STUDENT HANDOUT "A"

Jail Standards And Suicide Prevention

Since the early 1960s the legislature and various regulatory agencies have sought develop some type of standard for the efficient operation of county jails and lockups. From these efforts two basic types of standards have emerged by which jail operations are measured. Standards are shaped by Supreme Court decisions in cases regarding conditions of confinement. These cases are typically civil rights cases alleging 8th amendment issues of cruel and unusual punishment. When the courts rule on these issues, a precedent is set that tends to govern any similar issues in other facilities. The second type of standards has emerged from the growing body of self-regulatory standards and accreditation procedures promulgated by professional and federal agencies to stimulate facility improvement through voluntary, administrative action.

Before the Prison Litigation Reform Act of 1996, courts had traditionally taken an active role in monitoring the jail systems. This was known as the "hands on era", a period of time when the courts began to focus on issues of confinement, especially as they applied to civil rights. As the pendulum of justice began to swing to the opposite side, the courts became inundated with civil rights suits, underscoring the need to search for ways to relieve the flow of cases that were congesting the system. Out of this came the professional associations, groups of correctional professionals who sought to reduce litigation through self-government.

These self-governing organizations addressed the root cause of litigation by drafting standards to be used as models for jail policies and procedures. Although correctional standards in general are not legally binding and do not set constitutional requirements, the U.S. Supreme Court has stated that such standards have the ability to serve as guidelines or benchmarks in assessing the "duty of care" or "reasonable conduct." Jail standards have become a yardstick for measuring conditions of confinement.

The active role played by the courts, sometimes referred to as "judicial activism", encouraged the development of increasingly specific self-regulatory standards by executive and professional organizations. In turn, the availability of these standards provides for a new level of objectivity to litigation challenging the conditions of confinement.

A study to determine the impact of the American Correctional Association (ACA)'s correctional standards on court rulings found that 1) courts often consult ACA standards when attempting to determine appropriate expectations in a correctional setting; 2) courts sometimes cite ACA standards as the basis for establishing a court standard or a requirement in a decision; and 3) courts have sometimes utilized ACA standards and accreditation as a component of a continuing order or consent decree.

While the ACA provides standards with which the courts are familiar, those standards are not applied to every case. In some cases, less restrictive standards are applied based on the court's view of the constitutional or statutory requirement. In others the court given the circumstances of the case might establish a higher standard. The court often prefers to consider the totality of conditions rather than rely on specific standards to meet constitutional requirements.

The effective management of a jail requires the jail administrator to make decisions regarding the parameters within which his practices must fall. The correctional standards provided by associations and other agencies and funded institutions are presented as guidelines for operational policy. This provides the platform on which to build policies utilizing the best practices rather than relying on minimum compliance.

The purpose of jail standards is to encourage sheriffs and jail administrators to reexamine existing policies, procedures, and practices, and to aid in policy planning development, and modification. The standards may also assist jail officials to achieve greater uniformity in the operation and management of facilities by serving as a measure for effective operation (the report card), and as a guide to developing lesson outlines for more effective training.

In the past, many organizations have developed and presented national standards for use in jail facilities. However, it has only been recently that suicide prevention standards have been added and because of its infancy, those standards sometimes tend to vary in nature and focus to the extent that some fail to address the real issue of prevention.

The American Correctional Association's Standards for Adult Local Detention Facilities are the most widely recognized national jail standards. However, in the beginning these standards focused on the general operation and administration of the jail without addressing such issues as health and mental health care. As the issues of mental health and suicide came to the fore front, subsequent editions of the standards contained amendments and provisions that were aimed at addressing these concerns. The second edition, published in 1981, included sections on the screening and supervision of suicidal inmates, health appraisals, as well as responding to medical emergencies. The following sections reflect the change:

> 2-5174: Written policy and procedure require that all high and medium security inmates are personally observed by a correctional officer at least every 30 minutes, but on an irregular schedule. More frequent observation is required for those inmates who are violent, suicidal (emphasis added), mentally disordered or who demonstrate unusual or bizarre behavior.
>
> 2-5273: Written policy and procedure require medical screening to be performed by health-trained staff on all inmates upon arrival at the facility. The findings are recorded on a printed screening form approved by the health authority. The screening process includes at least the following procedures...Past and present treatment or hospitalization for mental disturbance or suicide (emphasis added)...
>
> 2-5274: Written policy and procedure require that a health appraisal for each inmate is completed within 14 days after arrival at the facility. Health history and vital signs are collected by health trained or qualified health care personnel and all other data is collected only by qualified health care personnel. (Appraisal includes review of mental status.)

In addition, standard 2-5271 required the establishment of a training program to provide instruction in various areas, including "The ability to respond to health-related situations within four minutes...Administration of first aid and cardiopulmonary resuscitation (CPR)...Recognition of signs and symptoms of mental illness, retardation, emotional disturbance and chemical dependency."

The Discussion section of standard 2-5271 included the following:

> "...If emergency treatment is not provided within four minutes in certain situations, lives can be lost. All correctional officers should have standard first aid training. Minimally, one health trained correctional officer per shift should be trained in cardiopulmonary resuscitation (CPR) and recognition of symptoms of illness most common to inmates."

In 1983, standard 2-5174 was revised to state:

> 2-5174: Written policy and procedure require that all high and medium security inmates are personally observed by a correctional officer at least every 30 minutes, but on an irregular schedule. More frequent observation is required for those inmates who are mentally disordered or who demonstrate unusual or bizarre behavior: suicidal inmates are under continuing observation (emphasis added).

The following year the requirement of a suicide prevention program was added to the standards, and it provided the strongest ACA commentary to date:

> 2-5271-1: Added August 1984. There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with responsibility for inmate supervision are trained in the implementation of the program.
>
> DISCUSSION: Staff have a responsibility for preventing suicides through intake screening, identification, and supervision of suicide-prone inmates. They should receive special training in the implementation of a suicide prevention program.

In January 1989, standard 2-5083 was revised to require that the topics of “signs of suicide risk” and “suicide precautions” be included in the training curriculum for new correctional officers. In addition, standard 2-5273 was revised slightly to change “medical screening” to “medical, dental, and mental health screening.”

In 1989, the ACA published the Standards for Small Jail Facilities, developed for jails housing 50 or less inmates. The manual incorporated standards 2-5174 and 2-5273 from the Standards for Adult Local Facilities, but did not require 2-5271-1 detailing the written suicide prevention program.

In March 1991, the ACA issued the third edition of the Standards for Adult Detention Facilities. With a few exceptions, there were no substantial revisions in the suicide prevention protocols. A more substantive change in the third edition, however, was standard 2-5174 (Supervision) being replaced by the following:

> 3-ALDF-3D-08: Written policy, procedure, and practice require that all special management inmates are personally observed by a correctional officer at least every 30 minutes on an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; suicidal inmates are under continuous observation (emphasis added).

Further, while standard 2-5271-1 (Suicide Prevention and Intervention) had contained the ACA’s strongest commentary regarding suicide prevention by emphasizing that “staff have a responsibility for preventing suicides...,” that language was curiously removed from the third edition and the standard(renumbered as 3-ALDF-4E-34) was revised to read:

> There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with responsibility for inmate supervision are trained in the implementation of the program.
>
> Comment: The program should include specific procedures for intake screening, identification, and supervision of suicide-prone inmates.

It should also be noted that standard 3-ALDF-1D-12 of the third edition also required all correctional staff to have annual instruction in both suicide prevention ("signs of suicide risk" and suicide precautions") and cardiopulmonary resuscitation.

Finally, in June 2004, the ACA released the fourth edition of its jail standards. Entitled Performance-Based Standards for Adult Local Detention Facilities, the mandatory suicide prevention and intervention standard (4-ALDF-4C-32) of the volume states the following:

> A suicide-prevention program is approved by the health authority and reviewed by the facility or program administrator. It includes specific procedures for handling intake, screening, identifying, and supervising of a suicide-prone inmate and is signed and reviewed annually.
>
> The program includes staff and inmate critical incident debriefing that covers the management of suicidal incidents, suicide watch, and death of an inmate or staff member. It ensures a review of critical incidents by administration, security, and health services. All staff with responsibility for inmate supervision are trained on an annual basis in the implementation of the program.
>
> Training includes but is not limited to:
>
> - identifying the warning signs and symptoms of impending suicidal behavior;
> - understanding the demographic and cultural parameters of suicidal behavior, including incidence and variations in precipitating factors;
> - responding to suicidal and depressed inmates;
> - communicating between correctional and health care personnel;
> - using referral procedures;
> - housing, observation, and suicide-watch level procedures; and
> - follow-up monitoring of inmates who make a suicide attempt.

In 1983 the Commission on Accreditation for Law Enforcement Agencies (CALEA) developed some standards that included lockups, small jails, etc. these standards remained vague with regard to suicide, possessing no specific instruction regarding intake/screening, or management of suicidal inmates and made no mention of required suicide prevention training for staff.

In fact, only two CALEA standards were casually related to suicide prevention:

> 72.5.5: A written directive prescribes methods for handling, detaining, and segregating persons under the influence of alcohol or drugs or who are violent or self destructive.
>
> Commentary: The holding facility is not normally equipped to provide treatment to persons under the influence of drugs or alcohol, and such persons should be detained in other facilities, when available. When these facilities are not available, special consideration should be given to ensuring

> that the potential for detainees to injure themselves or others is minimized. Such detainees should remain under close observation (emphasis added) facility staff.
>
> 72.8.1: A written directive requires 24-hour supervision of detainees by agency staff, including a count of the detainee population at least once every eight hours, and establishes procedures to ensure that the detainee is visually observed (emphasis added) by agency staff at least every thirty minutes.
>
> Commentary: ...Care should be taken during physical checks that the detainee does not anticipate the appearance of agency staff. Detainees who are security risks should be under closer surveillance and require more frequent observation (emphasis added). This classification includes not only detainees who are violent but also those who are suicidal or mentally ill or demonstrate unusual or bizarre behavior.

The fourth edition of the CALEA standards was released in January 1999. This edition still did not specifically address practices to address the management of suicidal inmates but rather made such suggestions as:

> Agencies are encouraged, but not required, to introduce direct physical checks whenever possible, but detainees may be observed through audio/visual means.

Possibly the most comprehensive and practical guidelines for suicide prevention were presented by the National Commission on Correctional Health Care (NCCHC). Their standards for Health Services in Jails not only required that jails develop a written suicide prevention plan (J-58), but also listed the essential components to such a program:

- identification,
- training,
- assessment,
- monitoring,
- housing,
- referral,
- communication,
- intervention,
- notification,
- reporting,
- review

The National Commission on Correctional Health Care offered other standards specifically related to suicide prevention that are examined in-depth in other sections of this lesson.

Correctional standards have often been viewed with some skepticism, sometimes referred to as too general or vague, lacking in enforcement power, and often politically-influenced. The early standards did little to provide guidelines for jail administrators in dealing with health care and suicide issues. Even the adoption of current standards is no guarantee that individual facilities have

put those procedures into operation. There are many cases of “accredited” jail facilities that are under court order for inadequate conditions of confinement.

Most of the national standards were developed as recommended procedures rather than regulations that measured outcome, giving basis to the complaint that they lacked enforcement power. Only recently has the term “performance based” been used in the evaluation of jails and jail standards..

While these standards may seem ineffective in specific cases, the that management of jails and conditions of confinement have greatly improved since correctional standards were first promulgated in the early 1960s and the relationship between suicide prevention and national correctional standards has progressed significantly in recent years.

Because suicide remains the leading cause of death in jails, it has caught the attention of several national organizations and other influential bodies and made them aware of the need to develop standards to address the specific area of suicide prevention, and to keep them current by reviewing and revising them as needed.

Most national standards now address suicide prevention separately and distinctly, rather than consigning to a footnote in medical care standards. National guidelines for suicide prevention have provided the opportunity and framework for both large and small jail systems to create and build upon their policies and procedures for the prevention of suicides.

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Standards Set By The Court

The Civil Rights Division of the U.S. Department of Justice conducted an investigation of the jail in Dallas County, Texas regarding conditions of confinement. In December 2006, they released a report citing numerous instances where the Dallas County Jail’s “mismanagement contributed to preventable deaths, hospitalizations and unnecessary harm”. The report was based on on-site inspections at the jail, as well as review of hundreds of documents (including policies and procedures, grievances, and medical and mental health files).

As a result of these findings, in November 2007, the Department of Justice and Dallas County entered into a settlement agreement to improve medical and mental health care within the jail system.

This “Agreed Order” containing mental health and suicide prevention requirements was filed in the United States District Court for the Northern District of Texas.

United States v. Dallas County et al (Civil No. 307 CV 1559-N)

The following provisions concerning suicide prevention are contained in that order.

4. Suicide Prevention:

a. Defendants shall develop policies and procedures to ensure the appropriate management of suicidal inmates, and shall establish a suicide prevention program in accordance with generally accepted professional standards of care.

b. Defendants shall ensure that suicide prevention procedures include provisions for constant direct supervision of actively suicidal inmates and close supervision of special needs inmates with lower levels of risk (e.g., 15 minute checks). Officers shall document their checks. Suicide prevention policies shall include procedures to ensure the safe housing and supervision of inmates based on the acuity of their mental health needs. Cells for suicidal inmates shall be retrofitted to render them suicide-resistant (e.g., elimination of protrusive shower heads, exposed bars, unshielded lighting or electrical sockets).

c. Defendants shall ensure that all staff are trained on suicide response, prevention, and detection. Staff posts will be equipped with 911 rescue tools.

d. Defendants shall ensure adequate administrative mortality and morbidity review of custodial suicides and serious suicide attempts review following a custodial suicide or suicide attempt. At a minimum, the review shall include:

(1) critical review of the circumstances surrounding the incident;

(2) critical review of procedures relevant to the incident;

(3) synopsis of all relevant training received by involved staff;

(4) pertinent medical and mental health services/reports involving the victim;

(5) possible precipitating factors leading to the suicide or attempt; and

(6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.

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In the case of Cook v. Sheriff of Monroe County, No. 03-14784 the United States Court of Appeals for the Eleventh Circuit granted judgment on civil rights claims and negligent training and supervision claims against a Florida sheriff arising out of a detainee's suicide after his requests to see a psychiatrist failed to be granted.

After reviewing the facts, the court found the following the institutions policies and procedures to be inadequate in the following areas.

The intake/screening and assessment process was inadequate.

First,

MCDC failed to properly assess Tessier's suicidality, despite at least 2-3 written requests by Tessier for psychiatric treatment. MCDC's mental health and suicide assessment forms are inadequate to detect either mental illness or impending suicide. Daniel Tessier did in fact abuse alcohol and crack cocaine and had prior suicide ideation (all known suicide risk factors) and MCDC's assessment procedures failed to detect this

The frequency of checks were inadequate. This finding is an example of the courts' use of jail standards promulgated by self-regulatory associations (Florida Model Jail Standards, 7.18).

Second,

Since MCDC's own suicide prevention policies and procedures admit that most jail suicides occur with[in] the first 72 hours of incarceration, Tessier should have been put on close observation (viz., within arm's reach 24/3) at admission. One hour checks are grossly insufficient to prevent jail hangings (which can occur in only 4 to 5 minutes; See Florida Model Jail Standards, 7.18).

The court found the training procedures inadequate.

> *Third,*
>
> *MCDC's suicide prevention training procedures are unclear and inadequate to prevent jail suicides. All that was mentioned in the record was some available in-service suicide prevention videos.*

The court found that proper medical/mental health care was not provided.

> *Fourth,*
>
> *Had Daniel Tessier seen a psychiatrist @ MCDC and been properly evaluated and treated for anxiety (e.g., given a benzodiazepine) or depression (e.g. given an SSRI antidepressant), he would more likely than not have not suicided at MCDC.*

Failure to act on repeated requests for psychiatric treatment constituted neglect.

> *Fifth,*
>
> *Officer Whortenbury should have read Daniel Tessier's 2nd written request for psychiatric treatment . . . and notified the MCDC Care Center . . . immediately. Two to three suicide "cries for help" were ignored by MCDC.*

A history of prior suicides showed a knowledge of the conditions lacking adequate suicide prevention measures and the facility failed to attempt corrective action concernig these conditions.

Sixth,

MCDC had an excessive number of suicides in a two year period (viz., from 1997 to 99). The average jail suicide rate is 1XX-XXX-XXX (Bonner, 1992). MCDC's probably exceeds the average rate (I am in the process of getting inmate population numbers which will allow me to calculate that MCDC suicide rate). MCDC failed to correct, modify, or otherwise change serious suicidogenic conditions at their jail. Officer Kerr was personally involved with 3 of the MCDC suicides.

The cells were not suicide proofed. Once again, this finding shows the use of jail standards promulgated by an independent organization.

Seventh,

The cells at MCDC were not suicide proofed (See Florida Model Jail Standards, 8.07). Eighth, MCDC was deliberately indifferent to Daniel Tessier's serious medical needs.

The court found a violation of the 8th amendment.

Ninth,

MCDC violated Daniel Tessier's constitutional right to not suffer cruel and unusual punishment, by ignoring his written requests for psychiatric treatment and evaluation.

The court found the facility's lack of response to be contribute to the inmate's suicide.

Finally,

Had MCDC responded appropriately and promptly to Daniel Tessier's psychiatric condition, it is more likely than not that he would not have committed suicide at the MCDC.

Can Prior Suicides In Jail Exemplify Deliberate Indifference?

In Wever v. Lincoln County, the complaint alleged that the sheriff failed to take any corrective action in the areas of training and supervision of personnel following two other prior inmate suicides in the jail. On November 4, 2004, the U.S. Court of Appeals for the Eighth Circuit ruled that the sheriff was not entitled to qualified immunity. Without qualified immunity, an officer can be sued as an individual as well as in his official capacity, thus attaching the officer's personal assets in the event of judgment in favor of the plaintiff.

On December 8, 2001, Dennis Wever committed suicide in the Lincoln County Jail in North Platte, Nebraska, despite the fact he had threatened suicide to both arresting officers and jail personnel. His family subsequently filed a federal lawsuit against Lincoln County, its sheriff, the North Platte Police Department, its chief of police, and several officers alleging that their deliberate indifference was the proximate cause of Mr. Wever's death.

The following excerpt taken from an article published in the Jail Suicide/Mental Health Update - Winter 2004 edition demonstrates the necessity of taking a pro-active approach to suicide prevention.

Wever v. Lincoln County (No. 03-3633, 2004
U.S. App. Lexis 22974, 8th Cir. 2004.

Before MORRIS, SHEPPARD, ARNOLD, MAGILL, and MURPHY,
Circuit Judges.
MAGILL, Circuit Judge.

This case arises from the following tragic facts. On December 8, 2001, Lincoln County officers responded to a 911 call from an emotionally despondent Dennis Wever. Though Wever threatened to kill himself if jailed, the officers arrested Wever, brought him to jail, placed him in an isolation cell, and gave him a blanket upon his request. Less than half an hour after making the threat, Wever hung himself with the blanket. He was the third person in five years to commit suicide in the Lincoln County jail.

Wever's mother, acting as his personal representative, brought a section § 1983 claim against James Carmen, the sheriff of Lincoln County, and various officers, alleging that his deficient training and supervision of the officers involved in the arrest and incarceration deprived her son of rights under the Fourteenth Amendment.

Carmen moved for summary judgment based on qualified immunity and for dismissal for failure to state a claim. The district court denied the motion, holding that the complaint stated a violation of the Fourteenth Amendment and that Carmen had not established he was due qualified immunity. We have jurisdiction to review the district court's denial of qualified immunity pursuant to 28 U.S.C. § 1291, and we affirm.

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This case shows that a history of inaction and the absence of an adequate suicide plan can result in serious litigation. A failure to review each case and initiate measures to prevent subsequent incidents of the same nature resulted in an adverse ruling from the court.

Lacking qualified immunity, the officers can be sued as individuals and if judgment is rendered against them, their personal assets can be attached. When deliberate indifference is shown, the courts tend to deny immunity. The standard for deliberate indifference requires showing that the officer is aware that a condition exists that is harmful to the inmate but in spite of the knowledge, makes a conscious decision to place the inmate in an environment subject to that condition. The prior suicides were evidence of the officers' awareness that a harmful condition existed in the inadequacy of their suicide policies yet made a conscious decision to continue with policies and a jail environment that was fraught with danger for the suicidal inmate.