JAIL SUICIDE/MENTAL HEALTH UPDATE

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

Summer 2005 **Volume 14 • Number 1**

MODEL SUICIDE PREVENTION PROGRAMS PART 1

In Missouri, a 43-year-old woman was sent to a county jail for failing to complete the community service conditions of her the probation following a driving while intoxicated conviction. Within hours of her confinement, she was observed to be confused and disoriented — crawling on the floor and talking to herself. She was placed on suicide precautions and required to be observed at 15-minute intervals. A few days later, she was dead. The autopsy showed she died from an intestinal hemorrhage due to alcoholism. A subsequent investigation indicated that a jail sergeant falsified the observation log. Following her death, the county attorney referred to the incident as a "very unexpected event." The sheriff stated that "I think it is a unique, isolated incident…not everything is preventable."

In California, a 27-year-old man was arrested for public intoxication and a parole violation. He was transported to the county jail and placed in an observation cell. He hanged himself several hours later, the second suicide in the facility in less than a month. According to the jail commander, "We have 1,000 inmates in custody on any given day and 35 staff on duty. So, even under the best of circumstances, there is going to be a window of opportunity to try (suicide) if they're determined to do it." The facility averages two suicides per year. A county supervisor was not convinced, suggesting that even if jail staff followed policy "we need to take a close look at what happened and try to implement some corrective procedures. Maybe we should look at the type of assessment we do at intake to possibly identify inmates with suicidal tendencies."

In Pennsylvania, a 49-year-old man was transported to the county jail following his arrest for driving while intoxicated. Apparently despondent after both his parents and wife had died within the past 16 months, the inmate first attempted suicide by jumping head first off an upper bunk in an attempt to break his neck. He was placed on suicide precautions and observed at 15-minute intervals. He then attempted to hang himself with a bed sheet, but officers intervened and prevented any further serious injury. A few days later, the inmate lodged pieces of orange peel and paper in his throat and nose, as well as bound his hands behind his back so he could not involuntarily free his air passage when he started to choke. He then placed a sheet over himself so that the officer conducting rounds would assume that he was sleeping in the bunk. The inmate was eventually found unresponsive in his bunk and pronounced dead.

In South Carolina, a coroner's inquest jury found that the suicide of an inmate was the result of medical neglect at the county jail. The victim had a long history of mental illness. During his eight days of confinement, he never received his court-ordered psychotropic medication. The judge stated it was not the first time her court orders for medication had not been followed at the jail: "Oftentimes they do not get the medications as prescribed. Either they don't get the medications or they don't get the prescribed medication because they're not on the prison healthcare services formulary." The coroner concluded that "If it hadn't been for the inaction of other people, the inmate would still be alive."

In Texas, two inmates committed suicide in the same housing unit within a three-day span. Although both inmates had histories of mental illness, the suicides appeared unrelated. The warden appeared disinterested: "Our concern is more if we suspect foul play...we always go back and review our policies and procedures to see if there's anything we could do to prevent it." He then added, "I have no idea why they do it. If I ever did, I could probably do a better job of preventing it."

*Why do some jail systems experience an inordinate number of inmate suicides or deaths attributed to obvious deficiencies while others of comparable size are spared the tragedy? Some observers would call it good fortune, while others believe that "attitude" and comprehensive policies and procedures are the keys to suicide prevention in correctional facilities (Hayes, 2005). The **Update** has continually stressed that negative attitudes (e.g., "If someone really wants to kill themselves, there's generally nothing you can do about it") impede meaningful jail suicide prevention efforts.*

*Our most loyal readers will recall that the **Update** profiled model jail suicide prevention programs several years ago (Volumes 7*

INSIDE. . .

and 8 in 1998). Beginning with this issue, we will revisit the topic by examining several model suicide prevention programs operating in jail systems of varying sizes throughout the country. Programs have been evaluated (and on-site case studies conducted) according to the following criteria:

- *Intake screening to detect both current and prior suicidal behavior, as well as further and periodic assessment of suicide risk by mental health staff;*
- *Suicide prevention training for correctional, medical, and mental health staff;*
- *Levels of communication between outside agencies, among facility staff, and with the suicidal inmate;*
- *Suicide-resistant, protrusion-free housing of suicidal inmates;*
- *Levels of supervision for suicidal inmates;*
- *Timely emergency intervention by correctional and medical personnel following a suicide attempt;*
- *Provision of critical incident stress debriefing to affected staff and inmates, as well as completion of a multidisciplinary mortality review following an inmate suicide and/or serious suicide attempt; and*
- *A low rate of inmate suicides for an extended period of time.*

We begin our special series by highlighting the suicide prevention program currently operating within the Albany County Correctional Facility in Albany, New York.

Albany County Correctional Facility

Originally constructed in 1931 and renovated as recently as 1993, the Albany County Correctional Facility in Albany, New York is located northwest of the state capitol and adjacent to the county airport. James L. Campbell is the Sheriff. With a rated capacity for 1,035 beds, the Albany County Correctional Facility is the fifth largest county jail in the state. On the day of our visit in April 2005, the count stood at 767, with pretrial inmates representing the vast majority (about 70%) of the population. During the past year, over 7,000 inmates were admitted into the facility and the average daily population was 787.

Sabu George, 28-years-old, entered the Albany County Correctional Facility on October 28, 1998. Charged with violation of probation stemming from a driving while intoxicated charge, he was assigned to the mental health housing unit and observed at 15-minute intervals. On November 2, he was dead, a victim of suicide by hanging. Less than a year later on June 28, 1999, Gregory Lee Richardson died in restraints in the facility. The 42-year-old inmate had a long history mental illness, including schizophrenia. These two deaths were very controversial, resulting in significant media coverage and investigations by several outside agencies, including the New York State Commission of Correction.

According to David J. Kelley, Ph.D., coordinator of Adult Forensic Services at the Albany County Correctional Facility, the deaths of Messrs. George and Richardson also resulted in an internal review of mental health services provided to inmates at the facility. The general consensus was there were too few staff and too few programs for the rising mentally ill population. Regarding suicide prevention, "we needed to go back to the basics," according to Dr. Kelley.

The "basics" were a previously initiated statewide program designed to reduce jail suicides. Launched in 1985, the Local Forensic Suicide Prevention Crisis Service Model was developed through the cooperative efforts of the state Office of Mental Health, Commission of Correction, Ulster County Department of Mental Health, and a statewide task force. The Crisis Service Model was a multifaceted initiative designed to facilitate the identification, referral and treatment of inmates who were suicidal and/or seriously mentally ill. The program was specifically designed to establish administrative and direct service linkages among county jails, police lockups and local mental health programs. It also clearly defined the roles and responsibilities of mental health and local correctional agencies in the identification and management of high-risk inmates. In essence, jail suicide prevention became the joint responsibility of local jails and mental health programs.

Although refined over the years, the Crisis Service Model currently contains the following major components (Cox and Morschauser, 1997, pp. 180-181):

- **Policy and procedure guidelines to clarify roles of county jail, police department lockup, and mental health agency personnel**. These guidelines promoted shared mental health and local jail responsibility for inmates, coordination among departments, and minimum services.
- **Screening of detainees by trained jail/police officers**. A basic principle of this program was that officers were valued as "first responders" and persons most likely to first identify signs of suicidal behavior by inmates. It was also recognized that suicide is a rare event and that most of the upstate jail facilities were too small to financially justify full-time medical or mental health staff. Therefore, reliance on jail staff to perform the pre-cell assignment and on-going suicide risk screening functions was essential. The screening required use of a structured suicide prevention screening guideline at intake to identify high risk inmates as well as observation for risk indicators during routine rounds and at times of high stress.
- **Supervision**. Establishment of more rigorous levels of supervision for high risk inmates was required to ensure safety. After the initial assessment at booking, provisions for continuous observation for signs of suicide risk were required to identify high risk inmates during the remainder of their incarceration. Although this requirement appears obvious, it was not routinely performed prior to program

implementation. In fact, a protocol had not been established in all jails to formally identify inmates as high risk to communicate such information across shifts, and to continue the more intensive supervision until another risk decision was made.

- **Mental health observation housing**. As an adjunct to the levels of inmate supervision, special units or cells with varying levels of mental health and medical supervision were required for the management of high risk inmates. In small jails, this often resulted in a cell located in close proximity to the officer's post being designated as an increased observation area for high risk inmates.

- **Scheduled mental health treatment**. In order to manage inmates identified as high risk either at booking or later in their incarceration, timely mental health treatment (e.g., medication, crisis intervention, case management and release planning) was required. The goals of these services were short-term and focused on suicide prevention, stabilization of acute psychiatric symptoms, reduction in the risk of clinical decompensation, and continuity of care at jail admissions and release.

- **Crisis intervention**. Provision for timely emergency mental health and medical backup was required to respond to suicide attempts and other mental health crises. These services were arranged through on-site staff, on-call procedures, and/or agreements with local emergency rooms.

- **External hospitalization**. Provision for short-term psychiatric in-patient treatment was required for persons with serious mental illness or persons who were severely suicidal to the extent that stabilization was not possible within the jail setting. In the state of New York, this short-term hospitalization was provided through transfer to state or locally operated forensic hospitals or with security guard arrangements to civil hospitals operated by the locality or the state.

- **Training for both jail and mental health staff**. In 1985, an eight-hour crisis intervention/ suicide prevention training curriculum was developed for local jail and mental health/medical staff. This training component was revised and expanded in 1990, again in 2000, and now also includes a four-hour refresher training curriculum (New York State Office of Mental Health, Commission of Correction, and Ulster County Department of Mental Health, 2000).

- **Communication**. The training, policy and procedure aspects of this program emphasized the necessity for clearly defined communication across all levels of correctional, medical and mental health staff, as well as communication with detainees and, when possible, communication with families and significant others. Communication was the foundation for accomplishment of both the suicide prevention and service enrichment goals of this project.

- **Investigation and monitoring of inmate deaths**. Careful investigation, including psychological autopsies,

WE'RE STILL LOOKING FOR A FEW GOOD PROGRAMS

Future issues of the ***Jail Suicide/Mental Health Update*** will be devoted to exemplary suicide prevention programs operating within correctional facilities throughout the country. Does your facility's suicide prevention policy contain, and do your practices reflect, the following critical elements?

- Intake screening to detect both current and prior suicidal behavior, as well as further and periodic assessment of suicide risk by mental health staff;
- Suicide prevention training for correctional, medical, and mental health staff;
- Levels of communication between outside agencies, among facility staff, and with the suicidal inmate;
- Suicide-resistant, protrusion-free housing of suicidal inmates;
- Levels of supervision for suicidal inmates;
- Timely emergency intervention by correctional and medical personnel following a suicide attempt;
- Provision of critical incident stress debriefing to affected staff and inmates, as well as completion of a multidisciplinary mortality review following an inmate suicide and/or serious suicide attempt; and
- A low rate of inmate suicides for an extended period of time.

If you believe your correctional facility operates an exemplary suicide prevention program, and would like it to be considered as a possible case study in an upcoming issue of the ***Update***, please send copies of your suicide prevention policy, screening/assessment forms utilized to identify suicidal inmates, and total number of suicides and your facility's average daily population for each year from 1995 thru 2004 to:

Lindsay M. Hayes, Project Director
Jail Suicide/Mental Health Update
40 Lantern Lane
Mansfield, MA 02048
(508) 337-8806
Lhayesta@msn.com

was also critical to the success of the program. An investigation of completed suicides in local jails provided valuable information which could be utilized to prevent future suicides. Results of such investigations were utilized to develop the original suicide prevention project and are continuously utilized in local training and statewide conferences for alerting staff to particular trends or even new information critical to suicide prevention.

- **Staff debriefing**. Suicides and serious suicide attempts have an impact on the staff members involved in the crisis response. The program's guidelines strongly encouraged the development of a structured debriefing which was routinely required for staff who were involved in incidents of suicide. The training materials encouraged staff to be aware of the potential negative impact and to seek help.

During a three-year period of 1985 through 1987, technical assistance was offered to interested New York State counties in the development and maintenance of the Crisis Service Model. All 57 upstate counties, including Albany County, and most police departments participated in the process. To date, the results are very impressive. In 1984, county jails and police department lockups (including New York City) experienced 32 inmate suicides. In 2004, these same facilities experienced only 15 suicides. This decline is even more dramatic when viewed in the context of the inmate population size. From 1984 through 2004, the average daily population increased over 10,000 inmates from 18,113 to 29,977. However, the jail suicide rate was significantly reduced from 177 deaths per 100,000 inmates in 1984 to 50 deaths per 100,000 inmates in 2004. As shown in Table 1, the number and rate of jail suicides in the state of New York has remained stable during the most recent 10-year period.

Albany County was not the first jurisdiction to adopt the Crisis Service Model, but it was not far behind. And its success in preventing inmate suicides parallels other jails in the state. As seen by Table 2, since Mr. George's death in October 1998, the Albany County Correctional Facility (ACCF) has not had any further suicides through May 2005 — a period of almost seven years and 50,000 admissions. It also has established a suicide rate that is far below the statewide average.

Suicide prevention efforts at the ACCF are patterned after seven principles: 1) Identify suicidal inmates with serious mental health problems and to manage them in a timely manner; 2) Minimize the incidence of suicide among persons incarcerated within the Albany County Correctional Facility; 3) Stabilize acutely mentally ill and/or suicidal inmates and to provide facility safety; 4) Prevent decompensation among locally incarcerated inmates with a history of mental illness; 5) Provide all seriously mentally ill inmates access to mental health care within a reasonable amount of time; 6) Facilitate continuity of care for all seriously mentally ill inmates upon their release from jail; and 7) Foster cooperative working relationships between the jail and local medical/mental health service providers.

These seven principles are accomplished through adherence to the state's Crisis Service Model that was tailored to the needs of the ACCF. For example, all staff, including correctional, medical and mental health personnel (as well as individuals working in maintenance, kitchen, education, etc.) are required to complete the 8-hour suicide prevention training program and 4-hour refresher course. A suicide prevention screening form is administered to all arrestees upon intake and booking. Mental health and medical services are available 24-hours a day, and include an Adult Forensic Unit of both full-time weekday and partial weekend on-site coverage from two staff psychologists (including Dr. Kelley, the coordinator),

Table 1
SUICIDE RATES IN JAILS WITHIN NEW YORK STATE*
1995 TO 2004**

YEAR	AVERAGE DAILY POPULATION	SUICIDES	RATE (Per 100,000)
1995	32,248	15	46.5
1996	34,075	17	49.8
1997	33,058	18	52.8
1998	33,868	22	65.3
1999	29,876	14	46.8
2000	29,700	12	40.4
2001	28,789	13	45.1
2002	29,420	16	54.3
2003	30,237	19	62.8
2004	29,977	15	50.0
1995-2004	**312,248**	**161**	**51.5**

*Includes New York City Department of Corrections
** Source: New York State Commission of Correction

Table 2
ALBANY COUNTY CORRECTIONAL FACILITY
AVERAGE DAILY POPULATION AND INMATE SUICIDES
1995 to 2004*

YEAR	AVERAGE DAILY POPULATION	SUICIDES	RATE (Per 100,000)
1995	693	0	0
1996	726	0	0
1997	739	1	135.3
1998	721	1	138.6
1999	770	0	0
2000	719	0	0
2001	760	0	0
2002	832	0	0
2003	900	0	0
2004	877	0	0
1995-2004	**7,737**	**2**	**25.8**

*Source: Albany County Sheriff's Department

3 licensed clinical social workers, a psychiatric nurse, mental health assistant, and 25 hours per week on-site from a psychiatrist. The Adult Forensic Unit is staffed by the Albany County Department of Mental Health. A 48-bed-Special Housing Unit for acutely mentally ill was designed with input from the mental health coordinator. And although the ACCF has implemented all of the necessary procedures to run a model suicide prevention program, four key areas — intake screening, constant supervision, identification of risk following court proceedings, and inter-agency cooperation — form the backbone of the program.

Intake Screening

Upon entry into the ACCF and prior to initial cell assignment, all inmates are screened by booking deputies. The screening includes: 1) Obtaining verbal reports from any person regarding the inmate's behavior and/or statements; 2) Determining whether the inmate attempted suicide and/or received mental health services during prior incarceration in the facility; and 3) Administering the Suicide Prevention Screening Guidelines form.

The Guidelines form, developed in conjunction with the state's Crisis Service Model and appearing on page 6, is divided into four sections: observations of the arresting/transporting officer; personal data; behavior/appearance; and action. Following completion of the form, the tour commander is notified of the results whenever the inmate expresses extreme embarrassment, shame, or feelings of humiliation as a result of the charge or confinement; threatens suicide; has attempted suicide within the past month; expresses feelings of hopelessness; is intoxicated, incoherent or showing signs of withdrawal or mental illness; refuses to answer any questions; the arresting/transporting officer believes the inmate is a suicide risk, or the inmate has scored "8" or more on the Guidelines form. The tour commander will review the form, place the inmate in a holding cell and immediately contact the Adult Forensic Unit. Critical to the comprehensiveness of intake screening process, ACCF policy states that "the Booking officer also has discretion to refer inmates to Mental Health even if the above criteria are not met. It is preferable that too many inmates are referred rather than overlook the one inmate who may be suicidal."

The Suicide Prevention Screening Guidelines form is unique for several reasons. Normally taking less than five minutes to complete, the form is administered separately from the medical intake form. It is exclusively devoted to identifying suicidal behavior in arrestees, and encourages communication between the arresting/transporting officer and the booking deputy regarding the arrestee's mental health status. Since the arresting officer can frequently provide insight into both the arrestee's behavior and emotional state, as well as the circumstances of arrest that may not be apparent or are hidden from the booking deputy, their observations are critical from the standpoint of suicide prevention.

In addition to the screening process during booking, inmates are screened separately by medical staff and classification personnel. The medical screening form includes the following lines inquiry: "Have you ever been hospitalized or treated for psychiatric problems?" "Have you ever considered or attempted suicide?" "Are you feeling depressed or extremely sad?" "Do you want to hurt yourself or someone else." In addition, ACCF has recently enacted a policy in which classification staff are required to consult the facility's automated inmate management system to determine whether the newly arrived inmate was a suicide risk during a prior ACCF confinement. Following these processes, correctional staff are instructed that if they hear an inmate verbalizing a desire to commit suicide, observe an inmate acting despondent or making a suicidal gesture, or otherwise believe an inmate is at risk for suicide, immediate steps are taken to ensure that the inmate is continuously observed until mental health, medical or supervisory assistance is obtained. According to Dr. Kelley, "No one in the ACCF is shy about referring an inmate to mental health staff or placing an inmate on suicide precautions."

Form 330 ADM (CC) (4/01)

State of New York
COMMISSION OF CORRECTION
Office of Mental Health

SUICIDE PREVENTION SCREENING GUIDELINES

DETAINEE'S NAME	SEX	DATE OF BIRTH	MOST SERIOUS CHARGE(S)	DATE	TIME

NAME OF FACILITY	NAME OF SCREENING OFFICER	*Detainee showed serious psychiatric problems during prior incarceration* YES _____ NO _____

Check appropriate column for each question

	Column A **YES**	Column B **NO**	General Comments/Observations All "YES" Responses Require Note to Document
OBSERVATIONS OF ARRESTING/TRANSPORTING OFFICER			
1. Arresting or transporting officer believes that detainee may be a suicide risk. **If YES, notify supervisor.**			
PERSONAL DATA			
2. Detainee lacks support of family or friends in the community.	No Family Friends		
3. Detainee has experienced a significant loss within the last six months (e.g., loss of job, loss of relationship, death of close family member).			
4. Detainee is very worried about major problems other than legal situation (e.g., serious financial or family problems, a medical condition or fear of losing job).			
5. Detainee's family member or significant other (spouse, parent, close friend, lover) has attempted or committed suicide.			
6. Detainee has history of drug or alcohol abuse. (Note drug and when last used.)			
7. Detainee has history of counseling or mental health evaluation/treatment. (Note current psychotropic medications and name of most recent treatment agency.)			
8. Detainee expresses extreme embarrassment, shame, or feelings of humiliation as result of charge/incarceration (consider detainee's position in community and shocking nature of crime). **If YES, notify supervisor.**			
9. Detainee is thinking about killing himself. **If YES, notify supervisor.**			
10a. Detainee has previous suicide attempt. (Explore method and check for scars.)			
b. Attempt occurred within last month. **If YES, notify supervisor.**			
11. Detainee is expressing feelings of hopelessness (nothing to look forward to). **If YES, notify supervisor.**			
12. This is detainee's first incarceration in lockup/jail.			
BEHAVIOR/APPEARANCE			
13. Detainee shows signs of depression (e.g., crying, emotional flatness).			
14. Detainee appears overly anxious, panicked, afraid or angry.			
15. Detainee is acting and/or talking in a strange manner (e.g., cannot focus attention; hearing or seeing things which are not there).			
16a. Detainee is apparently under the influence of alcohol or drugs.			
b. If **YES**, is detainee incoherent, or showing signs of withdrawal or mental illness? **If YES to both a & b, notify supervisor.**			

TOTAL Column A _____

Officer's Comments/Impressions

ACTION

If total checks in Column A are 8 or more, or any shaded box is checked, or if you feel it is necessary, notify supervisor and institute constant watch.

Supervisor Notified: YES _____ NO _____

Constant Supervision Instituted: YES _____ NO _____

Detainee Referred to Medical/Mental Health: YES _____ NO _____

If YES:

	EMERGENCY	**NON-EMERGENCY**
medical	_____	_____
mental health	_____	_____

Signature and Badge Number of Screening Officer: _____

Medical/Mental Health Personnel Actions: (To be completed by medical/MH staff)

Constant Supervision

In November 1999, the state Commission of Correction (SCOC), an agency that provides both oversight and assistance to state and local correctional facilities, issued a memorandum regarding the supervision provided to suicidal inmates. Following an investigation of several inmate suicides, the SCOC's Medical Review Board had determined that "a supervisory interval of 15 minutes is not adequate as a suicide prevention precaution." The SCOC then revised its interpretation of the state's minimum correctional standards by requiring all suicidal inmates to be observed under "constant observation." According to the SCOC interpretation of constant observation:

> "The required elements include *uninterrupted personal visual observation* from a post that affords *a continuous clear view* of those under supervision, and sufficient proximity to afford the ability to *immediately and directly intervene* in any situation that threatens health or safety. In some settings, this requires the assignment of a correctional officer to each inmate under constant supervision (commonly referred to as *one-on-one supervision*). In others, the physical plant configuration may allow more than one inmate to be constantly supervised by a single officer. Video surveillance is not sufficient to satisfy these requirements. There are conditions, illnesses and injuries for which a supervisory interval reduced to 15 minutes is entirely adequate and appropriate, but suicide attempt is not one of them."

Given these new regulations, correctional facilities (including Albany County) began to revise their supervision policies. Within the Albany County Correctional Facility, two levels of supervision are now afforded to suicidal inmates: 1) *constant observation* is reserved for inmates "who voice suicidal thoughts without a clear plan or intent to hurt themselves, or who are intoxicated, psychotic or disorganized to such a degree that staff believe them to be at risk for self-harm." One officer may supervise up to four inmates under this observation level, and mental health staff provide assessments of these inmates on a daily basis; and 2) *one-to-one supervision* is reserved for inmates "who are found to actively attempting to harm themselves or are voicing immediate intent to do so, as well as with inmates who are unable to control their behaviors to such a degree that they place themselves at imminent risk for harm." One officer is assigned to maintain direct visual observation of the inmate on a continuous basis, and mental health staff provide daily assessments.

While there traditionally has been a reluctance to use constant supervision in many jails throughout the country, it has never been an issue in the ACCF or any other facility in the state of New York (even before the advent of the new SCOC regulation). Correctional officers are specifically assigned the responsibility to observe suicidal inmates and the use of overtime is generally not an issue. According to Dr. Kelley, "when we place inmates on constant supervision, we're telling them — 'you're safe. We're not going to let you or anyone else harm you.' We take that responsibility very seriously." In addition, very few suicidal inmates are stripped of their clothing and issued either safety smocks or paper gowns. ACCF policy warns that "being 'stripped' is stressful in itself (e.g., temperature, embarrassment). Thus, the smock should be used only in cases of active suicidal ideation in which the clinician believes the client is at risk. It should not be used for disciplinary or behavior management reasons. Also, the safety smock should be used as a temporary measure, not a permanent solution, and the time a client is 'stripped' should be limited." Correctional and mental health officials see little reason to remove clothing from an inmate that is under constant supervision. "For us to go beyond constant watch and deprive inmates of both their clothing and the little dignity they may be holding onto, they have to be actively trying to hurt themselves," Dr. Kelley said.

Identification of Risk Following Court Proceedings

Court appearances also can be a particularly stressful event for an inmate. The Albany County Correctional Facility sustained three inmate suicides during the summer of 1989. All three victims had appeared in court within a few days of their deaths. In response to these suicides, the ACCF instituted a policy in which ***all*** inmates on the mental health caseload who return from court are temporarily placed on suicide precautions (i.e., constant supervision) until they can be assessed by mental health staff. The mental health caseload includes inmates who are deemed seriously and/or persistently mentally ill, chronically mentally ill, have a history of suicidal behavior, or are currently taking psychotropic medication. While there was some initial resistance to this second layer of assessment, all staff quickly realized the benefit of the practice.

Perhaps the case of Jason Wick (a pseudonym) best exemplifies the need for this additional layer of assessment. On January 20, 2004, he entered the ACCF on a charge of 2nd degree murder. Mr. Wick expressed suicidal ideation during intake and was placed on suicide precautions. He was then seen daily by mental health staff until February 1, when he was cleared from constant observation and transferred to the mental health unit. Mr. Wicks was then seen on daily rounds and weekly counseling sessions by mental health staff. Facing a bail reduction hearing on May 28, he expressed mild suicidal ideation but denied any intent or plan to mental health staff. On June 1, Mr. Wick returned to the ACCF from the court hearing and was automatically placed on suicide precautions pending an assessment. He was then seen by mental health staff and appeared anxious about the unknown outcome of his bail hearing. Mr. Wick expressed suicidal ideation and remained on suicide precautions. Two days later on June 3, he was informed by his attorney that his bail had been reduced. Mr. Wick was able to talk with his sister and was informed that his family remained supportive and would try to raise funds to post his bail. He was then reassessed by mental health staff and, relieved at the support from his family and reduction in bond, denied any further suicidal ideation and was cleared again from suicide precautions. Mr. Wick remains on the mental health caseload and is seen on a regular basis.

Inter-Agency Cooperation

The success of a suicide prevention program is often determined by the relationship that exists between correctional, mental health, and medical staff. Many preventable suicides result from poor communication amongst these three disciplines. Cooperation

and communication problems are often caused by lack of respect, personality conflicts, and other boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides. The ACCF enjoys a solid relationship between the three disciplines, particularly amongst correctional and mental health staff. According to Dr. Kelley, "It's never us versus them." There are monthly medical advisory committee meetings (comprising the first deputy superintendent, medical administrator, and mental health coordinator), as well as a separate medical-mental health management meeting. Mental health staff are in the housing units on a regular basis, interacting with both inmates and correctional staff. They make *daily* rounds of both the mental health and segregation units — going cell-to-cell. Nursing staff also make daily rounds of the segregation unit. Mental health staff also automatically assesses each inmate transferred to segregation to ensure that an inmate's mental health is not contraindicated by the placement. They work with correctional staff in devising behavior management plans for inmates deemed to be manipulative. And an integrated health care record better ensures effective communication between medical and mental health staff.

Inter-agency cooperation is not limited to inside the walls of the ACCF. For example, concerned about how to address the needs of an increasing number of individuals with mental illness becoming involved with the criminal justice system, several county agencies (including the Albany County Correctional Facility, Albany County Department of Mental Health, and Office of the Public Defender for Albany County) formed an multidisciplinary committee to address the issue. Coined the Options Committee, the group soon grew to 20 members. Its mission included managing the integration of existing health, mental health, substance abuse and social service systems to match client needs with available services. As a result of the Options Committee's work, various programs and services have been implemented, including improvements in mental health services in the ACCF and opportunities for pre-trial diversion.

The case of Barbara Griffin (also a pseudonym) is indicative of both inter-agency cooperation within the Albany County Correctional Facility, as well as overall jail suicide prevention efforts. Ms. Griffin, 50-years-old and a native of Nigeria, was arrested by Albany police officers on a charge of grand larceny and booked into the ACCF on the afternoon of April 12, 2005. She was administered the Suicide Prevention Screening Guidelines form and positive responses were received regarding the arresting/transporting officer's belief that she was a suicide risk (Question No. 1), she was concerned about her children (Question No. 4), and she was thinking about killing herself (Question No. 9). Ms. Griffin was placed on constant observation and assessed by mental health staff less than an hour later. She self-reported a significant mental health history, including prior suicidal behavior. Although subsequently denying suicidal ideation to mental health staff, she remained on constant observation due to her unstable behavior and history.

Following the assessment, staff at the ACCF's Adult Forensic Unit requested and received copies Ms. Griffin's community mental health records from the Albany County Department of Mental Health. The records revealed that her suicidal ideation was chronic and exacerbated, in part, by a continuing threat of deportation. She was very concerned about her children, including a disabled adult son for which she provided full-time care. Her history was very troubled; it included physical abuse from her husband and a prior conviction for submitting a false birth certificate to obtain social services for her disabled son.

Ms. Griffin was seen the following day (April 13) by mental health staff. She was given supportive counseling and appeared much more stable. The clinician reviewed the mental health records with her client and subsequently decided to clear Mr. Griffin from constant observation. She was placed in the mental health unit and scheduled to see the psychiatrist.

On April 19, Ms. Griffin wrote a "kite" suggesting that "I am very depressed. I need to talk to someone who cares." The mental health referral was given to Adult Forensic Unit staff by a correctional officer. When seen by her clinician, she appeared anxious but not suicidal. She was again given supportive counseling. Ms. Griffin attended a court hearing the following day (April 20) and, upon her return, was automatically placed on suicide precautions and referred to mental health staff for assessment. She was cleared from suicide precautions following the assessment, and subsequently seen by the psychiatrist who prescribed psychotropic medication. She remained on the mental health unit and was provide with regular follow-up mental health services.

Conclusion

In conclusion, it should be noted that the Albany County Correctional Facility's success is not limited to suicide prevention. The facility is accredited by both the New York State Sheriff's Association and the National Commission on Correctional Health Care. Its mental health housing unit is one of the few in the state to be certified as a "clinical treatment program satellite" by the state Office of Mental Health.

Developing a model suicide prevention program is more than simply having a policy containing all the required components — it is ensuring that staff have knowledge of, and implement, the components. Suicide prevention is also more than management personnel attending regular monthly meetings — it is demonstrating that the collaborative group has an intuitive sense as to when a particular inmate may be most at risk for suicide and positioning themselves for appropriate intervention. In the end, it comes down to people like Barbara Griffin, who just wanted to talk with "someone who cares" — and received such attention from each of the ACCF staff with whom she interacted. The Albany County Correctional Facility exemplifies the best in suicide prevention programming.

For more information on suicide prevention efforts at the Albany County Correctional Facility, contact David J. Kelley, Ph.D., Coordinator, Adult Forensic Unit, Albany County Correctional Facility, 840 Albany Shaker Road, Albany, New York 12211, (518/869-2683; 518/869-2704-Fax), or e-mail: DKelley@albanycounty.com

EDITOR'S POSTSCRIPT: Even model jail suicide prevention programs are not immune from inmate suicide. On June14, 2005, a few months after our visit, the Albany County Correctional Facility suffered its first suicide in almost seven years when a 21-

year-old man committed suicide by hanging. The State Commission of Correction is currently investigating the death.

References

Cox, J. F. & Morschauser, P. C. (1997), "A Solution to the Problem of Jail Suicide," *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 18 (4): 178-184.

Hayes, L. M. (2005). "Suicide Prevention in Correctional Facilities," in *Handbook of Correctional Mental Health*, edited by C.L. Scott and J.B. Gerbasi, American Psychiatric Publishing, 69-88.

New York State Office of Mental Health, Commission of Correction, and Ulster County Department of Mental Health (2000), *Suicide Prevention and Crisis Intervention in County Jails and Police Lockups: Basic Program Trainer's Manual*, Albany, NY: Authors. ❑

Tax Would Help Keep Mentally Ill Out of Jail

Washtenaw County, through its jail millage request, is asking voters to make the largest mental-health spending decision in county history. The proposal's plan to improve services and treatment for mentally ill offenders would cost $84 million over 20 years —- more than 25 percent of the $314 million that would be generated by the levy. The proposal would provide more assessment, more treatment, more beds outside the jail and more support to help mentally ill inmates once they've left jail than the county has ever offered.

"It is unprecedented," said Donna Sabourin, executive director of the county's Community Support and Treatment Services, formerly known as Community Mental Health. Sabourin said her counterparts in other counties are "amazed and impressed….. Washtenaw County is way ahead of the curve on this." The concept is known as mental health diversion —- keeping mentally ill people who are not violent offenders and whose crimes often result from untreated mental illness from being incarcerated.

Many county groups serving mentally ill people, including the Washtenaw County chapter of the National Alliance for the Mentally Ill and the St. Joseph Mercy Health System, have endorsed the proposal, but critics of the millage ask whether the money would be put in the right places and what would happen after the levy ends in 20 years. "We should not be passing bond issues of this magnitude that are basically operating costs unless we have some plan of what we'll do when the bond issue is finished," said Rosemary Sarri, professor emeritus from the University of Michigan and an active researcher with U-M's Institute for Social Research. "I think the mistake that was made was to put all of this into one issue." Sarri said she favors the mental health aspects of the proposal, "but the solution isn't just to build jail beds. We need to think about how this will be paid for afterwards, since it's mostly operating costs."

Identifying the Need

County mental health officials estimate that 25 percent of jail inmates have some sort of mental illness, primarily depression, bipolar disorder and schizophrenia. That percentage represents only those who are being seen by a psychiatrist or are on prescribed medication. "Certainly there are additional people in jail showing depression, anxiety. If it's being managed through counseling, those people aren't counted," Sabourin said. "There's a significant gap in our society as a whole and in our community in having a full range of mental health services available for all citizens..... There is no identifiable funding stream to serve the population we have targeted."

Screening for mental illness among jail inmates is limited to a brief interview by corrections officers, with more comprehensive assessments done only for those already on psychotropic medicine or those being treated through county services.

Yet county psychologist Daniel Ing, who works with and assesses jail inmates, said he sees a need to assess everyone, something that would happen if the millage passes. "People are committing the petty crime side of things and they're suffering from illness," Ing said. "We have people who come here (to the jail) who need treatment but don't have it and go back into the community untreated, and then end up back here." Ing, who also has worked in county mental health outside the jail, said inmates are far more motivated to adhere to a treatment program than mentally ill clients who are struggling with basic food and shelter issues. "Having the stability the jail provides in relation to everyday needs, then people are able to look at issues they are dealing with," he said. And, he said, providing an entire assessment for everyone who becomes incarcerated would help the community as well as the inmates. "Taxpayers would benefit just as a whole with fewer individuals going around untreated," Ing said.

Diane Davidson said she believes her 27-year-old son could have avoided going to prison if the provisions in the Feb. 22 millage request were in effect during the past decade. She said her son, John, who suffers from mental illness and substance abuse, underwent years of repeated arrests and jail time. When first arrested, he wasn't in the mental health system, so he didn't get a mental assessment and the pattern continued. "It was a vicious revolving door," Davidson said, adding that her son was imprisoned for three years after repeated stints in the Washtenaw County Jail and then a Charlevoix County facility before he was caught stealing a car. "I'm convinced that if we'd had mental health assessment capability in jail here, his earlier experiences in jail before he ended up north could have been avoided. We'd have had a more intensive treatment program for him," said Davidson, the executive director of the Washtenaw Housing Alliance, which has endorsed the jail proposal. Davidson, who has participated in the county's mental health diversion subcommittee, has for years spoken openly about her son's illness and convictions. She said the mental health initiatives under the millage would provide better care for mentally ill people. "Over the long haul, the recidivism rate would go down, and we'll do a better job across the board," she said.

Gloria VanAlstine, a Scio Township mother of a son with mental illness and substance abuse problems, also sees hope in the proposal. She said the new, 96-bed jail pod that would house

inmates with medical and special needs, as well as general population inmates, would have greatly helped her son. "When he ended up in jail due to stealing to get these drugs, what he really needed was drug rehabilitation," VanAlstine said. "One of the problems is that once someone like my son has been in jail, then it's not as easy to get into drug rehabilitation because he basically detoxed in jail."

Outlining the Costs

While the three-quarter mill property tax levy would be in effect, cost projections show that the mental health part of the $314 million plan would steadily increase, due to inflation and rising numbers of people using the services. During most of those years, mental health diversion would cost at least half as much as the overall, additional jail operating expense. For example, in 2015, additional jail operating costs covered by the millage would be an estimated $9.4 million and mental health diversion would be $4.8 million. By 2024, additional operating costs would be $13.4 million and mental health diversion would be $7.2 million.

The mental health money would be spent in several ways. For starters, there would be more training for law enforcement officers in recognizing and working with mentally ill people. The county also would provide better assessment of the mental status of an inmate; build three new six-bed crisis residential facilities, one of which would help those with both mental illness and substance abuse problems; and put in place long-term referral and treatment services tailored to those diverted from the jail.

The price tag would be steep. The crisis residential services alone, for the 24 people who could be housed at one time, would cost $7,200 a day, or $2 million a year. Each client would use those services for very short-term periods, from eight to 30 days, Sabourin said. Yet the cost is half what it would be to hospitalize such mentally ill offenders, she said. The long-term treatment services in the plan would cost $10,507 a year for each client, for an estimated $1 million a year for nearly 100 clients. Yet that cost is less than half of what incarceration costs a year, Sabourin said.

Staffing is another issue. Nearly 60 new employees would be needed, either through direct county hires or contracted services, to make the millage proposal work, Sabourin said.

The critics of the costs include those who want the county to consider the front end first —- providing social and mental services that would prevent people, including those with mental illnesses, from going to jail in the first place. "We recognize the community needs jails but so much research shows that if you invest in kids early on there is less juvenile delinquency, less crime, less jail service to teenagers and young adults," said Susan Miller, a community member and co-chair of the Zero to Five Action Group, which focuses on early childhood issues. The group has made that recommendation to the county. "Wouldn't it be wonderful if the community would look at both ends," Miller said. "Yes, we need improvements in the jail..... but we'd like to talk about social and emotional health for kids."

The movement to deinstitutionalize mentally ill people began in the late 1970s, Sabourin said, and accelerated in Michigan in the 1990s, during former Gov. John Engler's administration. "Over the years there had been a whole series of hospital closures..... There had been promises made that the money would follow people into the community (through community mental health boards). But there was a strong sense (under Engler) that fewer funds were transferred during his administration than previously," Sabourin said.

Over time, the percentage of mentally ill jail inmates rose. Sabourin said there is a direct correlation between the hospital closures and the larger mentally ill jail population today. "If the (state) money had followed people as we'd understood it would when we started this, and had been maintained instead of being decreased, putting more people at risk, we wouldn't see as high a number of mentally ill inmates," Sabourin said.

The National Institute of Corrections estimates that the trend to deinstitutionalize reduced the number of mentally ill patients in state hospitals from nearly 600,000 nationwide in 1959 to about 70,000 in the late 1990s. And, by 1998, an estimated 283,000 mentally ill adults were in prison and jail nationwide; another 547,800 were on probation. Locally, no historical records exist of mental illness and inmates at the jail, sheriff's Cmdr. Dave Egeler said.

But mental health advocates and correctional facility leaders have been working —- on a limited basis —- to keep those who are mentally ill, but not violent offenders, out of the jail. In 2001, a jail diversion agreement was worked out among the county's criminal justice, public safety and mental health systems. Sabourin said it came about after the state Department of Community Health issued a policy statement setting expectations for community mental health to negotiate such agreements in each county. However, there was no money attached to the policy.

UPDATE
ON THE INTERNET

Recent issues of the ***Jail Suicide/Mental Health Update*** are now available on the Internet at:

www.ncianet.org/cjjsl.cfm

Check us out on the Web!
www.ncianet.org/cjjsl.cfm

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.pbstandards.org/resources.aspx
www.gainsctr.com

The Long-Term Results

What would county residents get for their investment? Local mental health community advocates say this proposal might be the best hope mentally ill people have had in years to counter the long-term effects of the hospital closings in the early 1990s. Both the National Alliance for the Mentally Ill of Washtenaw County and the Shelter Association of Washtenaw County have endorsed the proposal. Ellen Schulmeister, executive director of the Delonis Center, Ann Arbor's homeless shelter, sees the proposal for mental health diversion as another example of how the community has come together to help disadvantaged populations. "If people are appropriately assessed and given treatment, then maybe fewer would be here, down the road," she said, referring to the homeless shelter. "I see it as an appropriate tool that may help prevent homelessness and keep people out of jail..... In the long run, it could save the community money."

The local NAMI also supports the millage, particularly the mental health aspects. "It's good because it's not just about adding jail space. There's lots of programs that will benefit these people without them just being incarcerated," said Chuck Hughes, president of NAMI of Washtenaw County. "We feel a lot of people are being incarcerated who have mental illness problems. This way they can receive the treatment they need and should get," Hughes said. "It's too bad we don't have the resources to do it without a millage."

NOW AVAILABLE: SPECIAL ISSUE OF *PSYCHIATRIC SERVICES*

The July 2005 issue of *Psychiatric Services* (a monthly journal published by the American Psychiatric Association) is devoted to mental health and the law. Articles include:

- "An Actuarial Model of Violence Risk Assessment for Persons with Mental Disorders," in which John Monahan, PhD and his co-authors describe their study of the validity of the multiple iterative classification tree model in distinguishing between patients with high and low risk of violence in the community after discharge from a psychiatric facility;

- "Validation of the Brief Jail Mental Health Screen," in which Henry J. Steadman, PhD and associates report on a study they conducted to validate the Brief Jail Mental Health Screen—a revision of the Referral Decision Scale—in a large sample from four jails in Maryland and New York;

- "Major Mental Disorders, Substance Use Disorders, Comorbidity, and HIV-AIDS Risk Behaviors in Juvenile Detainees," in which Linda A. Teplin, PhD and her colleagues determined the prevalence of 20 HIV-AIDS risk behaviors among juvenile detainees with and without mental disorders or substance use disorders;

- "Clinical Outcomes of Defendants in Mental Health Court," in which Roger A. Boothroyd, PhD and his co-authors report on outcomes of 116 clients of a mental health court in Broward County, Florida compared with 110 defendants from a regular magistrate court;

- "Rediversion in Two Postbooking Jail Diversion Programs in Florida," in which Marcus T. Boccaccini, PhD and colleagues examined rediversion patterns in two post-booking jail diversion programs in Florida to assess the extent to which the programs served repeat clients;

- "Incarceration Associated with Homelessness, Mental Disorder, and Co-Occurring Substance Abuse," in which Dale E. McNiel, PhD and co-authors assessed relationships between homelessness, mental illness, and incarceration in a large sample of inmates of the San Francisco County Jail system;

- "Relationship Between Criminal Arrest and Community Treatment History Among Patients with Bipolar Disorder," in which Cameron D. Quanbeck, MD and associates studied the relationship between criminal arrest and gender, substance abuse disorder, and use of community mental health services among inmates in the Los Angeles County Jail who had a diagnosis of bipolar I disorder and a history of psychiatric hospitalization; and

- "Rearrest and Linkage to Mental Health Services Among Clients of the Clark County Mental Health Court Program," in which Heidi A. Herinckx, MA and her co-authors present the results of their study of rearrest and linkage to mental health services in a sample of 368 misdemeanants with severe and persistent mental illness who were served by the mental health court in Clark County, Washington.

For more information regarding the availability of *Psychiatric Services* (Volume 56, Number 7, July 2005), contact the American Psychiatric Publishing, Inc., 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209, (800/368-5777) or e-mail at appi@psych.org, website: www.appi.org.

Stripping Inmates Naked in the Name of Suicide Prevention

In March 2005, the American Civil Liberties Union (ACLU) of Michigan announced that it would join in three lawsuits that had been filed against the Saginaw County Jail in Saginaw for allowing jail personnel to strip inmates and house them naked in segregation. The three lawsuits, *Rose v. Saginaw County*, *Whittum v. Saginaw County*, and *Brabant v. Saginaw County*, were filed in the United States District Court, Eastern District, Northern Division, and assigned to Judge David M. Lawson. In January 2005, Judge Lawson found in *Rose* that the practice of holding detainees naked in segregation was unconstitutional, but he has yet to rule on damages in that case.

In all three cases, those arrested were misdemeanor, pre-trial detainees held for minor offenses. In both *Rose* and *Brabant*, the jail policy allowed jail personnel to remove all clothing from detainees and house them in segregation if they were perceived as uncooperative. As a result, naked detainees could be viewed by both jail personnel and other inmates of the opposite gender. The *Whittum case* challenges the jail's strip search policies as violating a state law that limits strip searches to inmates who were arrested for a felony or were suspected of having drugs, weapons, or contraband.

One of the plaintiffs in the lawsuits, Amanda White, then 21-years-old, was in the jail after being beaten by her boyfriend and released from an emergency room. It was Ms. White's first offense for intoxication. According to the lawsuit, in spite of the fact that she had stitches in her head and broken ribs, jail officers, some of whom were men, forcibly stripped her after she begged to use a bathroom and then left her in "the hole." In the process, one of the stitches was dislodged and the medical appliance to support her broken ribs was withheld.

Linda Rose, 36-years-old, was being detained on a misdemeanor when she was put in "the hole" after repeatedly asking if she could call her parents for help. "I knew what they were doing to me was wrong," said Ms. Rose. "I squatted in a corner with my arms crossed over me for three hours trying to stay out of the camera's view because I knew that strangers were watching me naked. I never want this to happen to anyone again."

According to Saginaw County, the policy of stripping inmates naked and housing them in segregation was initiated in August 1996 following an incident that ended in the suicide of a detainee who had been placed in administrative segregation. The detainee, dressed in a standard-issued orange jail jumpsuit, was placed in the segregation cell and left unobserved for several hours. He then wedged his jail uniform between the cell door and the door frame and hanged himself. Approximately three months later, another inmate vandalized one of the direct observation cells and rendered it unusable.

As a result, jail officials formulated a policy that called for disruptive detainees to be placed in segregation cells and mandated that "any inmate placed into these cells would be placed into them without clothes." Inmates would remain naked in the cells until such time that he or she no longer posed a threat to him/herself, others, or the secure operations of the jail.

According to Saginaw County Sheriff Charles Brown, "it's taking away the chance that the person may hurt themselves or somebody else, and once they sober up or once they become cognizant of what they're doing, you may have saved that person from tremendous injury." Although the county's main justification for stripping inmates naked and placing them in administrative segregation was the prevention of suicide, Sheriff Brown gave additional reasons at his deposition: "Inmates can obviously stuff (their clothes) down their throat, they can obviously hang themselves, they urinate on their clothing and throw it at the deputies, defecate on it and throw it at the deputies, which has been done many times, they could actually use the clothing to, if the guard got close enough, to wrap it around his neck."

The sheriff's argument was bolstered by reports from two expert witnesses for the county who believed that "placing a detainee for a limited duration under close supervision, in the nude, in an administrative segregation cell, is a reasonable alternative legitimately related to detention objectives," and that "by removing their clothing, a greater degree of protection was provided to the inmates."

Yet, according to Christopher Pianto, the Flint lawyer who initially filed the lawsuit on behalf of the 22 *Rose* plaintiffs in 2001, the placement of inmates without clothing into segregation cells subjected them to unreasonable and illegal conditions of confinement. Therefore, the Saginaw County Jail policy was unconstitutional. He cited the case of a former inmate who provided a statement alleging that trustees would vie for the job of emptying the trash cans near the closed circuit television monitor in order to view the naked pre-trial detainees in the segregation cells. "How is it possible for the sheriff to testify that 'there is absolutely nothing wrong with what we did?"' asked Mr. Pianto.

After hearing all the arguments, Judge Lawson ruled, in part, that:

> "the question in this case does not focus on the reasonableness of placing uncooperative and disruptive detainees in administrative segregation. Rather, the issue is whether the regulation requiring removal of all of the detainees' clothes violates the Constitution. Courts in this Circuit have recognized that prisoners have a liberty and privacy interest in shielding their naked bodies from view by others, especially members of the opposite gender.
>
> The Court finds, however, that confining such detainees with no clothing whatsoever is an exaggerated response to the articulated security and safety concerns of the defendants in light of the importance of the right described in this Circuit's precedents and the availability of reasonable alternatives. First, there is a rational connection

between the interest of jail security and confining unruly prisoners in segregation, but that alone does not justify removing all their clothes. One of the defendants' experts states that the practice amounts to 'behavior modification,' but that purpose suggests a punitive rationale that is not permissible under the Due Process Clause. The defendants also argue that obstreperous detainees could use their clothes to assault guards, but once the detainee is in the segregation cell, that concern dissipates. Finally, the defendants offer suicide prevention as a rationale, but none of these plaintiffs were screened for suicidal tendencies, and the intake papers indicate that they were not suicide risks. Moreover, according to the defendants' expert, the "operational system" in place included both voice and visual "officer monitoring . . . documenting security checks every 15 minutes, [and] monitoring by medical personnel." There is no indication that these measures were in place in 1996 when an inmate committed suicide, and they appear to be quite adequate to ensure that a detainee is not using clothing to harm him/herself. Further, the Saginaw County jail has a 'suicide cell' available for those prisoners who truly are suicide risks.

Second, the plaintiffs had no alternative means of exercising their right to privacy. Once their clothes were removed, they were exposed to all who could view them in the segregation cell by video monitoring device or through the slot in the door. The record indicates that some of the plaintiffs were observed naked by members of the opposite gender. They had no way to protect that 'special sense of privacy in their genitals' or avoid the 'especially demeaning and humiliating' experience and 'degradation' resulting from the 'involuntary exposure of them in the presence of people of the other sex.'

Third, the defendants argue that allowing the detainees in the segregation cells to maintain some vestige of their modesty will result in substantially increased administrative costs. They contend that keeping disruptive and violent detainees in cells with other detainees would impact guards and other detainees; other detainees would be subject to the disruptive and violent conduct of one detainee; jail staff would be forced to focus their attention on one detainee who is violating the security and orderly operation of the jail to the necessary detriment of other detainees and to their other responsibilities; and posting one officer outside the segregation cell while one detainee is housed in the cell with his or her clothing on would place a serious strain on the resources of the jail. Most of these arguments, however, address the practice of placing disruptive prisoners in isolation to begin with, a practice not challenged here.

The alternatives to naked confinement include those discussed in the cases cited above, such as allowing detainees to wear underwear, *Johnson v. City of Kalamazoo*, 124 F. Supp. 2d at 1104, 1106; providing paper suicide gowns, *Wilson v. City of Kalamazoo*, 124 F. Supp. 2d at 858; and restricting access by jail personnel of the other gender, *Kent v. Johnson*, 821 F.2d at 1222; *Everson v. Michigan Department of Corrections*, 391 F.3d at 756. As mentioned above, the guards also could make use of the jail's suicide observation cell. Given the magnitude of the right to privacy in one's own body described by the cases, these rather rudimentary alternatives demonstrate the unreasonableness of the defendants' regulation and a violation of the Due Process Clause. The policy requiring confinement in the nude also is unreasonable under the Fourth Amendment. The scope of the intrusion is substantial. The manner in which clothes are removed depends on the degree of vehemence exhibited by the detainee, but at times will include the forced removal of clothes by guards of the other gender. The justification for the extraordinary measure does not withstand scrutiny for reasons stated earlier. And the removal of clothing at times occurred in view of other jail personnel. Although the record demonstrates that isolating many of these plaintiffs was justified as a legitimate security measure because of their outrageous conduct, the Court is persuaded that society recognizes as legitimate an inmate's subjective expectation that he or she may not be required to forfeit all clothing and covering, even for a brief time, when he or she has been detained for relatively minor violations, there is no individualized suspicion of drug, weapon, contraband possession, and there is no indication that he or she is suicidal.

> The Court finds, therefore, that the plaintiffs have shown that the defendants' policy of taking all the clothing from detainees confined in administrative segregation violates the Fourth and Fourteenth Amendments of the Constitution based on the undisputed facts. They are entitled to partial summary judgment on their Section 1983 claim against the County of Saginaw.

Judge David M. Lawson's full opinion in *Rose v. Saginaw County* [353 F. Supp. 2d 900 (E.D. Mich. 2005)] can be found at: http://www.mied.uscourts.gov/_opinions/Lawsonpdf/01-10337DML.pdf.

In the midst of this litigation, Saginaw County officials told Judge Lawson that they had discontinued the practice of stripping inmates naked in segregation. In May 2005, however, the ACLU of Michigan filed a motion challenging the Sheriff' Brown's assertion that the practice had ceased. The civil rights group alleged that "evidence indicates that even after the practice was allegedly stopped in December 2001, inmates were routinely stripped of their clothing by force and placed in 'the hole.' The policy of providing isolation cell detainees with paper gowns is not uniformly followed and the paper gowns, which tear easily, are inadequate to cover private body parts. In addition, prisoners are forced to use the gowns either as toilet paper or to remove the mace that is sprayed in their face when the guards strip them of their clothes."

The U.S. Justice Department is said to be investigating the ACLU's most recent allegations. ❑

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.

Vermont

In March 2005, the state agreed to pay $750,000 to settle a lawsuit filed by the family of an inmate who committed suicide in a Department of Corrections (DOC) facility during 2003. The family stated that they planned to use most of the money to help other state inmates fight grievances over their treatment in custody.

James Quigley, 52-years-old, committed suicide by hanging at the Northwest State Correctional Facility in St. Albans on October 7, 2003. "I feel it's the beginning of greater changes for the penal institution," the decedent's mother, Claire Quigley, told the *Burlington Free Press*. Her lawyer, David Sleigh, said most of the money will be used to establish a fund to provide legal representation for inmates who, like Mr. Quigley, contest their treatment in prison. Mr. Sleigh said he will determine the best way to invest the money to keep the fund going.

An independent investigation commissioned by the state and released in March 2004 found the state was at least partly responsible for the death of Mr. Quigley. In 1980, he began serving a life sentence for murder in Florida and was transferred to Vermont in 2001 as part of an interstate compact agreement According to investigators, during the next two years, Mr. Quigley prepared many grievances of his own and assisted a number of other inmates in preparing legal grievances and lawsuits against the Northern State Correctional Facility (NSCF) in Newport — and later the Northwest State Correctional Facility (NWSCF) in St. Albans. As a result, the NSCF superintendent recommended that Mr. Quigley be kept in solitary confinement until he could be sent back to Florida because he was considered "an escape risk." In the interim, it was recommended that he be transferred to the NWSCF — known as the state's most secure facility. Although Mr. Quigley kept out of trouble, he suffered various forms of mistreatment, including the withholding privileges such as showers, recreational time and personal items. By September 2003, lawyers were investigating whether his civil rights were violated by being held in segregation without sufficient cause.

The investigators concluded that "the placement of James Quigley…..(into solitary confinement) …..for 118 days was not adequately supported and likely reflected retaliation against the inmate for filing grievances and lawsuits." As a result of Mr. Quigley's treatment, several employees, including two prison superintendents, were suspended.

In the last two days of his life, James Quigley wrote letters to both his attorneys and mother that expressed frustration at being held in segregation. "Two weeks ago I got four injections in my back," he wrote to his mother. "They helped somewhat, but other than that, I've received no health care, in spite of numerous requests. There is still chronic pain, which has recently been exacerbated because it's cold and rainy and there is no heat whatsoever."

Robert Hofmann, the current DOC Commissioner, said litigating the Quigley case for several years would not have been in the state's interests. Meanwhile, he said, the death was one of the catalysts for changes within the department, including a comprehensive assessment and subsequent revamping of both suicide prevention and mental health services. As Ed Paquin, executive director of Vermont Protection & Advocacy, Inc., told the *Free Press*, Mr. Quigley was a "classic jailhouse lawyer….He brought a lot of attention to issues that were not paid attention to."

Texas

Since state budget cuts affecting almost every public entity that deals with mental health, getting an individual with mental illness into treatment can be challenging. The head of the mental health services division of the Galveston County Sheriff's Office appears up to the challenge. In March 2005, Lieutenant Jaime Castro told the *Galveston County Daily News* that he was preparing a pitch to county commissioners and to University of Texas-Medical Branch (UTMB) officials for a mobile mental health unit. "Everybody's downsizing their services or programs," he said. "It seems like everybody's closing down but me."

Lieutenant Castro's plan is to take a doctor, nurse, social worker and medication to the scenes of people in urgent need of treatment. The only two places in the county for urgent mental health treatment are the acute in-patient psychiatric beds at the UTMB and any bed at the Galveston County Jail.

Harris County started a similar program more than two years ago, which now consists of six vehicles with doctors, nurses and social workers to treat the mentally ill wherever they are when they need assistance. "Our commissioner's court increased spending on it, which they certainly wouldn't have done if weren't successful," said Tom Mitchell, director of the Harris County program. Diana Villareal, a psychiatrist with the Harris County program who previously worked with the mentally ill in Galveston County, said treatment that did not involve jail was also more effective. "Once the legal system gets involved, a patient is much more resistant to treatment, because criminal law is much more adversarial than treatment," she told the *Daily News*. "This program has also allowed us to help people in a way that preserves their dignity, which is important."

The Harris County program costs approximately $1.7 million a year. Lieutenant Castro said a van and salaries for the professionals necessary to staff it would cost Galveston County less than a third of that. County Judge Jim Yarbrough said that the county's budget was tight, and that a program costing six figures would likely require sacrifices to other programs or county functions. "I don't think anyone would

argue that we're spending a lot of money on mental health under the current system," he said. "And it seems apparent that, over time, we'll save the county taxpayers' money, but that is hard to prove, going into something. Like we'll be doing with other departments when budget time comes, the question we'll ask is, what are your higher priorities?" Lieutenant Castro said the county would more than make its money back, in the long run. "It's just cheaper to be able to deal with people at their homes than in a hospital, or the jail," he said. "Almost every day, I answer a call because someone stopped taking his medication and is acting up, to the point they're a danger to themselves or to someone else. If we can treat them, or provide the medication they need on the spot, we'll save a lot, because right now, jail and UTMB are our only options for those people."

Judge Yarbrough said that approximately 15 percent of county jail inmates had mental health issues. "If you use the estimate we've been given, that it costs about $40 a day to keep someone incarcerated here, multiply that by 120, which would be 15 percent of 800, which I'd call a very conservative estimate of our jail population," he said.

That math worked out to a cost of $1.7 million a year to house people with histories of mental health problems in the jail. "Obviously, even if there were a way to treat some of these people in a way that kept them out of jail, we still wouldn't be saving that entire amount," he said. "But this mental health issue is going to do nothing but get more widespread. One thing it isn't going to do is go away."

County Probate Judge Gladys Burwell, who presides over civil commitment proceedings, also said starting such a program here would create long-term savings. "For every person who could be treated like that, taxpayers will save the cost of having that person hospitalized, or jailed," she said. "Of course, it would also be a more humane way of dealing with those people."

Lieutenant Castro told the *Galveston County Daily News* that he hoped to have a proposal that would allow for the launch of a mobile mental health unit by the end of this year.

Indiana

According to the American Civil Liberties Union (ACLU), the extreme isolation and sensory deprivation found in the state's Secured Housing Unit at the Wabash Valley Correctional Facility in Carlisle caused four suicides and numerous self-mutilations by mentally ill inmates since 2000. In February 2005, the ACLU's National Prison Project and Indiana Civil Liberties Union filed a class-action lawsuit alleging that inmates with mental illness are confined in the facility's Secured Housing Unit (SHU) under brutal conditions. "Locking up prisoners with mental illness in small windowless cells is psychological torture," said Ken Falk, Legal Director of the Indiana Civil Liberties Union. "Confinement for lengthy periods of time in 24-hour isolation would compromise even a healthy person's sanity."

The ACLU charges that the inmates' mental illness is exacerbated by the unbearable conditions in the 288-bed SHU, which have caused inmates to hallucinate, rip chunks of flesh from their bodies, rub feces on themselves and attempt suicide. "A disproportionately high number of mentally ill prisoners are transferred to the SHU because they are often misidentified as trouble-makers in prison," said David C. Fathi, an attorney with the ACLU's National Prison Project. "If mentally ill prisoners receive inadequate mental health care or their disease worsens because of the extreme deprivation within the SHU, it is likely they will find it difficult to obey prison rules and will remain stuck at the facility indefinitely."

Inmates only leave their cells at the SHU to shower or for solitary recreation in a small walled compound, but recreation is often canceled because of bad weather. The cells remain illuminated at night and the unit is extremely noisy, as the inmates, who cannot see each other, shout in order to communicate. Inmates are also restricted in their ability to keep books, letters, family photographs or other personal items in their cells. There is no limit on how long an inmate can spend in the SHU, and many remain there for several years.

According to the ACLU, little has changed in the SHU since Human Rights Watch detailed many of the abuses faced by mentally ill inmates in a 1997 report entitled *Cold Storage: Super-Maximum Security Confinement in Indiana*. "Warehousing severely ill and psychotic individuals under conditions that increase their suffering by exacerbating their symptoms, and in facilities that lack adequate mental health services, can only be characterized as cruel," the report conditioned.

The lawsuit, *Mast v. Donahue*, was filed in U.S. District Court in the Southern District of Indiana and seeks a ban on placing mentally ill inmates in the SHU. No monetary damages are sought. It can be found at: http://www.aclu.org/Prisons/Prisons.cfm?ID=17412&c=121.

California

A licensed vocational nurse who worked for a correctional health services contractor committed suicide shortly after being booked into the Solano County jail in Fairfield on June 18, 2005. Marrisa Honda, 32-years-old, was booked into the jail at 4:29 am and found unresponsive exactly 31 minutes later, apparently after strangling herself with a 10-inch long telephone cord in the holding cell. "This is a terrible, terrible tragedy," Sheriff Gary R. Stanton told the *Daily Republic*. "Our thoughts and prayers are with her family and loved ones at this time."

The series of events that led to Ms. Honda's suicide began during the early morning hours of June 18 while she and her sister were traveling together on the highway. Sheriff's department investigators said that Ms. Honda and her sister were in the midst of a heated argument when at some point Ms. Honda is believed to have grabbed the car's steering wheel, causing it veer across several lanes. The erratic movement of the car caught the attention of a state Highway Patrol officer who pulled the car over. It was at that point that Ms. Honda was suspected of being under the influence of alcohol and arrested. She was then transported to the Solano County jail for booking.

Sheriff Stanton stated that Ms. Honda was cooperative and answered all the intake screening questions, including one where is she was asked if she had thought about hurting herself. "She responded initially 'Yes,'" the sheriff told the *Daily Republic*. "When we followed up with another, more direct question about whether she was actually feeling suicidal, she told our staff 'Yes, I have thought about hurting myself, but not right now.'" Sheriff stated Ms. Honda displayed no other behaviors that would prompt the jail staff to place her on suicide precautions "While our investigation is on-going, it appears this case was handled by the book. I don't believe there was anything we could have done to anticipate her actions," the sheriff said.

The suicide of Marrisa Honda follows the February 2004 death of Roberto Soto who also utilized a telephone cord to commit suicide in the Solano County Jail. Following Mr. Soto's death, the cords were shortened from 12 to 10 inches. Sheriff Stanton said his agency was in a quandary over what to do. On one hand, he believes state law requires that intake cells within jail facilities have telephones, and that inmates be afforded a certain degree of privacy to conduct on a conversation with their attorneys, bail bond agents or family members. On the other hand, the corded telephones — even at 10 inches in length — continue to offer an opportunity for suicidal inmates to hurt themselves. The sheriff said jail staff have considered and largely rejected "speaker" telephones because their use cannot guarantee an inmate's privacy. Likewise, telephones with "breakaway" cords have been rejected out of concern that the loose handset could be used as a weapon. "There's got to be some kind of telephone technology out there that will provide us an answer," he told the *Daily Republic*.

> "Everybody's downsizing their services or programs. It seems like everybody's closing down but me."

EDITOR'S NOTE: It should be noted that state law in California does ***not*** *require or mandate that telephones be placed* ***inside*** *of holding cells, only the inmates have reasonable access to a telephone during confinement. In fact, state jail standards in California caution jail officials of the hazards inherent in corded telephones placed within cells.* ***Title 24: Minimum Standards for Local Detention Facilities*** *states, in part, that "Telephone cords provide a mechanism for suicide attempts and consideration of telephone placement should be given in the design of a facility. Telephones should be placed in locations where they can be observed by staff. Because inmates have used telephone cords in suicides and suicide attempts, a short receiver cord should be considered and there are alternative telephone designs that eliminate the cord entirely."*

We have spoken about the hazards of placing wall-mounted telephones with metal cords of varying length inside cells on many occasions (e.g., ***Jail Suicide/Mental Health Update****, Volume 12, Number 3, Fall 2003;* ***Jail Suicide/Mental Health Update****, Volume 11, Number 4, Winter 2003). Given the known inherent danger of placing corded telephones within cells, correctional officials are faced with two options — relocating the corded telephones to a common area (e.g. dayroom) that is regularly observed by staff or replacing the corded telephones with cordless systems.*

New Hampshire

Approximately two hours passed before any Manchester Police Department employee realized that a suicidal man had succeeded in killing himself in a holding cell at the station, according to an investigative report released in February 2005. Before hanging himself with his shirt on January 20, 2005, Julian Wisz, 43-years-old, made the sign of the cross on his chest, a movement captured on closed circuit television (CCTV). An inmate in another cell reported hearing him pray — "Jesus forgive me, I can't do it anymore….Jesus, forgive me, I can't take it," Mr. Wisz was also heard to be crying.

The 70-page investigative report, completed by Detective Sergeant Nick Willard and obtained by *The Union Leader*, concluded that a lack of communication was responsible for the suicidal inmate not being observed on suicide precautions. Although booking officer Anna Marie Martin told Sergeant Willard that she had problems that night getting the CCTV monitor to work, she was not informed that Mr. Wisz was suicidal.

Captain Mark Putney said he did not have Mr. Wisz's cell locked into any of his monitors because he had not been told the inmate was suicidal, nor that the CCTV monitor in the booking area was not working. The captain told Sergeant Willard that although he was aware the inmate's girlfriend (Patricia Gouin) was en route to the police station to fill out a "prayer" statement for involuntary emergency hospitalization, the woman had not arrived prior to the end of his shift.

The investigation found, however, that the Manchester Police Department was clearly aware of Mr. Wisz's risk for suicide. Ms. Gouin had called the police that day when he had threatened to hang himself or throw himself off a bridge. When police arrived at her house, Mr. Wisz was observed to be intoxicated and unstable. He was arrested for criminal trespass, simple assault and criminal threatening. Upon intake at the police station at approximately 7:00pm, his booking sheet indicated that Mr. Wisz was brought in for protective custody (as being at risk for suicide). Ms. Gouin arrived at the police station a few hours later and filled out a "prayer" statement indicating that her boyfriend had threatened to commit suicide and needed to be involuntarily hospitalized. In addition, Mr. Wisz's psychologist called the station to inform police that her patient was suicidal. Finally, the Greater Manchester Mental Health Center was contacted by the police department to conduct a mental health evaluation of Mr. Wisz.

According to a CCTV videotape recording of the death, Mr. Wisz hanged himself approximately nine minutes after Officer Martin checked his cell at 10:50pm. Officer Robert Powers, who relieved her shortly after 11:00pm, never conducted any rounds in the 10-cell facility. At approximately 1:00am on January 20, Mr. Wisz was found hanging in his cell by a detective who happened to be in the cellblock to interview another inmate.

Police Chief John A. Jaskolka said his department realizes the seriousness of Mr. Wisz's death. "I wish to assure all members of the community that every effort will be made to prevent this type of incident from happening again," he said in a prepared statement that was published in *The Union Leader*. "Any violation of policies or procedures made by Manchester Police Department personnel that might be identified during these investigations will be addressed, and appropriate action will be taken," he added.

New York

In January 2005, the state Commission of Correction (SCOC) found that the former medical director at the Saratoga County Jail in Ballston Spa was "directly implicated" in the May 2004 suicide of inmate James Pecor for cutting his dosage of psychotropic medication. The SCOC report also charged that the doctor "negligently ordered medications for inmates without any physical assessment" as a common practice. The state oversight board recommended disciplinary action before the state Department of Health.

Dr. Russell Peacock retired in October 2004 (of his own accord) while the SCOC investigation was still under way. "After 34 years and at my age, I thought it was time," he told *The Saratogian*. Although the doctor refused to discuss the investigation, Saratoga County Sheriff James Bowen told the newspaper that "They raked him for this….Dr. Peacock was the doctor here for over 30 years. He did a good job for us."

James Pecor, 25-years-old, had a long history of mental illness and multiple hospitalizations. On April 3, 2004, he was arrested for domestic violence and transported to the Saratoga County Jail. For reasons that remain unknown, Dr. Peacock cut the dosage of his psychotropic medication. On May 8, Mr. Pecor was placed in segregation after tobacco was found in his cell. He was then found hanging by a bed sheet attached to the ceiling light at approximately 10:30pm. Officers initiated cardiopulmonary resuscitation, but he was subsequently pronounced dead at the local hospital.

According to the SCOC report, "Dr. Peacock willfully withheld Pecor's appropriate treatment….Dr. Peacock also negligently ordered medications for inmates without any physical assessment, which commission investigators found to be common practice for Dr. Peacock. These same negligent practices repeated themselves in each of Pecor's incarcerations. This gross negligence and incompetence on the part of Dr. Peacock was directly implicated in Mr. Pecor's death." The report also found that Mr. Pecor was self-medicating himself with another inmate's psychotropic medication. Although Sheriff Bowen defended the doctor by stating that he had the right under state corrections law to change inmate prescriptions, SCOC investigators determined that Dr. Peacock should have consulted with the jail psychiatrist before changing the dosage of Mr. Pecor's medication.

The SCOC also concluded that Dr. Peacock was illegally running a pharmacy at the Saratoga County Jail. He had a bulk stock of medication, including controlled substances, and a bulk stock of homeopathic remedies. According to the report, Sheriff Bowen had previously told the doctor to stop this practice in 2003. The SCOC said that doctors are allowed to run a pharmacy in their own offices, but the county jail is not a doctor's office and was not licensed to store controlled substances.

In addition to the recommendation for disciplinary action against Dr. Peacock, the SCOC recommended numerous corrective actions in the delivery of mental health services at the Saratoga County Jail.

Michigan

Getting inmates with mental illness out of jail cells and into residential or out-patient treatment while they are awaiting trial could help ease overcrowding in county jails throughout the state. That was one recommendation from a task force report released in March 2005. The task force was examining ways to open beds in the state's overcrowded jail and prison system without spending new dollars on construction.

Inmates with mental illness often wait weeks or months for examinations to see if they are competent to stand trial, said Marge Bossenbery, a sentencing guidelines specialist for the Department of Corrections. "If we could divert them pre-trial and get them into treatment, it would free up space," she told a Lansing newspaper. But Terry Jungel, executive director of the Michigan Sheriffs' Association, said there were too few programs available to tap for that assistance. "It's a great concept, it just doesn't work in practice because we have no place to take them," he said. Mr. Jungel, a member of the Michigan Task Force on Jail and Prison Overcrowding, said better mental health services is the "silver bullet" that can curb overcrowding in the state's 81 county jails.

The 19-member Task Force was formed in June 2004 after sheriffs and county officials protested Governor Jennifer Granholm's plan to tighten sentencing guidelines and lock out more offenders from the state 50,000-bed prison system. Local officials said that would simply shift the high cost of incarceration down to the 19,000-bed county jail system. Governor Granholm, who created the task force, has since also proposed that $4 million be offered in grants next year to create alternative community programs such as additional residential treatment for the mentally ill. The Task Force concluded that the closing of 10 state psychiatric hospitals from 1992 to 2001 funneled many of the seriously mentally ill into the county jails.

The Task Force report also encouraged communities to expand pretrial diversion options for persons charged with nonviolent crimes who cannot afford to post bonds prior to trial. Kent County, for example, experienced a significant decrease in its nonviolent pretrial population following the initiation of a pretrial diversion program. Other recommendations included using fines and community service in lieu of jail time for nonviolent offenders; allowing probation officers to waive low-level probation violations instead of arresting probationers for technical offenses; encouraging state probation officers, responsible for writing pre-sentencing reports for judges, to process the most serious prison-bound felons first in order to expedite their transfer from jail to prison; training police officers to recognize signs of mental illness so offenders can be taken to emergency treatment centers instead of jail.

The *Michigan Task Force on Jail and Prison Overcrowding: Final Report* can be found at: http://www.michigan.gov/documents/report_119595_7.pdf

Iowa

Gary Maynard, director of the state Department of Corrections, recently announced that steady progress was being made to improve living conditions and treatment programs at the Clinical Care Unit of the Iowa State Penitentiary in Fort Madison where four inmates have committed suicide during the past two years (see ***Jail Suicide/Mental Health Update***, Volume 13, Number 3, Winter 2004, page 17). "I think eventually we will have a very good system" of providing care for mentally ill prisoners, he told the *Des Moines Register* in June 2005. "I think it will be one of the better systems, relative to the rest of the country. Nobody has it solved. I can guarantee you it is a big, big problem everywhere."

The 140-bed Clinical Care Unit was the focus of a critical report in February 2005 by a consultant for the National Institute of Corrections. The unit has been without an administrator for over a year, and the report faulted state officials for poor management and inadequate mental health staffing. In addition, the consultant found that, although inmates in the unit had individual treatment plans, the only beneficial treatment they were receiving was their psychotropic medication. There was also a problem of excessive lockdown due to a lack of programming.

According to Larry Brimeyer, DOC Deputy Director, efforts are now being made to encourage inmates to get out of their cells and engaged in a wider variety of activities. "We have changed that tremendously. These inmates now have access to many services inside the penitentiary compound" that were not previously available, Mr. Brimeyer told the *Des Moines Register*. "There is the dining hall, the gym, the yard" and other areas where mentally ill offenders are permitted when other inmates are engaged in other activities. The agency has also hired treatment staff to work in the evening, thus allowing mentally ill inmates to be more involved in recreational and social activities after 4:00pm.

Dr. Edward O'Brien, DOC Medical Director, said an effort was also underway to change the culture within the unit to benefit mentally ill inmates. "This is not something that you will see in any reports, but we are having officers take an inmate to lunch just because he doesn't get along well in a group setting," Dr. O'Brien said. "Instead of leaving him in his cell, they will assign somebody to take him to lunch. I think the sensitivity of the staff to these individuals has grown exponentially."

With regard to mental health staffing, Director Maynard had previously expressed frustration that the state's entire prison system of approximately 8,600 inmates was served by only one psychiatrist. That has since changed with the hiring of two more full-time psychiatrists, a part-time contract psychiatrist and a psychiatric nurse-practitioner. The department recently opened a 24-bed psychiatric housing unit at the Medical and Classification Center in Oakdale which will allow for more treatment of inmates with acute mental health and/or chronic behavioral issues in a less restrictive setting. The state legislature has provided funds to hire 29 additional mental health staff.

Finally, construction is under way on a 180-bed special needs unit at the Oakdale facility which will open in early 2007. "There is such a spectrum of these men. Some of them are socially inept. Some of them are mentally retarded….A fair number are psychotic. There seems to be an increasing number of those who are finding their way to us, and one wonders if the Department of Corrections isn't becoming the safety net for those kinds of persons," Dr. O'Brien said.

State Ombudsman Bill Angrick, who has been monitoring treatment of mentally ill offenders, said it was too early to judge the department's response to problems in the Clinical Care Unit. "We are keeping on top of that and asking questions," he told the *Des Moines Register*. Sylvia Piper, executive director of Iowa Protection and Advocacy Services, a nonprofit disability rights group, complimented Director Maynard. She said that he has been responsive to concerns raised by advocates for mentally ill offenders and that he is making progress. "It's nice to be in a position where we are actually seeing some movement and change, and we are excited about it," Ms. Piper said.

Missouri

In a unanimous opinion, a three-judge state Court of Appeals panel ruled in April 2005 that an officer at a county juvenile detention facility "never physically assisted" in rescuing a teenager found hanging in a room, resulting in neglectful conduct.

According to the ruling, Michael Vaughn was hired by the St. Louis County's Juvenile Court in 1988 and was working as an officer at the county's Juvenile Detention Center June 9, 2002. He was assigned to Unit G which housed six youth. Four of those youth —- including the 15-year-old boy who attempted suicide —- were locked in their rooms at approximately 1:45pm when that youth managed to tie his arms behind his back and tried hanging himself with clothing wrapped around a Bible and a hardcover book he jammed into his window. Mr. Vaughn was returning another boy to his room when they walked past the suicidal youth's room and saw him hanging. Mr. Vaughn opened the door and ordered the other boy to free the hanging victim. The youth tried, but could not rescue the victim on his own. Mr. Vaughn then left the area and called the front desk for help, then waited for two other officers to arrive before returning to the victim's room, where the other officers cut the youth down. The youth survived the suicide attempt and was hospitalized for nine days before being returned to the detention facility.

A subsequent investigation by the state's Division of Family Services (DFS) concluded there was probable cause to find that Mr. Vaughn neglected the suicidal youth. In February 2003, he petitioned the St. Louis County Circuit to review the matter and, following a trial, a judge later affirmed the DFS finding. His bid for a new trial or other relief was also rejected.

Upon appeal to the state Court of Appeals for the Eastern District, Mr. Vaughn argued that the lower circuit court had erred, insisting that he had followed the facility's "check, call, and care" procedure and provided the necessary care during the emergency. John Snipes, the assistant superintendent at the detention facility, had previously testified at trial that in such medical emergencies,

officers were trained to "check the scene making sure there are no other incumbent dangers, call for help and then go to assist until help arrives."

Although Mr. Vaughn claimed he followed the correct protocol in handling the crisis, the appellate court found otherwise. The court wrote there was evidence that when Mr. Vaughn first checked on the youth, he threw water on the boy's face and then remarked, "See, there's nothing wrong with him. He's OK." He then left the room, leaving an undersized youth to try to save the suicidal youngster's life. In addition, Mr. Vaughn carried a personal alarm that, if triggered, was designed to activate a loud siren indicating an emergency. He never used the alarm and instead went to a nearby office and called the front desk to report the emergency, then waited roughly two minutes for other officers to arrive before they went to assist the youth. Even then, the court wrote, "there is evidence indicating that Vaughn never physically assisted" the other officers in rescuing the teenager."

The Court of Appeals concluded on April 19 that "Taking all of this evidence into consideration, we find that the circuit court's finding of probable cause of neglect by Vaughn was supported by substantial evidence." The full opinion in *Vaughn v. Missouri Department of Social Services* (ED84172) can be found at: http://www.osca.state.mo.us

Michael Vaughn was never criminal charged in the case and his attorney, citing privacy concerns, has declined to disclose his client's current employment status.

South Carolina

In the first lawsuit of its kind in the state, prisoners and an advocacy group contend the state Department of Corrections (DOC) has failed to adequately treat mentally ill inmates for several years. The lawsuit, filed in June 2005, seeks class-action status on behalf of all mentally ill inmates in the state's 29 prisons. The exact number of affected inmates is not known, although the lawsuit alleged that as of 2004, the DOC had diagnosed 2,146 inmates — approximately 9 percent of the state's approximate 24,000 inmate population — as being mentally ill. The lawsuit requested that a judge order the DOC and the state General Assembly — also named as a defendant — to "design, maintain, fund and provide resources for a reasonable and adequate system" for treating mentally ill inmates.

Gloria Prevost, executive director of Protection and Advocacy for People with Disabilities Inc., a plaintiff in the lawsuit, said she and others met privately earlier this year with DOC Director Jon Ozmint and his staff to "possibly see if a lawsuit could be avoided….We could not agree on the next steps to do that," she told *The State*.

State Representative Bill Cotty, a member of the House Ways and Means Committee, said he could not predict whether the Legislature would find extra money next year for mentally ill inmates. Asked by *The State* whether he thought those inmates receive inadequate treatment, Mr. Cotty, a lawyer, replied, "I've seen cases where people allege that, and I've seen little proof where that is the truth."

The lawsuit does not seek monetary damages on behalf of inmates. One of the state's most powerful law firms, Nelson Mullins Riley & Scarborough — which often defends businesses in lawsuits — is representing the inmates (pro bono). The lawsuit was filed by the state's Protection and Advocacy for People with Disabilities agency on behalf of three mentally ill inmates and other affected inmates. The lawsuit gives graphic details of the three inmates' allegations:

- A male inmate suffering from paranoid schizophrenia and who has a "history of bizarre behavior, including drinking his own urine," has been kept for most of his 14 years in prison in a segregation cell at least 23 hours a day instead of being treated at a psychiatric hospital;

- A female inmate, who suffers from schizophrenia and who is mentally retarded, set herself on fire with a cigarette lighter after being without her medication for two days. The department failed to forward her medication after she was discharged from an in-patient psychiatric facility; she saw a psychiatrist twice while she was in segregation for 37 days.

- A male inmate with a history of self-mutilation was confined in a restraint chair for 16 hours after cutting himself on his arms and re-opening his wounds after he was treated. He cut himself twice the next day after being left naked in his cell; eight months passed before he saw a psychiatrist.

DOC Director Jon Ozmint confirmed that he had met with plaintiffs counsel earlier in the year regarding treatment of mentally ill inmates in the prison system. "I wanted them to tell us what the problems were," he told the *Associated Press*. "We would be glad to work with them to address them, but they never once volunteered to help us…or identified any inmates' needs that we're not meeting."

According to the lawsuit, however, three separate studies since 1999 have found problems with the delivery of mental health services in the prison system, including a lack of staffing and proper training. "The need has been clearly articulated," said Dave Almeida, director of the state chapter of the National Alliance for the Mentally Ill. "What else is there (except a lawsuit) when you have three studies, and you can't get the job done?"

Kansas

A policy of examining deaths of inmates in state and local custody is getting credit for helping to keep jails and prisons safe for both the prisoners and the officers supervising them. One state official said because of the 13-month-old law, inmate suicides are a more visible issue, which could change how some officers are trained. Others contend jails and prisons are now more accountable. "The initiative seems to be working," Sonny Scroggins, a Topeka human rights activist who pushed for the law, told the *Associated Press* in August 2005. "We need checks and balances and we can't have accountability without a mechanism like this."

The law took effect on July 1, 2004, and last year the Kansas Bureau of Investigation (KBI) reviewed 42 deaths in custody. Most of the deaths (i.e., 29) were from natural causes, but 10 were suicides, while two resulted from accidents, and one from a hunger strike.

Change, however, did not come without a modification of the law. Earlier this year, legislators revised the law to make sure the KBI focused on deaths involving suspicious circumstances or suicide, rather than natural causes. "When we don't do our job, bad things are going to happen," Coffey County Sheriff Randy Rogers told the *Associated Press*. "The KBI can use it as a tool to make sure we're dotting Is and crossing Ts."

Before the law was enacted, the KBI typically investigated between 5 and 10 inmate deaths a year, most of which involved suspicious circumstances (and not all suicides), said Kyle Smith, KBI Deputy Director. But Mr. Scroggins and others were concerned that deaths were not being fully reviewed by officials; or information about them, disclosed to the public. Legislators enacted the law, requiring the KBI to investigate all deaths of inmates in city, county or state custody. But in the month after the law took effect, the KBI was swamped with investigations, including two suicides in one week at the Sedgwick County Jail in Wichita. KBI officials asked legislators to modify the law this year. They did, deciding the KBI did not have to investigate if an autopsy, preliminary autopsy report or death certificate, determined the death was from natural causes, or if the inmate had received regular care from a licensed physician.

KBI Deputy Director Smith said investigating deaths from natural causes strained the KBI, citing a case in which the family of a terminally ill prisoner decided to end life support. But he said investigations still determine whether there were any unusual circumstances, such as manslaughter or murder, so county prosecutors can be notified. "It doesn't eliminate the civil aspects of the case, whether there was negligence or if someone should have been on suicide watch and wasn't," he added.

In addition, the KBI reports on its completed investigations to the chairmen of the House and Senate committees that handle crime legislation every three months. State Representative Ward Loyd, chairman of the House panel, said it was important for the public to know about such incidents. "The question I have from the suicide standpoint is if they have satisfied themselves that everything was done to avoid the suicide," Representative Loyd said.

Sheriff Rogers is also president of the state Sheriffs' Association and said the KBI investigations will give law enforcement agencies data they can share among themselves or in training. And KBI Deputy Director Smith said agency officials may use the data in training law enforcement officers so they too can, for example, better identify inmates who are suicide risks. "I think it's done a lot to elevate the suicide issue. I think a lot of sheriffs have taken it to heart," he said. ❑

JAIL SUICIDE/MENTAL HEALTH UPDATE

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

This publication is supported by Cooperative Agreement Award Number 04J34GJD9 from the National Institute of Corrections (NIC), U.S. Department of Justice. Points of view or opinions stated in this document do not necessarily represent the official position or policies of the U.S. Department of Justice.

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

AVAILABLE JAIL/PRISON/JUVENILE SUICIDE PREVENTION MATERIALS

And Darkness Closes In...National Study of Jail Suicides (1981)
National Study of Jail Suicides: Seven Years Later (1988)
Training Curriculum on Suicide Detection and Prevention in Jails and Lockups—Second Edition (1995)
Curriculum Transparencies—Second Edition (1995)
Prison Suicide: An Overview and Guide to Prevention (1995)
Juvenile Suicide in Confinement: A National Survey (2004)
Jail Suicide/Mental Health Update (Volumes 1-13)

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

Lindsay M. Hayes, Editor/Project Director
National Center on Institutions and Alternatives
40 Lantern Lane
Mansfield, Massachusetts 02048
(508) 337-8806 • (508) 337-3083 (fax)
Web Site: www.ncianet.org/cjjsl.cfm
E-Mail: Lhayesta@msn.com

or

NIC Information Center
1860 Industrial Circle, Suite A
Longmont, Colorado 80501
(800) 877-1461 • (303) 682-0558 (fax)
Web Site: www.nicic.org