JAIL SUICIDE/MENTAL HEALTH UPDATE

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USE OF 'NO-HARM' CONTRACTS AND OTHER CONTROVERSIAL ISSUES IN SUICIDE PREVENTION

In the quest to prevent suicides, various interventions sometimes spark controversy — either because of their unconventional nature, quick-fix philosophy, or concern for liability. We addressed controversial suicide prevention issues in the ***Update*** *several years ago. In revisiting the topic again, we provide a sampling of several controversial approaches found in the area of suicide prevention in correctional facilities.*

'No-Harm' Contracts

Stephen Achen was arrested by officers from the Davis (California) Police Department during the late evening of July 26, 2000 and charged with false imprisonment and corporal injury to his girlfriend (Laura Hamilton). During the arrest, police officers noticed "scabbed over cuts to his left wrist" and were informed by Ms. Hamilton that Mr. Achen "had tried to harm himself a few days ago." Mr. Achen was transported to the Davis Police Department and later to the Yolo County Jail. Upon arrival at the county jail, the intake nurse completed a medical screening form in which Mr. Achen's chief complaints were gastro-intestinal bleeding, depression, and suicidal ideation. Mr. Achen stated to the nurse that he had attempted suicide approximately two weeks ago by cutting his wrists, but was not currently suicidal. He also stated he was under the care of a psychiatrist and had been prescribed psychotropic medication. Although he denied current ideation, the nurse determined that Mr. Achen was at risk for suicide and placed him under suicide precautions.

On the afternoon of the following day (July 27), Mr. Achen was assessed by a psychiatric nurse at the facility. According to the assessment, the inmate "reports he is feeling sad, not depressed, has no suicidal ideation, intent or plan….Suicide risk low, inmate gave verbal no-harm contract." The nurse's plan was to discontinue the suicide watch and reassess Mr. Achen in one week. The inmate was also seen by the physician assistant who wrote in the progress notes that "patient gave verbal agreement for no self-harm, verify meds, psych. ref." Although Mr. Achen's medication was eventually verified, he was never referred to the jail psychiatrist for assessment.

On July 28, Mr. Achen called Laura Hamilton and threatened to commit suicide if she did not drop the criminal charges. Ms. Hamilton subsequently called the police department and informed them of the suicide threat. Two days later, Mr. Achen approached a jail sergeant and told her that he would become suicidal if he did not receive his psychotropic medication. According to the sergeant's report:

> "I saw that Achen was concerned but in the hour that I was in the housing unit he seemed to get more concerned. He started to perspire and had a nervous demeanor. It is difficult to explain but I knew he needed attention by the psych. nurse. An officer contacted medical staff to evaluate Achen. I also spoke to the psych. nurse personally and asked her to speak with Achen. She indicated that she had a long list of inmates to see and I again urged her to add Achen to the list as he was exhibiting signs of mental upset at this time. She agreed to see him briefly and advised me that she had gotten Achen to agree to a "verbal contract" not to harm himself. Not being impressed with the concept of "verbal contracts" of this nature, I emphasized the need for her to see him that day."

As a result of the sergeant's concerns, Mr. Achen was seen briefly by the psychiatric nurse on July 30, but not placed on suicide precautions. According to her progress note of the interaction with Mr. Achen:

> "He was anxious and feeling suicidal earlier today. When reminded of the verbal no-harm contract given to writer on 7-27-00, inmate was able to renew his verbal; resolve to not harm himself. Anxiety is high — constant fidgeting during interview and moderate gross tremor of outstretched hands. Report feeling anxious inside — like

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> something terrible is happening. No indication on chart if pharmacy was phoned to verify meds….Says he is playing handball when able, reading, writing and talking to COs, peers and nurses whenever possible to deal with his anxiety and suicidal ideation. Again assures writer he has no intention of harming himself while in YCJ….high anxiety and labile moods…verify meds in AM…reassess in one week."

The psychiatric nurse was unable to assess Mr. Achen one week later because he committed suicide in the Yolo County Jail on August 5, 2000. A lawsuit is pending.

Various mental health agencies develop contracts with potentially suicidal inmates, seeking assurances that their clients will not engage in self-injurious behavior between therapy sessions. Correctional agencies will, in turn, request that each in-coming inmate sign a boiler plate letter as an apparent shield against liability. An example of one such contract:

> "I promise not to harm myself while incarcerated at the Smith County Jail. If I should have any tendency to harm myself, I will immediately alert the staff."

In truth, however, most legal experts opine that a no-suicide contract is simply a self-serving sheet of paper that does *not* provide a correctional agency or mental health therapist with legal protection.

While there are many positive *therapeutic* aspects to no-suicide contracts, most clinicians agree that once an inmate becomes acutely suicidal, their written or verbal assurances are no longer sufficient to counter suicidal impulses. As offered by two observers: "We do not think that one can reason reliably with persons in severe suicidal crisis, any more than one can reason with a person who believes God is sending them personal messages via advertising billboards, or with someone who is convinced (medical evidence to the contrary) that a tumor is going to result in death...there is no harm associated with 'suicide contracts' so long as the therapist does not succumb to the illusion that the contract is likely to prevent a suicide" (Clark & Kerkhof, 1993, p. 9). And perhaps more importantly, the intent of the contract should not only be to commit the inmate to no-harm, but also the facility and therapist to appropriate intervention (Daigle, 1997).

When an Inmate Denies and/or Does Not Threaten Suicide, Can They Still Be Suicidal?

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

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

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

Not unlike his brethren around the country, Sheriff Baker seems to take the simple, direct approach to suicide prevention — if an inmate does not threaten suicide or denies being suicidal, then they must not be suicidal, now or at any time while they're in my facility! Because Joseph Rehrig never actually threatened suicide, he was never considered a risk for self-injury. Yet he was clearly a potential risk for suicide. Arrested for sexually assaulting a young boy and facing the possibility of spending the remainder of his life in prison, he appeared embarrassed and despondent during police questioning. At a minimum, Joseph Rehrig should have been referred to mental health staff for assessment. There are other examples of such tunnel logic.

James Edward Roberts, Jr. was found hanging by a sheet in his Shawnee County (Kansas) Jail 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 a 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."

Similar to the issue of 'no-harm' contracts, the cases of Joseph Rehrig, James Roberts, and the other cases throughout the country (see ***Jail Suicide/Mental Health Update***, Fall 2000, 10 (1): 1-6) highlight a disturbing trend of both correctional and health care (medical and mental health) staff to often ignore either subtle or even obvious signs of potentially suicidal behavior simply because the inmate did not verbalize a threat or offered an unconvincing denial during the booking process or during later stages of confinement. It certainly is not unusual to hear a sheriff tell a local newspaper reporter following an inmate suicide — "We

screened him at booking, and by his denial, he gave us no indication that he was suicidal."

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

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

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

Stripping a Potentially Suicidal Inmate Naked

In April 2001, the City of Kalamazoo, Michigan reached a modest settlement with three men who claimed they were stripped naked as a suicide prevention measure shortly after entry into the city jail. During the intake process, each was asked whether he was suicidal; each refused to answer the question. Based upon the non-response, each man was ordered to remove their clothes and placed in a cell naked without any protective covering whatsoever. The plaintiffs alleged that they were kept in these conditions from 6 to 18 hours. The settlement was spurred by a federal judge's ruling several months earlier that the city's practices were unconstitutional:

> "…it would not have been violative of due process to detain plaintiffs clad only in their underwear, as a suicide prevention measure, for short periods of time. However, to strip plaintiffs naked and provide them no means of covering their bodies, forcing them to expose private body parts to viewing by female officers and to video surveillance for several hours, where the city's legitimate interest in suicide prevention could ostensibly have been just as well served by less degrading and humiliating means…is a practice which, on its face, is actionable as an unnecessary and unwarranted infliction of suffering" (*Wilson v. City of Kalamazoo,* 127 F. Supp. 2d 855 (W.D. Mich. 2000).

Some jails, regardless of an inmate's suicidal lethality, automatically strip a potentially suicidal inmate of all their clothes and house them in an isolation cell. Of course, this practice is very degrading and can worsen feelings of depression. Although paper gowns, "suicide smocks," and/or "safety" blankets are often provided to inmates stripped of their clothing, these measures are still insufficient without proper staff observation. More appropriate measures should include constant observation, placement in a "suicide-resistant" cell, and prompt and continuing intervention by mental health staff. As one observer noted many years ago: "Less attention should be paid to physically restricting him from suicide by removal of all potential suicide implements and more attention should be paid to providing essential human interaction with staff or other inmates, to hopefully provide alternative solutions and services" (Denoon, 1983, p. xxiv).

Use of Closed Circuit Television Monitoring as an Alternative to Staff Observation

Francis Finnegan was arrested by officers from the Pawtucket (Rhode Island) Police Department on August 8, 1998, charged with breaking and entering, and transported to the city jail. He was intoxicated and became combative with officers during the booking process, resulting in the use pepper spray on the inmate. Mr. Finnegan was then placed in a cell sometime after 10:40pm. A closed circuit television monitor (CCTV), located in the desk sergeant's office, rotated through images of nine cells in the cellblock. The monitor was situated approximately 30 feet from the desk. Officers were not required to conduct physical checks of the cellblock area, located in the basement of the police department. Rather, the desk sergeant, who was primarily responsible for reviewing reports, answering the telephone, and greeting the public, was expected to periodically glance up at the monitor.

According to a CCTV videotape that recorded movements in his cell, Mr. Finnegan could be observed standing in the front of the cell door at 5:13am, placing his socks around his neck and tying them to the door, and then attempting to sit down on the floor. The ligature apparently became loose. He then stood up, walked over to his bunk, and sat down. At 5:18am, he could be observed again returning to the front of the cell door, tying the socks around his neck and to the bars, and lowering himself to the floor. In addition to Mr. Finnegan's suicide attempts being recorded yet unobserved by police department staff, his actions were not heard because the audio monitoring system had been unplugged, apparently a common practice used by officers to reduce noise emanating from the cellblock area.

At approximately 5:30am, an officer observed a "smudge" in the upper corner of the CCTV monitor in Mr. Finnegan's cell. He subsequently walked downstairs to the cellblock area to investigate. Mr. Finnegan was found to be hanging from the cell bars by his socks. He was subsequently cut down, transported to the local hospital, and pronounced dead. An internal affairs investigation into Mr. Finnegan's death concluded that "no one is asked to watch the cellblock for an entire eight hours of a shift. There simply are too many other interruptions in the front office for this to occur." A lawsuit against the City of Pawtucket is pending.

Utilized predominantly in small jail facilities and police department lockups that lack adequate staffing, CCTV is a popular yet deadly form of inmate supervision. As graphically shown above, CCTV does not *prevent* an inmate suicide, it simply *records* a suicide attempt in progress. Other, less visual deaths have occurred while officers were viewing, but not really observing what was on camera. Various officers report suffering from "monitor hypnosis" or burnout, although some facilities limit the number of hours that any one officer can view a monitor and rotate staff during a single shift. Other serious problems include CCTV reception that is often fuzzy or distorted (e.g., a sock appearing like a "smudge"), equipment breakdowns, and officers being distracted from monitor viewing by other responsibilities. In addition, the mere presence of CCTV camera may encourage suicidal or other acting-out behavior, particularly from manipulative inmates. As aptly stated by one officer following a recent jail suicide: "You can't pickup everything on the monitors. It is not like just sitting there watching them from outside the cell."

If utilized, CCTV should be used *only* as a supplement, not as a substitute, for staff observation; and an officer should not be assigned to view a monitor for more than one hour without being relieved by another staff member.

'Don't Talk To Suicidal Inmates'

Various correctional facilities still maintain a long-outmoded policy which discourages officer interaction with inmates, particularly suicidal individuals. Staff are told, in effect, to "just do your job, nothing more." Many still cling to the belief that simply asking an inmate about their suicidal thoughts will cause them to attempt suicide. While such a policy may not meet very much staff resistance, it is primarily a negative philosophy which hinders the staff's ability to search for signs and symptoms of suicidal behavior. Good communication between officers and inmates is considered a critical element to suicide prevention. Agencies which discourage such communication can expect a high rate of suicide within their jails.

Dealing With Inmates We Label as 'Manipulative'

Few issues challenge jail officials and staff more than management of inmates we deem manipulative. It is not unusual for inmates to call attention to themselves by threatening suicide or even feigning an attempt in order to avoid a court appearance or bolster an insanity defense; gain cell relocation, transfer to the local hospital or simply receive preferential staff treatment; or seek compassion from a previously unsympathetic spouse or other family member. As discussed above, manipulative behavior and suicide attempts can also be provoked by the presence of CCTV — wherein the inmate believes he/she has an attentive audience from which to persuade.

Although the prevailing theory is that any inmate who would go to the extreme of threatening suicide or even engaging in self-injurious behavior is suffering from at least an emotional imbalance that requires special attention; too often correctional officials (with the support of mental health staff) conclude that the inmate is not dangerous and simply attempting to manipulative his or her environment. They often suggest that such behavior be ignored, punished, and/or not reinforced through intervention. In fact, it is not unusual for mental health professionals to resort to labeling, with inmates engaging in "deliberate self-harm" termed "manipulative" or "attention seeking;" and "truly suicidal" inmates seen as "serious" and "crying for help" (Franklin, 1988). Recent research has warned that correctional staff and mental health clinicians should *not* assume the inmates who appear manipulative are not also suicidal, i.e., they are not necessarily members of mutually exclusive groups (Dear, Thomson, & Hills, 2000).

Clinicians routinely differentiate behavior they regard as genuine suicide attempts from other self-injurious behavior labeled as self-mutilation, suicidal gestures, parasuicide, manipulation or malingering (Haycock, 1989). Such labeling, however, may reflect more upon the clinician's reaction to self-injurious behavior or the inmate rather than the inmate's risk of suicide (Thienhaus & Piasecki, 1997). It has also been suggested that all (correctional, medical and mental health) staff should relinquish the tendency

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ON THE INTERNET

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www.ncianet.org/cjjsl.cfm

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

www.hhpub.com/journals/crisis/1997
www.nicic.org/jails/defrault.aspx
www.ojp.usdoj.gov/managingoffenders/mentalhealth.htm
www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
www.performancebasedstandards.org
www.gainsctr.com

to view self-injurious by inmates according to expressed or presumed intent:

> "There are no reliable bases upon which we can differentiate 'manipulative' suicide attempts posing no threat to the inmate's life from those 'true, non-manipulative' attempts which may end in death. The term 'manipulative' is simply useless in understanding, and destructive in attempting to manage, the suicidal behavior of inmates (or of anybody else)" (Haycock, 1992).

Other clinicians would disagree and argue that self-injurious behavior displayed by "truly suicidal" and "manipulative" inmates should result in different interventions. For suicidal inmates, intervention that promotes close supervision, social support, and access to, or development of, psychosocial resources is crucial. For manipulative inmates, intervention that combines close supervision with behavior management is crucial in preventing or modifying such behavior (Bonner, 1992).

Historically, the problem has been that manipulative behavior was ignored or resulted in punitive sanctions, including isolation. Yet inmates deemed manipulative and faced with punitive sanctions often escalate their behavior and die, either by accident or miscalculation of staff's responsiveness. These punitive sanctions have also become part of a correctional facility's suicide prevention policy. It is certainly not uncommon for a policy to now include a protocol that requires a potentially suicidal inmate to be housed in a special housing unit in which their movement is extremely limited with little, if any, excess to recreation and other basis amenities (visiting, telephone calls, showers, etc.) Their restricted movement is exacerbated when they are stripped of their clothing and issued "suicide smocks."

Such punitive measures might deter some manipulative behavior, but what becomes of those who are potentially suicidal and despondent during their confinement yet reluctant to seek out mental health services because they assume lockdown, a suicide smock, and loss of basic amenities will result? They potentially remain unnoticed until their suicide attempt.

Although there are no perfect solutions to the management of manipulative inmates who threaten suicide or engage in self-injurious behavior, *the critical issue is not how we label the behavior, but how we react to it*. Several guidelines are often recommended: 1) utilize preventive steps (e.g., increased supervision) to discourage manipulative behavior; 2) avoid punitive measures as a response to manipulative behavior — it could escalate the behavior, result in more serious gestures, and potential deter suicidal inmates from seeking out services; 3) efforts to determine whether an inmate is manipulative or actually suicidal is *not* the officer's responsibility, the behavior should simply be observed and documented; and 4) refer the inmate to mental health/medical personnel for assessment and *individual* management.

Playing Catch-up With the Jail Logs

In far too many instances than correctional officials would like to admit, and despite housing logs indicating otherwise, inmates throughout the country are left unobserved for time periods beyond those required by policy. In almost all cases, the issue is seemingly unimportant because an officer's shift tends to be uneventful. In other words, no harm, no foul. The issue, however, gains notoriety when a serious incident occurs, such as an inmate suicide. During any preliminary investigation, the concern is not necessarily limited to whether the inmate had been placed under suicide watch and still successfully committed suicide, but rather is expanded to include an equally important question of how long was the victim lingering before correctional staff arrived at the cell. And one of the principle focuses of any subsequent litigation would be the integrity of the housing log and whether it accurately reflected an officer's observation of the inmate and cell block area immediately prior to the incident. Compounding the problem, and perhaps in anticipation of subsequent investigation and litigation, is the tendency of some staff to retrace their steps after the incident and falsely document that the cell checks were made as required. If discovered, the repercussions of playing catch-up with the log can be a dangerous game.

On September 2, 1997, 16-year-old Justin Smith was found hanging from a loose sprinkler head in his cell at a boot camp facility administered by the Harris County (Texas) Juvenile Probation Department. The youth had been confined in the program since May 1997 for stealing a bicycle and curfew violations. Justin suffered from severe depression, had been prescribed psychotropic medication, and had threatened suicide as well as engaged in self-harm several times during his four-month stay at the boot camp. Although not on suicide precautions at the time of his death, Justin was required to be observed at 15-minute intervals.

When the youth was found dead at 7:45pm, room logs initially indicated that officers had completed the 15-minute visual checks as required. A subsequent investigation, however, revealed that the youth was not observed as initially reported. In fact, two officers had initially completed a room log to indicate that Justin was observed at 15-minute intervals until 12:00am — *a period of more than four hours after his death*. The officers admitted to creating falsified documents and stated it was routine practice to fill out the log sheets beforehand in order to speed up their paperwork at the end of the shift. Both officers were criminally charged with falsification of documents and tampering with evidence. The family of Justin Smith subsequently filed a lawsuit against the county and the two officers. A federal court judge would later rule that the "Plaintiffs specifically allege that the practice of pre-recording and then avoiding visual checks was so pervasive as to constitute a custom or policy, and that such a practice was the result of inadequate training. While municipal liability based on inadequate training is difficult to establish, Plaintiffs have alleged facts that support such a theory" *Smith v. Blue*, 67 F. Supp. 2d 686 (S.D. Tex. 1999).

Stephen Carson was arrested on a charge of domestic violence and transported to the Tazewell County (Illinois) Jail on January 22, 1998. He was intoxicated and allegedly despondent over the pending loss of his three young children in a custody battle with his estranged wife. Mr. Carson was combative and uncooperative during the booking process, and was subsequently charged with assault following an altercation with a jail deputy. He was then

placed in a segregation cell. Pursuant to jail policy, a housing log reflected 30-minute checks of Mr. Carson's cell throughout the day and night. At 6:55am the following morning, a deputy went to Mr. Carson's cell in order to give him an insulin shot for diabetes. Upon arrival, the deputy found the inmate hanging by a strip of blanket tied to a ventilator cover on the wall. *A state pathologist later determined that Stephen Carson had been dead for 9 to 14 hours.*

A subsequent grand jury investigation concluded that the jailers, including two sergeants, were watching television and a Steven Seagal movie ("Fire Down Below") during the night of the suicide and later falsified the facility's housing logs to indicate the checks had been made. In addition, and unbeknownst to the jailers, their subsequent telephone conversations amongst themselves and with a union representative immediately following discovery of Mr. Carson's body were tape recorded by the county's communications ("911") center. The telephone conversations, a transcript of which was obtained by the Pekin *Daily Times*, reflect panic and confusion. "We've got a massive problem up here....we've got a dead man in two-six," one jailer told his sergeant. Following discovery of the body, the initial telephone call was not made to the paramedics, sheriff, or county coroner, but rather to the union representative. "Get ahold of .... right now," said another jailer. "Do not answer any questions....until we talk to ...." During the telephone conversation with the union representative, a jailer stated, "We just found him a few minutes ago. There were no time checks done back there in his cell, in the hole...we heard him bangin' until about 4:30 and that was it...so we didn't think nothin' of it." When the union representative asked, "(Expletive), there were no time checks done?" the jailer responded, "There's logs, but the camera shows that we didn't go back there."

In another conversation, two jailers exchange the following words: "I'm done because I was supposed to work down here. I'm done, I know they're gonna (expletive) fire me." The other jailer responded, "They can't fire you over it....They can write you up for a (expletive) dead person?" During another exchange, an unidentified caller asks, "Oh God, what are you gonna do...why weren't you guys checkin' on him?" The response: "He was bangin' most of the night...we watched a movie." When asked if they at least took turns making periodic checks, the jailer stated, "No, in the hole we usually never check on...he as bangin' in the hole and we thought he was sleepin'... I gotta get off the phone because they're wantin' to protect everything..."

Six Tazewell County jailers were later indicted on 30 felony counts of official misconduct stemming from Stephen Carson's suicide. The union representative was indicted on two counts of perjury for allegedly lying to the grand jury about whether he ever spoke with the jailers regarding their cell checks on the morning of Mr. Carson's suicide. Most of the jailers later pleaded guilty to official misconduct, received probation, and resigned their positions at the Tazewell County Jail. In August 2000, the county settled a lawsuit that had been filed by Mr. Carson's family.

Scotty Sisk entered the Shawnee County (Kansas) Jail on July 2, 1999. Four days later on July 6, jail staff received a telephone call from the inmate's family informing them that Mr. Sisk had threatened suicide. As a result, he was placed on suicide precautions (at 8:50pm) which required observation by jail staff at 15-minute intervals. At 11:30pm, Mr. Sisk was found hanging by two jail officers. A subsequent investigation revealed that the log sheets that documented the officers' observations were highly suspicious. For example, an officer originally wrote "11:30pm" in the box reserved for the 11:15pm cell check, and then crossed it out and wrote "11:15." In addition, in the row designated for the 11:30pm check, the officer wrote "okay" in the health status column despite the fact that Mr. Sisk was not "okay" when he was found at that time to be hanging from a wall plate by shredded blanket. Although denying that he missed any of the required 15-minute cell checks on Mr. Sisk, the officer later testified at trial (in a lawsuit brought by the Sisk family) that it was "possible" he went back to the officer's station *after* the suicide and filled in the 11:15pm and 11:30pm time checks. A nurse testified at trial that she did not observe any officers in the cellblock area from 10:10pm until 11:30pm, and that the last cell check documented on the log was at 10:10pm. In April 2003, a federal jury found that the officers and their supervisors were negligent in the suicide of Scotty Sisk.

Policy of 'Never Entering a Cell Without Backup'

The policy of many correctional facilities is that an officer is never to enter a cell without backup support. From the standpoint of officer safety, few could argue with the soundness of this policy, although other jail administrators support a more flexible policy which allows officers to use their judgment in asking themselves — "Is the inmate faking and planning an escape?" If the alleged victim is hanging with his/her feet off the floor, there is little doubt that the scene is genuine. If, however, the inmate is sitting or kneeling on the bottom bunk, it could be a different situation and the inmate could be feigning an attempt. Staff should always be instructed, however, not to be misled into believing that hanging attempts only occur when the body and/or feet are off the cell floor. Numerous successful suicides occur in the sitting and/or kneeling position.

What happens in a police department lockup where only *one* dispatcher/jailer is on duty? Does the individual wait 5 to 10 minutes for backup support, e.g., a patrol officer to arrive from the streets? Or even in a larger jail facility where only one correctional officer is assigned to a housing unit and backup support (including medical personnel) is several minutes away. Does the officer wait or enter the cell?

If a correctional officer (including police personnel) is allowed discretion and chooses to enter the cell without backup support, they must first make the proper notification for backup support, medical staff, and emergency medical services (EMS) personnel (if needed) *before* entering the cell. Upon entry, the officer should begin life-saving measures (e.g., loosing or removing the ligature, checking vital signs, and initiating first aid and cardiopulmonary resuscitation (CPR) as appropriate, etc.) until assisted by backup personnel. If prohibited from entered the cell without backup support, the officer must, at a minimum, make the proper notification for backup support, medical staff, and EMS personnel (if needed); secure the area outside the cell; and retrieve the emergency response bag (that should include a first aid kit, pocket

mask, microshield or face shield, latex gloves, and emergency rescue tool).

Of course, all correctional staff should be trained in both first aid and CPR; all housing units should have an emergency response bag. All responding correctional staff should *never* wait for medical personnel to arrive before entering a cell or before initiating appropriate life-saving measures, including first aid and CPR. Without exception, consistent with national correctional standards, if cell entry is not immediate and/or requires the presence of a cell entry team, it should occur no later than four minutes from initial notification of the emergency.

The issue of whether or not correctional staff should enter a cell area to rescue an inmate in the midst of a suicide attempt without proper backup support is indeed a difficult decision that continues to stir controversy. Of course, it could also be illustrative of a facility that lacks adequate staffing to protect the health and safety of both officers and inmates.

When No Vital Signs Exist, Don't Presume That Death Has Occurred

There have been a number of incidents when, without the victim displaying any vital signs, life-saving measures were never initiated. Those staff apparently did not realize or were inadequately trained to know that the purpose of CPR was to re-establish vital signs — to "get life started again."

Michael Langford was found hanging from the upper bunk of his cell by a laundry bag cord at the Union County (Mississippi) Jail on April 9, 1999. The officer entered the cell, cut the cord away from Mr. Langford's neck, but did not initiate CPR. According to his report of the incident, "I stood right there with Langford on the floor. I seen that he was not breathing, but did not touch him until the paramedics arrived" approximately 10 minutes later.

At approximately 3:00pm on August 22, 2000, Trina Hatch was found hanging from a television bracket by a sheet in her cell at the Teton County (Idaho) Jail. An officer called out to other personnel and the sheriff was the first to arrive at the cell. He checked Ms. Hatch's vital signs, found none, and chose *not* to initiate CPR. Instead, the sheriff instructed the dispatcher to notify emergency medical services personnel. The victim's body continued to hang from the television bracket while a deputy took crime scene photographs. Ms. Hatch was eventually cut down when she was pronounced dead by the physician who arrived 30 minutes later.

Related to the issue of inadequate training, there are other instances in which CPR was not initiated because correctional staff feared the victim might suffer from an infectious disease, including AIDS. Beyond the need for additional training to educate reluctant staff, all housing units should be equipped with CPR pocket masks, latex gloves, and other appropriate infectious disease equipment. Of course, only a physician, emergency medical service personnel, or other professionals as designated by state law, can pronounce an individual dead. Until such time, standard first aid and CPR must be initiated and continued until staff are relieved by qualified medical personnel.

The failure to initiate life-saving measures, including CPR, has resulted in litigation. For example, in *Heflin v. Stewart County*, 958 F.2d 709 (6th Cir. 1992), a deputy at the Stewart County (Tennessee) Jail went to the cell for Hugh Allen Heflin on September 3, 1987 and observed a sheet tied to the cell bars. The deputy immediately went to the dispatcher's office, told the dispatcher to call the sheriff and EMS personnel, picked up the cell block keys, and returned to open the cell. When the deputy entered the cell, he observed the victim "hanging by the neck on the far side of the shower stall." Mr. Heflin's hands and feet were tied together, a rag was stuffed in his mouth, and his feet were touching the floor. With *the body still hanging*, the deputy checked for a pulse and signs of respiration, but found none. The body still felt warm. The deputy then opened Mr. Heflin's eyes and found the pupils were dilated. He concluded from these observations that the victim was dead. While the deputy was still in the cell, a jail trusty arrived with a knife to cut the ligature. The deputy ordered the trusty out of the area and the victim remained hanging. The sheriff arrived shortly thereafter and directed the deputy to take pictures of Mr. Heflin before he was removed from the ligature.

The family of Mr. Heflin filed a lawsuit against the county and at trial the plaintiffs introduced evidence that the defendant maintained a policy of leaving victims as discovered, despite the medical procedures available to initiate resuscitation. They ultimately prevailed and a jury awarded damages to Mr. Heflin's family based upon proof that the defendants' acted with deliberate indifference after discovering the victim hanging. The defendants appealed by arguing that the Mr. Heflin was already dead and their action or inaction could not have been the proximate cause of his death. A federal appeals court ruled that "there clearly was evidence from which the jury could find that Heflin died as the proximate result of the failure of Sheriff Hicks and Deputy Crutcher to take steps to save his life. They left Heflin hanging for 20 minutes or more after discovering him even though the body was warm and his feet were touching the floor...The unlawfulness of doing nothing to attempt to save Heflin's life would have been apparent to a reasonable official in Crutcher or Hick's position in 'light of pre-existing law'..." The court also affirmed the jury award to Mr. Heflin's family.

In a related case that did not involve an inmate suicide, another federal appeals court ruled that three 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" *Tlamka v. Serrell*, 244 F.3d 628 (8th Cir. 2001).

'Protecting the Scene of the Crime'

Various correctional and police department officials still continue maintain antiquated policies which treat the cell of an alleged suicide as a crime scene and require that it be "preserved." Associated with the crime scene perception is the conclusion that the body should not be touched. Literal application of this belief can lead to the absurdity of leaving a person hanging (as shown above) when they might otherwise be alive.

In another recent example, Thomas Woods was found hanging in the sitting position from the cell door by a blanket at the Taylor (Michigan) Police Department during the early morning of March 17, 2001. Responding officers were instructed to take photographs of the victim and *not* to touch the body. When EMS personnel arrived several minutes later, the police were still taking photographs and initially refused to allow paramedics to enter the cell. An argument ensured until an EMS supervisor reminded police personnel of a state EMS protocol that they were required to follow. The officers reluctantly stepped aside, paramedics cut the ligature away from the victim's neck, noticed the body was warm with no lividity, took vital signs, and initiated CPR. Mr. Woods was transported to a local hospital and subsequently pronounced dead.

Needless to say, preserving life should always be the first priority. Police departments and correctional agencies which place "preserving-the-scene-of-the-crime" policies first can be expected to garner a high degree of liability. In fact, the decision not to cut down a hanging victim upon the belief that the "crime scene" was to be preserved may also persuade a fact-finder that staff were indifferent or lacked training.

Use of Inmates to Conduct Suicide Watch

In early October 1991, Mike Robertson and Richard Greene (pseudonyms) were cell mates in a county jail located in northern New Jersey. They had met approximately six weeks earlier at a county psychiatric hospital where both were being treated as a result of unrelated suicide attempts. Robertson and Greene were now housed in the jail's mental health unit and, based upon their continued suicidal threats and ideation, had been placed under the highest level of suicide watch — constant observation by an "inmate observation aide" and checks by a correctional officer at 15-minute intervals. Housed together, these two inmates frequently talked about suicide. On several occasions, Robertson told Greene that he wanted to go back to the county hospital and thought a feigned suicide attempt would guarantee his chances of transfer. Greene, on the other hand, was genuinely despondent about life, saw little positive value in his future, and frequently contemplated "hanging up."

In the late afternoon of October 4, Richard Greene tied one end of his bed sheet to a ceiling vent and the other end to his neck. Stepping onto the sink, Greene turned to his cell mate and asked him not to interfere. He stepped off the sink and, before losing consciousness, heard Robertson yelling for assistance. Shortly thereafter, officers responded to the scene and initiated life-saving measures to Greene. At the same time, Mike Robertson walked though the open cell door into the corridor where he was met by Kurt Bernard (a pseudonym), the inmate observation aide assigned to Robertson and Greene. The aide was sitting on a chair dutifully recording Greene's suicide attempt in his log as required by jail policy. As Robertson walked past Bernard toward the shower area, the aide asked where he was going. Robertson responded that he needed to make a telephone call. Bernard, apparently not noticing that Robertson was clutching a white shoelace in his right hand, continued writing in his log. Approximately 20 minutes later, another inmate began yelling for assistance from the shower area. Bernard quickly responded and observed Mike Robertson hanging from a shower fixture by the white shoelace. As the aide began to lift the inmate's body, an officer arrived and cut the ligature. Robertson was placed on the floor and although CPR was promptly initiated, the inmate, once viewed as manipulative, was later pronounced dead at the local hospital.

Why were two suicidal inmates housed together under suicide watch in a cell with an exposed ceiling vent, access to shoelaces, and allegedly under the constant surveillance of an inmate observation aide? Not surprisingly, litigation was filed as a result of Mike Robertson's suicide.

Until recently, national correctional standards have not addressed the issue of using non-staff resources in the supervision of suicidal inmates. In early 2003, however, the National Commission on Correctional Health Care released the revised versions of both its prison and jail standards, and inserted the following passage into the suicide prevention section of each volume: *"When a facility employs other inmates in any way in the suicide prevention program (e.g., companions, suicide-prevention aides), the inmate's role is supplemental to and does not take the place of staff supervision"* (NCCHC, 2003). In addition, only a handful of local and state jurisdictions throughout the country use inmate observation aides to observe suicidal inmates, most in an effort to supplement staff observation at 15-minute intervals and to avoid use of staff for constant supervision (Hayes, 1995).

In New York City's Riker's Island facilities, inmate observation aides are selected according to written guidelines and receive extensive training. They are paid for their services and are deployed in mental observation, punitive segregation, administrative segregation, and new admission housing areas. Aides are instructed "to promptly inform correctional officers or mental health staff when they believe an inmate poses a risk of suicide, presents an immediate danger of suicide, or is engaging in bizarre behavior" (Rakis and Monroe, 1989, p.154-155). In Rhode Island, trained inmate aides have an expanded role as peer counselors and befrienders of potentially suicidal inmates. Their duties include: 1) reaching inmates before they become suicidal risks; 2) befriending inmates who are depressed and alert psychiatric, medical or psychological staff to a developing crisis; 3) listening to inmates' problems; 4) asking relevant questions to potentially suicidal inmates in order to assess their suicidal risk; and 5) informing new arrivals of what to expect in prison in regard to daily routine (rules, visitation privileges, telephone calls, etc.) and where to get help (Lester and Danto, 1993).

The controversy surrounding use of inmates to conduct suicide watch is perhaps best exemplified by the Federal Bureau of Prisons (FBOP). According to FBOP policy,

> "the suicide watch may be conducted either by institution staff or, when authorized by the Warden, 'inmate companions' chosen by the Program Coordinator.... Companions shall be selected based upon their ability to perform the specific task but also for their reputation within the institution. They should be mature, reliable individuals who have credibility with both staff and inmates. They must be able, in the Program Coordinator's judgment, to protect the suicidal inmate's privacy from other inmates, while being accepted in the role by staff.

> Finally, they must be able to perform their duties with minimal need for direct supervision…." (Federal Bureau of Prisons, 1995, p. 8).

Assigned to four-hour shifts and paid on a performance basis, companions are required to continuously observe suicidal inmates. They are not placed in a clinical or therapeutic role, and are trained in basic aspects of suicidal behavior, communication, and procedures necessary to summon staff assistance.

What is most interesting about the program is that it is *not* uniformly utilized across the federal prison system. According to an early survey of FBOP chief psychologists (i.e. program coordinators), Schimmel, Sullivan and Mrad (1989) found that 70 percent of respondents used the option of inmate companions, yet warned that "no other issue so clearly appears to generate a strong opinion one way or the other." In a more recent survey, White and Schimmel (1995) found that 65 percent (a slight decrease compared to the earlier survey) of FBOP facilities used inmate companions, and 72 percent of all suicide watch hours in these facilities during 1992 were performed by inmate companions. Of the 35 percent of responding chief psychologists that did not use companions, most cited philosophical or ethical problems, liability concerns, or security and logistical issues at their particular facility.

As one observer has previously noted: "Issues of accountability (and liability) must be considered in terms of inmate-peers' supervisory/ monitoring responsibilities and the potential for negligence of duties. While mandatory inmate-peer training programs and procedures of staff oversight are vital buffers in this process, national standards and legal precedence solely hold facilities and correctional staff responsible for inmate supervision. One can envision a cocky lawyer in a wrongful death lawsuit challenging an administrator or clinician's use of inmate-peers, who in fact are incarcerated for criminality and a 'lifestyle of irresponsibility and untrustworthiness.' Other concerns include confidentiality violations whereby the inmate's suicidal state and/or emotional disturbance, and consequential behavioral or disclosing reactions, are witnessed by the inmate-peers. Obviously, there is no standard of accountability or protection to insure this peer does not further disclose such information to other inmates. While creating privacy conflicts, this outcome can create further interpersonal problems in the prison setting for the suicidal inmate, such as being 'weak,' etc." (Hayes, 1995b).

Inmate observation aides or inmate companions. By whatever name, the *informal* use of other inmates in suicide prevention can have various positive attributes, such as having "an extra set of eyes" watching suicidal inmates, and providing needed companionship to alleviate despair and the loneliness of single-cell isolation. On the other hand, ethical and legal concerns accompany the *formalized* use of inmate observation aides, as well as accountability and issues of confidentiality. Most importantly, despite promises to the contrary, use of other inmates to conduct suicide watch results in relaxation of both correctional and mental health staff responsibilities for inmate safety and treatment. Some correctional agencies rationalize the use of observation aides as a means to eliminate the need to automatically restrain or strip potentially suicidal inmates of their clothing. In reality, when used strictly as an alternative to staff supervision of actively suicidal inmates, observation aides are simply a budgetary rationalization for inadequate staff coverage.

Conclusion

Some may argue that 'no-harm' contracts, closed circuit television monitoring, playing catch-up with the logs, stripping inmates of the clothing, ignoring or punishing inmates we deem as manipulative, and use of inmate observation aides are no more than typical controversial issues in suicide prevention . Others may argue that all these issues simply and collectively exemplify further separation of correctional, medical, and mental health staff from suicidal inmates.

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Discharging Inmates with Mental Illness and Co-Occuring Disorders into the Community: Continuity of Care Planning in a Large, Statewide Department of Corrections

by
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Introduction

In order to settle a class-action lawsuit, the City of New York City agreed earlier this year to provide discharge planning services to inmates with mental illness when they are released from the city jail system (Saulny, 2003). In 1999, the Urban Justice Center, New York Lawyers for the Public Interest, and other plaintiffs filed a lawsuit (*Brad H. v. City of New York*) charging that the city jail system routinely discharged inmates with mental illness into impoverished neighborhoods without adequate continuity of care planning. The plaintiffs alleged that offenders were frequently released with $1.50 and two subway tokens, without release plans, government benefits, housing, or other services. Many individuals were dropped off near subway stations between the hours of 2:00am and 6:00am. The attorneys argued that the City of New York and its contract vendors were legally responsible to provide discharge planning to inmates with mental illness, and failure to do so increased the risk that this group would more likely relapse, engage in aggressive acts harmful to others, attempt or complete suicide, be unable to care for themselves, and become homeless. All of these potential outcomes increased the likelihood of re-arrest and return to jail (Reed, 2001).

The City of New York initially denied legal responsibility to provide discharge planning to this population. The defendants noted that they operated a correctional, not a psychiatric, facility; their purposes were incarceration and detention, not treatment. Moreover, they argued that the high turnover rate, relatively short lengths of stay, and nature of release limited the treatment provider's ability to make effective discharge planning. Release was based on judicial factors, rather than psychiatric condition. Moreover, mentally ill offenders were difficult to place in the community. Frequently, these individuals demonstrated (1) excesses in bizarre, unusual, and aggressive behaviors, (2) deficits in self-care skills areas, (3) deficits in interpersonal skills, and/or (4) deficits in instrumental role performance. Many community agencies were reluctant to work with these clients. On January 8, 2003, however, the City of New York agreed to provide mentally ill inmates with access to the psychiatric treatment they need to maintain their stability after release. The services would include assistance obtaining housing, access to outpatient treatment and medication, and the means to pay for those services in cases were the inmate was indigent (see pages 18-19 of this ***Update*** issue for more information on the case).

We believe that the *Brad H.* settlement will have dramatic national implications. Mandated discharge planning would have a tremendous impact upon jails and prisons, and also upon community mental heath and substance abuse services, which would have to provide these services. The numbers of offenders are staggering, and the complexity of their emotional and physical problems is daunting. According to recent estimates, over 800,000 adults with mental illness are in jail, prison or on probation each year throughout the country (Bureau of Justice Statistics, 1999). It has been argued that offenders in general have many more health and mental health problems than individuals in the community, primarily caused by their lifestyles which frequently include transient behavior, financial instability, and such high-risk behaviors as intravenous drug use, smoking, and multiple sex partners. Most often offenders do not have health insurance and lack supportive, positive, and enduring relationships, which contribute to their emotional and health instability (McVey, 2001).

Despite the daunting obstacles to offender community transition, several jurisdictions have developed some promising practices to meet the challenge. The Community Transition Project in Seattle, Washington screens mentally ill inmates, begins case management services six months prior to release, and completes entitlement applications, housing, community supports, and crisis plans prior to release (Wertheimer, 2002). A number of state department of corrections have also addressed this responsibility and are developing release planning for the inmates with mental illness returning to the community (e.g., Massachusetts Department of Correction, 1999: Texas Council on Offenders with Mental Impairments, 2001, and McCormack, 1999). This article describes the continuity of care initiatives developed by the Pennsylvania Department of Corrections.

Community Transition Services for Inmates With Mental Illness and Co-Occurring Disorders Being Discharged from the Pennsylvania Department of Corrections

The Pennsylvania Department of Corrections (PADOC) consists of 26 prisons housing more than 40,000 inmates. Approximately 16 percent of the offenders are tracked on the automated Mental Health/Mental Retardation (MH/MR) tracking system and carry a psychiatric diagnosis, which includes approximately 3 percent who are rated seriously mentally ill, i.e., they display "a substantial disorder of thought or mood that significantly impairs judgment, behavior capacity to recognized reality, or cope with the ordinary demands of life." During 2001, the PADOC released 10,486 inmates to the community (9,800 males and 686 females): 29 percent of the inmates completed their maximum sentence; 47 percent were released on parole for the first time, and 19 percent were re-paroled. Approximately 35 percent of the inmates returned to inner-city communities in Philadelphia County, 10 percent to Allegheny County (Pittsburgh), and 5 percent to Dauphin County (Harrisburg) (PADOC, 2002).

A recent comparison (Schaefer, 2003) of parole and max-out data during a subsequent 12-month period ending May 2003 for inmates on the mental health rosters with inmates who were not on the rosters showed that inmates with serious mental illness were more likely than not to serve their full sentences, rather than receiving parole:

- Inmates with no mental health history were paroled 81.7% of the time (n = 4,320) and maxed-out 18% of the time (n = 969);

- Offenders with a mental health history, but who were no longer considered mentally ill, were paroled 73.7% of the time (n = 547) and maxed-out 26.3% of the time (n = 195);

- Inmates diagnosed with mental illness were paroled 65.3% (n = 466) and maxed out 34.7% of the time (n = 248); and

- Inmates diagnosed with serious mental illness were paroled 45.1% of the time (n = 78) and maxed out 54.9% of the time (n = 95).

For the last decade, the PADOC has implemented a series of continuity of care policies and procedures and established collaborative relationships with numerous public and private agencies to assist inmates with MH/MR needs, co-existing substance abuse problems, and significant medical needs make a better transition from institutional care to life in the community. The PADOC has employed three broad strategies:

- Establishing automated tracking, improved treatment services, and enhanced release planning for inmates with mental illness and co-occurring disorders, which are clearly specified in policy;

- Enhancing collaboration with other agencies and jurisdictions, including development of, and participation in, statewide and local Interagency Forensic Task Forces composed of key "stake holders" who are interested in, or impacted by, the release of these inmates into the community; and

- Developing specialized Community Corrections Centers and other community transition programs for offenders with mental illness and co-occurring disorders.

1) Establishing Automated Tracking, Improved Treatment, and Release Planning for Inmates with Mental Illness

Improved Tracking. In 1994, the PADOC implemented an automated MH/MR tracking system to follow inmates with mental illness to ensure that they did not fall between the cracks in the mental health delivery system. Information included on the MH/MR tracking system included the inmate's International Classification of Diseases (ICD) diagnosis, Global Assessment of Functioning (GAF) score, history of mental health commitments, IQ score, rating of substance abuse treatment needs, and various demographic data. Currently, during the year prior to prison discharge via parole or "maxing out," the institutional team assesses the inmate's need for development of an individual treatment plan focusing on community transition. As noted above, approximately 16 percent of the inmate population is placed on the MH/MR roster, and a small subset of this roster, approximately 3 percent of the population, is rated as seriously mentally ill.

Continuity of Care Policy for Offenders Retuning to the Community Through Parole or "Maxing Out." In 1994, PADOC staff also collaborated with Office of Mental Health and Pennsylvania Board of Probation and Parole (PBPP) to develop policy directions for continuity of care planning procedures for (1) inmates with mental illness who would be paroled in the community, as well as (2) inmates who were unlikely to receive parole, and hence serve their full sentence. Currently, the policy requires the interdisciplinary mental health treatment team (composed of the psychologist, psychiatrist, unit counselor, and unit custody staff representative) to staff the inmate 12 months, and again 6 months, prior to prison release for continuity of care planning. The protocol outlines procedures for obtaining a release of information from the inmate, contacting community MH/MR resources, arranging civil commitments for clients who meet involuntary commitment criteria, notifying law enforcement authorities regarding the release of inmates who is considered dangerous (but not committable), and providing inmates with a 30-day supply of medication. It should be noted that most offenders with mental illness are "maxing out" into the community rather than being paroled.

In 2003, the protocol is being updated to expand the membership in the multidisciplinary team to include the Drug and Alcohol Treatment Specialist (DATS), Correctional Health Care Administrator (CHCA), and vendor Health Care Release Coordinator. The DATS was added in response to the growing realization that the majority of the mentally ill offenders also display serious co-occurring substance abuse disorders. The CHCA was added in recognition of the need to coordinate services to meet the concurrent medical needs of the many of the inmates, and assist in the application for various benefits to which the inmate might be entitled, e.g., Medical Assistance, Veterans benefits, Temporary Assistance to Needy Families (TANF), and SSI.

The new protocol also includes revised release of information and confidentiality procedures. The new procedures allow nonconsensual release of some information to county MH/MR administrators and select agencies, including professional treatment staff, when a summary or portion of the record is necessary to provide for continuity of proper care and services.

Medical Release Planning Policy. The PADOC recognizes that prison inmates are a high-risk health group. In addition to mental illness, certain diseases such as tuberculosis, HIV/AIDS, hepatitis C, and sexually transmitted diseases pose a particular threat to the community. The department acknowledges the need for close coordination and good communication between correctional health and mental health staffs and other public health agencies. In 2001, the PADOC developed a medical services release planning policy which provided directions for connecting the inmate with whatever medical and income maintenance benefits to which he/she might be entitled, including those outlined above (PADOC, 2001a). Within the prison system, a medical vendor provides medical and psychiatric services to inmates. The contract now requires the vendor to hire Health Care Release Coordinators who are responsible for reviewing an inmate's Medical Release

Summary to determine needed community-based health care referrals. The Release Coordinator also assists the inmate with other tasks, such as helping them to complete the Medical Assistance application.

2) Enhancing Collaboration with Other Agencies and Jurisdictions, including Development of State-Wide and Local Interagency Forensic Task Forces

Nationally, mentally ill offenders have a high rate of recidivism and tend to cycle through a variety of criminal justice and psychosocial settings, in part because of lack of coordination among service providers. Forensic clients have multiple needs for treatment and supervision, and a host of other public and private sector agencies must be involved in those services. In Pennsylvania, these relevant agencies include the PBPP, Office of Mental Health and Substance Abuse Services (OMHSAS), Bureau of Drug and Alcohol Programs, Department of Health, Office of Income Maintenance, Office of Mental Retardation, Department of Aging, and various advocacy groups, including the National Alliance for the Mentally Ill, and Pennsylvania Protection and Advocacy (PP&A) agency. Traditionally, there have been friction and turf conflicts between these agencies. However, national research provides us with some suggestions to respond to the needs of inmates with mental illness. Conly (1999) has summarized recent research that recommended the following strategies for agencies responding to the needs of mentally ill offenders:

- Inter-agency agreements;
- Consensus on defined goals;
- Cross training;
- Regular meetings of key agency representatives; and
- Use of "boundary spanners," persons who facilitate communications across agencies and professions, to coordinate policies and services.

Statewide Inter-Agency Forensic Task Force. The engine that drives the PADOC's continuity of care activities is the statewide Inter-Agency Forensic Task Force (IFTF). In 1999, the PADOC and the National Alliance of Mentally Ill established an inter-agency task force composed of the key forensic stakeholders in Pennsylvania who have an interest in continuity of care for the MH/MR inmates. The initial IFTF members included NAMI, PADOC, Office of Mental Health and Substance Abuse Services (OMHSAS), Office of Drug and Alcohol Programs, PBPP, PP&A, and Philadelphia and Allegheny County MH/MR Agencies. The members collaborated in planning developing new continuity of care initiatives, such as the Forensic Integration and Recovery — State (FIR-St), Community Reintegration of Offenders with Mental Illness and Substance Abuse (CROMISA), and Forensic RE-entry and Development (FRe-D) programs described later in this article. Subsequently, the Counsel for the House Judiciary Committee, Executive Director of the MH/MR Administrators Association, representatives from other counties, and staff members from county jails have joined the IFTF.

Regional Inter-Agency Forensic Task Forces. The success of the IFTF in developing collaborative relationships between agencies, minimizing turf warfare, and addressing forensic problems on a state level, prompted the Deputy Secretary of Office of Mental Heath and Substance Abuse Services to establish a pilot task force to address local forensic problems in the five-county Philadelphia area. The Southeast Regional Task Force included representatives from OMHSAS, PADOC, MH/MR administrators from the counties, mental health and substance abuse services providers, emergency staff, public defenders, district attorneys, prison staff, and mental health advocates in the area. The task force has sponsored a local forensic conference, and two of the counties have joined to obtain grant monies to fund a collaborative continuity of care program.

Model Collaborative Partnership Established with County MH/MR Administrators in Philadelphia and Allegheny Counties. During the state-wide FITF meetings, PADOC mental health services developed even better working relationships with the MH/MR agencies in Philadelphia and Allegheny (Pittsburgh) counties, which was important because approximately half (40% and 10% respectively) of the inmates return to those urban areas. In 2000, the Philadelphia MH/MR office approached the PADOC to assist the city agency develop a database of Philadelphia inmates with mental illness who were incarcerated in the PADOC and the dates they were returning to the city. The two agencies developed a mechanism whereby each of the 26 prison facilities generates a list of all of its MH/MR roster inmates who will "max-out" in the next 12 months, and this information is forwarded to the Philadelphia agency to arrange aftercare resources. In some cases, Philadelphia MH/MR staff visits the facilities to review records, discusses the case with PADOC staff members, and interviews the inmate.

The PADOC subsequently developed a similar working relationship with the MH/MR agency in Allegheny County. MH/MR caseworkers have also visited all 26 prison facilities to review the treatment records and interview the inmates and prison staffs. Moreover, Allegheny County caseworkers have also picked up the inmate at the prison on his/her discharge date and escorted them back to Pittsburgh to obtain housing, make final arrangements for entitlement benefits, and/or buy clothing.

Establishing collaborative partnerships with Philadelphia and Pittsburgh MH/MR agencies addresses half of the PADOC's re-entry problem and serves as a model for establishing collaborative relationships with MH/MR administrators in the 65 other (mostly rural) counties in the state. Mental health treatment resources are scarcer in rural counties, and MH/MR agencies are more often reluctant to provide services to offenders returning to their communities. The PADOC and OMHSAS mental health staffs are meeting with the statewide MH/MR Administrators Association to discuss pre-release activities and develop plans to coordinate transition services with MH/MR and criminal justice staffs in each of those jurisdictions. The PADOC Central Office plans to notify each county MH/MR agency director via written correspondence and e-mail of all of the names, max-out dates, and other information regarding inmates who are presently receiving mental health treatment and will be returning to the community within the next 12 months. In its correspondence, the

PADOC will advise the MH/MR administrators of potential risk factors posed by inmates with mental illness returning to the community without treatment, and will invite the agency to send case workers to the facility to interview the inmate, meet with staff, and participate in the continuity of care planning process. The correspondence will be copied to the Executive Director of the MH/MR Administrators Association and the forensic representative of OMSAS. In the past, mental health staffs in the 26 prison facilities have completed the continuity of care procedures.

Memoranda of Understanding. The PADOC has entered into Memoranda of Understanding (MOU) with approximately 10 counties, and plans to initiate more MOUs.

Enhanced Communication with County Court and Jail Systems. This article has primarily addressed the issue of continuity of care at the "back door," when an inmate returns to the community. The PADOC is also very interested in continuity of services at the "front door," when an inmate enters the prison system from the community or county jail. Seeking to improve communication with county jail systems, the Secretary of Corrections made several presentations to the Association of Commonwealth Trial Court Judges Association, and provided them with a mechanism to recommend/request special services for the individuals whom they commit to the PADOC. The PADOC Chief of Psychological Services has also made presentations to trial judges to (a) describe prison mental health services and (b) solicit their assistance in assuring that any previous mental health assessments and treatment records follow the inmate from court into the PADOC. The Chief of Psychological Services and the Philadelphia MH/MR Director recently met with the Philadelphia trial judges to request their assistance obtaining previous assessment and treatment records, which might be helpful in developing mental health treatment plans for the inmates.

3) Developing Specialized Community Corrections Centers and Other Community Transition Programs for Offenders with Mental Illness and Co-Occurring Disorders

The PADOC has traditionally operated an extensive system of Community Corrections Centers (CCCs) or halfway houses across the state to transition inmates from institutional life back into the community. Department staff operate 14 CCCs and vendors run approximately 50 additional centers. In the past, CCC unit directors have been reluctant to accept inmates with mental illness. Accordingly, in the last five years, the PADOC has begun to fund CCCs for special needs offenders. To date, the agency has sponsored the development of specialized transitional Community Corrections Centers for inmates with mental illness and substance abuse (MISA) problems in Philadelphia, Erie, and Pittsburgh.

FIR-St Program. In early 1999, the PADOC and Forensic Interagency Task Forces reviewed the problem of developing a systematic approach for transitioning mentally ill offenders from prison to the community. The collaborative program would be piloted in Philadelphia, since 40 percent of the inmates return to that county. The PADOC would fund the project, with support from the PBPP, Philadelphia Behavioral Health System, Drug and Alcohol Services, and the advocacy community.

The PADOC issued a Request For Proposals, and ultimately awarded the contract to Gaudenzia, a drug and alcohol treatment agency "whose mission is to teach chemically dependent individuals to lead drug-free lives" (Stokes, 2001, p. 102). The agency modified its treatment model and staff recruiting to meet the needs of mentally ill substance abusers. On July 1, 1999, the Forensic Integration and Recovery-State (FIR-St) opened its doors to inmates with mental illness and co-occurring disorders transitioning back into the Philadelphia five-county area. FIR-St is a 25-bed, co-educational program which accepts referrals from the PADOC and PBPP. The unit employs a modified therapeutic community treatment model and, when there are parole violations, the model employs graduated parole sanctions whereby minor infractions of parole rules are dealt with in the community, rather than by bringing the offender back into the prison. By May 2003, nearly 175 inmates had been discharged into the community through the FIR-St program.

Coleman Center. The Coleman Center is a 20-bed unit for mentally ill male offenders returning to the Philadelphia County area. The Center houses the same clientele as the FIR-St program, however, it can also serve as a "halfway back" program in which inmates who have encountered problems in the community can return briefly to the program rather than being re-incarcerated. Based upon the success of the FIR-St and Coleman Center programs in Philadelphia, similar programs are being planned in Allegheny County.

CROMISA programs. In 1999, PBPP and Office of Health initiated the Community Re-Integration of Offenders with mental Illness and Substance Abuse (CROMISA) programs for parolees returning to the Erie County area. A second program was subsequently established Allegheny County.

Community Orientation and Reintegration Program. The transition from prison through the Community Corrections Centers has been enriched by the development of the Community Orientation and Reintegration (COR) program. The COR program is a two-phased program designed to address the critical adjustment period between the inmate's adjustment and his/her return to the home community. COR provides for an individualized and targeted approach based on the inmate's risk factors. The first phase of the program is completed in prison during the several weeks prior to discharge and addresses numerous critical issues, including parole responsibilities, employment preparation, vocational evaluation, personal finances, substance abuse education, AA/NA meetings, housing, family and parenting, mental health, life skills, antisocial attitudes, community (give back) services. The second phase of COR includes two weeks of programming in the Community Corrections Center. Phase II prepares the inmate for a gradual return to family and community during the four-to six-week program. CCC facility staff, PBPP staff, and PADOC Community Corrections staff, determine the inmate's release date from the centers.

It should be noted that COR is a highly structured program that does not allow much variation for special needs inmates. Most of

the men and women who are referred for CCC placement, or who go through the COR program, are general population inmates who generally do not display significant special needs and are likely to be paroled. The COR program may not always be applicable to inmates with special needs, and inmates who are likely to max-out often require more specialized services. Unfortunately, these are the very inmates who are most likely to pose a behavioral problem when they return to the community.

FRe-D Program for Females. In September 2000, the PADOC obtained a federal grant to establish the Forensic Community Re-entry and Development (FReD) project, which is located in the state's largest female prison facility — the State Correctional Institution (SCI) at Muncy. SCI-Muncy houses the most seriously mentally ill females in the system. Most of the women on the MH/MR roster also suffer from co-occurring substance abuse disorders, and also have mental retardation. The women are placed in the FReD program 12 months prior to release. A community placement specialist is assigned to work with the clients and prepare them for community living; helping them develop a re-entry plan that address their needs; and identifies and establishes contact with resources for MH/MR treatment, substance abuse programming, housing, and other services that will be needed in the community. The grant includes monies for subsidized housing.

Discussion

Many critics have documented the damaging effects of prisons and psychiatric hospitals upon prisoners and patients serving long terms of incarceration. The deleterious effects include the development of dependency upon the institution to meet their basic needs, acquisition of anti-social attitudes and values that might may be incompatible with the resident's family culture; isolation from family, friends, and contacts in the community; and estrangement from the outside world, in which the family and/or community have changed while the inmate was incarcerated, making their later readjustment more difficult (Sommer, 1974). The re-entry hardships for the offenders with mental illness are even more myriad and profound; difficulties include the dual stigmas of mental illness and incarceration accompanied by problems connecting and/or re-connecting with MH/MR services in the community, which may have failed the inmate before. Randy Starr, incarcerated/hospitalized for five years after being found not guilty by reason of insanity following the murder of his mother, has chronicled his personal difficulties with community re-entry (Starr, 2000; Lundin, 2002).

Recognizing the potential for inmate re-entry problems, American Correctional Association (ACA) Standard 3-4330 mandates that correctional settings show that "Written policy, procedure and practice require continuity of care from admission to discharge from the facility, including referral to community care when indicated" (ACA, 1990). In addition, the National Commission on Correctional Health Care (NCCHC) Standard P-E-13 states that prison "facility clinicians ensure patents' health needs are met during transition to a community provider…Close coordination is encouraged between designated health staff and any correctional, probation, or parole staff responsible for planning inmate release" (NCCHC, 2003). Finally, the Council of State Governments (CSC) has recommended "collaboration among correction, community corrections, and mental health officials to effect the safe and seamless transition of people with mental illness from prison to community" (CSC, 2002, p. xviii).

Unfortunately, as noted by McVey (2001), there are many obstacles to providing continuity of care services to mentally and physically ill inmates:

- Prison systems are frequently regarded as the "step-children" of public agencies, rather than a component in the continuum of social service agencies. Community agencies frequently distance themselves from working with offenders, apparently believing that once the offenders are removed from the community and incarcerated, they are exempt from receiving services;

- Public service agencies frequently do not coordinate their mandated activities. Many agencies work unilaterally, rather than employing intra-agency coordination and case management; and

- Prison locations are frequently remote from the offender's home community.

In addition to these obstacles, inmates have been closely supervised for years and, in most cases, have been provided mental health services that are often superior to that which they received prior to their incarceration. These offenders have been well protected from more predatory inmates, and their time has been highly structured. Now they are moving from 2 to 6 hours of free time per day to 24 hours of free time per day, with substantially less supervision.

We believe that the strategies developed by the Pennsylvania Department of Corrections will help overcome many these obstacles. The monthly meetings of the Forensic Inter-Agency Task Force (FITF) have forged close working relationships between the PADOC, Office of Mental Health and Substance Abuse Services, PBPP, other public and private agencies, and the advocacy community. The FITF meetings have been the catalyst that fostered many of the continuity of care endeavors, and the PADOC has been the primary agency assisting NAMI to lead the task force, hosting the meetings, directing the agenda, and providing/obtaining funding for the projects. The FITF has also allowed key staff members in agencies that work with the same clients to develop both collaborative working relationships and model transitional programs. In addition, the frequent contacts by the PADOC and OMHSAS with the county MH/MR administrators have sensitized the agencies to the needs of the returning offenders, as well as the risks associated with failing to provide those needs. Departmental procedures for moving an inmate to a prison closer to his/her home community can ease the transition, as well as limit the possibility for misadventure occurring during the long trip home. Finally, strategies in which the county MH/MR case worker visits the facility to acquaint him/herself with the offender and participate in their treatment planning are likely to be very beneficial to the agency, offender, and community.

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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

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News From Around the Country

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

Florida

The state of Florida knows exactly how many people are locked up in its county jails every month — but it has no idea how many of them die there. Since 1996, there's been no state oversight of jails and no mandatory investigations of inmate deaths. The Department of Corrections once had that authority, but it was forced to turn it over to the county sheriffs who run most Florida jails. Now state officials don't even keep a body count — and the sheriffs have been left to police themselves.

That's what the *Tallahassee Democrat* discovered after three inmates died recently at the Leon County Jail. So far, there is no evidence of wrongdoing, but the cases highlight the lack of outside scrutiny when an inmate dies. Even Leon County Sheriff Larry Campbell said he's surprised the state doesn't collect information on inmate deaths. And the chairman of a committee that sets Florida jail standards has promised to raise the question at a statewide meeting.

As with many law-enforcement issues, the idea of having sheriffs watch themselves has proponents and critics. "The jails are all local fiefdoms of the county sheriffs, and that's the way the sheriffs wanted it," said Peter Siegel, an attorney with the Miami-based Florida Justice Institute. "The sheriffs have more political power than the prisoners. That's what it comes down to."

No one had died at the Leon County Jail for 18 months — until March. Josh Washington, 24, was the first to die. He'd been arrested in a traffic stop and charged with marijuana possession. He was being booked into the jail when he went into convulsions and lost consciousness. An autopsy later revealed that he'd swallowed a large amount of cocaine, possibly during his arrest. Ruth Hubbs, 39, died two months later in the jail's medical unit. She had been locked up for more than a year on a burglary charge. According to the Sheriff's Office, she had a history of mental problems and began "talking to walls" in the days before her death. Her autopsy proved "inconclusive," pending the results of a toxicology screen. Clyde Fuller, 26, died earlier this month, also in the medical unit. His death came just hours after he was arrested on charges of trespassing and resisting arrest without violence. The Sheriff's Office reported that he fought with jail deputies and had to be subdued with pepper spray before they strapped him into a restraint chair. No cause of death has been established yet.

The Sheriff's Office followed its routine in the deaths, running parallel investigations — one by homicide detectives, one by internal-affairs investigators. "These are the same people who investigate murders in this county," Campbell said. "It's not like we're going to let the jail investigate the jail." The Sheriff's Office also invited the Florida Department of Law Enforcement to help in Hubbs' case after her family raised questions. FDLE usually investigates inmate deaths only by request from jail officials, according to a department spokeswoman. The Sheriff's Office said it would turn any evidence of a crime over to prosecutors, punish any violations of jail policies and report the deaths to the U.S. Department of Justice. Still, the main responsibility for the deaths will start and stop in the sheriff's headquarters on Municipal Way.

It wasn't always like that in Florida. The state began regulating county jails in 1974, establishing minimum standards that included rules on medical care and the amount of space every inmate should get. The Department of Corrections had the job of enforcing those rules but rarely did until the settlement of a civil-rights lawsuit more than a decade later. As part of the settlement, DOC began annual inspections of county jails and investigations of all inmate deaths, sexual assaults by guards and other incidents. The department eventually sued 44 counties over jail conditions. Those suits led to a building boom of 60 county jails to relieve crowding. By 1994, the department was conducting more than 500 investigations a year.

Some sheriffs said the inspections gave them leverage for jail money from county commissions. Others didn't like the state's snooping in their back yard. Critics said state prison experts weren't qualified to inspect county jails, which are run differently. They also noted that Corrections had its own problems with inmate abuses and deaths. Then the department's inspection team got

the ax — and those involved have different explanations of how that happened.

Tom Burlinger is a former sheriff's deputy and now spokesman for the Florida Sheriffs Association in Tallahassee. He said he received a call in 1995 from then-Corrections chief Harry Singletary, who needed to cut his budget and wondered whether sheriffs could do their own inspections and investigations. Burlinger said he explained that some sheriffs wanted Corrections to continue but that they'd manage if the department couldn't. "DOC in fact wound up cutting some of its budget, including those inspections," Burlinger said. In 1996, lawmakers eliminated the Corrections Department's jail responsibilities from state statutes.

Singletary has a different recollection. He said it wasn't his idea to drop the jail oversight, which he called a "good, fair, objective process" that frequently put the state at odds with the counties. "It was not a budget issue," said Singletary, who now works for the Leon County Schools. "... The sheriffs association, the sheriffs and the county commissions did not want us to have that oversight."

Either way, the sheriffs were on their own. They could still hire Corrections for inspections and investigations, but Corrections conducted only 15 inquiries in state jails over the next two years, according to the Florida Corrections Commission. The Legislature finally took away even that last bit of authority in 1999 — against the commission's recommendation.

To keep up standards, state sheriffs formed the Florida Model Jail Standards Committee. That group set jail guidelines covering everything from inmate meals to medical care to professional behavior by correctional officers. It also created an accreditation process and set up mandatory annual cross-inspections by trained volunteers from other counties. Many other states use the same kind of system, according to the federally operated National Institute of Corrections.

Still, the standards committee doesn't investigate or keep numbers on how many die in jail. Marion County Sheriff Ed Dean, committee chairman, said he calls in FDLE to investigate deaths in his jail and never thought about keeping statewide statistics. He plans to discuss it with the committee next month. "I can't promise which way the conversation will go, but we will take it up," he said.

Meanwhile, Congress has passed the Federal Death in Custody Act. The law was tied to state prison-building grants and requires reporting all deaths of arrestees or inmates. Chris Mumola, who runs the project for the Justice Department's Bureau of Justice Statistics, said county jails receive little of the grant money and can't be compelled to report deaths. But about 99 percent of the nation's 3,000-plus jails have cooperated, he said. The department expects to release a report by year's end that will detail 2001 deaths and follow with annual reports, he said.

Sheriff Campbell said he doesn't mind reporting the deaths in his jail and thought the state already kept that information. "That wouldn't scare me," he said. "I think we take exceptionally good care of the people in our custody."

Whether the current system is good enough depends on whom you ask. Civil-rights attorneys are skeptical, especially those who remember jail abuses of the '70s and '80s. They advocate a central state authority that ensures jails meet high standards and reviews inmate deaths. It's the same position the Florida Corrections Commission took when the Legislature removed that responsibility from DOC. "I think with the absence of any oversight, many of the sheriffs run their jails horrendously," said Siegel, the Miami attorney who has been involved in several jail lawsuits. They couldn't care less how people are treated, he said. "It's a secret, closed society."

Burlinger, with the sheriffs association, said he's puzzled by those who think sheriffs shouldn't oversee their own jails — even though they trust sheriffs with the more sensitive job of arresting people.

One man who can see it from both sides is the attorney who helps sheriffs protect their budgets. That's Dan Condon, general counsel for the Hunt Insurance Group in Tallahassee. The company administers the Florida Sheriffs Self-Insurance Fund and oversees payouts when member jails are successfully sued. Condon said he argued before the Corrections Commission in 1998 that state involvement with county jails gave a greater sense of propriety to inspections and investigations. "Any time you have an outside person look at something and say it's clear, it has more credibility than if *you* look at what you did and say, 'I did OK,'" Condon said last week. Still, he's reluctant to discuss whether he still sees a need for state oversight. He said he thinks sheriffs generally run clean jails. "As a rule, they do a good job of determining whether they screwed up or not," he said. "I haven't really seen any cataclysmic results of DOC not doing investigations." But Condon said the real trouble here is human nature: People will always be suspicious of those who police themselves.

The above article — "County Jails Police Themselves, Investigations of Inmate Deaths Have No Oversight" — was written by Tony Bridges, a staff writer for the ***Tallahassee Democrat****. It appeared in the June 22, 2003 edition of the newspaper and is reprinted with the permission of the* ***Tallahassee Democrat****.*

Pennsylvania

In June 2003, an investigation was launched into a recent suicide at the Westmoreland County Prison in Greensburg to determine if health care personnel erred in not placing an inmate under suicide precautions and then later covered up that decision after the man killed himself.

Robert R. Steadman, 33-years-old, hanged himself in the facility on April 18, 2003, four days after he was confined for failing to make a family court-ordered payment. During a previous incarceration at the prison in January 2003, Mr. Steadman had threatened suicide and was placed on suicide precautions. He was subsequently released, re-incarcerated on April 14, but not placed on suicide precautions.

According to the *Tribune-Review*, initial sources close to the investigation said there had been reports that at least one intake counselor noted in Mr. Steadman's case file that the inmate was

to be placed on suicide precautions when he was readmitted to the facility. Instead, he was assigned to a general population housing unit. An internal investigation allegedly looked into reports that a document was falsified and replaced to show there was no notation that Mr. Steadman was a suicide risk. According to a county official, those allegations proved to be unfounded. "I believe somebody outside the prison said something was changed, but I don't believe it was. I can't recall if there was any evidence," Prison Board Chairman Tom Ceraso told the *Tribune-Review* in June 2003. "I don't believe we are looking into it anymore."

However, as a result of Mr. Steadman's suicide, as well as three other such deaths since 2000, several new suicide prevention protocols have been implemented in the 450-bed facility. For example, when an arrestee now enters the Westmoreland County Prison, an intake officer will conduct a computer check to determine if the individual had previously been confined in the facility and whether that confinement included suicide precautions. If the inmate had previously been placed on suicide precautions, they would automatically be placed on precautions again when re-entering the facility until assessed by mental health staff. In addition, the intake screening form was revised to reflect greater emphasis on the identification of suicide risk, observation forms were revised, closed circuit television monitors will be installed in the medical unit (where two of the suicides occurred), and additional staff will be hired.

Nebraska

In September 2003, Lancaster County will begin a new program aimed at diverting individuals with mental illness from the county jail in Lincoln. The Lancaster County Mental Health Jail Diversion Project, one of just 17 programs funded nationally by the federal grants through the Substance Abuse Mental Health Services Administration, will eventually work with more than 100 people with mental illness and substance abuse who have been charged with non-violent misdemeanor offenses.

According to Dean Settle, executive director of the Community Mental Health Center, with a three-year budget of $700,000, the program will include two case workers (each with a 15-person caseload), a mental health worker at the jail, and a program manager. Grant funding also will pay for an evaluation of the program. The two case managers will work with clients for six to nine months, helping them find and keep housing and employment, getting them into appropriate treatment programs when necessary, encouraging them to take their medication, making sure they get to court appointments, and encouraging healthy decisions and stability.

Although the jail often houses individuals with mental illness who have broken the law, it is not the best place for them, Jail Administrator Michael Thurber told the *Lincoln Journal Star* in July 2003. Simply incarcerating these individuals does not stop their behavior. "They keep coming back," he said. The pilot program is based on the simply assumption that stabilizing a person will do more to stop the unacceptable behavior that leads to arrest than jail time, according to Dean Settle. Sometimes these people have stopped taking medication. Perhaps they have missed previous court dates and now face additional charges. The caseworker will help them manage legal affairs, housing problems, medication, he said. Although Lancaster County already diverts some people from jail — to either a detoxification center for those who are intoxicated or a crisis center for those having a psychotic breakdown, the new grant offers an additional avenue. "I've not seen anything like this, really trying to divert the mentally ill from a jail facility," said Mr. Thurber. "We were lucky to get the grant."

New York

In August 1999, Brad H., was a 44-year-old homeless man with schizophrenia who had grown up in a state psychiatric hospital and had been treated for mental illness each of the 26 times he had been jailed as an adult. However, no one ever planned for Brad H.'s continued psychiatric care, or on how he would obtain Medicaid benefits, Social Security disability payments, or housing upon his release from jail. As a result, Brad H. and seven other inmates with mental illness filed a lawsuit contending that the 25,000 inmates treated for mental illness each year in the New York City jail system were being released without proper provisions for treatment or a way to continue their medication. The suit was entitled *Brad H. v. City of New York*, 185 Misc.2d 420; 712 N.Y.S. 2d 336 (Sup. Ct. 2000); 276 A.D. 2d 440; 716 N.Y.S. 2d 852 (App. Div. 2000).

The city had originally balked at providing discharge-planning services for inmates being released from its jails (such as those located at Riker's Island). Instead, the inmates were dropped off at Queens Plaza, a transportation hub, in the middle of the night with $1.50 and a two subway tokens. People who took medication while incarcerated were released without a supply to carry them until they could obtain and fill a prescription. No one ensured that they had access to public benefits—for which applications often take months, without special intervention and assistance. As the trial judge wrote in his initial decision, the release of prisoners without needed treatment planning risks "a return to the cycle of likely harm to themselves and/or others" and their resulting re-arrest. In July 2000, the judge ordered the city to provide discharge planning for jail inmates with mental illness. The city appealed, but the initial decision was unanimously upheld by the Appellate Division of the New York State Supreme Court on October 31, 2000. The city's subsequent appeal to the state's highest court was also denied.

On January 8, 2003, the City of New York finally settled the *Brad H.* case, agreeing to provide discharge planning services for inmates who are "seriously and persistently mentally ill." Under the precedent-setting agreement, discharge planning includes an individualized assessment of the person's needs for mental health treatment, public benefits (such as Medicaid, SSI and Food Stamps) and appropriate housing, and requires the city to assist the released inmates with obtaining the services and resources they need. According to the agreement, in order to be designated as "seriously and persistently mentally ill," an individual must currently meet criteria for a DSM-III-R diagnosis other than alcohol or drug abuse, organic brain syndromes, developmental disabilities, or social conditions, and satisfy at least one of the following requirements:

1) Receives SSI or SSD due to mental illness;

2) Has extended impairment in functioning due to mental illness, operationalized as a Global Assessment of Functioning score of 50 or less or at least two of the following — difficulties in self-care, restrictions of daily living, difficulties in maintaining social functioning, and/or deficiencies in concentration, persistence, or pace; or

3) Is reliant on psychiatric treatment, rehabilitation, or supports to avoid the functional impairments previously listed.

"We think it's a terrific result, and it will, once implemented, do great things for a terribly vulnerable population," Christopher K. Tahbaz, a partner at Debevoise & Plimpton, a Manhattan law firm that provided pro bono assistance to the Urban Justice Center, a non-profit advocacy group that brought the suit with the New York Lawyers for the Public Interest, told *The New York Times*. The city also recognized the benefit that such discharge planning services provided both for the released inmate and for the community in general. According to Corporation Counsel Michael A. Cardozo, settlement discussions had been prolonged because of the complexities of coordinating the agencies needed to enact a plan. He told *The New York Times* that "Despite these complexities, New York City has developed a program unique in the country in its content and scope which we believe will provide significant assistance to mentally ill inmates with the hope that these inmates will be able to successfully reintegrate into the community."

Heather Barr, an attorney for the Urban Justice Center who was instrumental in crafting the agreement, recently wrote in the *Correctional Mental Health Report* (May/June 2003, 5 (1): 1, 2, 15-16) that, although not perfect, "the *Brad H.* settlement will come to be viewed as a success not just legally, but also programmatically, and will encourage a broader approach to discharge planning or, better yet, a concerted effort to provide defendants with services rather than jail."

Georgia

When a judge again considers whether the DeKalb County Jail's medical care should be freed from court supervision, a key issue might involve the death of Tony Louis. On April 1, 2003, the 19-year-old hanged himself with a sheet tied to a light fixture in his cell. Five days earlier, a jail officer recommended to his superiors that Mr. Louis be referred to mental health staff after the inmate had tied strips of cloth to the light fixture. The referral never occurred.

DeKalb Sheriff Thomas Brown demoted the jail supervisors, a decision, he believes, shows his willingness to immediately correct problems at the county jail. According to the sheriff, the facility's recent accreditation by the National Commission on Correctional Health Care also proves those problems are exceptions, not the rule. "As far as I'm concerned, we have this system fixed," Sheriff Brown told the *Atlanta Journal-Constitution* on July 24, 2003.

However, according Tamara Serwer, an attorney from the Southern Center for Human Rights that is representing inmates in a class-action lawsuit, Mr. Louis' death and another suicide earlier this year are proof that the jail's medical contractor and the jail staff should be under closer scrutiny. To Ms. Serwer, the jail's accreditation is limited to written policies and does not ensure those policies are being effectively implemented in the facility. "You can't be so defensive — that 'We've got all these policies, so it can't be our fault' — that you don't look underneath," she said.

Those arguments are likely to be repeated in court. Superior Court Judge Hilton Fuller is overseeing DeKalb County Jail's medical services to approximately 3,000 inmates after finding the county violated the 2001 agreement that originally settled the lawsuit. The county recently lost an appeal on that issue. A three-judge Georgia Court of Appeals panel rejected a claim that Fuller had run out of time to enforce his order because the original agreement gave the county 18 months to comply, a time span that has expired. The appellate court said the county could not be rewarded after it "ran out the clock" without fulfilling the agreement. The appellate court also rejected an argument that the county should be released from Judge Fuller's oversight because it has made a good-faith effort to comply. The county must now meet the requirements the judge set when he issued the contempt order. The county has filed a notice that it will ask the Georgia Supreme Court to review the Court of Appeals' decision.

Although the county attorney would not comment while the case was in litigation, Ms. Serwer noted that this was the third time the Court of Appeals had ruled against the county in the case, and that one of the appellate judges in the latest ruling favored penalizing the county for pursuing a frivolous appeal. She said the county has a right to appeal further, but said, "I'm somewhat disappointed that we're still playing that game."

Sheriff Brown said he could again ask Judge Fuller to end court supervision of the jail after a court monitor visits the facility in the next few months. The sheriff said medical care has improved to the point that any problems found by the monitor will only illustrate that no jail system is perfect. Ms. Serwer told the *Atlanta Journal-Constitution* that the jail has made progress in establishing policies, "but we haven't seen a sustained implementation of those policies and procedures."

Oklahoma

In June 2003, a police officer and jailer-dispatcher were suspended as a result of the suicide by hanging of Darrel Wayne Stafford in the Eufaula City Jail. The suspensions came as a result of the state Jail Inspection Division's finding that the victim's belt and shoelaces should have been taken from the victim following the booking process. Police Chief Larry Osmond declined to reveal the ligature used in the incident.

Mr. Stafford had been booked into the jail at approximately 7:30am on June 14, charged with an outstanding warrant for failure to pay a fine for public intoxication. Shortly after 12:00pm, the jailer-dispatcher began feeding the detainees. When Mr. Stafford failed to respond, the jailer called out to police officers who found the victim hanging by his neck from a screen in the cell.

The Eufaula City Jail has three cells which can hold up to nine inmates. Each cell is equipped with a small shower, raised concrete

slab (which serves as a bench), toilet, sink, and telephone. Heavy wire screen covers a CCTV camera and light fixture in each cell. The metal cell doors have one small screened window through which jailers can look, as well as a "bean hole" used to pass food trays to inmates. "The jailer couldn't see (Stafford) through the screen," Chief Osmond told the *McAlester News-Capital & Democrat*, indicating the inmate was to the right of the door. In addition, the corner of the cell cannot be seen by a CCTV camera. "I don't know if (Stafford) was aware of that or what," Chief Osmond stated. "I think it was one of those situations where if you want to do it, you're going to do it."

Maryland

Following reports that a housing area of the Baltimore County Women's Detention Center where an inmate recently committed suicide was left unattended for approximately 40 minutes before her death, jail officials have discontinued the longstanding practice of ordering staff to leave their posts for routine duties. Sommer Brooks, 23-years-old, had been held in the facility since being accused of the brutal torture and murder of her mother in January 2003.

Jail Administrator Jim O'Neill told the *Baltimore Sun* that lack of jail staff on the housing floor should not be blamed for the July 19 suicide. "An officer makes rounds every hour. Ms. Brooks could have hung herself with the officer on the floor." Some jail staff, however, believe that "collapsing" or leaving posts unattended is among the most dangerous staffing practices highlighted by the suicide. "If an officer wasn't needed there, there wouldn't be one on the floor at all," said Nick Haynes, a former detention center supervisor and field representative for the county's Federation of Public Employees, the union that represents about 240 correctional officers and supervisors.

Following several months of evaluation at Clifton T. Perkins Hospital Center, the state's maximum-security psychiatric hospital, a psychiatrist concluded that Ms. Brooks was competent to stand trial. She was returned to the county jail on June 10. Despite several earlier suicide attempts, several psychiatrists agreed that Ms. Brooks could be taken off suicide watch on June 30. She was then placed under protective custody.

On July 19, the officer watching Ms. Brooks and approximately 50 other inmates was ordered to leave the floor unattended while she processed two new inmates at the facility. As a result, no staff was on the floor between 12:05am and 12:45am, when a supervisor discovered the inmate had hanged herself. Five days later on July 24, jail staff received a new directive stating that the practice of leaving posts unattended to perform routine duties, such as processing new inmates or taking meal breaks, "shall cease immediately as we continue to maintain the safety and security of the facility."

Jeffrey Magness, president of the union, told the *Baltimore Sun* that "I agree with Mr. O'Neill that if this inmate had wanted to kill herself, she would have found a way." But, he said, it was both tragic and unnecessary that it took a death to address the dangerous practice of leaving posts unattended. ❑

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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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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