JAIL SUICIDE UPDATE

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SECURITY AND MENTAL HEALTH PROFESSIONALS: A (TOO) SILENT PARTNERSHIP?

by
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The criminal justice literature is replete with references about the importance of establishing and maintaining suicide prevention and crisis intervention services within the jail environment. National jail standards call for a specific amount of training for correctional officers on mental health and suicide issues. Civil rights, professional malpractice and negligence litigation have resulted in many court orders forcing jail (and prison) systems to improve their mental health training programs by incorporating into them information on dealing with suicidal prisoners. Some courts have also required jail facilities to hire mental health staff, through either contractual agreements or sheriff's office employment.

While surely everyone employed in jail systems can agree that security and mental health staff need to work cooperatively with each other for the well-being of the inmate and the overall health of the jail system, there is little written about how this cooperation can be established and nurtured. What does cooperation entail? How are professional boundaries safeguarded while professional territoriality, often common and destructive in jails, is diminished? How do we maintain the security of the institution while being flexible enough to allow for the delivery of adequate mental health services — and vice versa? What special needs of detention officers and mental health staff must be addressed in order to effect a cooperative relationship? Is it even possible for this cooperative relationship to exist?

This article asserts that a cooperative relationship, in real terms not solely in spirit, can be developed and, in fact, must be developed, between both professional detention officers and mental health clinicians working within the jail environment. I begin by taking a look at the literature that currently exists that speaks to this subject, including some of the accepted national jail standards. Next, a brief look at the case law is presented, noting various courts' involvement in mandating training requirements and in hiring mental health staff. The third section focuses on the struggle that exists between mental health and detention staff, often seen in territorial claims perhaps based more on philosophical-occupational ideologies than on what is good for the inmate-client and the jail system. Finally, suggested strategies for achieving a true, cooperative, multi-disciplinary, multi-responsibility team approach towards preventing suicides and improving mental health conditions within the jail environment are presented.

Jail Standards and Related Literature

All of the national jail standards call for a certain amount of orientation and follow-up training for custodial staff in suicide assessment, prevention and interdiction techniques. These standards also demand the participation of medical and mental health professionals in in-service training and other continuing education courses that may be required for professional licensure. The American Correctional Association (ACA)'s *Standards for Adult Local Detention Facilities* (1991) call for the proper credentialling of health care employees (3-ALDF-4E-9) and training that deals with emergency responses to critical health-related incidents (3-ALDF-4E-24). In a similar vein, the National Commission on Correctional Health Care ("NCCHC")'s *Standards for Health Services in Jails* (1992) specifies that a suicide prevention plan must be in place; that all staff having contact with inmates be trained to identify suicide potential (J-54); that health care staff hold applicable professional certification (J-17) and receive 12 hours of yearly in-service training (J-22); and finally, that correctional officers receive health-related training on a bi-yearly basis (J-23).

While all of these are appropriate accreditation mandates, jail standards are understandably unable to spell out methods to ensure the establishment of a respectful and effective interplay between detention officers and medical/mental health staff so that suicide and crisis intervention services are truly based on a team approach. Much of the

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relevant literature reflects the struggle to adequately and inoffensively define "the team" and its duties (Cimino, 1987). Perhaps because of this struggle, the "team" is often described as being comprised of only mental health clinicians. For example, one multi-disciplinary mental health program described in the literature boasted an effective suicide prevention program, but its identified team members were all mental health clinicians (Long, 1991). This kind of description is pervasive in the literature and places correctional officers in a double bind with regard to their job performance. On one hand, officers and supervisors receive training by a mental health clinician in an effort to enable them to identify suicidal crises and symptoms of mental illness. On the other hand, despite receiving this training they are rarely treated as though they are part of the mental health team.

Researchers have recognized that the cooperation of both mental health and security staffs is required to prevent jail suicides. Both need to be able to assess the potential for self-destructive behavior (Jerrell & Komisaruk, 1991). However, even innovative mental health programs in jails have been presented as being entities separate from the security operation — reinforcing the isolative nature of many of the ancillary services offered in jails (e.g., mental health, education, substance abuse and religious programs). Other authors have recommended separate training goals for security and mental health staffs, but advise the establishment of a program review process where jail and mental health staff members meet periodically to "increase the accountability of jail and mental health staff for providing security and treatment" (Landsberg, 1992, p. 110). A 1991 Report to Congressional Requesters regarding the mental health operations of the Federal Bureau of Prisons (FBOP) noted that not all inmates were being screened for mental health and suicide problems. A plan to implement more training to "improve the ability of mental health staff and others (e.g., correctional officers) to identify and manage mentally ill inmates" is in the works — perhaps with the hope of compensating for the shortage of mental health staff in the FBOP as a whole (United States General Accounting Office, 1991, p. 13).

Detention officers and mental health clinicians do, of course, have different primary areas of expertise within the detention facility. Experience tells us, however, that neither can function optimally without the other and when seen in this light, both types of professionals are naturally part of two teams: the security team and mental health team. The courts have implicitly recognized this for years.

Court Involvement

It is clear that a pretrial detainee has a right to some mental health care, if needed, while incarcerated (*Bowring v. Godwin,* 1977; *Inmates of Allegheny County Jail v. Peirce,* 1979). The nature and extent of this care has largely been left undefined; perhaps because of the difficulty in differentiating between inmate behaviors which require custodial versus clinical intervention (O'Leary, 1989). Generally, pretrial detainees are entitled to diagnostic services, some level of treatment so that inmates are not emotionally worse off then when they were admitted, and the maintenance of accurate and confidential records (Cohen, 1988).

In fact, treatment within the jail is most often limited to short-term crisis intervention services, aimed at delivering support to the inmate during stressful periods of confinement (Dvoskin, 1989). One court noted:

> The jail is not a mental health facility; nor do we intend that it become one. However, it must be organized and staffed to meet emergency situations, to make appropriate referrals, and to properly care for and protect those who must be housed in the jail for whatever reasons despite their mental illness.

(*Inmates of Allegheny County Jail v. Peirce,* 1980, p. 643. In this case, the court reviewed the jail's mental health services or, more accurately, the lack thereof and ultimately explicitly recognized the absence of a mental health staff member in the jail. Subsequently, the court ordered jail officials to hire a psychiatrist, psychologist or psychiatric social worker for the position of mental health administrator).

This writer's position as a mental health clinician in a county detention facility was secured by a consent decree following a series of completed suicides and serious suicide attempts in the early 1980s. In *Garcia v. Board of County Commissioners of El Paso County* (1985), the parties consented to a judgment that, in part, forced the jail to secure the on-call emergency assistance of a licensed mental health clinician 24 hours daily, and provide enhanced training in suicide prevention and mental illness for all security personnel. Though the El Paso County Sheriff's Department in Colorado Springs, Colorado went further and contracted for the delivery of daily on-site clinical services, as well as the mental health/suicide prevention training for all detention personnel, it was recognized early on that the mental health worker acting alone could not effectively provide comprehensive psychiatric services. Similar to most jails in the country, the El Paso County Detention Facility experienced an onslaught of prisoners during the 1980s, with its population increasing from 200 inmates in 1983 to nearly 800 inmates in 1991. With the active participation of detention officers in suicide prevention and crisis intervention efforts, there were ***no*** completed jail suicides through a nine-year period (beating the odds with a combination of skill and luck).

A very recent example of court intervention in a jail's procedural operation involves a Washington, D.C. federal judge who ordered jail officials to follow 18 steps in improving services in the District of Columbia Detention Facility. These steps call for improvement in the provision of psychiatric diagnostic services and, if warranted,

psychiatric hospitalization (within eight hours) to suicidal inmates. This court order followed four suicides which occurred in the jail facility over a period of recent months (Harriston & Torry, 1993).

The Dual Professional Struggles in Our Correctional System

Jail administrators have sought to involve community mental health and criminal justice agencies in the effort to care for mentally ill inmates, but have faced "significant obstacles" in doing so, since jails have not historically been seen as institutions that either "required or deserved their services" (Kalinich et al., 1991). The blame, of course, cannot be placed on the community mental health system alone, since jails themselves have historically been operated "as closed systems without [inviting] outside review by. . .human service agency administrators and/or advocacy groups" (Cox & Landsberg, 1989, p. 185). In part, as a result of this polarization between jails and mental health agencies, many jail administrators have arranged for on-site contracted services with mental health staff, opted to use the crisis services available to the community at large, or have made no arrangements for mental health services at all. Indeed, much of the research in jail mental health problems and programs points to a serious need for an increase in the number of jail mental health clinicians (Torrey, et al., 1992). While waiting for the funds to become available to support these mental health workers, correctional staff who have the potential to fulfill some "paraprofessional" responsibilities have been largely ignored (Coleman, 1988).

While different correctional employees are expected to contribute to the identification of problem inmates, the provision of mental health services has traditionally been seen to be the sole responsibility of mental health staff (Coleman, 1988). Despite efforts to train detention officers and other employees in assessment and intervention strategies, mental health staff are quick to point out that actual therapeutic services belong to their domain alone. Not surprisingly, other professionals within the institution respond accordingly; the atmosphere can be territorial and competitive. Classification personnel see housing, work assignments and security risk assessment as their bailiwick; security officers see security enforcement as their mission; and medical employees focus on the physical health of the prisoners. In reality, a strong identification with one's principle area of expertise is desirable, evidencing a personal "investment" in one's professional responsibilities However, in terms of suicide prevention and crisis intervention, successful programming requires cooperation and coordination between various jail staff members.

At least on a philosophical level, researchers have shown that detention personnel tend to support the value of mental health services within the jail facility. Steadman, McCarty and Morrissey (1986) found "little support. . .for the thesis that correctional and mental health staff in jails operate from fundamentally opposite and antagonistic perspectives" (p. 92). The professional struggles that do exist may have more to do with a lack of understanding about each others' roles than with disagreements about jail "treatment" ideologies. In one effort to facilitate understanding and respect, the National Institute of Corrections (NIC) — Jail Center sponsored a seminar in the mid-1980s designed for teams of one mental health worker and one security officer employed in the same detention facility. The initial focus was placed on identifying and breaking down the mythical barriers to effective security-mental health interaction in the jail. Participants, including this writer, were asked to discuss their assumptions about a teammate's professional role and persona. Many of the old purposeless labels of "bleeding heart," "do-gooders," "molly-coddler," "jailer," "guard," etc. that conjured up negative images were dispelled, and identification of complementary security and mental health functions were pursued (with the assumption that new revelations would be acted on upon return to the team's facility).

Of course, it is much easier to facilitate open, honest and sometimes painful communication between security and jail mental health clinicians in an artificial environment (such as NIC) over an extended period of time (3-5 days) than to do so in a matter of hours on the premises of a detention facility. This means that the mythical barriers to an effective secure mental health detention program must be brought down by ***action*** rather than solely by discussion. A description of appropriate actions follows in the next section.

Strategies for a True Team Approach

The key to an effective team approach in suicide prevention and crisis intervention is found in throwing off the cloaks of territoriality and embracing a mutual respect for the detention officer's and mental health clinician's professional abilities, responsibilities and limitations. All of us, regardless of professional affiliation, need to make a dedicated commitment to come forward and acknowledge that suicide prevention and related mental health services are only effective when delivered by professionals acting in unison with each other. Just as the security officer alone cannot ensure the safety and security of the jail facility, neither can the mental health clinician alone ensure the safety and emotional well-being of the individual inmate.

Reader Evaluation
of the
Jail Suicide Update

Please complete and return the enclosed form to assist the National Center on Institutions and Alternatives in assessing the value and utility of the ***Jail Suicide Update***. Your evaluation is greatly appreciated.

To succeed in this endeavor requires us to do away with some of the myths of correctional treatment. Where or why these myths developed does not matter; what matters is that we recognize them as working against the institution's efforts to prevent suicides and emotionally disruptive behavior. ***The first two myths that must be discarded are those that suggest there must be total confidentiality of mental health services in jails and the notion that there are clear-cut boundary lines dividing the responsibilities of the security officer and mental health clinician.*** Other myths that must also be destroyed are:

1) The mental health clinician (perhaps by osmosis?) has some inherent knowledge of suicide prevention;

2) The detention officer is the only person who may regard suicide as an inevitable occurrence;

3) The detention officer has too many other responsibilities to worry about and, therefore, should not be burdened with feedback about an inmate's mental state;

4) The mental health clinician is not concerned about the security of the facility; and finally,

5) One professional is more capable, more intuitive and more skilled than the other at preventing suicides and de-escalating volatile emotionally-based reactions.

Recognizing that these myths exist is the first step, but working to dispel them must occur concurrently with the following change processes:

Communication. A communication system, written and oral, must be in place through which detention and mental health staff can share information about suicidal inmates. Common sense tells us that interdicting in the suicide process does not require an extensive review of an inmate's personal history by either professional. The threat of revealing confidential (and irrelevant) psychiatric information is removed when there is recognition that the most important information needed to prevent suicides is that which deals with the ***here and now and the immediate future*** (Lombardo, 1985). In reality, it is a security officer who invariably discovers the suicidal inmate, particularly during the intake process, but also during routine security checks. If the officer has adequate training in crisis intervention and is comfortable using the related skills, they often know about the issues with which the inmate is dealing. Looked at in this light, there is little reason to justify the silence or, at best, reluctance on the part of mental health staff when it comes to giving the officer information and/or feedback about the issues impacting the suicidal inmate. ***The very worst jail suicide programming uses confidentiality as an excuse to justify a unilateral information delivery process.*** If we want security officers to work together with mental health staff to prevent suicides, mental health staff must work together with them. There is no place in the jail for unidirectional flow of information—bilateral communication is essential.

What does this mean? Mental health staff must encourage correctional officers to dialogue with them about inmate behaviors and/or emotional reactions that may signify suicide thoughts or mental illness. After assessing the inmate, the clinician should get back to the correctional officer with information that includes: discussion of the officer's accuracy or perhaps misinterpretation of the inmate's behavior; what the officer can do to assist in providing the inmate with continued mental health care; what the mental health clinician's continued role will be; and, of course, appreciation for the officer's concern that led to the initial referral. This dialoging must not be gratuitous; it must be sincere and done with the realization that it is an integral part of an effective multi-disciplinary, multi-responsibility mental health program.

Education. This article has largely focused on officer-clinician intervention in suicide crises, but serious suicidal ideation and intent do not present themselves when a person is in a rational state of mind — with the exception perhaps of those persons choosing to die because of serious illness rather than face a prolonged, painful "natural" death. There is almost always a window of opportunity during which effective intervention can be made in the suicide crisis. For the suicidal person, there is generally an ambivalence about choosing life or death, an uncertainty that is both cognitive and emotional in nature and therefore susceptible to the impact of therapeutic intervention. In short, suicide is part of a larger mental health problem. This may diagnostically translate into depression, low self-esteem, psychosis, anxiety, etc.

Education ("training") for detention officers ***and*** jail mental health staff must therefore include not only identification of the signs and symptoms of suicide, but also entail the recognition and means of dealing with the signs and symptoms of mental illness/emotional problems. The benefits of this education extend far beyond the jail walls. Considering the prevalence of major mental illnesses in society at large, no one can escape from witnessing the impact of mental illness on both the individual and greater society. Learning about mental illness increases our sensitivity to the difficulties experienced by and because of the mentally ill population. Further, in over 15 years of involvement in suicide prevention and mental health training, this writer cannot recall a seminar participant who had not been personally exposed to someone suffering from mental illness or suicidal thoughts. Many times these issues are seen in our own families, colleagues or circle of friends. A timely example of this is illustrated in the recent findings that the suicide rate among New York City police officers is twice as high than that in the general population (National Public Radio, 1993).

Finally, education must be geared toward ***both*** the correctional officer and mental health clinician. Crisis intervention and suicide prevention courses are generally offered, if at all, as electives during graduate school education. While assessment of depression and/or suicide and mental illness may be reviewed as part of the content in required course work on psychopathology or diagnosis, generally very little attention is paid to the specific topics of suicide prevention and crisis intervention. Not only do graduate schools of social work and psychology need to incorporate more specific information relative to these areas, they also should ensure that education on the mental health-related "issues and problems special to corrections and its offender population" is available to graduate students (Powitzky, 1981, p. 6). At least some in-service training should be designed for presentation to all the professional groups together, i.e., detention officers and mental health clinicians (Haddad, 1993).

Team "Practice." One method of respecting an inmate's right to confidential assessment and treatment, while maintaining a strategy of clinical-correctional teamwork, is to invite a security officer to join a mental health clinician in an assessment interview. The jail (or prison) mental health worker, as well as security officer, who deny having had the experience of being frightened to see an inmate alone is not being honest with themselves or others. In reality, there is plenty of reason to be frightened of certain people, both in and out of jail. The unpredictability of behavior and beliefs that accompany some psychotic and suicidal conditions ***calls for*** caution on the part of the professional who must interact with an emotionally ill inmate. At these times, the mental health clinician who assesses the inmate should take the opportunity to invite an interested detention officer to sit in. There are three benefits to doing so — and are nearly risk-free if organized properly and in advance:

1) It is a learning experience for both professionals; an opportunity to learn about mental illness and how to assess a person suspected of having a mental illness or suicide crisis;

2) It provides an added measure of safety and security which contributes to a more complete interview and assessment process; and

3) It is an effective way to live out the kind of cooperative relationship we want to develop and encourage between mental health staff and detention officers.

Both the officer and mental health worker must agree that the inmate's revelations are confidential ***and*** privileged. While not foolproof, if the officer is asked to reveal the inmate's communication in court, the clinician can claim, on behalf of the inmate and under their professional code of ethics (and often under state statute), that the detention officer was working at the time under the clinician's professional license and thus has a privileged relationship with the client/inmate (for example, see LA. Rev. Stat. 37:2714, 1983). While this hands-on practice may not appeal to all officers or clinicians, certainly both parties and the institution have much to gain from it.

Of course, mental health records are rightfully considered to be confidential documents in which the inmate has a right to expect privacy. It is important for mental health staff to safeguard the privacy of these records. However, this is no excuse for withholding information about inmate crises, suicidal and homicidal behavior, and security risks from detention staff. To effectively intervene in these types of emergency situations, all "caretakers" — mental health and security professionals alike — must share verbal information. The record may explain some inmate behavior to the clinician, but it does not alone magically enable any staff member to intervene in the situation at hand. Information in the record does not have to and should not be revealed, but information about the inmate's ***current*** functioning and the treatment plan must be shared between all involved staff.

The Team. Every team has at least one leader. The mental health team should be led by a mental health clinician, but include detention officers. The security team should be led by a corrections' professional, but include mental health clinicians. Neither can operate effectively without the other. It is imperative that jail administrators give their explicit support to this team concept, but the team itself ***must*** be made up of at least some line staff. ***Perhaps one of the greatest deficiencies in national jail standards is that regularly scheduled meetings between representatives of the mental health staff, program staff and correctional staff (specifically line personnel) are not required.*** Much like the "staffings" that occur in schools, psychiatric hospitals and other human service agencies, these meetings can facilitate both the educational process and the interrelationship building process that must occur in a detention treatment program. While jail standards [e.g., NCCHC (J-03)] call for quarterly meetings to discuss health/mental health care issues, they are designated as "administrative meetings" having a different focus than the inter-disciplinary staffing would have. Front line mental health and security staff, along with supervisors and administrators, should meet regularly for informal, educational discussions on the subject of maintaining a secure, minimally emotionally disruptive environment. Certainly after a completed suicide occurs it is particularly important to bring the security and mental health staff together to review the incident through the psychological autopsy process.

Implications for the Future

The relationship between security and mental health professionals is a partnership, one that must be brought to the forefront in detention facilities. All data indicate that the numbers of pretrial detainees are rising, with no end in sight. The current proposed national crime bill illustrates

this forecast with its inclusion of millions of dollars for prison construction and an increase in police officers across the country.

Mental health and corrections professionals must be partners in the prevention of jail suicides and mental health-related critical incidents. It's time to get vocal about it, to communicate about the issues on which we agree as well as disagree. The investment of time and energy to take this (too) silent partnership public will pay off in the numbers of lives protected and saved. Most of all, putting an end to this silence has the potential to make our own occupational positions more satisfying. In jail, silence is ***not*** golden.

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NO-SUICIDE DECISIONS AND SUICIDE CONTRACTS IN THERAPY

They are referred to by a variety of names — "Behavior Contracts," "No-Harm Contracts," or "Suicide Contracts" — and often contain the following language: I _____ PROMISE NOT TO HARM MYSELF WHILE INCARCERATED AT THE SMITH COUNTY JAIL. IF I SHOULD HAVE ANY TENDENCY TO

HARM MYSELF, I WILL IMMEDIATELY ALERT THE STAFF. But are these "contracts" effective in preventing jail suicides? What impact, if any, do they have should an inmate not honor the signed document and subsequently commit suicide?

The effectiveness of suicide contracts are also being questioned in the general community, where therapists try to apply additional safeguards on their patients. In a recent issue of ***Crisis: The Journal of Crisis Intervention and Suicide Prevention*** *(Volume 14, Number 3, 1993), suicide contracts were the subject of an editorial by Dr. David C. Clark and Dr. Ad J.F.M. Kerkhof, Editors-in-Chief of the journal. Although the editorial focuses upon contracts in the community, the advice offered by Clark and Kerkhof can be easily applied to the jail environment and, therefore, it is reprinted below with their permission.*

"Suicide contracts" are employed by many therapists in a variety of settings during their work with suicidal patients. The spirit of this verbal contract between patient and therapist is that the patient promises not to harm him- or herself during the period between therapy sessions, or at least not to do so without making contact with the therapist first.

So far as we can determine, only Drye and colleagues (1973) have discussed this kind of therapeutic maneuver at length. However, these authors never proposed a "suicide contract" between patient and therapist in the form generally invoked today. Instead, they described a long, detailed transaction between patient and therapist, shaped by explicit criteria and conditions, that constitutes a "no-suicide decision" rather than a "suicide contract." Their procedure would require the better part of an hour in therapy — time that most therapists do not ordinarily devote to defining and elaborating a suicide contract with their patients.

We believe that there is no harm associated with "suicide contracts," so long as the therapist does not succumb to the illusion that the contract is likely to prevent a suicide. There are also many positive aspects to a suicide contract in therapy. It is important for the therapist to teach the patient various things:

- About the different kinds of suicidal phenomena — thoughts, impulses, behaviors — that the therapist needs to monitor;
- That the therapist continues to be interested in changes in these symptoms over time; and
- That if suicidal impulses develop or become more insistent in between regular appointments, the patient should contact the therapist immediately.

It is tempting for the therapist to rely on a suicide contract for reassurance that the patient will not attempt suicide during treatment. In the United States, for example, many programs encourage therapists to make a "no-suicide contract" and to document that verbal contract in the treatment record. This is thought by many to provide a safeguard against liability in the event of a death by suicide, and subsequent lawsuits for negligence or malpractice, but in truth evidence of such a suicide contract probably affords the therapist no substantial legal protection.

It is also tempting to rely on a suicide contract for freedom from worry. The therapist may be tempted to imagine, "I have done everything I can for this patient until the next therapy session, and he/she knows to call me if a suicidal crisis develops — hence I do not need to worry about the possibility of a sudden, unanticipated suicide attempt." But again, in truth, the existence of a suicide contract probably provides no such protection.

It has been estimated that the ratio of nonfatal to fatal suicide attempts in the general population is in the vicinity of 20:1. Thus therapists treating patients at risk for suicidal behavior, particularly those treating relatively low risk patients in outpatient settings, may make many suicide contracts with many different patients over time and never experience a patient's death by suicide — simply because the odds are in their favor. The fact that a therapist has used the "suicide contract" as a therapeutic maneuver many times and has never lost a patient by suicide does not constitute evidence that this form of intervention is effective.

Our concern is focused on the one suicidal patient in 20 who develops insistent suicidal impulses. We believe that many patients in acute suicidal crisis, including those with considerable psychological depth and resources when not in an episode of acute psychiatric illness, do not have the capacity to resist the internal logic, the emotional tug, and the pain relief offered by the solution of suicide when they are ill. These patients temporarily lose all sense of the impact their death would have on beloved others. Sometimes, when listening to such a patient describe his or her experience of suicidal thoughts, the irresistible quality of the suicidal impulse is evident. More often, the strength of the impulse can be inferred from the patient's strenuous efforts to rationalize, romanticize, or otherwise justify the suicidal preoccupations, by donning a cloak of intellectualism, philosophical detachment, existentialism, cynicism, or religious fervor.

The point is that once suicidal preoccupations have reached an extreme level of intensity, there is a great danger that the patient has become irrefutably convinced of the sense and value of his or her suicidal ideas, so that all verbal interventions (i.e., interpretations, discussions, negotiations, pleas) are rendered totally ineffective. We do not think that one can reason reliably with persons in severe suicidal crisis, any more than one can reason with a person who believes God is sending them personal messages via advertising billboards, or with someone who is convinced (medical evidence to the contrary) that a tumor is going to result in death. In this kind of acute and severe crisis, the patient's verbal assurances are not sufficient to convince us that he or she can resist the suicidal impulses. The clinically appropriate response is to

provide unremitting 24-hour supervision, usually in the form of psychiatric hospitalization, and to institute those psychotherapeutic, psychopharmacological, or other treatment measures that might be expected to alleviate the severity of the depressive symptoms or other underlying illness states.

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LITIGATION: *JONES V. THOMPSON* AND THE ISSUE OF RESTRAINTS

Can a jurisdiction be found liable for using restraints on an inmate following a suicide attempt? Yes, according to Judge John Daniel Tinder of the United States District Court, Southern District of Indiana, when the —

> *extended use of three-way restraints, coupled with the absence of medical review or treatment and the denial of even basic amenities such as personal hygiene and toilet usage, was not reasonably related to a legitimate goal or interest of the Jail. It was, therefore, 'punishment' in a constitutional sense and cannot be excused by the circumstances which initially justified some restraint. This was nothing short of flagrant governmental abuse which is decried by the Due Process Clause.*

On March 31, 1993, Judge Tinder ruled in Jones v. Thompson [818 F. Supp. 1263 (S.D. Ind. 1993)] that Madison County and various jail staff were liable for both compensatory and punitive damages. He wrote the following "findings of fact:"

Plaintiff David Michael Jones ("Jones") is an inmate of the Indiana Department of Correction who was formerly and periodically confined in the Madison County Jail ("the Jail").

Insofar as pertinent to the present action, Jones was arrested in December 1988 for battery and for sale of a counterfeit drug. The Jail's logs show his arrest on December 19, 1988 and a medical entry for December 20, 1988 providing Jones with medication to lessen the effects of his withdrawal from drugs. It also noted his date of birth to be July 18, 1958, his height to be 5'11" and his weight to be 160 pounds.

Jones was assigned to the second floor in "B" Block. After a point, he became despondent. His girlfriend was four months pregnant. He saw his girlfriend when he was looking out the window of the jail. His ex-wife had his girlfriend in the car and talked her into becoming an exotic "topless" dancer despite her pregnant condition. This was very upsetting to Jones so he took a bed sheet and tied it around his neck and tried to hang himself. This occurred during the afternoon of January 25, 1989.

Jail staff found him, took him down, chained him and placed him on a cart. He was then taken via that cart, face down, to a "detox" unit located on the first floor of the Jail. The window of the detox unit was large and faced the Jail's main control area. Jones had only been in the jail approximately two weeks at that point. He had had no incident reports on him as of that point.

The detox unit into which Jones was placed was a barren room. It had a steel bench, about 18 inches wide and of undetermined length, but Jones could not mount it without assistance because of the restraints kept on him.

While in the detox unit, Jones remained with few exceptions in a three-way restraint, consisting of a belly chain wrapped around his stomach area, handcuffs on his waist and leg shackles on his legs and then a chain was run between the leg chains and the ankle chains through the belly chain. His feet were about six inches apart. All that Jones could do in terms of movement was roll or creep. He could not stand or sit, but could only squat. At any one time he could not raise higher than about a little above his waist level. The most descriptive appellation for this method of restraint is that the plaintiff was "hog-tied."

When he was first placed in the detox unit he was laid on the cement floor and left. There was no mattress in the cell. There was no blanket. He could not even get up to the steel bench in the detox tank without help from jail staff. The Plaintiff was bare above the waist and was without shoes, sandals or socks.

Jones stayed in that chained condition for approximately one week. He was visited during that time by his mother, his girlfriend and his stepsister. They came in to help try to calm him down. When visitors came, they were allowed to go into the cell, but he was not released from his chains. In order to be fed he had to have help sitting up. Jail staff

would unhook his left hand and hand him a tray. After eating, his hand would be handcuffed back to his waist.

He was unable to use the toilet facilities because of his chained condition so he would often just use the drain in the floor when he was lying on the floor. The drain was under the bench and there was a hole in the floor. He did this because he couldn't stand up to use the toilet for the reasons already described.

During this time Jones was also without articles for personal hygiene and was not allowed to shower or change clothes. During this time Jones was also distraught and combative.

Jones was removed from the detox unit for the first time after his placement to be taken to the office of Dr. Richardson, who interviewed and evaluated Jones on January 30, 1989 for the purpose of determining his competency to stand trial and to evaluate him for suicidal potential. This session during which Jones remained shackled to some extent, was conducted at the Center for Mental Health in Anderson, Indiana and resulted in Dr. Richardson's opinion that Jones was competent at the time of the alleged offenses, was competent to stand trial and was "a suicide risk and possible homicide risk." The report containing this opinion was apparently issued on February 10, 1989. Dr. Richardson intended for this information to be "passed to the jail," but there was no evidence that it was.

Jones' first shower after being placed in the detox unit was after his interview with Dr. Richardson. Family members were permitted to visit and other lay persons did visit (including Chris Wallace, another inmate) to help Jones calm down.

These efforts, over a period of days, were sufficiently successful that on February 1, 1989 Jones was taken from the detox unit and placed in a (regular) cell with Chris Wallace.

The next medical entry in the Jail's logs is for July 1989, when Jones requested an increase in his prescription for valium. The request was denied. There are no records showing when or why the valium prescription started. There are also no medical notes of treatment, consultation or the like in reference to Jones' attempted suicide or the following week he spent in the detox unit.

At the times pertinent to this suit the Madison County Sheriff's Department contracted with an outside group of physicians to provide medical care for jail inmates. These physicians were not contacted regarding Jones' attempted suicide or the use of restraints on him following the attempted suicide.

Jones suffered minor physical injuries during his ordeal in the form of bruises on his wrists, elbows and ankles. He also suffered emotional distress and anxiety because everyone passing by the Jail's control desk, in addition to those who came specifically to visit him, could see him in his restrained condition.

A second use of restraints on Jones occurred in late May 1989. These were used after a number of incidents in which he had been disruptive, abusive and threatening to the jail staff. On this second occasion the third chain, running between the ankle chain and the waist chain, was not used and though placed in the detox unit Jones was not deprived of the basic necessities for his care and welfare.

Any conclusion of law stated below, to the extent that it constitutes a finding of fact, is herein incorporated by reference as an additional finding of fact by the court.

Judge Tinder then made several "conclusions of law," including the determination that "while the government may not punish a pretrial detainee, it may impose on him conditions and restrictions necessary to maintain jail security. . .it is clear that some restraint and extraordinary intervention was warranted when Jones was found trying to commit suicide. Obviously, he needed to be taken down so the suicide attempt would be unsuccessful. He needed to be sufficiently secured so that further efforts, if made, would not endanger him." However, the court also determined that even though Madison County and its staff "did not intend to harm detainee or others who were similarly situated, it was its custom to be completely indifferent to detainees in severe restraints, and that custom was cause of deprivation of detainee's due process rights."

Who, therefore, was responsible for the deprivation of David Jones' rights? The court determined that since the inmate was housed in the detox unit at the direction of Jail Administrator (Captain) Doris Maxey, and "likewise kept in such severe restraints without medical evaluation at her direction, she is liable for the violation of his rights." The court also concluded that former Sheriff Mark Thompson was also liable because the "actions and inaction were the result of both policymakers of Madison County — Sheriff Thompson and Captain Maxey — and of the custom and practice to apply restraints without medical consultation and to keep them on for extended and undocumented periods without review. ***The practice may be infrequently invoked, but is nonetheless barbaric.*** *As Defendant Humerickhouse testified, jail deputies had been trained on how to apply restraints but not on when to take them off or how to ensure a detainee's welfare during the time the restraints were in use."*

Although Judge Tinder also held Sergeant Randy Humerickhouse liable to a lesser extent because as shift commander he made no effort to intervene and have a medical evaluation conducted regarding the continued need for "hog-tying" inmate Jones, most of the court's criticism was directed at Madison County and Captain Maxey — "The humane treatment of detainees such as Jones is the County's obligation and it must entrust that

WE'RE LOOKING FOR A FEW GOOD PROGRAMS

The National Center on Institutions and Alternatives (NCIA) has recently been awarded a grant from the National Institute of Corrections (U.S. Justice Department) to develop a monograph entitled — ***Prison Suicide: An Overview and Guide to Prevention.*** The monograph will include a thorough review of the prison suicide literature (recent research, state prison standards, and relevant case law); model prevention programs; and available training resources.

In regard to model suicide prevention programs, NCIA will identify several programs operating in prisons throughout the country, conduct an on-site case study on a select number of programs, and highlight the case studies in the monograph. (Our readers may recall that several model ***jail*** suicide prevention programs were highlighted in Volume 3 of the ***Jail Suicide Update.***) In selecting the prison programs to highlight, the following suicide prevention elements will be reviewed:

- ❑ comprehensive policies;
- ❑ formal intake screening;
- ❑ suicide prevention staff training;
- ❑ access to timely assessment and treatment services;
- ❑ supervision and housing of inmates;
- ❑ timely medical intervention following an attempt;
- ❑ environmental/architectural facility design that reduces suicide potential; and
- ❑ extended incident-free period of suicides.

If you believe that your prison facility operates a model suicide prevention program, and would like to be considered as a possible case study in the monograph, NCIA would very much be interested in receiving pertinent information for the preliminary evaluation. Please send a brief description of the program, a copy of the appropriate policies and/or procedures, and all screening and assessment forms to:

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responsibility to those capable of and willing to carry it out. This starts with the command and procedures in the Jail, which the evidence in this case shows to be shockingly deficient. Perhaps most compelling in this regard is the fact that, at least as of the trial, this 'hog-tying' procedure was still in use in the Madison County Jail under the auspices of Captain Maxey."

On May 18, 1993, Judge Tinder awarded inmate David Jones $12,000 in punitive and compensatory damages, as well as $22,479.49 in attorney fees. ■

PEPPER SPRAY IN SUICIDE PREVENTION: AN EFFECTIVE TOOL?

As jail facilities continue to find ways to prevent inmate suicides and deter suicidal behavior, oleoresin capsicum (OC) is beginning to find its way into jail policy manuals. Commonly referred to as "pepper spray," OC sprays were thought to be effective law enforcement tools utilized in subduing violent and out-of-control arrestees, while reducing police officer injuries and excessive-force complaints. OC spray temporarily inflames the eyes and the mucous membranes of the nose and throat, with its effect lasting from 45 to 60 minutes. Based upon its apparent success, numerous jail facilities have begun to utilize OC spray to thwart suicides in progress or even deter inmates who threaten suicide. Caution, however, might be the best policy following recent deaths of several arrestees whose deaths have been linked to OC spray.

In early January 1994, while deputies from the Kent County Sheriff's Department in Grand Rapids, Michigan were attempting to transfer Richard McCrumb to a hospital for psychological treatment, he became violent and officers subdued him with OC spray. Mr. McCrumb subsequently died and an autopsy will determine what effect, if any, the OC spray had on his death.

The death of Richard McCrumb follows the much publicized and controversial death of Angelo Robinson in July 1993. Mr. Robinson was confronted by police officers in Concord, North Carolina, who were called to the scene of a disturbance outside a local nightclub. Mr. Robinson, 6-foot-1 and weighting 308 pounds, was allegedly drunk and sprayed with OC after violently resisting arrest. He died within minutes of being transported by officers to the Concord police station. According to the October 15, 1993 issue of *Law Enforcement News* (LEN), Mr. Robinson's death sparked rioting in the town, located a few miles northeast of Charlotte, during which one store was burned down, windows were smashed, and eight police officers, two fire fighters and several residents were injured. A state of emergency and curfew were temporarily imposed.

Adding to the controversy was an autopsy report of Mr. Robinson's death by Dr. Lisa Flannagan of the North Carolina Medical Examiner's Office. The report, released in late August 1993, stated that Mr. Robinson suffered from an enlarged heart and a chronic lung condition that may have been aggravated by the spray, causing him to choke on his own vomit. Dr. Flannagan stated that "the cause of death in this case is asphyxia due to bronchospasm precipitated by the pepper spray. . .There is no physical injury to explain his death. Based on the temporal relationship between his being sprayed with the pepper spray and his apparent respiratory compromise and rapid demise, I believe that this agent served as the precipitating factor in the chain of events."

The medical examiner's findings were quickly attacked by officials from Advanced Defense Technologies, Inc., the company that produced the brand of OC spray used on Mr. Robinson. Howard Perry, the company's president, told LEN that — "Nowhere in her autopsy does she even establish there was any pepper internally or externally in the decedent, only that she was told that he was sprayed with pepper. . .The autopsy says there is a complete lack of physical evidence as to why he died. It's her conclusion that because of any lack of evidence, then the pepper must have had something to do with it." Mr. Perry also criticized the Concord police officers, stating that "the suspect was intoxicated, passed out in the cruiser, vomited and choked to death on his own vomit. . .Our contention is, and will continue to be, that the guy died because of a lack of proper medical attention. . .Had he received proper medical attention, he most likely would have lived — no matter what the cause of his collapse was."

Since this controversial death, several police departments in North Carolina and elsewhere have temporarily suspended use of all OC sprays pending further investigation. In addition, LEN reported that the North Carolina Attorney General's Office issued an OC spray advisory bulletin which included the following recommendations: 1) Remove the subject from the area of exposure and place in fresh air; 2) Ask the subject if he/she suffers from any respiratory diseases or problems, such as asthma, bronchitis or emphysema. If the subject displays respiratory problems, seek medical attention for the subject immediately; 3) Assure the subject that the effects of the OC spray are temporary; 4) Flush the subject's face with water or apply a wet towel to hasten recovery (using a mild soap that contains a grease-cutting agent that will remove the OC and speed recovery); 5) While transporting the subject to a police or medical facility, monitor his condition and watch for signs of breathing difficulty, nausea or other physical discomfort. Never leave the subject unattended until the effects have completely diminished or the individual indicates they have fully recovered from the effects of the spray. Medical attention should be given to individuals sprayed with OC if symptoms have not disappeared within one hour; and 6) Inform detention facility officials that the suspect has been sprayed.

JAIL SUICIDE UPDATE

This technical update, published quarterly, is part of the National Center on Institutions and Alternatives (NCIA)'s continuing effort to keep state and local officials, individual correctional staff and interested others aware of developments in the field of jail suicide prevention. Please contact us if you are not on our mailing list, or desire additional copies of this publication. As NCIA also acts as a clearinghouse for jail suicide prevention information, readers are encouraged to forward pertinent materials for inclusion into future issues.

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AVAILABLE JAIL 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 (1988)

Curriculum Transparencies (1988)

Jail Suicide Update (Volume 1, 2, 3 and 4)

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

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