JAIL SUICIDE/MENTAL HEALTH UPDATE

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SPECIAL ISSUE: THE EVOLVING WORLD OF JAIL SUICIDE LITIGATION

A federal appeals court recently ruled that the incidence of five inmate suicides in a 300-bed county jail in Wisconsin during a five-year period was not a significant indicator of suicide prevention practices within the facility; whereas another federal appeals court ruled that three inmate suicides in a small Louisiana county jail during the sheriff's tenure was one of several significant indicators of deliberate indifference. Confused? In previous issues of the ***Jail Suicide/Mental Health Update****, we have periodically discussed the relationship of jail suicide and liability. These topics have become deeply intertwined, with the suicide of an inmate rarely occurring without the immediate question being asked — "Am I liable?" To date, the question is difficult to answer as courts continue to approach liability with inconsistency, leaving public officials, jail administrators, and their personnel often faced with confusing and unpredictable rulings.*

In again revisiting this topic, we asked attorney David W. Lee, an experienced litigator and writer in the field of civil rights law, to review and analyze current federal case law. The result is "Personal Liability Against Correctional Officials and Employees for Failure to Protect the Suicidal Inmate Under 42 U.S.C. §1983," an analysis of the federal courts' current interpretation of "deliberate indifference" — the legal yardstick used to measure most jail suicide liability. This special issue also includes a comprehensive listing of all reported case law from the federal courts, news from around the country, and an article regarding a promising new program in California that seeks to provide appropriate services to mentally ill offenders.

PERSONAL LIABILITY AGAINST CORRECTIONAL OFFICIALS AND EMPLOYEES FOR FAILURE TO PROTECT THE SUICIDAL INMATE UNDER 42 U.S.C. §1983

by
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I. Liability Under 42 U.S.C. §1983 Against Correctional Officials and Their Employees Generally

Title 42 U.S.C. §1983 is the most powerful and significant federal civil rights statute, and has the potential of imposing large financial damages upon correctional officials in numerous types of scenarios. This statute imposes the same requirements of care upon all correctional officials and employees, regardless of whether these individuals operate and/or work in city or county jails, or state or federal prisons.

A §1983 lawsuit is filed directly against the correctional official; it is no defense that a public official or employee was acting within his or her scope of employment with regard to the alleged §1983 violation. *Hafer v. Melo*, 502 U.S. 21, 112 S. Ct. 358, 116 L. Ed. 2d 301 (1991). Compensatory and punitive damages are unlimited in nature and can be imposed directly against the correctional official. *Memphis Community School District v. Stachura*, 477 U.S. 299, 106 S. Ct. 2537, 91 L. Ed. 2d 249 (1986) (holding that compensatory damages may include not only out-of-pocket loss and other monetary harms, but also such injuries as impairment of reputation, personal humiliation, and mental anguish and suffering); *Smith v. Wade*, 461 U.S. 30, 103 S. Ct. 1625, 75 L. Ed. 2d 632 (1983) (holding that punitive damages can be imposed in a §1983 case for "reckless or callous disregard of, or indifference to, the rights or safety of others, ..."). And prevailing plaintiffs in §1983 cases are entitled to full attorneys' fees and costs if the verdict they are awarded is more than nominal

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in nature. *Nephew v. City of Aurora*, 830 F.2d 1547 (10th Cir. 1987) (en banc) (holding that the district court is required to award full attorneys' fees with regard to all awards that exceed mere nominal damage awards).

Obviously, cases involve the death of the prisoner, which means that damages incurred, will be significant if the public official and/or employee is found to be liable.

II. The Impact of *Farmer v. Brennan* in Jail Suicide Cases

In the landmark case of *Farmer v. Brennan*, 511 U.S. 825, 114 S. Ct. 1970, 128 L. Ed. 2d 811 (1994), the Supreme Court held that a correctional official may be liable under the Eighth Amendment for denying humane conditions of confinement if they know that inmates face substantial risk of serious harm and disregard that risk by failing to take reasonable measures to abate it. The standard of liability is proof that the official acted with "deliberate indifference" to the substantial risk of serious harm. Although *Farmer* was a civil rights case brought against federal prison officials pursuant to *Bivens v. Six Unknown Named Agents of the Federal Bureau of Narcotics*, 403 U.S. 388, 91 S. Ct. 1999, 29 L. Ed. 2d 619 (1971), it is settled that state, county and municipal correctional officials can be sued under 42 U.S.C. §1983 using the same constitutional principles as those used in cases against federal prison officials. *Evans v. Ball*, 168 F.3d 856, 863 n.10 (5th Cir. 1999); *Gordon v. Hansen*, 168 F.3d 1109, 1113 (8th Cir. 1999). And there is no difference with regard to the immunities afforded officials in a *Bivens* action as compared to those afforded state officials in a §1983 action; the qualified immunity defense is the same. *Wilson v. Layne*, 526 U.S. 603, 609, 119 S. Ct. 1692, 143 L. Ed. 2d 818 (1999); *Harlow v. Fitzgerald*, 457 U.S. 800, 818 n.30, 102 S. Ct. 2727, 73 L. Ed. 2d 396 (1982).

So what is "deliberate indifference"? The Supreme Court ruled in *Farmer* that a correctional official and/or employee is deliberately indifferent when the individual:

> "knows of and disregards an excessive risk to inmate health and safety; the official must both be aware of the facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference" (at 837).

In other words, deliberate indifference occurs when the individual ignores facts that would lead that official to believe there is substantial risk of serious harm to the inmate. *Farmer* also made clear that a correctional official must ensure that inmates receive adequate food, clothing, shelter, and medical care, and must "take reasonable measures to guarantee the safety of the inmates..."(at 833).

With regard to §1983 liability for jail suicide, even before *Farmer* was issued by the Supreme Court, it was universally assumed that the Supreme Court cases involving deliberate indifference under the Eighth and Fourteen Amendment applied to situations where inmates committed suicide. See, for example, *Belcher v. City of Foley*, 30 F.3d 1390, 1396 (11th Cir. 1994) (without mentioning *Farmer*, which had been decided three months earlier, court held that prisoners had an Eight Amendment right "to be protected from self-inflicted injuries, including suicide....." *Estate of Hocker v. Walsh*, 22 F.3d 995, 1000 (10th Cir. 1994) (knowledge of specific risk of suicide was not enough to impose liability under §1983 upon sheriff); and *Rhyne v. Henderson County*, 973 F.3d 386, 393 (5th Cir. 1992) (holding that periodic checks of suicidal prisoner were not shown to have been inadequate).

III. Post-*Farmer* Cases Involving Liability Under 42 U.S.C. §1983 for Failure To Protect The Suicidal Inmate

After *Farmer*, there was unanimous agreement that the principles involving deliberate indifference to the serious medical needs of an inmate controlled suicide cases, as well as cases involving other potential harm to inmates caused through inattention (or worse) by correctional officials toward inmates. *Gregoire v. Class*, 236 F.3d 413, 417 (8th Cir. 2000) (noting that it was well-established that a risk of suicide by an inmate is a serious medical need that cannot be treated with deliberate indifference by jail or prison officials).

Recent cases demonstrate the potential for §1983 liability to be imposed against correctional officials for not acting diligently with regard to the suicidal inmate. In *Comstock v. McCrary*, 273 F.3d 693 (6th Cir. 2001), the estate of an inmate at a Michigan state prison brought a 42 U.S.C. §1983 action against a psychologist, medical doctor and physician's assistant. He had been referred for a psychological evaluation by a correctional officer who had observed him acting despondently in the cell, and who had heard that the previous shift's officer had removed sharp objects from the inmate out of concern for his safety. During a meeting with the prison psychologist, the inmate reported feeling depressed, stated that his nerves were shot, and that he felt like he was going to die. The next day, the inmate advised the physician's assistant that his main problem was that other inmates had threatened to kill him because they believed he was a snitch. The same morning, the inmate was interviewed by the prison psychologist who noted that he suspected something was going on between the inmate and the other prisoners. The psychologist noted that there was a change from the inmate's demeanor the day before, in that he was now less anxious and not as worried and uptight as he had been. However, later that afternoon, the inmate committed suicide in his cell by hanging himself with a sheet fashioned into a rope.

The inmate's estate sued, claiming that the Eighth Amendment had been violated by the defendants' displaying deliberate indifference to his medical needs, and that they failed to protect him from harm. In ruling on the defendants' motion for summary judgment, the Sixth Circuit utilized the guidance of *Farmer* in ruling that a prison official may not escape liability if the evidence showed that he merely refused to verify underlying facts he strongly suspected to be true, or declined to confirm inferences of risk that he strongly suspected to exist. *Comstock*, 273 F.3d at 703.

In *Comstock*, the court held that the prison psychologist had subjective knowledge of the inmate's risk of suicide because he had placed him on close observational status the day before the

suicide. The psychologist was also aware that the inmate was having problems with other prisoners, which was at least one precipitating factor in the suicide. *Id*. at 704-05. The psychologist also testified that when he visited the inmate, the whole cell block seemed to be in a uproar, and that he perceived that the other prisoners did not like the inmate for some reason. The court held, therefore, that the prison psychologist subjectively perceived the risk of serious harm to the inmate, including the fact that his mental state was effected by the other prisoners' dislike for him. *Id*. at 706.

The court also noted, however, that the psychologist could still prevail if he responded reasonably to the subjective risk, even if the harm ultimately was not averted. The court stated that when the psychologist discharged the inmate back to his administrative segregation cell, he failed to follow the prison's policies with regard to suicide prevention. The prison policy was that a psychologist's evaluation of an inmate who has been placed in close observation must include a review of the inmate's institutional file and health record, as well as an interview with the individual. There was nothing in the record to indicate that the psychologist followed these procedures. *Id*. at 709. The court held that the psychologist's conduct was more than negligence because he had previously found that the inmate was sufficiently at risk to put him on suicide watch only the day before. The court held that the psychologist's actions violated clearly established law, and that he was not entitled to qualified immunity.

With regard to the physician's assistant, the court held that the plaintiff was unable to present facts which would show that the physician's assistant subjectively perceived a substantial risk of serious harm to the inmate's health and safety. With regard to the prison medical doctor, the court held that there was no showing that the doctor approved or knowingly acquiesced in the actions of the prison psychologist. Therefore, the court held that the prison medical doctor was entitled to qualified immunity.

In *Boncher v. Brown County*, 272 F.3d 484 (7th Cir. 2001), an inmate committed suicide in a Wisconsin county jail, and his estate brought an action under 42 U.S.C. §1983, contending that jail officials were deliberately indifferent to the risk of the inmate's suicide and deprived him of life without due process of law. The inmate had been arrested after a domestic altercation. He had a long history of alcoholism and had attempted suicide at least three times, but this history was allegedly not known to arresting officers or jail personnel. These officers also did not know that the inmate had often told his ex-wife that he planned to kill himself in jail.

When interviewed during booking, the inmate had answered "yes" when asked whether he had mental or emotional problems. He also answered affirmatively when asked whether he had ever attempted suicide, to which he responded that he had a couple of days ago "but was fine now." The inmate said this in what the officers thought was a joking manner, and he had been jovial and cooperative since his arrest. The officers thought he was a "happy drunk." For these reasons, the jail officials put him in a regular jail cell, rather than the suicide watch cell. Within 45 minutes, the inmate hung himself with a bed sheet.

Significantly, the intake officers who decided that the inmate was not suicidal were not defendants in the case. Rather, the defendants were administrators, including the county sheriff.

The court noted that jail officials who decided to take no precautions against the possibility of an inmate's suicide — for example, not to have any suicide prevention policies — could be found to be deliberate indifference. They would be ignoring a known and serious risk of death to persons under their control whose safety they were responsible for. *Id*. at 486. The court held that, although there had been five suicides in the 300-bed county jail within the previous five years, this number was not a meaningful index of suicide risk. The court held that jail officials did not exhibit deliberate indifference, especially in light of the fact that the county jail was in compliance with the state's minimum standards for suicide prevention. *Id*. at 487.

In *Sanville v. McCaughtry*, 266 F.3d 724, 734 (7th Cir. 2001), a mother a mentally ill inmate who committed suicide while incarcerated in the state prison brought a §1983 action against several prison officials, physicians, and correctional officers. The court noted that the failure of correctional officials to provide for the basic human needs of inmates may rise to the level of an Eighth or Fourteenth Amendment violation. Prison officials have a duty, in light of the Eighth Amendment's prohibition against cruel and unusual punishment, to ensure that the inmates receive adequate food, clothing, shelter and medical care. *Id*. at 733.

In *Hott v. Hennepin County*, 260 F.3d 901 (8th Cir. 2001), an inmate in a county jail in Minnesota had been screened for medical and psychiatric problems during routine intake procedures. The inmate denied having any suicidal ideation, but complained of back and neck pain received in a recent automobile accident. He was treated with Advil and Tylenol during incarceration. Approximately 22 days later, a jail nurse conducted a detailed

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

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/pubs/jails.htm
http://www.nicic.org/pubs/prisons.htm
http://www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
http://www.performance-standards.org/resguides.htm
http://www.gainsctr.com

health assessment and no indication of suicide risk was noted. Two years earlier, however, medical personnel at a county hospital had documented that the inmate had attempted suicide, was an increased risk for subsequent attempts, and that he suffered from hypomania and bipolar personality disorder. *Id*. at 903-04. The inmate did not advise jail personnel about the existence of these medical records, or authorize anyone to obtain his medical records.

The decedent's estate contended that the county jail had an obligation to investigate the inmate's mental condition because of his habit of making strangling gestures while he was there. The court, however, held that there was no evidence that jail personnel interpreted these gestures as a suicide threat, as opposed to an indication he was experiencing continuing neck pain from his automobile accident. And even if the inmate was visibly glum, this fact, as well as the fact that jail personnel had not obtained medical records from any county hospital, was not a sufficient showing that they were subjectively deliberately indifferent to his need for medical care.

The evidence had also showed that a deputy charged with conducting cell checks failed to conduct those checks in accordance with jail policy. The court held, however, that the deputy's failure to conduct these checks was not sufficient to constitute a substantial risk to general inmate safety. The court upheld the granting of summary judgment in favor of the deputy on the constitutional theory. *Id*. at 906-08. On a theory of negligence under Minnesota state law, however, the alleged failure to conduct cell checks as required by jail policy created a genuine issue of material fact and the granting of summary judgment was reversed as to the deputy who failed to make the checks.

In *Thompson v. Upshur County*, 245 F.3d 447 (5th Cir. 2001), the Seventh Circuit held that the estate of an inmate who died of a medical condition associated with his delirium tremens failed to show that the sheriff was deliberately indifferent to the inmate's serious medical needs. The victim had collided with objects in his cell, and eventually died from seizures that were associated with delirium tremens. The estate had claimed that the sheriff's failure to instruct his staff on the potentially life threatening nature of delirium tremens was deliberate indifference. However, given the lack of evidence that any inmate had previously suffered adverse serious health problems, this could not be shown to be deliberate indifference on the part of the sheriff sufficient to establish liability under §1983. Liability under §1983 could not be shown from a single alleged violation of constitutional rights. *Id*. at 463.

The court in *Thompson,* however, held that a genuine issue of material fact existed with regard to a jail sergeant's actions concerning the inmate because the sergeant was aware that: the inmate's blood alcohol level at arrest was over 0.3%, he was hallucinating and at times speaking incoherently, he was injuring himself in his cell, and he was experiencing delirium tremens. Although the sergeant responded to this situation — by requiring close observation of the inmate, placing him in a strait jacket (but without a helmet kept available for this type of situation), dressing a womb on his head, placing mattresses in the cell, calling the hospital to ask for medical advice — this was insufficient in that none of these responses involved arranging for professional medical assistance for the inmate's serious medical need (delirium tremens).

In *Brown v. Harris*, 240 F.3d 383 (4th Cir. 2001), the court held that jail officials were not subject to liability under 42 U.S.C. §1983 when an inmate hanged himself in the jail. There was no evidence that the inmate was of unsound mind when he took his own life, and even assuming that the jail supervisor was informed that the inmate was suicidal, the supervisor did not act with deliberate indifference to the inmate's medical needs because he was placed on "medical watch" which established constant video surveillance of the cell.

In *Jacobs v. West Feliciana Sheriff's Department*, 228 F.3d 388 (5th Cir. 2000), the court held that a sheriff and a senior deputy who knew of a prior suicide in that same jail, under similar circumstances, could have been found by a jury to have acted with deliberate indifference to the inmate's known suicidal tendencies, and therefore, were not entitled to qualified immunity. The court noted that it was the third suicide that had occurred during the defendant sheriff's tenure. The court stated that "a state official's episodic act or omission violates a pretrial detainee's due process rights to medical care (and protection from harm) if the official acts with subjective deliberate indifference to the detainee's rights." *Id*. at 393. In addition, the senior deputy knew of the inmate's suicide risk, was in possession of loose bedding, and that a prior jail detainee had hanged himself in the same cell under similar circumstances. The court held that the senior deputy sheriff was not entitled to qualified immunity. However, a newly hired deputy who was only following orders which were not facially outrageous was entitled to qualified immunity.

To be liable under the Eighth Amendment for an inmate suicide, a prison official must be cognizant of the significant likelihood that an inmate may imminently seek to take his own life, and must fail to take reasonable steps to prevent the inmate from committing suicide. *Sanville v. McCaughtry*, 266 F.3d 724, 737 (7th Cir. 2001). As briefly offered above, in *Sanville*, a mother of a mentally ill inmate who committed suicide while incarcerated in the state prison brought a §1983 action against several prison physicians, wardens and correctional officers. A state prison physician who saw a mentally ill inmate on four occasions and who deferred to the inmate's wishes that he no longer wanted medication or psychiatric services was not deliberately indifferent; at the time of the physician's last visit, the inmate had been off his medication for three months and there was no indication that the inmate was suicidal or in danger of harming himself. *Id*. at 735-38. The court held — that where it was alleged that a mentally ill inmate had a history of mental illness and suicide attempts, recently lost nearly one-third of his body weight, written letters to his mother contemplating his death, written a last will and testament, told officers that he planned to commit suicide, and covered his cell door with toilet paper so that it was difficult to see the cell interior — sufficient information was available to make correctional officers aware of the inmate's substantial risk of suicide.

It must be established that a prison official had specific knowledge of a suicide risk; it is not enough that a reasonable official *should* have known of that risk. *Gregoire v. Class*, 236 F.3d 413, 417 (8th Cir. 2000). And even if an official knew of a risk of suicide, and the death does occur, the official is entitled to qualified immunity if they could reasonably believe that the response to the risk was not deliberately indifferent. In *Gregoire*, the court held that a prison case manager who waited longer than 30 minutes to check on an inmate after receiving a telephone call from the prisoner's ex-wife indicating that he planned to commit suicide was not exhibiting deliberate

indifference to the inmate's risk of suicide. *Id*. at 417-18. The court noted, however, that prison officials and staff being unaware of available information in the inmate's file of his "past treatment for depression and suicidal ideation and about previous recent classification as a suicide risk, may raise concerns about the adequacy of procedures at the prison for discovering and preventing suicide risks." *Id*. at 417 n.2.

In *Williams v. Mehra*, 186 F.3d 685 (6th Cir. 1999), the court held that prison psychiatrists were entitled to qualified immunity in the death of an inmate who had both major depression (with psychotic features) and suicidal ideation and later overdosed on prescription drugs that he had hoarded. The court noted that a correctional official can be held liable under the Eighth Amendment if the official knows of an excessive risk to inmate health or safety. *Id*. at 691. The court held that the plaintiff was required to show that the doctors actually knew that dispensing Sinequan tablets in a pill line constituted an excessive risk to the inmate's health or safety. *Id*. at 692.

In *Liebe v. Norton*, 157 F.3d 574, 576-78 (8th Cir. 1998), despite the fact that a jailer failed to notice exposed electrical conduit in the cell which the inmate hanged himself, 15 minutes elapsed between time the inmate was discovered and initiation of cardiopulmonary resuscitation, the court held that he did not act with deliberate indifference because he classified an inmate as a suicide risk, took measures of placing the inmate in a temporary holding cell, removed his shoes and belt, and provided frequent observation.

In *Collignon v* held that both the county and county psychiatrist had no obligation under the due process clause to stop a pretrial detainee from committing suicide once he had been released from jail on bail. In *Barrie v. Grand County*, 119 F.3d 862 (10th Cir. 1997), the court held that officers' conduct with regard to a jail suicide was to be judged by a deliberate indifference standard, rather than an objectively reasonableness standard. The court held that the conduct must rise to the level of deliberate indifference to a "known or obvious risk." *Id*. at 869. In *Belcher v. City of Foley*, 30 F.3d 1390 (11th Cir. 1994), the court held that the appropriate test is whether there was a "'strong likelihood' that a prisoner will take his own life." *Id*. at 1396. In *Rellergert v. Cape Girardeau County*, 924 F.2d 794 (8th Cir. 1990), the court upheld the district court's granting of a judgment notwithstanding the verdict in favor of a sheriff and deputy where the claim was that their deliberate indifference led to an inmate suicide. The court held that the measures taken in response to the inmate's stating that he had attempted suicide in the past did not constitute deliberate indifference, and the sheriff and deputy were entitled to qualified immunity. See also *Popham v. City of Talladega*, 908 F.2d 1561, 1564 (11th Cir. 1990) (some form of knowledge of suicidal tendencies of an inmate is necessary for liability to be imposed).

IV. Liability Under 42 U.S.C. §1983 to Adequately Train Correctional Personnel to Detect a Suicidal Inmate

The Supreme Court has ruled that governmental entities can be sued and held liable under 42 U.S.C. §1983 for failure to train staff or providing inadequate training if the failure to provide adequate training amounts to deliberate indifference to the rights of confined individuals. *City of Canton v. Harris*, 489 U.S. 378 (1989). In a jail suicide case, deliberate indifference is exhibited only when the inadequacy of the training was closely related to, or actually caused, the death. One court has held that to succeed, a plaintiff must "1) identify specific training not provided that could reasonably be expected to prevent the suicide that occurred and 2) ...demonstrate that the risk reduction associated with the proposed training is so great and so obvious that the failure of those responsible for the content of the training program to provide it can reasonably be attributed to a deliberate indifference to whether (the inmates) succeed in taking their lives." *Colburn v. Upper Darby Township*, 946 F.2d 1017, 1030 (1991). See also *Scott v. Clay County*, 205 F.3d 867, 879 n. 21 (6th Cir. 2000) (§1983 action against county permitted if county pursued an official custom or policy of failing to train, supervise, or discipline officers in a particular matter.) In *Simmons v. City of Philadelphia*, 947 F.2d 1042 (3rd Cir. 1991), the court held that a city could be held liable for being deliberately indifferent in failing to train officers in suicide prevention in order to properly evaluate the suicidal tendencies of intoxicated detainees.

V. Steps to Lesson the Potential for Liability Under 42 U.S.C. §1983 With Regard to Jail Suicide

Obviously, the best way to lessen liability under 42 U.S.C. §1983 for jail suicide is preventive action pursuant to policies designed to reduce the potential for suicide. It is critical that correctional officials ensure that their employees are regularly and competently trained with regard to detecting potentially suicidal behavior. In order to prevent liability under §1983 from being imposed, correctional officials and their employees must take reasonable steps to prevent the inmate from committing suicide. *Sanville v. McCaughtry*, 266 F.3d 724, 737 (7th Cir. 2001). As was noted above in *Comstock v. McCrary*, 273 F.3d 693 (6th Cir. 2001), when the prison psychologist allowed the return of the inmate to his administrative segregation cell, there was a failure to follow the prison's suicide prevention policy. Furthermore, the prison policy also required that a psychologist's evaluation of an inmate who has been placed on close observation must include a review of the individual's institutional file and health record, as well as an interview with the inmate. Documentation of what has been done is crucial. The court in *Comstock* noted that there was nothing in the record to indicate that the psychologist followed these procedures.

In addition to inadequate screening and assessment of a suicidal inmate, liability under 42 U.S.C. §1983 can be imposed for failing to immediately provide cardiopulmonary resuscitation to an inmate who is found to be hanging. In *Heflin v. Stewart County*, 958 F.2d 709 (6th Cir. 1992), the court held that a sheriff and deputy exhibited deliberate indifference to the inmate's serious medical needs by failing to cut him down when they found him hanging in his cell; instead they waited for medical personnel to arrive and photographs to be taken. More recently, the court in *Tlamka v. Serrell*, 244 F.3d 628, 635 (8th Cir. 2001), held that correctional officers could be sued for allegedly ordering inmates to stop giving CPR to an inmate who collapsed in a prison yard following a heart attack. The court stated that "any reasonable officer would have known that delaying Tlamka's emergency medical treatment for 10 minutes, with no good or apparent explanation for the delay, would have risen to an Eighth Amendment violation." *Id*. at 635.

It is hoped that this article has called attention to the real possibility of liability under 42 U.S.C. §1983 that correctional officials and their staff face when an inmate who exhibits suicidal behavior is confined in their facility. Indeed, the case law is confusing and unpredictable; yet the best defense against liability being imposed is to have competent training and sound procedures in place that reduce the likelihood of an inmate suicide occurring at all.

About the Author

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Inmate Suicide Case Law in the Federal Courts (1995 to the Present)

Offered below is a comprehensive listing of all inmate suicide case law from the federal courts, as published in either West's Federal Supplement (1st and 2nd Series) or Federal Reporter (2nd and 3rd Series) from 1995 to the present.

1995

Anderson v. County of Kern, 45 F.3d 1310, 9th Cir. 1995 (Use of safety cells to house suicidal inmates upheld)

Burke v. Warren County Sheriff's Dept., 890 F. Supp. 133, N.D.N.Y. 1995 (Summary judgment to all defendants, except one officer, who did not know that detainee was suicidal)

Frey v. City of Herculaneum, 44 F.3d 667, 8th Cir. 1995 (Original complaint in jail suicide case lacked specificity; permission granted to amend complaint against police officers)

Haney v. City of Cumming, 69 F.3d 1098, 11th Cir. 1995 (Qualified immunity to all defendants in jail suicide case)

Hardin v. Hayes, 52 F.3d 934, 11th Cir. 1995 (Reversed a trial court ruling for new trial in jail suicide case)

Litz v. City of Allentown, 896 F. Supp. 1401, E.D. PA. 1995 (City and officers not deliberately indifferent, as most, police chief was negligent by action or inaction)

May v. Fulton County, GA., 925 F. Supp. 769, N.D. GA. 1995 (*Juvenile*) (Plaintiff failed to create triable issue of fact regarding deliberate indifference; detention center personnel enjoyed qualified immunity; county enjoyed sovereign immunity from wrongful death claim)

Mullins v. Stratton, 878 F. Supp. 1016, E.D. KY. 1995 (No policy or custom amounted to deliberate indifference; failing to recognize scar from detainee's previous suicide attempt did not constitute deliberate indifference)

Pyka v. Village of Orland Park, 906 F. Supp. 1196, N.D. Ill. 1995 (Officers entitled to qualified immunity on claim of failure to provide medical care; village had no policy of deliberate indifference to suicide prevention; proximate cause issue would be determined by jury)

Swan by Carello v. Daniels, 923 F. Supp. 626, D. DE. 1995 (Although defendants could have done more to prevent prisoner's suicide attempt, they did not act with deliberate indifference; ruling on negligence claims deferred)

1996

Dolihite v. Videon, 74 F.3d 1027, 11th Cir. 1996 (*Juvenile*) (Issue of whether mental health professionals exercised professional judgment precluded summary judgment; issue of whether facility director and state officials were subject to supervisory liability precluded summary judgment; all defendants entitled to immunity on state tort claims)

Estate of Cole by Pardue v. Fromm, 94 F.3d 254, 7th Cir. 1996 (Allegations of medical malpractice were insufficient to show deliberate indifference; plaintiff failed to create genuine issue of fact regarding whether defendants were subjectively aware that detainee would commit suicide; erroneous medical treatment must be substantial departure from accepted professional judgment to constitute deliberate indifference; psychiatrist's classification of detainee as potential suicide risk (as opposed to a high suicide risk) was not deliberate indifference)

Estate of Frank v. City of Beaver Dam, 921, F. Supp. 590, E.D. WI. 1996 (Officers enjoyed qualified immunity; detainee did not demonstrate suicidal behavior)

Estate of Olivas v. City and County of Denver, 929, F. Supp. 1329, D. CO. 1996 (City, former police chief and officer not deliberately indifferent to detainee; second officer had actual knowledge of specific risk to detainee and by ignoring that risk, reasonable juror could conclude he was deliberately indifferent and not entitled to qualified immunity)

Gay v. City of Daleville, 953 F. Supp. 1315, M.D. AL. 1996 (Qualified immunity granted because although suicide prevention training and policy did not exist, actions did not rise to deliberate indifference)

Hartman v. Correctional Medical Services, Inc., 960 F. Supp. 1577, M.D. FL. 1996 (Summary judgment on grounds of qualified immunity denied because genuine issues of material fact existed as to whether defendants acted with deliberate indifference)

Heggs v. Grant, 73 F.3d 317, 11th Cir. 1996 (Defendants entitled to qualified immunity in their individual capacities for liability arising from suicide of arrestee who threatened suicide, but then withdrew threat)

Houck v. City of Praire Village, KS, 950 F. Supp. 312, D. KS. 1996 (Police chief's decision not to send arrestee to hospital rather than jail following shooting spree in home was not outrageous to constitute negligence or deliberate indifference)

Robey v. Chester County, 946 F. Supp. 333, E.D. PA. 1996 (Warden's failure to institute disciplinary proceedings following suicide did not preclude qualified immunity; counselor's failure to respond to detainee's requests to see him did not preclude qualified immunity; reasonable jurors could find that psychologist acted with deliberate indifference to detainee's psychological needs; fact issues existed on whether treatment of detainee was result of policy or custom

and whether such policy caused deprivation of constitutional rights; evidence supported punitive damage claim only against psychologist; county and prison board directors had sovereign immunity from state claims)

Steel v. Shah, 87 F.3d 1266, 11th Cir. 1996 (Inmate diagnosed as potential suicide risk and prescribed psychotropic drugs stated a claim of deliberate indifference to serious medical needs by asserting that prison psychiatrist discontinued his medication without evaluation or reviewing medical records)

Viero v. Bufano, 925 F. Supp. 1374, N.D. IL. 1996 (*Juvenile*) (Summary judgment denied because question of whether defendants were deliberately indifferent to juvenile's serious medical needs was a fact issue)

Williams v. Jabe, 947 F. Supp. 1130, E.D. MI. 1996 (Genuine issue of fact as to whether psychiatrists' treatment of prisoner constituted deliberate indifference; psychiatrists were not liable for negligent supervision of prison personnel; genuine issue of material fact precluded summary judgment in favor of psychiatrists on state claim of gross negligence)

Williams v. Lee County, AL., 78 F.3d 491, 11th Cir. 1996 (No basis for liability on sheriff and his personnel for claim of insufficient training and supervision; county not liability under theory that jail was defectively constructed and maintained; no liability for state claim of wrongful death of detainee)

1997

Barrie v. Grand County, UT, 119 F.3d 862, 10th Cir. 1997 (Defendant's duty to detainee was based on deliberate indifference standard, not objective reasonableness; defendants did not act with deliberate indifference)

Flores v. County of Hardeman, TX, 124 F.3d 736, 5th Cir. 1997 (Sheriff was not deliberately indifferent in providing detainee with protection against suicidal tendencies; trial court did not err in dismissing state claims)

Mathis v. Fairman, 120 F.3d 88, 7th Cir. 1997 (Jail personnel were not deliberately indifferent to detainee's strange behavior prior to suicide)

McDuffie v. Hopper, 982 F. Supp. 817, M.D. AL. 1997 (Doctors and providers not eligible for qualified immunity; genuine issue of material fact regarding whether treatment received by prisoner for mental health problems was deliberately indifferent to his medical needs precluded summary judgment)

1998

Collignon v. Milwaukee County, 163 F.3d 982, 7th Cir. 1998 (Officers and county psychiatrist not liable for decedent's suicide one day after release from custody)

Greffey v. State of AL. Dept. of Corrections, 996 F. Supp. 1368, N.D. AL. 1998 (Summary judgment granted to defendants who appropriately referred decedent, who had a history of suicidal behavior, for further assessment)

Hare v. City of Corinth, MS, 135 F.3d 320, 5th Cir. 1998 (Detainee's right to be free from officers' deliberate indifference to medical needs was clearly established at time of suicide; officers' conduct regarding possibility that detainee would commit suicide was objectively reasonable)

Hayes v. City of Des Plaines, 182 F.R.D. 546, N.D. Ill. 1998 (Fact question precluded striking immunity defense of claim that officers violated statutory duty to provide medical care to detainee)

Liebe v. Norton, 157 F.3d 574, 8th Cir. 1998 (Officer did not act with deliberate indifference because decedent was identified as a potential suicide risk and monitored more frequently; county also not deliberately indifferent because it had policies in place to prevent inmate suicides)

Owens v. City of Philadelphia, 6 F. Supp. 2d 373, E.D. PA. 1998 (Questions of fact precluded summary judgment to defendants on issues of deliberate indifference, qualified immunity, and adequacy of training program, and whether officers chose not to resuscitate victim)

Payne for Hicks v. Churchich, 161 F.3d 1030, 7th Cir. 1998 (No deliberate indifference without notice of decedent's risk of suicide)

Vinson v. Clark County, AL., 10 F.Supp. 2d 1282, S.D.AL. 1998 (Summary judgment granted because defendants did not act with deliberate indifference)

1999

Brewer v. City of Daphne, 111 F. Supp. 2d 1299, S.D. AL. 1999 (Summary judgment granted because plaintiffs were unable to prove that custom or practice of defendants reflected deliberate indifference to decedent's needs)

Diaz v. U.S., 165 F.3d 1337, 11th Cir. 1999 (Appeals court vacated lower court decision and ruled that wrongful death claim under Federal Tort Claims Act does not accrue on the date of death, rather it accrues when plaintiff knew or reasonably should have known that inmate received psychological treatment, and that there was connection between said treatment and death)

Ellis v. Washington County, 198 F. 3d 225, 6th Cir. 1999 (County's alleged failure to train staff on suicide prevention was not proximate cause of injury; neither city or jail staff proximately caused alleged injury; fact issues existed as to one jail staff's claim of qualified immunity)

Lambert v. City of Dumas, 187 F.3d 931, 8th Cir. 1999 (factual disputes as to whether probable cause for arrest, excessive force, and injuries suffered from alleged excessive force precluded summary judgment; officers not liable for wrongful death)

Sanders v. Howze, 177 F.3d 1245, 11th Cir. 1999 (Defendants entitled to qualified immunity because measures taken were not so inadequate to constitute deliberate indifference)

Thornton v. City of Montgomery, 78 F. Supp. 2d 1218, M.D. AL, 1999 (Plaintiff failed to show deliberate indifference required to establish jail officials' violation of inmate's substantive due process rights; jail officials' failure to prevent suicide or accidental death did not violate sections 1985 and 1986; city could not be held liable under section 1983)

Smith v. Blue, 67 F. Supp. 2d 686, S.D. TX 1999 (*Juvenile*) (Parents stated a valid claim of deliberate indifference for violating juvenile 14th Amendment right to medical protection against his own suicidal intentions; counties are not exempt from liability for wrongful death under Texas law; parents stated valid wrongful death claim)

Williams v. Mehra, 186 F.3d 685, 6th Cir. 1999 (*en banc*) (Rehearing and reversal of earlier appeals court ruling that found a treating psychiatrist acted with deliberate

indifference to risk of decedent's continued suicide attempts by medication overdose; psychiatrist entitled to qualified immunity)

2000

Cills v. Kaftan, 105 F.Supp.2d 391, D. N.J. 2000 (Line jail personnel who took inmate off suicide watch were not liable; fact issues as to adequacy of policy governing suicide watch precluded summary judgment for remaining defendants)

Estate of Novack ex rel. Turbin v. County of Wood, 226 F.3d 525, 7th Cir. 2000 (While jail personnel perhaps could have done more to become aware of the danger that decedent posed to himself based on the strange behavior that he was exhibiting, no indication that jail policies caused personnel to be deliberately indifferent in the face of a patently obvious suicide risk)

Gregoire v. Class, 236 F.3d 413, 8th Cir. 2000 (Case manager was not deliberately indifferent to inmate's risk of suicide and, therefore, entitled to qualified immunity)

Jacobs v. West Feliciana Sheriff's Dept, 228 F.3d 388, 5th Cir. 2000 (Sheriff and senior deputy, who knew of prior suicide under similar circumstances, could have been found to have acted with deliberate indifference to arrestee's known suicidal tendencies, but newly hired deputy, who only followed orders which were not facially outrageous, was entitled to qualified immunity)

Thornhill v. Breazeale, 88 F. Supp. 2d 647, S.D. MS. 2000 (Plaintiffs' claims viable against county because there was a genuine issue of material fact as to whether jail policies and conditions were reasonably related to a legitimate governmental interest; summary judgment granted to sheriff and deputy in their individual capacities)

Yellow Horse v. Pennington County, 225 F.3d 923, 8th Cir. 2000 (Correctional officer who removed inmate from suicide watch, as well as officer on duty at time of suicide, were entitled to qualified immunity; suicide prevention policy did not reflect deliberate indifference)

Williams v. Kelso, 201 F.3d 1060, 8th Cir. 2000 (Officers' failure to check vital signs was a matter of negligence, at most, not deliberate indifference; no Eighth Amendment requirement for jail staff to provide immediate medical attention to a disoriented, confused and belligerent detainee who had been arrested on an alcohol-related misdemeanor charge; there was no abuse of discretion in dismissing without prejudice the separate medical negligence and wrongful death claims against mental health care providers; jail supervisors entitled to qualified immunity on claim that they failed to segregate decedent upon booking)

Wilson v. City of Kalamazoo, 127 F.Supp. 2d 855, W.D. MI. 2000 (Defendants not justified in completely striping inmates naked, even for a short period of time, simply because they refused to answer a question as to whether they were suicidal)

2001

Boncher v. Brown County, 272 F.3d 484, 7th Cir. 2001 (Evidence regarding inadequate training, intake screening, and number of suicides in jail insufficient to show that jail officials were deliberately indifferent to risk of decedent's suicide)

Bowens v. City of Atmore, 171 F.Supp. 2d 144, S.D. AL. 2001 (Defendants granted summary judgment because decedent's history of suicidal behavior and suicide attempt in same jail several weeks prior to death does not reflect "strong likelihood" of suicide at the time of her death)

Brown v. Harris, 240 F. 3d 383, 4th Cir. 2001 (Evening assuming that jail supervisor was informed that detainee was suicidal, he did not act with deliberate indifference to detainee's medical needs where he placed detainee on "medical watch" with video surveillance)

Comstock v. McCrary, 273 F.3d 693, 6th Cir. 2001 (Evidence was sufficient to establish that prison psychologist subjectively perceived, and that he was deliberately indifferent to risk, that inmate might commit suicide; decedent's constitutional right to continuing medical treatment, once he had been determined to be suicidal, was clearly established)

Domino v. Texas Department of Criminal Justice, 239 F.3d 752, 5th Cir. 2001 (Psychiatrist's incorrect diagnosis that inmate's suicide threat was not genuine, but was made to obtain secondary gain, did not amount to deliberate indifference, although it might exemplify medical malpractice)

Hofer v. City of Auburn, 155 F. Supp. 2d 1308, M.D. AL. 2001 (Plaintiff could not establish that jail officials acted with deliberate indifference in failing to take preventative measures to avoid detainee's suicide attempt; evidence of prior suicide at city jail by hanging from protruding light fixture did not establish that officials were deliberately indifferent by failing to remove coat hook from jail cell)

Holland v. City of Atmore, 168 F. Supp. 2d 1303, M.D. AL. 2001 (Defendants granted summary judgment because decedent's recent suicide attempts several months prior to death did not reflect "strong likelihood" of suicide at the time of his death; jail officials' failure to prevent suicide did not violate sections 1985 and 1986)

Hott v. Hennepin County, 260 F.3d 901, 8th Cir. 2001 (Jail officer's alleged failure to conduct regular cell checks was negligent, but not deliberate indifference; jail was not negligent in failure to train and supervise staff in suicide prevention)

Jutzi-Johnson v. United States, 263 F.3d 753, 7th Cir. 2001 (Reversal of lower court bench trial verdict for plaintiff; no causal relation between jail staff's negligence and inmate's suicide because death not foreseeable)

Naumoff v. Old, 167 F. Supp. 2d 1250, D. KS. 2001 (Mother of decedent brought suit in her individual capacity, not as representative of her son's estate, and has no standing because she failed to make a claim for deprivation of familial association)

Sanville v. McCaughtry, 266 F.3d 724, 7th Cir. 2001 (Prison officers were aware of the substantial risk that inmate would commit suicide; viable claim that officers failed to take reasonable steps to prevent inmate's suicide; officers not entitled to qualified immunity on section 1983 individual liability claims; prison physicians were not deliberately indifferent to the substantial risk that inmate would commit suicide) ❑

Illinois: Preventable Jail Suicide Might Spur Changes in State Records Law

Mark Barnes, 19-years-old, entered the Will County Jail in Joliet, Illinois on September 28, 2001. During the intake screening process, he denied any current suicidal ideation, but acknowledged a recent history of depression and drug overdose. He was cleared for general population housing. One week later on October 5, Mr. Barnes committed suicide by hanging.

Apparently unbeknownst to jail staff, Mr. Barnes had been on suicide watch at the Tinley Park Mental Health Center (a state hospital located a few miles away) the day before he entered the Will County Jail. He was being treated at the hospital for major depression and a suicide attempt by overdosing on cocaine and antidepressant medication. Mr. Barnes had even informed the judge that revoked his probation that he had "wanted to commit suicide" while in a recent court-ordered residential drug treatment program.

"I can't believe it's happened," the victim's father told a reporter from the *Chicago Tribune*. "I thought when somebody is incarcerated, they look at somebody's record and they look at any red flags that might be present....I was in court when they incarcerated my son. He told the judge, 'I am depressed, and I have suicidal tendencies.' I just can't understand."

Tragically, a recently enacted law designed to allow the sharing of mental health records between state agencies and county jails, thus assisting in the identification of suicidal inmates like Mark Barnes, was not utilized in his case. Section 9.2 of Public Act 91-0536 (The Mental Health and Developmental Disabilities Confidentiality Act) was amended in January 2000 as follows:

> ...For the purposes of continuity of care, the Department of Human Services (as successor to the Department of Mental Health and Developmental Disabilities), community agencies funded by the Department of Human Services in that capacity, and jails operated by any county of this state ***may*** disclose a recipient's record or communications, without consent, to each other, but only for the purpose of admission, treatment, planning, or discharge. Entities shall not redisclose any personally identifiable information, unless necessary for admission, treatment, planning, or discharge of the identifiable recipient to another setting. No records or communications may be disclosed to a county jail pursuant to this Section unless the Department has entered into a written agreement with the county jail requiring that the county jail adopt written policies and procedures designed to ensure that the records and communications are disclosed only to those persons employed by or under contract to the county jail who are involved in the provision of mental health services to inmates and that the records and communications are protected from further disclosure.

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

On February 19, 2002, State Senator Kathleen Parker, who introduced the amendment, chaired a Senate Subcommittee on Mental Health in Chicago and stated that she planned to introduce legislation to further amend Public Act 91-0536 and make it mandatory, not voluntary, that county jails access mental health records from state agencies. (Currently, the Department of Human Service's Office of Mental Health collects records from all the public mental health facilities in the state, both state hospitals and the several hundred community mental health centers, which rely mostly on state funding.) "The whole idea behind it was that you prevent things like [Barnes' suicide]," Senator Parker stated. "It's important for people to be able to share that information. Not only when people come into the jails, but when they leave, so they're given proper treatment."

According to Pat Knepler, legislative and legal liaison for the Office of Mental Health, the current law has been largely ignored by almost 70 percent of the 102 counties in Illinois, including Will County. He said the Department of Human Services attempted to contact counties after the law was passed in order to publicize its use. "There wasn't a great deal of acceptance among law enforcement," he told the *Chicago Tribune*. "Their response was, 'Why do it?'"

Some county officials had raised concerns about liability as a reason not to use of the law. They said they were worried they would be held liable if an inmate committed suicide after the county had received their mental health records. DeKalb County Sheriff Roger Scott said he had never heard of the law but, once informed about it, he voiced opposition because of potential liability and a belief that the county already had a comprehensive screening process. "If they make it mandatory and we have a slip-up somewhere, then I would think we would be liable," he stated.

But now that the law exists and is widely known, counties risk greater liability by not using it, Arthur Wallenstein, Director of the Montgomery County Department of Correction and Rehabilitation in Rockville, Maryland, told the committee hearing. "I'd hate to be in front of a [judge] with a copy of the senator's bill and have to explain why I didn't use it," he testified. But Wallenstein also warned that not all blame should be placed on the county jails. He testified that the state needs to devise a system in which community mental health centers, which treat many of the low-income mentally ill who end up in jail, must track their clients if they go to jail. "If you learn your client is in jail, you follow your client to jail, and they will allow you in and treat you decently," he said, adding that jails need to be considered one more link in the community mental health system.

Will County Sheriff Brendan Ward had testified at the hearing that he did not know the law existed until he was asked by a reporter following Mr. Barnes' suicide. But after learning of the law, the sheriff said he would support using it — "I agree entirely with the sharing of information....(In the Barnes' case), there was no transfer of information from Tinley Park." Will County State's Attorney Jeff Tomczak said he had heard that the law had been passed but was not aware of its scope or the way it addressed confidentiality issues. Now that county officials are being made aware of the details of the law, it would be prudent to begin using it, he said. "Obviously, the more information they have about an inmate the better," he said.

In the wake of Mark Barnes' death, Mark Heyrman, a mental health advocate and University of Chicago law professor who drafted the original legislation with Cook County Jail officials, wrote to the sheriffs in all 72 counties that had not taken any steps to begin seeking the mental health records of inmates housed in their jails. "We're sending them the statute....and telling them that they may have some liability if they don't [start using the law]," he told the *Chicago Tribune*. "We want them clamoring to be included." Counties must work out confidentiality guidelines that satisfy the Office of Mental Health, Heyrman said. That means agreeing that only the jail's medical and/or mental health staff will have access to an inmate's records. Passing the law did not change protections of patient confidentiality because state law already permitted health care providers to share patient records with each other. The new law only attempted to bring jail health care providers "into the loop" of mental health care, he said.

Mental health staff at the Cook County Jail began using the system by retrieving information via telephone contact with the Office of Mental Health. But according to Dr. Carl Alaimo, a psychologist for Cermak Health Services, which provides mental health services at the jail, they are currently testing a computerized system that will allow health care staff to type an inmate's name into a database and immediately view the most recent records. Sharing mental health records not only improves treatment when patients are incarcerated, but also creates a continuity of care when they leave the facility, he said. ❑

LOCKED IN SUFFERING: KENTUCKY'S JAILS AND THE MENTALLY ILL

*In February and March 2002, **The Courier-Journal** in Louisville, Kentucky presented a comprehensive four-part investigative series on mentally ill offenders and suicide prevention practices within the state's county jail system. The series was written by staff reporters Jim Adams and Sara Shipley. One of the articles from Part Four of the series, entitled "State Acts to Improve Care," appeared in the newspaper on Sunday, March 3 and is reprinted below with permission of **The Courier -Journal.***

Kentucky has begun taking steps to improve mental health care for inmates in county jails — from adding suicide prevention training for new deputy jailers, starting this week, to encouraging jails to establish contracts for regular mental health services. In meetings last week, state officials also discussed:

- Reconsidering policies that have shut the doors of the state's public psychiatric hospitals to virtually any jail inmate charged with a felony.

- Trying to provide psychiatric medications to the jails at lower cost.

¨ Writing a mental health handbook for the jails.

The developments were prompted by a seven-month investigation by *The Courier Journal* into the treatment of the mentally ill in Kentucky's 85 county jails. Some changes requiring money — such as hiring new mental health workers — might be difficult, given the state's tight budget. But other improvements appear achievable with simple changes in policies, practices and rules. For instance, experts recommend using detailed screening forms that ask inmates about their mental health. This can help identify inmates who might need immediate treatment or pose a suicide risk.

The Courier-Journal stories, which began running last Sunday, reported that many jail inmates do not get basic mental health care, and that in the worst cases, some die. The newspaper found that at least 17 people committed suicide in Kentucky's jails during a recent 30-month period, most without having seen a mental health professional while in custody. At least two mentally ill inmates died in restraints during the same period. The newspaper also found, among other things, that deputy jailers get inadequate suicide prevention training; that state psychiatric hospitals exclude inmates charged with felonies; and that most jails do not have contracts with their community mental-health agencies.

The consequences of lapses in treating mentally ill inmates have stung some Kentucky jails recently. In McCracken County, for example, the Civil Rights Division of the U.S. Department of Justice concluded in 1999 that jail conditions violated inmates' constitutional rights because of, among other problems, inadequate medical and mental-health care. "The jail provides no mental health screening, evaluation or treatment on site, except for the provision of psychiatric medications in limited circumstances," the division wrote to the county judge executive. The county signed an agreement that was filed in court early last year requiring the jail, among other things, to provide "mental health services to incarcerated inmates by qualified mental health professionals" and to institute suicide prevention measures.

In Kenton County, a mentally ill inmate, Michael Labmeier, died after being hog-tied on January 29, 1999, and a lawsuit settlement last August resulted in a $400,000 payment to his estate. As part of the settlement, the jail agreed to train all employees "on dealing with mentally ill inmates."

Statewide — according to officials, advocates and others — change is needed in these areas:

Increased Training

The first step Kentucky should take is to provide all jail officers with basic training about mental illness, said Jim Dailey, advocacy director for the National Alliance for the Mentally Ill of Kentucky. "We've lost 17 people in our state when we are supposed to be providing care to them," he said. Dailey suggested that this training could employ some of a four-hour program for police officers that he is already developing under a $100,000 grant through the Kentucky Department for Mental Health and Mental Retardation Services. The goal is to train all 7,500 Kentucky police officers during 2003. Rep. Mary Lou Marzian, D-Louisville, who co-chairs a state commission on caring for the mentally ill, said she supported Dailey's idea and thought it sounded affordable. Dailey said that about half of his police curriculum could be used for deputy jailers as well. Jail employees should be trained in defusing crises, recognizing mental illness, preventing suicides, and understanding medications, he said. Dailey said deputy jailers might need eight hours of instruction, rather than the four police will receive, considering how much better-trained police are. State regulations mandate only 16 hours of overall training a year for deputy jailers.

A national expert on jail suicide prevention, Lindsay M. Hayes of the National Center on Institutions and Alternatives in Massachusetts, also recommends that jail officers get at least eight hours of initial training on suicide prevention and mental illness.

State Mental Health Commissioner Margaret Pennington also said she supported Dailey's idea, and she suggested that her office could work with the Department of Corrections, which regulates the jails, to make it happen. Corrections Commissioner Vertner Taylor said his office has made plans to offer mental health training at the Kentucky Jailers Association's annual training conference — but those sessions are not mandatory and would not reach every deputy jailer.

Also, in response to the newspaper's findings, the Corrections Department said that it would insert suicide prevention training into its 16-hour basic training for new deputy jailers, starting this week. The state already offers that topic in its advanced class, for deputies with at least three years of experience.

Enhance Ties To Agencies

Pennington said her department would like to provide a model written contract as a starting point for contract discussions between jails and community mental health agencies. Most jails do not have contracts with their local, state-supported mental health agencies, which often results in poorly defined responsibilities for treating inmates and in inadequate care.

A number of people interviewed said that the two state agencies with responsibility in this area — the mental health and corrections departments — need to work together to help the jails and the mental health agencies reach agreements. Dailey, the advocate for the mentally ill, for example, said he thinks every jail should be served by a designated person from its community's mental-health agency. "I think the comp-care center (the mental health agency) ought to be doing that, and be getting paid to do it," he said. Pennington agreed — but said the prospect of getting additional state money appears remote. Still, she said, "I think community mental health centers are the ideal entity to serve as the contractor because they are the safety net for those individuals when they come out of jails."

Last Monday, officials of the mental health department, the Corrections Department and the jailers association met and began discussing such issues. One idea, Pennington said, was producing a handbook that would tell jailers about mental illness, what mental health services are available, and how to find them. Another suggestion, she said, was seeing whether the state's access to drugs

at a bulk rate — used by both the mental health agencies and state prisons — also could be available to county jails.

Free Hospital Beds

Pennington also said that her department is re-evaluating the policies of three major state psychiatric hospitals that generally prohibit admission of jail inmates if they are charged with felonies. *The Courier-Journal* reported last Sunday that the only place available to such inmates, even in an emergency, is the 93-bed Kentucky Correctional Psychiatric Center at La Grange, which had an average wait of 6.6 days last year for emergency admissions. Pennington said that in re-examining the policies, her department will pay particular attention to inmates charged with non-violent felonies. It also will examine security issues and whether "the policy is sound for all people charged with felonies," she said. Hospitals, she said, "would have real difficulty" taking violent inmates unless they get security help from jails or the Corrections Department.

Improve Screening

One low-cost fix would be easy: Require jails to use a detailed screening form asking new inmates a series of questions to detect possible mental illness. The forms — which many states mandate — also are designed to catch an inmate who may be likely to try suicide. When told by the newspaper last month that some jails ask only one or two questions on mental health — which most experts say is inadequate — state corrections officials said they would provide jails with model screening forms.

On Feb. 22, Deputy Corrections Commissioner Hazel M. Combs sent every jail copies of forms used by the Jefferson County Jail and the Fayette County Detention Center. The forms include up to 16 questions on mental health, such as: Expresses feelings of hopelessness? Has a previous suicide attempt? History of psychiatric treatment? In an accompanying letter, Combs told the jailers that the forms are "for your review." Combs said in an interview last month that her department does not have the authority to require jails to use a specific form. Such a change would require the approval of the Kentucky Jail Standards Commission, a 12-person board that consists of half county officials, half state officials. "We will provide them (the forms) and just let everybody get a look at them," Combs said. "...Whether they adopt it is their choice....We can lead the horse to water."

Report Suicides

Kentucky does not require jails to report suicides to the Department of Corrections, and therefore does not learn lessons from them or track their frequency. For instance, the newspaper found that in one jail, two inmates hanged themselves from the same light fixture. But the state was unaware of that, and so it did not alert other jails about the potential dangers of such fixtures.

Combs, the deputy commissioner, said in a recent interview that the department will ask jails to voluntarily submit data about suicides, which could then be distributed to other jailers. That stops a step short of requiring jails to tell the state about suicides, or having the state independently investigate each case to see if anything went wrong. In her February 22 letter to jails, Combs included a one-page incident report describing a February 12 jail suicide in Calloway County. The letter says, "The goal of this information is to make you aware of the manner in which the act was committed so you can review your current structure, and take any proactive steps necessary to prevent an incident of this nature in your facility."

The 843 Commission

State officials have suggested that the proper forum for discussing these issues is the 843 Commission — a study group created in 2000 by Rep. Marzian's House Bill 843. The group is devoted to improving care of the mentally ill and substance abusers. The commission has looked at issues related to mentally ill inmates. But its early proposals in that regard — building regional jails specializing in mental health care, and starting "mental health courts" that would order treatment, not punishment, for mentally ill offenders — have gone nowhere in the cash-squeezed legislature. This year the commission settled for a downsized legislative package that includes money to open six new adult "crisis-stabilization" centers that might, through treatment, keep some people out of jail.

In the future, corrections and mental health officials could work out "common sense" solutions through the 843 Commission, Marzian said. Pennington, the mental-health commissioner, agreed that the two departments need to spell out their duties toward inmates. "I think that the people of the commonwealth would be better served by clarifying that issue, because clearly there are people in need," she said.

*To obtain a copy of the entire four-part series of "Locked in Suffering: Kentucky's Jails and the Mentally Ill," contact **The Courier-Journal**, P.O. Box 740041, Louisville, KY 40201, (502) 582-4480, or visit their website: http://www.courier-journal.com/cjextra/locked* ❑

News From Around the Country

Offered below are brief stories regarding jail suicide, mentally ill offenders, and other related topics that have recently occurred and/or been reported throughout the country.

Kansas

An inmate who committed suicide last year in the Shawnee County Jail in Topeka was not on suicide precaution status despite a warning from local police that he was potentially suicidal. James Edward Roberts, Jr. was found hanging by a sheet in his cell on December 17, 2001. He had been arrested two days earlier on charges of aggravated kidnapping, aggravated battery, aggravated robbery, rape and aggravated sodomy for allegedly abducting and raping a female acquaintance.

A detective from the Topeka Police Department, who was investigating the crime that led to Mr. Roberts' arrest, learned from the victim's family that Mr. Roberts' had told the woman that he planned to kill her and then himself. The detective then called the Shawnee County Jail and alerted officials to the potential of Mr. Roberts' suicide risk. The inmate was not placed on suicide precautions, nor referred to mental health staff for assessment. As Lieutenant Timothy Phelps, spokesman for the Shawnee County Department of Corrections, told the *Topeka Capital-Journal*: "Mr. Roberts made it very clear to the sergeant (who was interviewing him) that he had no intention of self-injury, that he had alot to live for and that he looked forward to addressing the charges against him." [See related article of "Suicide Risk Despite Denial (or When Actions Speak Louder Than Words)" in the ***Jail Suicide/Mental Health Update***, 10 (1): 1-6.]

Wisconsin

In October 2001, a federal judge ordered the state Department of Corrections to transfer five seriously mentally ill inmates out of the Supermax Correctional Institution in Boscobel and to allow an independent mental health examination of other inmates housed in the facility. United States District Court Judge Barbara Crabb issued the order [164 F. Supp. 2d 1096 (W.D. WI, 2001)] as part of a broader class-action suit (*Jones 'El v. Berge*) brought by inmates alleging their imprisonment at the Supermax prison amounted to cruel and unusual punishment in violation of the Eighth Amendment of the U.S. Constitution.

Judge Crabb's decision in *Jones 'El v. Berge* was extremely significant because it clearly prohibited the housing of "serious mentally ill" inmates in the state's Supermax facility, and could have similar repercussions to the admission of such offenders in other like prisons throughout the country.

Built at a cost of $47.5 million to house the "worst of the worst" offenders, the 500-bed prison has been in operation for almost two years. Approximately 300 inmates are now imprisoned in the facility, each confined one to a cell virtually 24 hours a day.

Ed Garvey, the lead attorney for the inmates, asked the court last summer to order the immediate transfer of seven prisoners that a psychiatrist found to be seriously mentally ill. Since then, two of the prisoners were sent to the Wisconsin Resource Center, the Department of Correction (DOC)'s secure treatment facility for mentally ill inmates. He had sought the transfer before the trial because a psychiatrist he hired to examine the inmates believed there was a chance seven of them could commit suicide before the trial was complete. "Some of them had already attempted suicide, and others were hearing voices commanding them to commit suicide," Mr. Garvey told the Milwaukee *Journal Sentinel* in October 2001.

Vincent Nathan, a lawyer, court monitor, and nationally recognized expert on conditions of confinement, had earlier testified that the Supermax Correctional Institution was "among the most punitive and restrictive (prisons) I have ever seen....I think this borders on barbarism." Mr. Nathan testified that he had visited many other Supermax-style prisons throughout the country but had never seen one that goes so far to punish inmates. "Everything is being done to make life as close to unbearable as it can be in a maximum-security prison," he said. Inmates were allowed only three showers a week, even though showers were in their cells. Once inmates were shackled and taken to exercise rooms, there was little to do but walk around the bare rooms. Prisoners using the law library were kept handcuffed. "There is a hopelessness, an endlessness to the process," Mr. Nathan testified.

In the opinion and order, Judge Crabb determined that "lacking physical and social points of reference to ground them in reality, seriously mentally ill inmates run the risk of breaking down and attempting suicide." Some prisoners spend all but four hours a week in their cells, which are lighted at all times. They have no access to clocks, radios, watches, cassette players, televisions or regular human contact, according to the ruling. "Most inmates have a difficult time handling these conditions of extreme social isolation and sensory deprivation, but for seriously mentally ill inmates the conditions can be devastating," the judge found.

Attorney Garvey also had asked the court to order a mental health assessment of *all* inmates at Supermax, but Judge Crabb said that was unnecessary. Instead, she ruled that non-department mental health professionals were to evaluate those inmates who:

- are prescribed psychotropic medications;
- have been hospitalized in a psychiatric institution at any time;
- have spent longer than 30 days at the prison's most restrictive level;
- have spent more than 90 days at Supermax without progressing beyond the prison's second most restrictive level;
- have been placed on the observation unit on suicide watch.

DOC officials had testified that the Supermax facility was never intended to house inmates who were seriously mentally ill and that the agency had an effective screening and assessment process to identify such inmates and transfer them to the state's Wisconsin Resource Center. The state subsequently agreed to comply with the court order to remove the five identified seriously mentally ill inmates, and began preparation for the up-coming trial in the class-action lawsuit.

In March 2002, however, a settlement agreement was reached in the larger class-action lawsuit. Under terms of the settlement, the Department of Corrections agreed to various changes, including the building of outdoor exercise areas, better ventilation of indoor recreational areas, additional programming, reducing mandatory minimum stays in the most restrictive levels of segregation from 30 to 7 days, additional out-of-cell time per week, and permanently prohibiting seriously mentally ill offenders from admission (and prohibiting inmates who become seriously mentally ill from remaining in the facility). The settlement also calls for the renaming of the Supermax Correctional Institution. As Warden Gerry Berge told the *Associated Press* on January 3: "It's the old

thing, 'What's in a name? As trivial as it might seem to some people, it has had a negative impact on how the prison is perceived."

On April 15, 2002, Judge Crabb resolved one of the last remaining issues in the lawsuit by defining which inmates were "seriously mentally ill" and should not be confined at the Supermax prison. "Seriously mentally ill inmates" were defined as those individuals who have been diagnosed with specific mental disorders or any other serious mental illness that would be worsened by confinement at the facility. She also ordered that all inmates at the facility be reassessed by June 10 to determine their mental statuses according to the new definition. "Persons with serious mental illness should not be subjected to conditions that cause them psychotic breakdowns; not only is such a breakdown a cause of great suffering and trauma for the inmate, but it increases the likelihood that the temporary psychotic state will become a permanent one," Judge Crabb wrote in her ruling.

Florida

A recent state investigation found numerous program deficiencies and staff failures that resulted in the October 2001 suicide of a 13-year-old boy at the Volusia County Regional Juvenile Detention Center in Daytona Beach. According to the report released in March 2002 by the state Department of Juvenile Justice's Bureau of Investigations, detention officers falsified head-count logs and failed to conduct required checks on the youth who was on close observation status at the time of his death.

Shawn Smith had a history of mental health problems and assaultive behavior on staff. According to the report, health care staff at the facility failed to conduct required evaluations, failed to review his mental health history, and failed to refer him to mental health treatment after he repeatedly sought those services. The report also found that both the facility superintendent and assistant superintendent failed to coordinate mental health services that may have helped alert authorities that Shawn was suicidal.

According to a statement released by state Department of Juvenile Justice Secretary William Bankhead, the report will be sent to the agency's assistant secretary for detention services for "appropriate corrective and/or disciplinary actions," as well as to the county prosecutor for review of possible criminal charges that may be brought against detention center staff. Secretary Bankhead said improvements had already begun in several areas that "needed quick attention," including requiring more frequent room checks, random checks "to ensure staff attentiveness," and daily notices to staff regarding medical and mental health alerts. "I extend my deepest sympathy to the family of the youth who took his own life...this past fall," the statement said.

Shawn Smith had been in state custody for approximately two years. While in Three Springs of Daytona Beach, a treatment center for adolescent sex offenders, he twice faced criminal charges for reportedly assaulting staff at the facility. As a result, the youngster was transferred to the Volusia County Regional Juvenile Detention Center in September 2001.

The four-month state investigation found that nine current or former employees or contracted providers failed to follow several procedures prior to the youth's death. For example, the senior officer in charge of the unit the night that Shawn died failed to conduct 10-minute room checks and five-minute "close watch" checks on the youth. The officer, who resigned four days after the suicide, falsely documented that he had performed required checks and "did not provide truthful information" to investigators. Another senior officer on duty that night did not check a client list that would have alerted him that Shawn was on "close watch supervision." As a result, the officer also did not check on the youth every five minutes as required.

In addition, a facility nurse failed to initiate a mental health referral for Shawn after the youngster made numerous sick call visits prior to his suicide. He had complained of frequent stomach and mouth aches, stress, and had not eaten for three days. Further, the contract physician twice refilled the youth's psychotropic medication, but failed to refer Shawn to a psychiatrist for evaluation.

Although Shawn had allegedly attempted suicide at the Three Springs treatment program between September and March 2000, both medical and mental health staff at the detention center never communicated with the treatment program regarding this history. Finally, the facility superintendent "failed to ensure the coordination of medical and mental health services" at the center despite an April 2001 review noting there had not been any meetings between mental health, substance abuse or medical personnel. At the time of Shawn's suicide in October, those meetings were still not taking place.

When contacted by a reporter from the *Daytona Beach News-Journal*, Shawn's mother, Terry Mestre, said the report confirmed her repeated statements that her son was not receiving proper care while in state custody. "I'm glad they admitted it," she said. "I asked them for a year to let Shawn go because they couldn't help him and weren't helping him, and they wouldn't let him go."

South Carolina

Officials acknowledged earlier this year that the December 2001 death of a homeless, mentally ill man exemplified the plight of the unmet needs of individuals with mental illness throughout the state.

Ronel Huggins, who had been found wandering naked in a Sumter hospital's parking lot on Christmas Day, died in jail on December 27, 2001 after being arrested two days earlier for indecent exposure. According to a report by Sumter County Coroner Verna Moore, his cause of death was listed as natural causes, but that the 43-year-old man died because he was a diabetic and had not received his insulin. Mr. Huggins had been admitted for evaluation in the hospital's emergency room the day before Christmas, but was discharged the following day and taken to the Sumter County Jail. He was then placed in the drunk tank.

Mental health advocates say Mr. Huggins represented one of the growing number of people who need mental health treatment from an increasingly fragile system. "You've got people falling through the cracks all over the place and in some cases ending up dead,"

David Almeida of South Carolina's National Alliance for the Mentally Ill, told the *Associated Press*. Sumter County Sheriff Tommy Mims agreed and stated that he was seeing more problems involving mental patients because "they're being delayed in receiving the treatment they need."

Hospital officials would not comment on Mr. Huggins' case but said that, although it no longer has an in-patient facility for psychiatric care, the hospital does not turn away anyone who in need of treatment.

In a similar case, Christopher Belin died on November 29, 2001 after being hit by a car near his Sumter home. A few days earlier, his family had taken him to the Santee-Wateree Mental Health Center in Sumter to be treated for schizophrenia, but the psychiatrist who saw him recommended intensive daytime treatment and scheduled another appointment with him for the next day. Clinic officials say people who show up in serious distress are not turned away. But they say budget constraints have severely hampered their ability to handle those cases.

Olivia Williams, executive director of the Santee-Wateree Mental Health Center, said recent cuts of more than $26 million in the state Mental Health Department have cost the agency 13 percent of its total state dollars and millions more in federal Medicaid funds. Programs at her clinic have been reduced or eliminated to the point where the center offers almost no counseling. "What took decades to build we have pretty well torn down in about eight months," Ms. Williams told the *Associated Press*. "That's across the state, not just at this mental health center."

The spillover is affecting local hospitals. Emergency room doctors throughout the state say that their facilities are being filled with patients who need treatment for mental illness but have nowhere else to go. They are often sent to the local jail.

Hearings in regard to the state Mental Health Department's budget began earlier this year with Governor Jim Hodges seeking a $2.5 million increase for the agency. House Republicans questioned the Democratic governor's plan for funding the increase, but agreed there was not much room to trim the agency further. "I think Mental Health had a particularly difficult time dealing with their budget cuts last year more so than some other agencies," conceded House Budget Committee chairman Bobby Harrell. "And we're going to keep that in mind as we write the budget this year."

Arkansas

In a letter he left on the body of his uncle, William Graley, 17-year-old murder suspect Steven Manuel told authorities he would kill himself if he was apprehended. Steven was subsequently arrested in Amarillo, Texas on January 15, 2002 and transferred to the Lafayette County Jail in Lewisville, Arkansas. On January 23, the youth hanged himself by tying a sheet around the bars of his cell.

According to the letter, Steven had written a biography of his life and said the reason he killed his 83-year-old uncle was because Mr. Graley told him that he (Graley) was Steven's father. Steven said in the letter that he knew it was not true. The last paragraph of the letter said, "This is why I ended the life of William Bill Graley, veteran of World War II on January 13, 2002, eleven days before his 84th birthday. I will end my own life as soon as I am confronted by the authorities, I promise I will pose no threat nor answer any questions." The letter was entitled "justifiable homicide."

Based upon the contents of the letter, Steven was placed on suicide watch at the Lafayette County Jail. The youth was allowed to keep his clothing and bedding in the cell. Sheriff's department personnel appeared unconcerned that Steven had a bed sheet in his cell. "If you didn't give them a sheet, they would find something else. He would have used his pants," Chief Deputy Pete Richardson told the *Texarkana Gazette*. He also stated that the youth no longer appeared suicidal. "He told me on the way back from Amarillo he was going to face the music and do his time," Chief Deputy Richardson said. Although placed on as 30-minute suicide watch, Steven Manuel was never assessed by either medical or mental health professional during his incarceration. The chief deputy also appeared unconcerned that the standard

frequency of his facility's suicide watch was a mere 30-minute observation. Steven was reportedly last seen alive when an officer checked his cell approximately 30 minutes before he was found dead.

According to Dr. Roger Talley, chairman of the 8th South Judicial District Committee for Criminal Detention Facilities, "There were no violations and have been no violations in the Lafayette County Jail of the Arkansas jail standards in the last three years. In regards to the fellow that hung himself, the jail was operated according the Arkansas jail standards. He was being checked on as prescribed by Arkansas jail standards — they were doing what they were supposed to be doing....There was nothing else that they could do."

Dr. Talley conceded, however, that the state jail standards did not even address the issue of suicide prevention. "I've searched the standards and could not find one mention of the word suicide," he told the *Texarkana Gazette*.

"To be real honest, there are times that despite all your precautions and best efforts, despite all of your policy, everybody's training, despite everything — people will still take their own life," said Dina Tyler, spokesperson for the Arkansas Department of Corrections. "You can stop a lot of it, to erase the chance that anybody will take their life ever again? That's ludicrous. You just do your very best with a good staff, good mental health and good policies and hopefully everybody is on their toes and watching."

The "best efforts" in Lafayette County were certainly questionable. Built in 1930 and renovated in 1973, the 21-bed facility was staffed by one officer per shift. Medical and mental health services are not provided, and there was no indication that the facility had adequate policies or staff training in the area of suicide prevention.

One of the few county or state officials who was reluctant to talk about the issue of jail suicide prevention and the death of Steven Manuel was Lafayette County Sheriff Sam Pierson, who told a *Texarkana Gazette* reporter that "I'm tired of talking about it."

Florida

As the personification of Broward County's failures in treating the profoundly mentally ill, John Beraglia was the inspiration for the creation of the county's Mental Health Court, a first across the nation. Almost five years after the model court was born, though, Beraglia succumbed to the illness that made him so familiar a face at the courthouse. Beraglia died, an apparent suicide, Sunday afternoon at the North Broward Detention Center — while under a suicide watch.

"John Beraglia gave birth to the Mental Health Court, and, once again, he will give birth to the hope and the common understanding that mentally ill people should not be in jail," said Chief Assistant Public Defender Howard Finkelstein, one of the court's chief architects. "The jail cannot handle mentally ill people, and when it fails, mentally ill people die," Finkelstein added.

While Beraglia was commonly believed to suffer from bipolar disorder or depression, his brother, 43-year-old Roy Beraglia, said his behavior became a problem only after a severe head injury in a motorcycle accident when he was 16. The Broward Sheriff's Office is looking into the circumstances of Beraglia's death, said spokeswoman Veda Coleman-Wright.

Beraglia, 41, was awaiting a hearing on a charge that he violated probation in a criminal-mischief case. A statement from the Sheriff's Office says Beraglia was placed under suicide watch after he attempted to slit his wrist with a spoon. Later, he suffered a severe head injury by banging his head against a wall. Coleman-Wright said several precautions were taken to protect Beraglia, including the removal of any clothing that could have been used to injure himself, having deputies observe him every 15 minutes, and having both nurses and doctors monitor his condition. "Beraglia started acting disorderly and proceeded to strike his head against the corner of a wall within his cell when medical staff attempted to intervene. The inmate was bleeding from his head and was transported to North Broward Medical Center in critical condition," the statement said. Beraglia was pronounced dead at 4:28 p.m., a short time after his arrival.

Roy Beraglia, who is a canine officer with the Broward Sheriff's Office, disputes the official account. Beraglia said he has been told his brother died following a forcible restraint by seven deputies. "They put him back in a chair and noticed he was limp. It doesn't take seven deputies to restrain a man who is handcuffed. A mental person doesn't deserve this type of treatment," Beraglia said. "I'm outraged."

Broward County Judge Ginger Lerner-Wren, who presides over the Mental Health Court, was saddened at Beraglia's death, but said courthouse staff did everything they could through the years to help him. "I have to say his death is tragic," the judge said. "But this was certainly not a case of mental health community system failure. In this particular case, we did not give up," the judge said. "He gave up."

Beraglia, a bear of a man at 325 pounds, had more than 145 convictions on his criminal record, and was a familiar face at the Mental Health Court. For years, courthouse and law enforcement officials tried to devise a plan for keeping him healthy — and out of jail.

The plans always failed. Beraglia preferred to live on the streets, where he was free to drink excessively, take drugs and live as he pleased, his lawyers said. "He just looked like a big, scary guy who was nothing but trouble," said Douglas Brawley, who supervised the public defenders in Mental Health Court. "But if you took the time to talk to him, he really wasn't." Brawley said he talked with Beraglia often, sometimes every day if his client wanted to chat. "He just wanted to live life the way he wanted to live life," Brawley added. Said Finkelstein: "John was one of those people who best exemplified the right to be crazy and free in America."

*The above article — "Jail Death Raises Troubling Questions" — was written by Carol Marbin Miller, staff reporter for the **Miami Herald**. It appeared in the September 18, 2001 edition of the newspaper and is reprinted with the permission of the **Miami Herald**.*

Following an autopsy and investigation by the Broward Medical Examiner's Office, Dr. Joshua Perper ruled in December 2001 that John Beraglia died of positional asphyxia while being subdued by correctional staff at the North Broward Detention Center. The death was ruled accidental. The findings of the Medical Examiner, who also interviewed inmates at the facility, were contrary to initial reports from the Broward Sheriff's Office stating that Mr. Beraglia died after repeatedly beating his head against the cell wall. Dr. Perper stated that the inmate did not die from a blow to the head. A grand jury investigation of the case is still pending. Mr. Beraglia was the first of three mentally ill inmates to die in the Broward County jail system since September 2001. In February, an inmate housed in the jail infirmary bled to death and his death was ruled a suicide. In May, an inmate housed in the mental health unit and suffering from paranoid schizophrenia reportedly died of heart disease. ❑

RECIDIVISM AMONG MENTALLY ILL OFFENDERS

by
Lynda Frost and Dick Sheppard

Client A, a 57-year-old male diagnosed with Schizophrenia, began interfacing with the criminal justice system at age 14 and has been arrested more than 50 times on charges ranging from misdemeanor theft, trespassing and public intoxication to felony weapon and drug offenses. For 30 years he drifted from place to place, at times being hospitalized at the local and state level in residential care.

Ms. E is a 27-year-old African-American female with a dual diagnosis of Bipolar Disorder and rug Dependence (crack cocaine). She began a cycle of homelessness, prostitution, arrests and incarceration at age 22. At the time of program admission, she was estranged from her family and had not been in contact with her nine-year-old daughter for four years.

DS is a 44-year-old male with diagnoses of Schizophrenia-Paranoid Type, Alcohol-Induced Psychotic Disorder with Delusions, and Learning Disorder-NOS. He was born to alcohol-addicted parents, raised in institutions and released from the in-patient mental health system at age 30. He has been a vagrant for the past 14 years and has been arrested numerous times for public intoxication and vagrancy.

The State of California has made a significant investment in determining the most effective strategies for helping these individuals — and thousands of other mentally ill persons — avoid further involvement in the criminal justice system by improving their ability to function within the community. The catalyst for this investment was the growing recognition that jails have become the treatment facilities of last (or perhaps first) resort for an increasing number of persons with mental illness. In 1984, for example, persons diagnosed with a mental illness comprised less than three percent of California's jail population. Today, it is estimated that between 7 and 15 percent of California's 74,000-plus jail inmates are mentally ill. Some of these offenders must be incarcerated because of the serious nature of their crimes; however, far more get caught in a cycle of re-offending due in large part to the lack of adequate community-based mental health treatment and services.

Against this backdrop, the California State Sheriffs' Association and Mental Health Association co-sponsored legislation in 1998 (Senate Bill 1485) that established the Mentally Ill Offender Crime Reduction Grant (MIOCRG) Program — an initiative that supports the implementation and evaluation of locally developed demonstration projects designed to curb recidivism among persons with mental illness. SB 1485 directed the California Board of Corrections (Board) to administer the MIOCRG Program and to assess its overall effectiveness in reducing crime, jail time and criminal justice costs associated with the mentally ill offender population. Since 1998, the Legislature has provided a total of $104 million to the MIOCRG program, which involves 30 projects in 26 counties. The grants for half of these projects resulted from legislative appropriations in 1998/99 and began in July 1999. For administrative purposes, the Board refers to this first group of grantees as MIOCRG I. Grants for the other 15 projects, referred to as MIOCRG II, resulted from an appropriation in 2000/01 and began in July 2001.

Collaborative Planning Process

In developing the framework for the MIOCRG Program, lawmakers recognized that cooperation and communication between law enforcement, corrections, mental health and other agencies, even when goals and expectations appear to conflict, was key to meeting the challenges posed by offenders with a mental illness. Lawmakers also recognized that one size doesn't fit all in crime prevention efforts. As a result, the MIOCRG Program requires that projects be collaborative and that they address locally identified gaps in jail and community-based services for persons with a serious mental illness. Specifically, to be eligible for a demonstration grant, SB 1485 required that counties form a Strategy Committee comprised, at a minimum, of the sheriff or department of corrections director; chief probation officer; county mental health director; a superior court judge; representatives of local law enforcement agencies and mental health provider organizations; and a client from a mental health treatment facility. By statute, the Strategy Committee was responsible for developing a Local Plan that describes the county's existing responses to mentally ill offenders, its identified service gaps, and its proposed strategies for addressing the mental health treatment and other needs of mentally ill offenders released from custody.

To support this undertaking, the Legislature earmarked a portion of the program's initial $27 million appropriation for local planning grants. In December 1998, in consultation with the Department of Mental Health and Department of Drug and Alcohol Programs, the Board awarded noncompetitive planning grants totaling over $1.2 million to all applicants (45 of California's 58 counties). Regardless of whether counties ultimately received a demonstration grant, they indicated that

they benefited immensely from this local planning process — not only in terms of identifying strategies for helping mentally ill offenders successfully reintegrate into the community but also in terms of establishing ongoing collaboration among the myriad of agencies that interface with these individuals.

Competitive Demonstration Grants

The Board's primary objective in awarding MIOCRG demonstration grants was to ensure that the Request for Proposal (RFP) process was both equitable and valid. Toward this end, the Board established an Executive Steering Committee (ESC) comprised of state and local corrections and mental health officials to provide recommendations on the content, format and requirements of the RFP; the proposal evaluation criteria and the weight associated with each rating category; and the proposal screening procedures (e.g., submission and review of written proposals, oral presentations, and final selection process). In awarding demonstration grants, SB 1485 required the Board to consider, at a minimum, the following criteria:

- percentage of the jail population with severe mental illness;
- demonstrated ability to administer the program, and to provide treatment and stability for persons with severe mental illness;
- demonstrated history of maximizing federal, state, local and private funding sources; and
- likelihood that the program will continue after state funding ends.

The ESC determined that the following criteria should also be used in evaluating the proposals: need for the program; probability of success; evaluation design; proposal quality; and oral presentation. The ESC also determined the scoring priority that would be given, pursuant to SB 1485, to proposals that included a local match exceeding the statutorily required 25 percent of the grant amount.

The Board approved the ESC's recommendations and, in March 1999, received 40 project proposals requesting a total of nearly $114 million. In May 1999, following an extensive review and priority ranking of these proposals by the ESC, the Board awarded available funds (approximately $22.9 million) to the following seven counties: Humboldt, Kern, Orange, Sacramento, San Bernardino, Santa Barbara, and Santa Cruz.

The 1999/00 State Budget allocated an additional $27 million to the MIOCRG and specified that most of this appropriation would support demonstration projects based upon the prioritized list already established by the Board. The Budget also capped grants at $5 million and specified that Los Angeles and San Francisco Counties would each receive $5 million for projects that target mentally ill offenders likely to be committed to state prison ("High Risk Models"). In addition to Los Angeles and San Francisco, the 1999/00 allocation and previously unexpended funds supported demonstration grants totaling over $27.7 million in the following six counties: Placer, Riverside, San Diego, San Mateo, Sonoma and Stanislaus. The Board repeated this entire process following passage of the 2000/01 State Budget, which contained an additional $50 million for the MIOCRG Program, and in May 2001, the following 15 counties received demonstration grants: Alameda, Butte, Kern, Los Angeles, Marin, Mendocino, Monterey, San Bernardino, San Francisco, San Joaquin, Santa Clara, Solano, Tuolumne, Ventura and Yolo.

Interventions and Challenges

The counties participating in the MIOCRG Program are providing a broad array of enhanced services to seriously mentally ill offenders — services that address the specific needs of these individuals as identified during the local planning process. The jail-based interventions that have been implemented include early identification and screening procedures; enhanced mental health assessments; case management and brokerage services; dedicated housing; pet therapy; and pre-release planning. Enhanced services in the community include intensive case management and probation supervision; assistance in securing short and/or long-term housing, vocational training, employment, and financial entitlements; individual and group counseling; life skills training; substance abuse testing; medication education and management; transportation services; crisis intervention; residential treatment; and day treatment or drop-in centers. Several counties also created a mental health court or dedicated court calendar as a part of their demonstration project.

On the whole, one of the biggest challenges MIOCRG I counties have had to grapple with is the slower than anticipated rate of client enrollment into projects (whether this also proves true for MIOCRG II counties remains to be seen). Counties are identifying potential program participants and conducting comprehensive assessments to determine if they meet the eligibility criteria established by the county. This screening process has involved hundreds — in a few counties, thousands — of offenders. In the end, the vast majority is found ineligible. One reason is that many offenders, once they are no longer under the influence of drugs and/or alcohol, do not have a serious mental illness as their primary diagnosis, thus excluding them from the program. In addition, many offenders are found ineligible because they committed offenses the county opted to exclude for pubic safety reasons or because they do not have the criminal justice history required for participation (e.g., a specific number of previous arrests). Of the nearly 2,800 inmates screened in one county, for example, less than six percent met the criminal justice criteria. The voluntary nature of these projects — i.e., any offender can refuse to participate — has also contributed to the fact that counties are serving fewer clients than expected at this point.

Not surprisingly, counties are also facing challenges in day-to-day program operations. Among these is the lack of temporary, transitional and/or long-term housing for clients. In response, counties are working to establish or expand ties with homeless shelters, motels, board and care facilities, and

rental units. Identifying effective treatment strategies for persons with a dual diagnosis (serious mental illness coupled with substance abuse), who comprise a large percentage of clients in many counties, has also been challenging.

Within a week of Client A's enrollment in the project, he was back in custody for public intoxication. Upon his release, medication compliance became a primary focus for the treatment team and staff began visiting him twice daily.

Upon release from jail, Ms. E was met by her case manager and admitted to the project's short term residential housing program as well as a 60-day highly structured drug and alcohol day treatment program.

The treatment plan for DS includes placement at a board and care facility, participation in an alcohol/drug outpatient program five days a week, random drug testing, and psychiatric treatment.

Program Evaluation

The primary objective of the MIOCRG Program is to determine "what works" in reducing crime, jail crowding and criminal justice system costs associated with the mentally ill offender population. Toward this end, SB 1485 requires the Board to evaluate the overall effectiveness of demonstration projects in relation to these outcome measures. In addition to the statewide evaluation, counties must assess the efficacy of their respective projects in meeting specified outcomes.

For the statewide evaluation, Board staff developed a research design, with considerable input and cooperation from funded counties, that requires grantees to collect and report common data elements concerning the target population (intake data), the services counties are providing to these individuals (intervention data), and the effects of the treatment interventions on curbing recidivism among offenders diagnosed with a serious mental illness (outcome data). Counties submit these common data elements every six months. Board staff then combines the data to create a considerably larger sample size, which increases the statistical power of the research and the extent to which positive results can be generalized.

Based on intake data reported on the first 1,900 clients participating in MIOCRG I projects, Board staff constructed the following general profile of the offenders at the time they entered the MIOCRG Program:

- the average age of participants is 38 years;
- males comprise approximately 62 percent of the participants;
- most of the participants (about 55 percent) have never been married;
- one-third of participants were unemployed at the time they entered the project;
- approximately 20 percent of participants were homeless and half lived in a home or apartment without support of any kind at the time of the qualifying arrest;
- the most frequently occurring diagnoses are depressive and bipolar disorders, followed by schizophrenia and other psychoses; and
- approximately three-fourths of participants have a substance abuse problem in conjunction with a primary diagnosis of a serious mental illness.

Since the primary goal of this program is to determine effective strategies for reducing recidivism among this population, criminal history is an important aspect of this profile. Data reported by counties indicate that during the three years preceding program entry:

- the mean number of bookings for participants is 4.3, the median is 3, and in five cases, the number of bookings was between 32 and 67;
- the mean number of convictions is approximately 2, and about one-fifth of participants had four or more convictions during the three years prior to entry into the program;
- the three most prevalent types of convictions were for drug offenses (25 percent); misdemeanors other than property or drug offenses, many of which are characterized by law enforcement as nuisance crimes (24 percent); and property offenses (20 percent); and
- the median number of days participants were in jail during the 36 months prior to program entry was 54, and five individuals spent more than 720 days in jail during this three-year period.

Although it will be a few years before an evaluation of all the data collected and reported by counties during the grant period can be undertaken, early trends are promising. In terms of new bookings into jail, for example, preliminary outcome data indicate that 52 percent of the clients receiving "treatment as usual" had new bookings following program entry compared to 39 percent of the clients receiving the enhanced treatment and services offered by these demonstration projects. Clients receiving enhanced services have also spent an average of nine fewer days in jail than their "treatment as usual" counterparts.

In addition to collecting and reporting common data elements for the Board's statewide evaluation of this program, counties are using locally developed research designs to test specific hypotheses related to their projects. These evaluations, which provide counties an opportunity to focus on unique aspects of their project, must include sufficient information about the participants, research design, nature and extent of treatment interventions, and data analysis procedures to permit replication of the program by others. The counties must also

conduct a process evaluation focusing on how the program operated (vs. the quantitative results it produced), and most counties will be conducting some type of cost/benefit analysis as part of their local evaluation.

The professionals collaborating on these demonstration projects — in many cases, to an unprecedented extent — include deputy sheriffs and correctional officers, deputy probation officers, judges, prosecutors, public defenders, psychiatrists, nurses, licensed clinical social workers, and substance abuse specialists. All of these individuals recognize that the vast majority of mentally ill offenders come in contact with the criminal justice system as a result of insufficient treatment, the nature of their illnesses, and the lack of social supports and other resources — and, regardless of their different roles and perspectives, the professionals associated with these demonstration projects are committed to making a positive difference in the lives of the clients they are serving.

Client A's progress during his first four months of intensive case management includes being fully compliant with his medications, regularly attending substance abuse counseling sessions, and avoiding contact with law enforcement. He has not used drugs or alcohol and is considering taking on a part-time job or returning to school.

Ms. E graduated from the day treatment program and, with the exception of a one-day relapse on her birthday, she has been clean and sober since her program involvement. She no longer prostitutes, sees her psychiatrist regularly, has learned money management skills and does volunteer work as a clerical assistant. She hopes to reunify with her daughter.

DS continues to reside at the board and care facility, actively participating in chores and activities offered there. He has maintained sobriety, is compliant with his medications, and has not been taken back into custody or required hospitalization. He has developed a strong support system and even has a "best friend" for the first time in his life.

About the Authors

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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, 8, 9 and 10)

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

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or

NIC Information Center
1860 Industrial Circle, Suite A
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(800) 877-1461 • (303) 682-0558 (fax)
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