individual capacities.

We are without jurisdiction to review the denial of the defendants' summary judgment motion regarding Sheriff Daniel in his official capacity. Municipal governments may not raise immunity defenses on interlocutory appeal. See *Nicoletti v. City of Waco*, 947 F.2d 190, 191 (5th Cir. 1991) (citing *McKee v. City of Rockwell*, 877 F.2d 409, 412 (5th Cir. 1989)). And since a suit against Sheriff Daniel in his official capacity is a suit against the Parish, we may not review the Magistrate Judge's denial of summary judgment regarding Sheriff Daniel in his official capacity. For these reasons, we must dismiss this appeal as it relates to the claim against Sheriff Daniel in his official capacity. The district court's decision that the individual defendants are not entitled to immunity will be reviewed on the merits.

B. The Individual Capacity Claims

We review a denial of summary judgment based on a claim of qualified immunity de novo, and consider all evidence in the light most favorable to the nonmovant. See *Blackwell v. Barton*, 34 F.3d 298, 301 (5th Cir. 1994). To determine whether an official is entitled to qualified immunity, we must determine: (1) whether the plaintiff has alleged a violation of a clearly established constitutional right; and (2) if so, whether the defendant's conduct was objectively unreasonable in light of clearly established law at the time of the incident. See *Hare v. City of Corinth*, 135 F.3d 320, 325 (5th Cir. 1998) (citing *Colston v. Barnhart*, 130 F.3d 96, 99 (5th Cir. 1997)).(2).

Regarding the first inquiry, the plaintiffs have stated a claim under currently applicable law for the denial of Jacobs's substantive due process rights. Unlike convicted prisoners, whose rights to constitutional essentials like medical care and safety are guaranteed by the Eight Amendment, pretrial detainees look to the procedural and substantive due process guarantees of the Fourteenth Amendment to ensure provision of these same basic needs. See *Bell v. Wolfish*, 99 S. Ct. 1861 (1979). A pretrial detainee's due process rights are "at least as great as the Eighth Amendment protections available to a convicted prisoner." *Hare II*, 74 F.3d at 639 (citing *City of Revere v. Massachusetts Gen. Hosp.*, 103 S. Ct. 2979, 2983 (1983)). In *Hare II*, which was a somewhat factually analogous prison suicide case, we observed that "the State owes the same duty under the Due Process Clause and the Eighth Amendment to provide both pretrial detainees and convicted inmates with basic human needs, including medical care and protection from harm, during their confinement." *Id.* at 650.

The plaintiffs have alleged that the individual defendants were deliberately indifferent to Jacobs's obvious need for protection from self-inflicted harm. It is well-settled in the law that "a state official's episodic act or omission violates a pretrial detainees' due process rights to medical care [and protection from harm] if the official acts with subjective deliberate indifference to the detainee's rights." *Nerren v. Livingston Police Dep't*, 86 F.3d 469, 473 (5th Cir. 1996) (citing *Hare II*, 74 F.3d at 647-48). (3). By alleging deliberate indifference to Jacobs's clearly established

Fourteenth Amendment rights, the plaintiffs have cleared the first hurdle in defeating the defendants' qualified immunity defense.

The second part of our qualified immunity analysis is to determine whether the defendants' conduct was objectively unreasonable in light of clearly established law at the time of Jacobs's suicide. As noted above, we have observed that at least since 1989, it has been clearly established that officials will only be liable for episodic acts or omissions resulting in the violation of a detainee's clearly established constitutional rights if they "had subjective knowledge of a substantial risk of serious harm to a pretrial detainee but responded with deliberate indifference to that risk." *Hare II*, 74 F.3d at 650; see also *Flores v. County of Hardeman*, 124 F.3d 736, 738 (5th Cir. 1997) ("A detainee's right to adequate protection from known suicidal tendencies was clearly established when Flores committed suicide in January 1990."). Thus, we must hold the defendants to the standard of subjective deliberate indifference in determining whether their conduct was objectively reasonable. See *Hare III*, 135 F.3d at 327. The determination of the objective reasonableness of particular conduct in light of the subjective deliberate indifference standard is a question of law for the court. See *id.* at 328. In *Hare III*, we explained the somewhat confusing relationship between the deliberate indifference and objective reasonableness standards as follows:

... for [an] appeal on qualified immunity, the subjective deliberate indifference standard serves only to demonstrate the clearly established law in effect at the time of the incident And under that standard-the minimum standard not to be deliberately indifferent-the actions of the individual defendants are examined to determine whether, as a matter of law, they were objectively unreasonable. *Hare III*, 135 F.3d at 328.

In other words, we are to determine whether, in light of the facts as viewed in the light most favorable to the plaintiffs, the conduct of the individual defendants was objectively unreasonable when applied against the deliberate indifference standard. See *id.* at 329.

In denying the defendants' motion for summary judgment regarding the individual capacity claims, the Magistrate Judge first found that for purposes of summary judgment, Sheriff Daniel and the two deputies all had subjective knowledge that Jacobs posed a serious risk of suicide throughout her confinement. Specifically, the Magistrate Judge found that the defendants had placed Jacobs on some kind of suicide watch, that she remained classified as being a suicide risk at all relevant times, and that a reasonable jury could infer from this evidence that they regarded her as a suicide risk until the moment she killed herself. The Magistrate Judge found that despite this subjective knowledge, the defendants:

"(1) placed Jacobs in a detox cell that purportedly permitted constant observation from the control room but which in fact had a substantial 'blind spot;' (2) allowed her to have loose bedding (to be used in the 'blind spot,' i.e., the bunk) despite defendants' admission that this was not advisable for a potentially suicidal person; (3) allowed the loose bedding in a cell that had multiple 'tie-off' points despite Sheriff Daniel's acknowledgment

that a suicide prevention cell should not have tie-off points and despite one of the still-uncorrected tie off points having been used in a prior suicide; (4) left Jacobs essentially unobserved for an as yet undetermined period of time, up to three quarters of an hour, in violation of Sheriff Daniel's unwritten policy of quarter-hour checks. Deputy Reech, who apparently had the keys to the cell block, was reading a newspaper in the lobby."

According to the Magistrate Judge, all of these factors precluded a finding that the defendants' conduct was objectively reasonable in light of the deliberate indifference standard.

The case law from our own and from our sister circuits offers little guidance for determining whether the defendants' particular actions toward Jacobs were objectively unreasonable in light of their duty not to act with deliberate indifference toward a known suicide risk. In *Hare III*, we noted that "while . . . the law is clearly established that jailers must take measures to prevent inmate suicides once they know of the suicide risk, we cannot say that the law is established with any clarity as to what those measures must be." *Hare III*, 135 F.3d at 328-29 (quoting *Rellergert v. Cape Girardeau County*, 924 F.2d 794, 797 (8th Cir. 1991)). It is well-settled, however, "that *negligent* inaction by a jail officer does not violate the due process rights of a person lawfully held in custody of the State." *Hare II*, 74 F.3d at 645 (citing *Davidson v. Cannon*, 106 S. Ct. 668, 671 (1986)) (emphasis supplied). Accordingly, to be considered deliberately indifferent to a known suicide risk, an officer's acts must constitute at least more than a mere "oversight." See *Lemoine*, 174 F.3d at 635 (noting that "oversight" in administration at juvenile behavior modification camp where deceased plaintiff died of heatstroke was not sufficient to demonstrate anything more than negligence and therefore qualified immunity was appropriate). Indeed, to defeat qualified immunity, the plaintiffs must establish that the officers in this case were aware of a substantial and significant risk that Jacobs might kill herself, but effectively disregarded it. See *Farmer v. Brennan*, 114 S. Ct. 1970, 1984 (1994).

While the Magistrate Judge evaluated the conduct of the three defendants collectively, we note that Sheriff Daniel and his deputies did not act in unison at every moment Jacobs was in the jail. Accordingly, prudence and our own precedent dictates that we examine each individual defendant's entitlement to qualified immunity separately. See *Stewart v. Murphy*, 174 F.3d 530, 537 (5th Cir. 1999) (in a section 1983 action, the conduct of each defendant who has been sued in his individual capacity should be examined separately).

i. Sheriff Daniel

The record before us reveals that Sheriff Daniel was aware that Jacobs had tried to kill herself once before and that she posed a serious risk of trying to do so again. Throughout the time Jacobs was in the jail, Sheriff Daniel considered her to be a suicide risk. Under Sheriff Daniel's supervision, Jacobs was placed in the detox cell, which had a significant blind spot and tie-off points, despite the fact that during Sheriff Daniel's tenure another detainee, James Halley, had committed suicide in the same cell by hanging himself from one of the tie-off points. Specifically, Halley tied a blanket around one of the bars in the window of the detox cell and hung

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

himself by fashioning the secured blanket around his neck and sitting down. Deputy Reech, and not Sheriff Daniel, initially ordered Jacobs to be placed in the detox cell. Nevertheless, Sheriff Daniel effectively ratified that decision by keeping Jacobs in the cell while he considered her to be a significant suicide risk. Moreover, Sheriff Daniel ordered his deputies to give Jacobs a blanket and towel, despite the fact that he still knew that she was a suicide risk. He did not offer any reason for doing so other than Jacobs's appointed counsel's suggestion that she be given these items, and in fact, he acknowledged that a suicidal person should not have loose bedding of any kind in a cell with them. Sheriff Daniel also acknowledged that it was not advisable to place a suicidal detainee in a cell with tie-off points, even though the detox cell had tie-off points. We note also that with full awareness that a prior suicide occurred in the detox cell by way of an inmate securing a blanket to a tie-off point therein, Sheriff Daniel did nothing to eliminate or conceal the tie off points in the detox cell, which cell Sheriff Daniel's own unwritten policy mandated as the appropriate cell for housing suicidal detainees.

Of course, Sheriff Daniel did not completely ignore Jacobs's suicidal condition, and in fact instituted some preventative measures, including not allowing Jacobs to have loose bedding during the first day and a half of her detention and instituting more frequent checks on her. However, those measures are not enough to mitigate his errors and, overall, his conduct was objectively unreasonable in light of his duty not to be deliberately indifferent. Indeed, based on our review of other pretrial detainee suicide cases, we conclude that there is sufficient evidence in this record for a jury to conclude that Sheriff Daniel acted with deliberate indifference to Jacobs's known suicidal tendencies. See *Hare III*, 135 F.3d at 329 (examining other pretrial detainee suicide cases as "backdrop of the deliberate indifference" standard when considering whether individual defendants might be entitled to qualified immunity).

In *Rhyne v. Henderson County*, 973 F.2d 386 (5th Cir. 1992), an official capacity case addressing the merits of a deliberate indifference claim, we found that a county and its sheriff were not liable under section 1983 for the suicide of a pretrial detainee even though the jail officials gave the detainee, who had already attempted suicide twice, a blanket, and failed to keep him under constant supervision. See *id.* at 393. Yet *Rhyne* actually supports our conclusion that Sheriff Daniel's conduct was not objectively reasonable. In *Rhyne*, we concluded that the county policies did not exhibit deliberate indifference because there was no evidence that those policies were "obviously inadequate." See *id.* at 392-93 ("A failure to adopt a policy can be deliberately indifferent when it is obvious that the likely consequences of not adopting a policy will be a deprivation of constitutional rights."). Additionally, in *Rhyne*, there was no evidence such as past suicides at the jail, "that would have alerted the Sheriff to the need for more frequent suicide checks." *Id.* at 393. Here, by contrast, Sheriff Daniel knew that placing a clearly suicidal detainee in a cell with tie-off points and a blind spot was "obviously inadequate." These accommodations became even more inadequate when one of the deputies, at Sheriff Daniel's direction, supplied Jacobs with loose bedding. Our holding in *Rhyne* suggests that the evidence of Sheriff Daniel's conduct could support a jury finding of deliberate indifference.

The two cases relied on by the defendants are distinguishable and do not support a finding of qualified immunity for Sheriff Daniel. In *Flores v. County of Hardeman*, 124 F.3d 736 (5th Cir. 1997), a sheriff initially placed Flores, a pretrial detainee, on suicide watch because he was acting strangely, but after twelve hours discontinued the watch because Flores seemed to be doing better. Flores was then given a blanket and checked every hour; later, he hung himself with the blanket. We found that the sheriff had not acted with subjective deliberate indifference because Flores did not give any indication of suicidal tendencies at the time he killed himself. See *id.* at 738-39. Unlike that kind of situation, where "nothing the [detainee] did so clearly indicated an intent to harm himself that the [officers] caring for him could have only concluded that he posed a serious risk of harm to himself," *Sibley v. Lemaire*, 184 F.3d 481, 489 (5th Cir. 1999), in this case, Sheriff Daniel was fully aware that Jacobs had actually attempted suicide once before, regarded her as a suicide risk at all times during her detention, and yet still placed her in the detox cell and ordered loose bedding to be given to her.

In *Hare*, Tina Hare, a pretrial detainee, threatened suicide and was moved to an isolation cell nearest to a camera. See *Hare II*, 74 F.3d at 637. One of the officers took away her shoes and belt, but left her a blanket, believing erroneously that she was not strong enough to tear it into a size suitable for harming herself. Hare was in fact strong enough, and hung herself with strips of the blanket. See *id.* at 637-38. A panel of our Court in *Hare III* found that the officers were entitled to qualified immunity because their conduct was "within the parameters of objective reasonableness," as measured by the subjective deliberate indifference standard. See *Hare III*, 135 F.3d at 329. However, *Hare III* is distinguishable on the basis that the officer in that case gave Hare the blanket in the reasonable, though mistaken, belief that she was not strong enough to hurt herself with it. In this case, the only reason Sheriff Daniel had for ordering that Jacobs be given a blanket and towel was that her attorney requested it, and that is insufficient to excuse Sheriff Daniel's decision. Sheriff Daniel still regarded Jacobs as a suicide risk and would have been well within his rights to decline the attorney's request on those grounds. Additionally, in *Hare III*, there was no evidence, as there is in this case, that the jailers were aware of a prior suicide by means similar to those made available to the suicidal detainee, in the very same defective and unaltered cell, in which the prior suicide victim was housed.

Sheriff Daniel knew that Jacobs exhibited a serious risk of suicide and placed her in conditions he knew to be obviously inadequate. He then ordered, without reasonable justification, that she have a blanket and towel, even though he knew that those items should not be in the hands of a seriously suicidal detainee. We would find it difficult to say that this behavior could not support a jury finding that Sheriff Daniels acted with deliberate indifference, and likewise we find it even more difficult to say that this conduct was objectively reasonable. For these reasons, as well as for substantially the same as those reasons given in the Magistrate Judge's order denying summary judgment, we affirm the denial of qualified immunity for Sheriff Daniel as to claims asserted against him in his individual capacity.

ii. Deputy Reech

Deputy Reech was the senior deputy on duty when Jacobs killed herself. Like Sheriff Daniel and Deputy Rabalais, he had actual

knowledge that Jacobs was a suicide risk at all times during her detention (4). He also knew about the earlier hanging suicide of James Halley in the detox room, and with respect to the Halley and Jacobs suicides, Reech deposed that there was nothing they (at the jail) could do to stop the detainees from killing themselves if they wanted to and that it wasn't their responsibility. Despite this knowledge, and the fact that nothing had been done to correct either the blind spot or the tie-off points in the detox cell, Deputy Reech ordered Jacobs to be placed in it for a suicide watch. Like Sheriff Daniel, Deputy Reech was on notice that these facilities were "obviously inadequate."

We note that it was Sheriff Daniel, not Deputy Reech, who made the decision that Jacobs be given a blanket. The fact that Reech did not make the decision that Jacobs should have a blanket would seem to militate in favor of finding qualified immunity, since after all, if no blanket had ever been provided, it would not have made any difference which cell he had placed her in. On the other hand, Deputy Reech did observe Jacobs lying on the bunk in the detox cell several times during the period when she had the sheet, and despite his awareness that a prior suicide occurred in the detox cell using a blanket and that suicidal inmates should not be given loose bedding, he did not take the sheet away from Jacobs. Additionally, Deputy Reech did not check on Jacobs as frequently as he was supposed to.

Given Deputy Reech's level of knowledge about the significant risk that Jacobs would attempt to harm herself and his disregard for precautions he knew should be taken, we conclude that there is enough evidence in this record from which a reasonable jury could find subjective deliberate indifference. And in light of Deputy Reech's failure to insure that adequate precautions were taken to protect Jacobs from her known suicidal tendencies, we find that Deputy Reech's conduct falls outside the realm of that which could be characterized as being objectively reasonable in light of the duty to not act with subjective deliberate indifference to a known substantial risk of suicide.

iii. Deputy Rabalais

Based on the summary judgment evidence, we conclude that no reasonable jury could find that Deputy Rabalais, who had only been on the job for about six months at the time of Jacob's death, acted with deliberate indifference, and we further find that his conduct, in light of the record evidence, was objectively reasonable, thus entitling him to qualified immunity from suit in his individual capacity. While Deputy Rabalais, like his co-defendants, had actual knowledge that Jacobs was a suicide risk at all times during her confinement, he did not make the decision to place her in the detox cell. As noted above, Deputy Reech, the senior deputy on duty with over twenty years of experience, made that decision. Deputy Rabalais likewise had nothing to do with the order that Jacobs be given a blanket and towel, which order was evidently interpreted by some unknown jail official as entitling Jacobs to a loose sheet instead.

In all the events leading up to the evening of Jacobs's death, Deputy Rabalais was essentially following orders. Additionally, there is no evidence that Deputy Rabalais knew about the Halley suicide in the detox cell, and he cannot be said to have been on the same notice as Sheriff Daniel or Deputy Reech that the facility

was "obviously inadequate." In light of his more limited knowledge, and the fact that the orders he received from his two superiors were not facially outrageous, Rabalais acted reasonably in following them.

The only element of Jacobs's detention over which Deputy Rabalais had direct control was the frequency with which he checked on her. Like Deputy Reech, Deputy Rabalais did not comply with Sheriff Daniel's unwritten policy of checking on Jacobs every fifteen minutes. However, this failure to abide by Sheriff Daniel's policy alone evinces at best, negligence on the part of Deputy Rabalais, which is insufficient to support a finding of deliberate indifference. See *Hare II*, 74 F.3d at 645-46. In light of the foregoing, we conclude that Deputy Rabalais conducted himself in an objectively reasonable manner with respect to his duty to not act with subjective deliberate indifference to the known risk that Jacobs might have attempted suicide, and that as a result, the Magistrate Judge erred in denying his motion for summary judgment on grounds of qualified immunity.

III. CONCLUSION

As a result of the foregoing analysis, we dismiss this appeal as it relates to the official capacity claims asserted against Sheriff Daniel for a lack of interlocutory appellate jurisdiction, we affirm in part the Magistrate Judge's order to the extent that it denies summary judgment on grounds of qualified immunity on the individual capacity claims asserted against Sheriff Daniel and Deputy Reech, and we reverse in part the Magistrate Judge's order to the extent it denies summary judgment on grounds of qualified immunity on the individual capacity claims asserted against Deputy Rabalais and we remand to the district court for entry of judgment in his favor.

APPEAL DISMISSED IN PART, AFFIRMED IN PART, REVERSED IN PART, and REMANDED.

NOTES

1. We have retained the seemingly inconsistent spellings of the sons' last names which appear in the record before us.
2. We pause here to identify the three *Hare* decisions which are referenced in this opinion. The original panel opinion in *Hare v. City of Corinth*, 22 F.3d 612 (5th Cir. 1994) is referred to as *Hare I*; our en banc review of that panel opinion in *Hare v. City of Corinth*, 74 F.3d 633 (5th Cir. 1996)(en banc) is referred to as *Hare II*; and the second panel opinion, *Hare v. City of Corinth*, 135 F.3d 320 (5th Cir. 1998), which followed the remand ordered by our en banc opinion, is referred to as *Hare III*.
3. The claim against the individual defendants is properly analyzed as an "episodic act or omission" case, as opposed to a "condition of confinement" case. See *Scott v. Moore*, 114 F.3d 51, 53 (5th Cir. 1997) (en banc) ("In an 'episodic act or omission' case, an actor usually is interposed between the detainee and the municipality, such that the detainee complains first of a particular act or, or omission by, the actor and then derivatively to a policy, custom, or rule (or lack thereof) of the municipality that permitted or caused the act or omission.").

4. Though he claims not to have been notified that Jacobs was on a suicide watch, he conceded that she was placed, by him, in the detox cell “probably” as a precautionary measure given her risk of suicide. □

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.*

Michigan

According to a report released in June, individuals with a serious mental illness are often hospitalized for only a few weeks and then unable to get into one of only a few community residential programs throughout the state. As a result, many people with mental illness are not being properly treated, subsequently commit crimes and land in jail. “I get very concerned that people are getting very little treatment and support other than medication,” Kathleen Gross, executive director of the Michigan Psychiatric Society, told the *Detroit Free Press*. “We know that for people’s lives to really improve, they need regular supports.”

The study, initiated by the state Mental Health Association more than two years ago, was meant to investigate what happened to patients who previously relied on the 10 state-run mental health hospitals that closed in the 1990s. While not advocating the reopening of the institutions, the report stresses there are not enough hospital beds for people who need to stay 90 days or more, as well as not enough community programs to fill the void. Not surprisingly, the report partly blames funding for the problem. In 1998, approximately 41 percent of the \$1.5 billion spent on community mental health programs went toward adults and children with mental illnesses. That equated to about \$3,900 per adult, \$2,600 per child — less than the cost of one year of some psychiatric medications.

But GERALYN Lasher, spokeswoman for the state Department of Community Health, said it is difficult comparing the spending between people with mental illnesses and people with developmental disabilities, who consume most of the rest of the state’s mental health budget. Many disabled people, she said, have physical ailments requiring expensive treatment. Lasher also said the state has various community programs for people with a mental illness, and “we feel there absolutely are long-term care options at the community level.”

Some, like Joanne Froh, would disagree. Ms. Froh said there were no programs that her brother Jim could immediately turn to when a Macomb County hospital discharged him after a month of treatment last year. Jim Plagens, a 40-year-old man who suffered

from paranoid schizophrenia, was sent to the hospital after setting his motel room on fire. Ms. Froh said he was homeless after the hospital released him and left with several medications that had to be taken at precise times. He was instructed to come back in a week to discuss being admitted into a longer-term community program, his sister said. But within eight hours of his hospital release, Jim Plagens was struck and killed by a van while wandering onto a Detroit-area street. “It was so unconscionable to me to think they would release somebody who is severely mentally ill with five different prescription medications he didn’t have the capacity to take as scheduled,” Ms. Froh told the *Detroit Free Press*. “It’s like giving an Alzheimer’s patient medication, sending him alone out the door and saying, ‘Go take care of yourself and take your medicine as prescribed’.” According to his sister, Jim Plagens, like many other patients, did not have the capacity to take his medication as scheduled and needed a structured residential program.

As Mark Reinstein, the Mental Health Association’s public policy director, concluded, “If we keep spending so little on mental illnesses, the problems are going to stay. You get what you pay for.”

New York

New York City officials must arrange for the continuing mental health care of thousands of inmates before they are released from New York City’s Rikers Island correctional facilities, a Manhattan judge ruled in July. Justice Richard F. Braun, of State Supreme Court in Manhattan, granted a preliminary injunction and gave class action status to a suit filed against the city last year by seven mentally ill inmates of the jail. The suit contends that the 25,000 inmates who are treated for mental illness at the correctional facilities each year were being released without proper provision for treatment in the community or a way to continue their psychotropic medication. The city has not disputed those claims, but argued that Rikers inmates have no legal right to the kind of pre-release planning required for mental hospital patients under state law.

Justice Braun found that the plaintiffs were very likely to win the lawsuit on its merits, and said they would suffer irreparable harm unless the city was required to provide them with a discharge plan while the case is fought in court. He rejected the city’s contention that because many of these inmates are held for less than 45 days, there would be no time to arrange for such services, instead agreeing with the plaintiffs that release planning could begin at the start of treatment. In the New York State prison system, for example, most prisoners who have been treated for mental illness during their incarceration are provided with a two-week supply of psychotropic medication, a two-week prescription and a referral to an outpatient mental health clinic.

Illinois

After sleeping on Chicago’s streets for 28 consecutive days, AELLENE Price had had enough. But she could not turn to homeless shelters for lodging. Several had barred her for bad behavior. A mental hospital where she was hearing voices released her after a week. So, Ms. Price grabbed a female tourist by the

neck and pushed her to the ground. She was arrested, pleaded guilty to battery and was sentenced to a year in jail. For a while at least, jail was a relief. She had amenities previously unavailable because of her mental illness. "I had a clean uniform, a water fountain, a shower, a roof over my head," Ms. Price said told a *Washington Post* reporter in June. "But then it started getting rough. The girls were fighting a lot, and I wanted to get out of there."

Ellene Price served only a few months of her jail term. Officials from Thresholds, a unique national psychiatric rehabilitation program based in Chicago, went to the sentencing judge and got her an early release. They enrolled her as a "member" in a program that offers intensive one-on-one counseling as well as assistance in meeting daily needs. "People are released from jail with just a prescription and the address of a mental health facility, which might have a month-long waiting list," said John Fallon, director of the Thresholds Jail Program, which aims to reach mentally ill people caught up in the cycle of incarceration, hospitals and the streets. "It's almost guaranteed that they're going to fail the way things are set up now."

The Thresholds Jail Program was launched less than three years ago, serving 45 mentally ill people with funding coming primarily from Thresholds' own coffers. Last year, the program received \$495,000 from the state Department of Mental Health and expanded its staff from three to eight caseworkers. "We're looking at people who are off the radar screen of mental health services," said Tom Simpatico, bureau chief for the Department of Mental Health. "These are highly recidivistic people who are not easily able to link up with community resources, so we need to find new solutions like this which can get them back in care."

Thresholds staffers hope their program can become a model for other states and receive enough government funding to serve the bulk of nonviolent mentally ill people in jail. The program costs approximately \$26 a day per person, compared with about \$70 a day to keep the same person locked up, or \$400 daily to keep that person in a public mental hospital. Thresholds identifies potential "members," as the patients are called, by working with personnel at the Cook County Jail. Members must be nonviolent offenders, and they must be willing to live on the north side of the city, where the program is based, upon their release. They also must have a mental illness, such as depression or schizophrenia, that responds to medication. Thresholds caseworkers accompany members to their court dates and — as they did for Ellene Price — usually convince judges to release the inmates from jail early into the program's custody. Caseworkers then find affordable housing for the members, usually in hotels where others from the program live. The workers visit members at least once a day, giving them their medication, a \$5 a day allowance and, for smokers, a daily allowance of cigarettes. They take members shopping or help them do their laundry, as well as go on group outings to the beach, baseball games or restaurants. Caseworkers are on call 24 hours a day and spend hours in the middle of the night visiting or looking for a member if necessary. Services remain available for as long as the client needs them. So far the program has been a measurable success in at least one area — since it started in September 1997, none of the 45 members has been rearrested.

Ronald Simmons, chief of adult forensic programs for the state, told the *Washington Post* that Thresholds "does an outstanding

job of assertive case management. They have done an admirable job of keeping these people stable and functional in the community."

At a May banquet, most members gave testimonials about how they have avoided arrest and hospitalization since being in the program. One success story is Richard Berry, a 43-year-old man who suffers from paranoid schizophrenia. Mr. Berry, arrested 137 times for minor offenses, has spent 11 of the past 20 years in mental hospitals which, he claims, are plagued by vampires and hair grease in the food. He has 13 brothers and sisters in Chicago, but has no contact with them. Yet Mr. Berry has not been arrested or hospitalized since entering the program a year ago. "Life is beautiful now," he said. "I have money, clean clothes, food to eat, a place to stay. I feel glad to be alive."

Ellene Price is also doing well. She has not been arrested in the six months since her release, has a stable home, a boyfriend, and is looking for work. "If I didn't have Thresholds, I would still be in jail and who knows what would have happened after that," she said. "I'd probably be somewhere deceased."

For more information on the Thresholds Jail Program, contact John Fallon at 4101 North Ravenwood Boulevard, Chicago, Illinois 60613, (773) 880-6260, ext. 277.

Tennessee

A new report says that nearly one in five inmates in jails throughout the state is mentally ill and in need of services. Approximately 3,500 inmates are mentally ill, and most are jailed for misdemeanor nuisance crimes — often panhandling, criminal trespass and disorderly conduct, according to the report released in June by the state's Criminal Justice Task Force. The group recommended mentally ill inmates be given access to mental health services equal to that of the general population and that diversion services be established to prevent them from "enduring unnecessary incarceration."

"This is a good start, (but) we've got a lot of work to do," George Haley, who was co-chairman of the task force with Davidson County Sheriff Gayle Ray, told the *Associated Press*. "So often the jail becomes the hospital and the housing facility, and they're the least competent to take care of sick people. It's not their job," said Haley, who also is president of the Tennessee Mental Health Planning Council.

The 28-member task force, comprised of criminal justice and mental health professionals from across the state, was established by the Department of Mental Health and Mental Retardation last year to recommend solutions to problems facing mentally ill inmates. The task force found that many inmates cannot afford bail, and others are repeatedly jailed because of a lack of mental health services, particularly in rural counties. According to the report, *Mental Health and Criminal Justice in Tennessee*, "There is a significant lack of appropriate housing, social service support and transportation for low-income and homeless individuals with mental illnesses and substance abuse problems." The task force recommended the state's TennCare Bureau reinstate benefits as

quickly as possible when inmates are released. TennCare enrollees now are dropped from the program when they're jailed. Once released, many patients have difficulty regaining TennCare coverage and can not get the services they need.

The Criminal Justice Task Force also found that law enforcement and jail personnel do not receive adequate training to deal with mental health crises, and many judges and attorneys are not aware of the need to evaluate inmates suspected of being mentally ill. In addition, many inmates are not referred to mental health services once they are released, setting the stage for repeated offenses and further incarceration. The report recommended that the Tennessee Corrections Institute, which inspects jails and trains personnel, should work with the Department of Mental Health and Mental Retardation to develop and enforce standards for handling inmates with mental illness. In addition, both law enforcement and community mental health professionals should be trained to handle mental health crises and to recognize and refer people with symptoms of mental illness for evaluation and treatment.

Mississippi

In handcuffs and jail garb, Joe Karen Bray recently stood in a Pike County courtroom in Natchez waiting for officials to decide her fate. But the 57-year-old woman had not committed any crime. After a lifetime of mental health problems that had put her in an institution seven times, Ms. Bray spent eight days in a Pike County Jail last spring waiting for a bed to become available at the state hospital in Whitfield. Her husband had had no choice but to charge her with a domestic disturbance in order to find a safe place for her to stay. "Jail is the best place for a criminal, and the worst place for a person who's mentally ill," her brother Jack Kelly, told the *Natchez Democrat* in July.

Yet Joe Bray's experience in jail is not unique. With an overloaded state mental health system, many people committed to state hospitals must often wait weeks for beds to become available. While waiting, they often return home to their families or held in jail because there is nowhere else for them to go. "That's the worst part of it, having to go to the courthouse and all that," Ms. Bray said. According to her brother, "No families are equipped in dealing with someone who is having a mental illness. It's a most unpleasant thing, but you have no options." The state is building seven regional crisis intervention centers that may help the problem, but in the meantime patients are still waiting for beds at Whitfield.

Roy Dunigan knew he needed help for his mental illness, but a nine-week waiting list at the state hospital in Whitfield kept him from getting help in time. The day a bed became available was the same day friends and relatives found his body hanging from a tree behind his aunt's house. "You can't wait nine weeks for someone who has mental, emotional or drug problems," said his mother, Hilda Lane, who remains frustrated at a system that could not help her only son. During his nine-week wait, Dunigan attempted to take his life two times. During the wait, he became frustrated and kept saying, "Mama, they're not going to call. It's been eight weeks. They don't care. Nobody cares," Mrs. Lane said.

Because of the problems generated by the long waiting list, Matilda Stephens of the Adams County Lifeskills Center (an assistance center for mentally ill and mentally handicapped people) said her program does not often work with the state hospital system. Instead it places its clients, usually about two a month, in private hospitals if needed. "When you're psychotic, to say you are going to wait six weeks or even four weeks, that would be like telling someone who has pneumonia" it will be four weeks before they can get help, she told the *Associated Press*.

New York

The deaths of two inmates under strikingly similar circumstances could prompt changes in correctional officer training and how inmates are restrained throughout New York State prisons, particularly for mentally ill inmates. Independent reports of the two deaths, before Corrections Commissioner Glenn Goord since June, each recommend revisions of prison procedures. From Dutchess County came a grand jury report on the death of inmate Hardat Persaud on November 16, 1999, at Fishkill State Prison in Beacon. From Franklin County came a relatively unusual district attorney's report on the death of inmate William Dean on Christmas Day 1999 at Franklin State Prison in Malone.

In both cases, the inmates had mental problems — Persaud was a schizophrenic and Dean was experiencing a psychotic episode at the time of his death. Both men died after being subdued by corrections officers — as many as eight for the 300-pound Dean and up to five in Persaud's case. Both men died of "positional asphyxiation" suffered when the inmates were forced to lie on their stomachs while at least one officer applied pressure to the prisoners' backs, apparently enough to fatally inhibit breathing.

Although separate grand juries determined that staff were not criminally responsible for the deaths, investigations did suggest the need for additional training and review of existing policy. "When you study Mr. Dean's death you see there were inadequacies in the way the situation was handled," Franklin County District Attorney Andrew Schrader told the *Associated Press*. "It really boils down to a lack of training." Schrader, who had repeatedly viewed a surveillance camera video tape of the incident, stated that the officers who subdued Dean at the medium-security Franklin State Prison were not experienced in "cell extraction." Dean, who had landed in the special housing unit after punching an officer earlier on Christmas Day, was restrained while a nurse gave him injections of psychotropic drugs. The officers were under the mistaken impression that the drugs would calm the inmate down, Schrader said. In the meantime, officers pinned Dean chest-first to the floor from behind and waited for the drugs to take effect. When Dean did "calm down," Schrader said, it probably meant he had passed out from lack of oxygen and was very close to asphyxiation. In both instances, officers only realized there were serious problems after inmates had become unconscious, according to descriptions of their deaths in both the *Malone Telegram* and *Poughkeepsie Journal*.

"It was clear to me from looking at it (the video) that these fellows were acting in good faith," District Attorney Schrader said of Dean's death. "There were some jerky little moves by officers, but nothing that was ultimately serious ... They weren't trying to hurt this fellow." Schrader said he recommended that state Corrections Commissioner Goord review how correctional staff are trained in restraint techniques. Although there were state Department of Correctional Services memos about the potential dangers of handcuffing someone behind their backs and leaving them on their stomachs, the information available to officers "didn't go far enough," according to the district attorney.

Robert Gangi, executive director of the Correctional Association of New York, a private non-profit prison advocacy group, told the *Associated Press* that the separate investigations both suggest that Dean and Persaud "died unnecessarily" and that there is a "serious burden weighing on the state to take steps to avoid these kinds of incidents in the future." Gangi said his agency staff frequently talks to officers who freely acknowledge their own "inadequacies" in dealing with mentally ill inmates. "I don't particularly blame the corrections officers," Gangi said. "I don't particularly blame the system. They are being put into an almost impossible situation where they are being asked to handle people with serious mental problems and people who act out violently They have this excessive and unreasonable burden of handling, confining and treating thousands of mentally ill people."

Nevada

While statistics are hard to come by, the new mental health unit at the Washoe County Jail in Reno is producing a number of success stories. Some patients, especially homeless individuals who fall through society's cracks, are being seen by a psychiatrist for the first time in their lives, unit social worker Jan Budetti told the *Reno Gazette-Journal* in September. "Some of them, if given a chance, can now go out there and live their lives. And they can be good neighbors," she said. Budetti recalls one former inmate, with the help of therapy and psychotropic drugs, who is now in college. There are other success stories as well — a former inmate now working at a convenience store rather than selling crack, another who is recovering at a veteran's hospital, and a third patient who is going to church and in the second phase of alcoholic treatment program.

Although many success stories may be out there, the jail has no way of keeping tabs on people who are released, said Dr. Ole Thienhaus, the facility's consulting psychiatrist. He and other staff believe that the revolving door at the Washoe County Jail isn't swinging quite so fast any more for the mentally ill. With more than 80 mentally ill inmates normally at the facility, the Washoe County Jail has more mentally ill people behind its doors than the Nevada Mental Health Institute. No suicides or suicide attempts have occurred since the new unit opened last June, Joan Williamson, the unit's mental health coordinator, told the *Reno Gazette-Journal*. Plexiglass walls on second-story balconies in the mental health pod have helped

prevent inmates from throwing themselves to the ground. Before the walls went up, there had been four suicide attempts and a suicide in less than two years.

With mentally ill inmates better controlled, incidents where deputies use various levels of force have been reduced to almost zero. In the first quarter of the year, there were only two incidents — an electric shock device was used in one and an inmate was physically removed from his cell in the other. In contrast, during the same time frame two years ago, five inmates had to be pinned down, pepper spray was used on eight inmates and two others had to be removed from cells. Thienhaus wouldn't say the new unit has moved the jail out of the dark ages, but he insists the jail now provides mental health services that are comparable to the Nevada Mental Health Institute. The unit's staff includes Thienhaus, two psychiatric nurses, a part-time social worker, and several deputies. Thienhaus credits the success to teamwork. Under his supervision, the staff provides group and individual counseling, psychotropic drugs and other programs. When inmates are released to the community, services are lined up for outpatient counseling, drug or alcohol treatment, emergency services, and other needs.

Assistant Sheriff Lee Bergevin stated that future plans for the mental health unit include replacement of some deputies with mental health technicians in order to provide the inmates with more attention. The unit currently has three deputies on day and swing shifts. Bergevin would like to reduce that to one deputy a shift and two technicians, while also adding a full-time social worker at the jail. □

THE MASSACHUSETTS FORENSIC TRANSITION PROGRAM FOR MENTALLY ILL OFFENDERS RE-ENTERING THE COMMUNITY¹

by

Stephanie W. Hartwell, Ph.D. and Karin Orr, M.S.W., L.I.C.S.W.

On April 1, 1998, the Massachusetts Department of Mental Health established the forensic transition program for mentally ill offenders. The primary goal of the statewide program, which followed clients for three months after their release from correctional facilities, is to coordinate services and assist in community reintegration. In the first year of the program, 233 mentally ill offenders received services. Seventy-four clients had been discharged as of April 1, 1999. At discharge, 42 of the 74 clients (57 percent) were living in the community and were receiving mental health services. The other clients were hospitalized immediately after release (20 percent), reincarcerated (10 percent), hospitalized after a brief stay in the community (3 percent), or lost to follow-up (11 percent). (Psychiatric Services 50: 1220-1222, 1999)

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When persons with mental illness are released from prison, they encounter all the difficulties inherent in being an ex-offender, but these difficulties are exacerbated by mental illness. For instance, mentally ill people often experience extreme social isolation when residing in the community, and the majority are at risk for a co-occurring substance use disorder (1,2). Their potential to be a danger to themselves or others increases when non-compliance with treatment is coupled with social isolation and substance abuse (3).

An assertive community treatment model of continuing care with attention to the specific vulnerabilities of mentally ill persons seems essential for public safety and future correctional diversion (4,5). Without monitoring and support after incarceration, mentally ill offenders will continue to cycle through social service agencies, courts, jails, and prisons (6).

Massachusetts' county houses of correction and state prisons manage approximately 22,850 inmates. It is estimated that 5 percent to 20 percent suffer from schizophrenia, bipolar disorder, or another mental illness (7). These inmates are expected to reside in the community after release (8). However, securing a place to stay and employment, managing medications, entitlements, and money, and coping with the adjustment from prison to the open community is daunting for those with a major mental illness and a criminal history (9).

This paper describes a Massachusetts program to ease the transition to community living for individuals with mental illness released from correctional facilities. Data from the first year of program operation are examined.

Method

The Program

In an attempt to ease community reintegration for mentally ill offenders completing prison sentences, the division of forensic services of the Massachusetts Department of Mental Health established the forensic transition program in 1998. The program is a statewide initiative that involves the collaboration of several state agencies to provide continuous services to inmates making the transition to community life.

The objectives of the forensic transition program are to coordinate services for clients of the Massachusetts Department of Mental Health during the transition from prison to the community; to maximize treatment outcomes for mentally ill offenders through early engagement, consistent support and a well-monitored transition; to enhance community safety by collaborating with state and public safety agencies and community service providers; and to develop a demographic profile to identify the most needed and most appropriate services for mentally ill offenders.

Eight program staff across six regions of the state work with inmates identified as mentally ill. At least three months before release, staff members begin to coordinate relevant psychosocial and criminal information for the treatment planning process. To help alleviate immediate obstacles to

community adjustment, staff members provide ongoing case coordination and consultation to community providers for up to three months after the client is released.

Although the services provided by the forensic transition program are interim and time-limited, they are informed by the most recent innovations in social service collaboration, including jail diversion and assertive community treatment programs. Staff from the Department of Corrections identify appropriate inmates for the program and provide their approximate release dates to program staff, who are employees of the Massachusetts Department of Mental Health. Program Staff are based in the community and do not have offices in the correctional facilities.

Once clients are identified, program staff conduct a review of their needs and seek appropriate community mental health resources. Essentially, client engagement begins while clients are still incarcerated and continues in the community. Clients are linked to intensive outpatient treatment programs that provide medication, rehabilitation, and proper support, including entitlements, housing, family counseling, and employment opportunities (10).

Data Collection

The program collects data about mentally ill offenders served and their functioning in the community after release from correctional facilities. Client data are captured at three time points. At baseline or three months before release, the client is interviewed by a program staff member. About two weeks after release, the staff member interviews the client in the community. The time-limited services of the program end at three months after release, when a staff member and client complete a form with disposition and outcome information, if the client has not been lost to follow-up.

Program staff have access to clients' clinical and criminal records. The forms they complete are reviewed and coded, and the client information is entered into the program database. Client data are organized under four headings: demographic information, clinical information and current criminal charge, service information, and outcome information. This method of organization allows staff to generate client and service profiles and comparisons.

Although the three-month period during which clients receive program services is brief, it is a critical time during which clients' adjustment can serve as a basis for examining success or failure of their community integration. Data from the program's first year of operation were analyzed to help program staff better understand how the interplay of demographic, clinical, and service variables contributes to successful community integration. Differences in client outcomes were examined to determine how they were related to clients' characteristics and service needs.

Results

During the first year of the program, 233 mentally ill offenders received services. The majority of clients were men (78 percent). Most clients were between the ages of 27 and 45 (65 percent). Approximately 60 percent of the offenders were white,

23 were black, 15 percent were Latino, and the remaining 2 percent were Native American. Nearly 30 percent of the clients reported that they would be homeless on release.

Clients' primary diagnoses included thought disorders (schizophrenia, schizoaffective disorder, or delusional disorder) for 124 clients, or 53 percent; mood disorders (major depression or bipolar disorder) for 84 clients, or 36 percent; and anxiety disorders (posttraumatic stress disorder or panic disorder) for 16 clients, or 7 percent. Nine clients had a primary diagnosis other than mental illness, including mental retardation and substance abuse. After the initial assessment, clients with mental retardation or substance abuse do not continue to receive services from the program.

Of the 233 mentally ill offenders who received services, more than half (124, or 53 percent) were serving time in county houses of correction for misdemeanors, with sentences of less than two-and a half years. A smaller percentage (103 offenders, or 44 percent) were completing sentences at state correctional institutions for major felonies, including violent offenses such as assault, robbery, sexual assault, and murder. The remainder of the clients served by the program were in jail awaiting trial. Clients emerging from state correctional facilities received more extensive risk assessments. Their lengthier sentences allowed staff more time to plan and prepare for safe community re-entry.

As of April 1, 1999, a total of 74 clients had been discharged from the forensic transition program after completing the three-month monitoring period. At time of discharge, 42 of the 74 clients (57 percent) were living in the community and engaged in mental health services. Fifteen clients (20 percent) were hospitalized immediately after release, seven (10 percent) were reincarcerated, two (3 percent) were hospitalized after a brief stay in the community, and eight (11 percent) were lost to follow-up.

Discussion and Conclusions

As the forensic transition program develops, several barriers need to be addressed to improve services and enhance clients' functioning in the community. More coordination between correctional staff and program staff is needed so that program staff are informed of the specific dates and times that clients are to be released from correctional facilities. Treatment engagement strategies need to be improved for clients who have little interest in the services offered by the program. Some refuse treatment or are lost to follow-up. Procedures must be refined so that client confidentiality is safeguarded when information is shared across service systems.

It is anticipated that these operational obstacles will be overcome with further experience, continued communication, and the development of clear policy statements and procedural guidelines. Despite these obstacles, data from the first year of operation indicate that clients of the forensic transition program are receiving the services they need to re-enter the community.

Acknowledgment

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Program Update

When contacted by the *Update*, the authors stated that the program is now in its third year of operation and, as of August 2000, a total of 159 clients had been discharged from the forensic transition program after completing the three-month monitoring period. At time of discharge, almost 63 percent were living in the community and engaged in mental health services. The remainder were either hospitalized immediately after release (21 percent), reincarcerated (3 percent), hospitalized after a brief stay in the community (5 percent), or disengaged from community mental health services (8 percent).

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MODEL LAW FOR ASSISTED TREATMENT

During the 1960s and 1970s, state laws governing the treatment of severe mental illnesses underwent sweeping reform through the country. Most notably, assisted treatment laws were changed to require a court finding of dangerousness before treatment could be provided to those incapable of recognizing their need for it. While well intentioned, reform efforts meant to protect people with mental illnesses, such as schizophrenia and manic-depressive illness, resulted in many of the most severely ill going without needed treatment and, in too many cases, becoming homeless, incarcerated, suicidal, victimized or prone to acts of violence.

Based in Arlington, Virginia, the Treatment Advocacy Center is a non-profit organization that was formed in 1998 to eliminate legal and clinical barriers to mental health treatment. According to the Center, outdated state codes, most developed decades before our current understanding of brain dysfunction and effective treatments for severe mental illnesses, need to be reformed. The Treatment Advocacy Center recently developed a *Model Law for Assisted Treatment* to spur the reform of these antiquated laws.

Jonathan Stanley, M.D., assistant director at the Center, writes in the preface of the publication that the *Model Law for Assisted Treatment* is a cautiously considered proposal to promote the provision of care for those who need it because of the effects of severe mental illness. At the same time, the *Model Law* includes numerous overlapping protections to safeguard those under court-ordered treatment and to ensure that only those for whom it is appropriate are placed or remain in assisted treatment. According to Dr. Stanley, the *Model Law* is more remarkable for what it is not, rather than for what it is. It is not entirely revolutionary nor does it eradicate the basic constitutional protections provided by current treatment laws. The document contains familiar provisions for emergency treatment; a subsequent certification for a treatment hearing by an examining doctor; a more lengthy process to petition for the treatment of someone less sick; under different names, outpatient commitment and conditional discharge; periodic reviews and possible renewals of treatment orders; and a host of other mechanisms common to current laws for securing treatment for those overcome by mental illness.

A cursory examination may give the impression that the *Model Law* maintains the status quo when, according to the Center, it is actually a compilation of the most effective provisions of existing state laws. Variations of virtually all the document's sections are the current law somewhere in the United States. In essence, according to Dr. Stanley, "we have combined each of the best available components into a statutory model better than any currently in effect."

The Model Law for Assisted Treatment is available from the Treatment Advocacy Center's website (<http://www.psychlaws.org>) or by contacting the agency at 3300 North Fairfax Drive, Suite 220, Arlington, Virginia 22201, (703) 294-6001. □

JAIL SUICIDE/MENTAL HEALTH UPDATE

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

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

AVAILABLE JAIL/PRISON 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 and 8)

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

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