JAIL SUICIDE UPDATE

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Trouble in Paradise: Jail Suicides on the Hawaiian Islands and a Police Department's Pro-Active Response

Say the word Hawaii and what do you see? Swaying palm trees, endless beaches and a perfect climate. The land of paradise called the Hawaiian Islands lies 2,400 miles southwest of California. It actually forms a 132-island chain, but the Hawaii that is best known to the world is confined to eight islands grouped closely together: Hawaii, Maui, Oahu, Kauai, Molokai, Lanai, Niihau, and Kahoolawe (in order of size). These eight islands account for over 99 percent of the total land area of 6,425 square miles in the State of Hawaii. The 50th state, entering the union in 1959, is not the smallest. Rhode Island, Connecticut and Delaware are smaller. The island of Hawaii, commonly referred to as the Big Island, is three times larger than Rhode Island and nearly twice the size of all the other Hawaiian Islands combined. Although the islands of Niihau and Kahoolawe are not inhabited, the State of Hawaii has approximately 1.2 million residents, most of whom reside in the capital city of Honolulu on the island of Oahu.

In many ways, Hawaii has isolated itself from the rest of the United States, not only by distance but in areas such as pollution, crime and culture. But similar to other states, Hawaii has been victimized by jail suicides. During the past 12 months, seven such deaths have occurred in police departments on three of the Hawaiian Islands. Four of the jail suicides have occurred on the island of Oahu, where the Honolulu Police Department (HPD) processes an estimated 30,000 detainees through its lockups each year. On May 23, 1991, Alex Teixeira was arrested for drunk driving and subsequently found hanging by his T-shirt from the cell bars of HPD's Pearl City Sub-Station lockup. On July 17, 1991, Brian Martin was arrested for killing his wife and later found hanging by a strip of blanket from the cell bars of HPD's main Pawaa cellblock in downtown Honolulu. On December 31, 1991, Bruce Hamrick was arrested for drunk driving and subsequently found hanging by a blanket from the cell bars of HPD's Wahiawa Sub-Station Lockup. And on January 6, 1992, Ronald Alcosiba was arrested on burglary charges and later found hanging by a tear-proof blanket from the cell bars of HPD's Pawaa cellblock.

On the island of Hawaii, the police department has experienced two suicides during the past year. In August 1991, an unidentified female detainee was found hanging from the cell bars in the Hawaii Police Department lockup in Kona. On March 7, 1992, an unidentified male detainee was found hanging by his shirt from the cell bars of the same lockup. He remains in a coma. And on the island of Kauai, Robert Grady was found hanging by electric wire stripped from a floor conduit on January 23, 1992, in Lihue's police department lockup.

Other neighboring islands have also experienced several jail suicide attempts, most notably the police department on the island of Maui which has had several attempts during the past year. The Maui County Police Department, however, has become "pro-active" in its approach to jail suicide prevention since the death of Angelia Monroe in April 1989.

Angelia Gaye Monroe

Angelia Gaye Monroe first came into contact with the Maui County Police Department on August 21, 1988. At 9:10 p.m., police were summoned to the residence of Michael Doherty, her ex-boyfriend, after receiving a call that Ms. Monroe was threatening to drown herself in the ocean. When police arrived, Mr. Doherty was restraining Ms. Monroe from entering the water. He related to police that he had recently tried to end his relationship with Ms. Monroe, but she had refused to accept the termination, seemed despondent, and was subjecting him to constant harassment. Following a brief exchange with the officers in which she stated — "This is not going to stop me, I'm going to kill myself some other way," Ms. Monroe was arrested for disorderly conduct and transported to the Maui County Police Department lockup in Wailuku. Due to her obvious suicidal behavior and severe intoxication, Ms. Monroe was subsequently assessed in the lockup by a county psychiatrist and transported to the psychiatric ward of Maui Memorial Hospital for further evaluation via involuntary commitment. She was treated and released from the hospital 48 hours later.

At 1:30 a.m. on January 29, 1989, police were again summoned to Mr. Doherty's residence to respond to an altercation between Ms. Monroe and her ex-boyfriend. When police arrived, Ms.

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Monroe was crying, severely intoxicated, and appeared to be in pain. She was uncooperative, however, and refused any treatment. Mr. Doherty alleged that she had entered the residence and punched him in the face. In his attempt to subdue Ms. Monroe, she lost consciousness and he called the police. Although an incident report was written and the case was classified as an "assault," Ms. Monroe was not arrested. Several days later, on February 3, 1989, police were again called to the Doherty residence to investigate a domestic dispute between Ms. Monroe and her ex-boyfriend. Mr. Doherty had again called police when Ms. Monroe entered his home and began hitting him. He could not subdue her and was forced to call the authorities. This incident was also classified as an "assault" and Ms. Monroe was issued a "12-hour cooling-off citation" and removed from the premises.

On April 4, 1989, police were once again summoned to the Doherty home at 5:24 p.m. in response to a domestic dispute. Mr. Doherty again complained that Ms. Monroe had entered the residence and was harassing him. He called police when she would not stop hitting him. Ms. Monroe, appearing severely intoxicated to the officers, was arrested for "abuse of family household member." The arresting officer then transported Angelia Monroe to the Department's central cellblock in Wailuku.

The central cellblock is housed within the administration building of the Maui County Police Department. The Department, with 297 uniformed officers, made 5,892 arrests during 1991. It has also has sub-stations located in Lahiana and Hana on Maui, as well as two stations on the islands of Lanai and Molokai (both of which encompass Maui County). Opened in 1987, the central cellblock in Wailuku contains eight single cells and a mass holding cell. An additional small temporary holding cell is located outside the cellblock with direct visibility to the receiving desk area. Staff supervision normally consists of one desk sergeant and a minimum of one receiving desk officer per shift, although the desk officer occasionally leaves the cellblock area to provide periodic security checks of the building, transport detainees, deliver mail, and pick up meals

Detainees, supervised at 30 minute intervals, are housed in the Wailuku lockup up to 48 hours and, should further incarceration be required, the Maui Community Correctional Center is utilized. Unlike most departments its size, the Maui County Police Department's Wailuku lockup has access to psychiatric evaluation of its detainees 24 hours a day. An out-patient mental health center, as well as psychiatric ward of the local county hospital, are located on the same street and within walking distance of the Wailuku Police Station. Detainees suffering from various forms of mental illness are routinely assessed in the lockup by one of two county psychiatrists, and transported to the hospital for further evaluation when appropriate.

Angelia Monroe was booked into the Wailuku lockup at approximately 6:00 p.m. on April 4, 1989. The receiving desk officer noted on the booking card that Ms. Monroe was crying and appeared to be severely intoxicated. She also seemed confused and disoriented, occasionally shouting at officers — "Why am I here, Why are you locking me up?" Ms. Monroe also asked for, and received, several opportunities to use the telephone in order to secure monies for her $250 bond. Her calls went unanswered. One receiving desk officer described her behavior as follows — "Monroe was very loud, shaking the bars of her cell, and yelling that she needed to get out. Monroe yelled that she thought Doherty should be in jail, not her. Monroe was loud all the while, yet had moments of quiet. Several times this writer thought she had 'passed out' due to her being intoxicated. She appeared to be asleep several times when this writer checked on her." When this desk officer last checked her cell at approximately 10:00 p.m., Ms. Monroe was sitting on the bunk with a blanket wrapped around her.

Between 10:00 and 10:20 p.m., a change of shifts occurred. A short time later at 10:28 p.m., the on-coming receiving desk officer began checking the cellblock. Only two detainees, including Ms. Monroe, were housed in the facility during the shift. When the officer came to Cell No. 2, he found Angelia Monroe hanging by a strip of blanket from the cell bars. The officer immediately ran back to the receiving desk area and yelled — "Open up two! I think she hung herself!" Two other staff responded to the cellblock area, including the desk sergeant and the receiving desk officer from the prior shift. As one officer held Ms. Monroe, another used a pocket knife to cut the blanket from the cell bars. She was placed on the floor and the three officers initiated first aid and cardiopulmonary resuscitation. Paramedics arrived from the hospital at 10:35 p.m. and continued first aid efforts. A slight pulse was subsequently detected and Ms. Monroe, still unconscious, was transported to the hospital. However, three days later on April 7, 1989, Angelia Monroe was pronounced dead at Maui Memorial Hospital.

Following her death, an autopsy revealed that Ms. Monroe had "scars on her left wrist consistent with a prior suicide attempt." Further investigation revealed that, following her August 1988 arrest and suicide attempt, Ms. Monroe moved to California and lived temporarily with her parents. While living in California, she sought mental health therapy as a result of the termination of her relationship with Michael Doherty. She also received psychotropic medication as a result of depression and a previous suicide attempt in Santa Barbara. Ms. Monroe returned to Maui in late 1988. This information was not available to jail staff during Ms. Monroe's incarceration because the Maui County Police Department did not require that detainees be screened for suicide and/or mental health risk

WE'RE BACK!

Following a brief hiatus, the ***Jail Suicide Update*** is back on schedule. Please contact us if you are not on our mailing list. As always, readers are encouraged to offer opinions or submit pertinent materials for inclusion into future issues.

during the intake process. Finally, shortly after Ms. Monroe's suicide, the Department decided to install closed circuit television (CCTV) in all the cells to enhance detainee supervision.

The Lawsuit

On July 11, 1989, the parents of Angelia Monroe filed a lawsuit in state court against the County of Maui and the Maui County Police Department. The family, represented by attorney Joel E. August, alleged in their complaint that "During her incarceration at the police station in Wailuku on April 4, 1989, employees of the Maui County Police Department failed to monitor the actions of Angelia Gaye Monroe with due care given their knowledge of her past and current mental and/or emotional condition and therefore failed to protect her against unreasonable risk of harm." The suit also alleged that "As a direct and proximate result of the negligence of the County of Maui and/or its agents, Angelia Gaye Monroe died on April 7, 1989 from the injuries sustained during the hanging. . ."

In the intervening months leading up to the scheduled September 1991 trial, both the Monroe family and County of Maui prepared their respective cases. As the trial date approached, however, attorneys for the family and county met to discuss a possible settlement. On December 17, 1991, both sides signed an agreement to settle the lawsuit. The County of Maui, without "admitting any negligence, liability or fault of any kind whatsoever," agreed to pay the Monroe family the sum of $20,000, as well as hire a consultant to assist the Maui County Police Department in implementing a suicide prevention program in its jail facilities. According to the settlement, the suicide prevention program would address, at a minimum, the following areas: "1) screening of inmates at time of booking for risk of suicide; 2) determining best area of jail for placement and surveillance of potentially suicidal inmates; 3) the nature, extent and duration of surveillance of high risk suicide inmates; 4) initial and continuing suicide prevention training of jail personnel in booking, suicide prevention, and emergency intervention; and 5) procedures for providing appropriate medical care to high risk suicide inmates. The foregoing shall include those policies and procedures outlined in Exhibit 'A' which is incorporated herein by reference for all purposes. It is intended that the suicide prevention program instituted pursuant to this agreement shall be of a continuing nature. It is further understood that the Maui County Police Department may from time to time amend the program to incorporate procedures which will assist in the goal of suicide prevention."

As shown below, Exhibit "A" was developed by consultant Lindsay M. Hayes, Assistant Director of the National Center on Institutions and Alternatives, in an effort to outline specific measures necessary to identify and respond to the needs of suicidal detainees. The outline was adapted from Standard J-58 of the National Commission on Correctional Health Care's standards for health services in jails.

The Suicide Prevention Program

During the week of March 9, 1992, the consultant provided technical assistance to the Maui County Police Department by meeting with Police Chief Howard Tagomori and his staff; inspecting the lockup's physical plant and making appropriate recommendations; conducting an 8-hour jail suicide prevention seminar to over 40 department personnel; and developing an intake screening form (see pages 4 and 5) and the written suicide prevention program. Detailed below are 32 of the 63 written policies of the Maui County Police Department's new suicide prevention program.

Exhibit "A"

1. **Staff Training:** All staff of the Maui County Police Department who come into contact with inmates would be trained in the recognition and handling of suicidal inmates, as well as in the components of the suicide prevention plan. Eight (8) hours of training is recommended.
2. **Identification:** Procedures that require medical/suicide prevention screening of all inmates upon admission, to include development of forms and systems for identifying past suicide risks in facility. Procedures for referral to outside health care agencies.
3. **Staff Communication:** Procedures for communication of information relating to potentially suicidal inmates between staff members, as well as outside agencies.
4. **Housing:** Procedures for the assignment of potentially suicidal inmates to appropriate housing within facility, and recommendations for modifications to the facility to ensure that designated cells are as suicide-resistant as possible.
5. **Supervision:** Procedures for adequate supervision of potentially suicidal inmates and procedures for documenting supervision. Levels of supervision, electronic and personal monitoring will be evaluated.
6. **Intervention:** Procedures for staff intervention prior to the occurrence of a suicide and during the progress of suicide. Includes recommendation that at least one staff per shift be certified in CPR.
7. **Reporting:** Procedures for reporting of potential, attempted and completed suicides to appropriate outside authorities and family members.
8. **Follow-Up/Review:** Procedures for the follow-up and administrative review by police chief (or his designee) of all attempted and completed suicides.

A) Staff Training

- All staff of the Maui County Police Department who come into contact with detainees shall be trained in the recognition and handling of suicidal detainees, as well as in the 8 components of the suicide prevention program.

- New recruits shall receive such instruction through the training academy. Current staff shall receive such instruction through scheduled training seminars. All jail suicide prevention training (6 to 8 hours in duration) shall be coordinated through the Training Division of the Maui County Police Department.

Maui County Police Department
Intake Screening Form

Detainee's Name	Date of Birth	Sex	Date	Time

Most Serious Charge	Report Number	Screening Officer

Was detainee a medical, mental health or suicide risk during any prior contact ***or*** confinement with Maui County Police Department? ☐ Yes ☐ No If yes, when: _____

Does the arresting or transporting officer believe that detainee is a medical, mental health or suicide risk now?
☐ Yes ☐ No

Officers' Observations

Yes	No		Yes	No	
_____	_____	Assaultive/Violent Behavior	_____	_____	Crying/Tearful
_____	_____	Loud/Obnoxious Behavior	_____	_____	Confused
_____	_____	Any Noticeable Marks/Scars	_____	_____	Uncooperative
_____	_____	Bizarre Behavior	_____	_____	Passive
_____	_____	Alcohol/Drug Withdrawal	_____	_____	Intoxicated
_____	_____	Unusual Suspiciousness	_____	_____	Scared
_____	_____	Hearing Voices/Seeing Visions	_____	_____	Incoherent
_____	_____	Observable Pain/Injuries	_____	_____	Embarrassed
_____	_____	Other Oberservable Signs of Depression. Explain: _____	_____	_____	Cooperative

Medical History

Yes	No	
_____	_____	Are you injured? If yes, explain: _____
_____	_____	Are you currently under a physician's care? If yes, explain: _____
_____	_____	(If female) Are you pregnant?
_____	_____	Are you currently taking any medication? If yes, list type(s), dosage(s) and frequency: _____
		_____

Do you suffer from any of the following?

Yes	No		Yes	No	
_____	_____	Hepatitis	_____	_____	Heart Disease
_____	_____	Shortness of Breath	_____	_____	Chest Pain(s)
_____	_____	Abdominal Pain(s)	_____	_____	Asthma
_____	_____	High Blood Pressure	_____	_____	Veneral Disease
_____	_____	Tuberculosis	_____	_____	Diabetes
_____	_____	Alcohol Addiction	_____	_____	Drug Addiction
_____	_____	Epilepsy/Blackouts/Seizures	_____	_____	Ulcers
_____	_____	Other Medical Problems and/or diseases. Explain: _____			

Suicide Assessment

Yes	No	
_____	_____	Have you ever attempted suicide? If yes, When?_____ How?_____ Why?_____
_____	_____	Have you ever considered suicide? If yes, When?_____ Why?_____
_____	_____	Are you now or have you ever been treated for mental health or emotional problems? If yes, When?_____ Inpatient: _____ Outpatient _____ Both _____
_____	_____	Have you recently experienced a significant loss (job, relationship, death of family member/close friend, etc.)? If yes, explain: _____
_____	_____	Has a family member/close friend ever attempted or committed suicide? If yes, explain: _____
_____	_____	Do you feel that there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)? If yes, explain: _____
_____	_____	Are you thinking of killing yourself? If yes, explain: _____

Additional Remarks: _____

Disposition

☐ General Population

☐ Special Watch

1) Supervision Levels: Active (5-15 minutes)_____ Constant_____
2) Housing Assignment: Cell #11 _____ Cell #3 _____ Other _____
3) Other precautions taken (removal of clothing, bedding, etc., if appropriate)_____

☐ Maui Memorial Hospital. If detainee is ***later*** returned to facility, list any special watch recommendations. _____

☐ Mental Health Service. If detainee is ***later*** returned to facility, list any special watch recommendations. _____

☐ Other disposition/referral/transfer._____

Failure to Answer/Refusal of Treatment

Detainee refused to answer (circle) ***or*** unable to answer (circle and state why _____) the verbal response sections of this screening form.

I, _____ (print name), refuse any type of medical treatment from the Maui County Police Department.

_____
(Detainee Signature)

_____ _____
(Screening Officer Signature) (Supervisor Signature)

B) Identification and Referral

- In order to supplement the identification of potentially suicidal behavior, as well as assess medical risk, ***all*** detainees (with exceptions noted below) shall be administered the Intake Screening Form prior to the placement in any cellblock of the Maui County Police Department, regardless of length of incarceration.

- The Receiving Desk Officer or Designee shall question the Arresting and/or Transporting Officer(s) regarding their assessment of medical and suicide risk exhibited by the detainee. Such information shall be entered on the Intake Screening Form ***prior*** to the Arresting and/or Transporting Officer(s) leaving the jail facility.

- The Receiving Desk Officer or Designee shall determine (either through computer check or manual file search) whether detainee was a medical, mental health or suicide risk during ***prior*** contact or incarceration with the Maui County Police Department. Such information shall be entered on the Intake Screening Form.

- Following completion of the Intake Screening Form, the Receiving Desk Officer or Designee shall confer with the Shift Supervisor. The Shift Supervisor shall then determine the appropriate Disposition (i.e., general population, special watch, Maui Memorial Hospital, Mental Health Service, or other disposition, referral, transfer, etc.) for the detainee.

- In cases of suicide risk, the detainee shall be immediately placed on "special watch" and the Shift Supervisor or Designee shall immediately contact the on-call psychiatrist through either the Mental Health Service or Maui Memorial Hospital, pursuant to S.O. 85-92. Should a request for emergency examination and hospitalization be warranted, procedures outlined in G.O. 29 shall be followed.

- A ***completed*** Intake Screening Form shall be taken on all detainees prior to placement in the cellblock, ***except*** under the following circumstances: a) Detainee refuses to comply with process; b) Detainee is severely intoxicated or otherwise incapacitated; c)Detainee is violent or is otherwise belligerent; d) Arrestee is undergoing a "court-ordered" booking and will be immediately released; or e) The number of arrestees exceed the number of jail staff available for processing.

- For detainees listed in a-c above, the Receiving Desk Officer or Designee ***shall still complete all non-questionnaire sections of the detainee's Intake Screening Form and make notation on Form regarding why the detainee was unable to answer the questionnaire section.*** The Shift Supervisor shall then make the appropriate Disposition. A continuing, but reasonable effort shall be made to complete the entire Intake Screening Form on detainees listed on 10:a-c above.

- Any detainee placed in the cellblock without having been administered a ***complete*** Intake Screening Form shall be placed on "special watch" until such form is completed or until the detainee is released from the jail facility.

C) Staff Communication

- Active communication between and amongst all staff of the Maui County Police Department, as well as outside agencies, shall be utilized in the prevention of jail suicides.

- The Shift Supervisor shall keep a separate (apart from the Prisoner Activity Log) and daily list or index card of all detainees on "special watch" for suicidal behavior, see also Section E. The list or index card shall be prominently displayed in the Receiving Desk area.

- Whenever possible, a detainee's confidentiality rights shall be upheld. However, the sharing of information between the Maui County Police Department and other appropriate medical, mental health and jail facilities shall be permitted under circumstances in which: a) Detainee is suicidal; b) Detainee is homicidal; c) Detainee poses a clear danger of injury to self or others; d) Detainee poses a clear and immediate risk of escape or riot; e) Detainee is receiving psychotropic medication; or f) Detainee requires transfer for medical or mental health reasons.

D) Housing

- Although the Shift Supervisor shall determine the most appropriate housing assignment for a suicidal detainee, such detainee shall be placed in a cell that has the most visibility to jail staff and Receiving Desk area. The most visible cells in the jail facility are Cells No. 11 and 3.

- All ***acutely*** suicidal detainees (i.e., actively threatening suicide and/or engaging in a self-destructive act) shall be housed in Cell No. 11 until such time as they are seen by mental health officials and/or transferred out of the jail. (On the rare occasion in which more than one acutely suicidal detainee is housed in the jail, Cells No. 11 and 3 shall be utilized.)

- Belts, neckties, shoelaces and other items (sharp or otherwise) that could easily be utilized to attempt suicide shall be removed from ***all*** detainees prior to placement in any cell. Such property shall be recorded on the Property Report and stored in the detainees' property folder.

- Removal of a suicidal detainee's clothing shall be avoided whenever possible, and only utilized as a last resort for periods in which the detainee is physically engaging in self-destructive behavior. Mental health officials shall be immediately notified when a decision has been made to remove a detainee's clothing.

- The use of physical restraints (i.e., handcuffs, straight jacket, etc.) shall be avoided whenever possible, and only utilized as a last resort for periods in which the detainee is physically engaging in self-destructive behavior. Detainees shall not be restrained in an unnatural position. Mental health officials shall be notified when a decision has been made to utilize physical restraints on a detainee for purposes of suicide prevention.

- All cells shall remain protrusion-free at all times. Detainees shall not be allowed to place personal items in cells that obstruct visibility by staff or CCTV.

E) Supervision

- All suicidal detainees that remain in the jail facility shall be placed under "special watch" by the Shift Supervisor. Mental health officials shall be notified whenever a detainee is placed on special watch.

- ***Special Watch*** is defined as supervisory precautions taken for suicidal detainees that require more frequent observation than 30 minute intervals. Special watch shall include two levels of observation:

a. ***Active Supervision:*** Reserved for a detainee who is ***not*** actively suicidal, but has expressed thoughts of suicidal ideation and/or has a prior history of suicidal behavior. ***Such detainee shall be physically observed in the cell by the Receiving Desk Officer or Designee at staggered (e.g., 5, 15, 10, etc.) intervals not to exceed 15 minutes.*** CCTV shall not be utilized to substitute active supervision.

b. ***Constant Supervision:*** Reserved for a detainee who is actively suicidal, either by threatening or engaging in the act of suicide. ***Such detainee shall be physically observed in the cell by the Receiving Desk Officer or Designee on a continuous and uninterrupted basis. The officer shall have a clear non-obstructed view of the detainee at all times.*** CCTV shall not be utilized to substitute constant supervision.

- Detainees having their clothing removed and/or placed in any restraining device shall, at a minimum, be physically observed by staff under "active supervision."

- CCTV shall be activated in all cells that contain suicidal detainees and remain on throughout the special watch period. CCTV shall be utilized as a supplement, not a substitute, to the physical observation levels provided by staff.

- Receiving Desk Officer or Designee shall document the "active supervision" check for each detainee in the Prisoner Activity Log as the check occurs, and document the "constant supervision" check for each detainee in the Prisoner Activity Log every 15 minutes.

F) Intervention

- Emergency equipment, including but not limited to, first aid kit, Model 911 Rescue Tool, disposable rubber gloves (to clear obstructions from mouth), and CPR oxygen bag-mask device, shall be placed in an easily accessible area of the Receiving Desk.

- All staff who come into contact with detainees shall be trained in standard first aid, as well as cardiopulmonary resuscitation (CPR).

- Any staff that discovers a detainee attempting suicide shall immediately respond and initiate first aid, as well as alert other staff to immediately call the paramedics at Maui Memorial Hospital.

- Staff shall never presume the detainee is dead and will continue appropriate first aid measures until relieved by arriving medical personnel.

- Although preserving the "crime scene" is important, staff shall always give priority, without exception, to rescuing the detainee.

G) Reporting

- In the event of a suicide attempt or completed suicide, the Shift Supervisor shall immediately notify the Watch Commander. The Watch Commander shall subsequently notify other appropriate police officials through the Department's normal chain of command, including but not limited to the Chief of Police, Criminal Investigation Division, and Internal Affairs Division.

- All staff who came into contact with detainee prior to the suicide attempt/suicide, shall be required to submit a statement as to their full knowledge of detainee and the incident.

H) Follow-Up/Review

- Following a jail suicide or attempt, should any staff become adversely affected by the incident, they shall be encouraged to seek "critical incident counseling" through the Department or appropriate outside agency. Such voluntary counseling and/or referral shall be strictly confidential.

- In the event of a serious suicide attempt (i.e., requiring hospitalization) or completed suicide, an Administrative Review shall be conducted independent from all other investigative efforts. The Review, authorized by the Chief of Police or Designee, shall include a comprehensive examination of the incident, including: a) Critical review of the circumstances surrounding the incident; b) Critical review of procedures relevant to the incident; c) Synopsis of all relevant training received by involved staff; d) Pertinent medical services and mental health reports involving victim; and e) Recommendations, if any, for change in policy, training, physical plant, medical or mental health, and operational procedures.

- A report shall be generated from the Administrative Review and forwarded to the Chief of Police or Designee for appropriate section.

Conclusion

Prior to the death of Angelia Monroe, the Maui County Police Department had not an experienced suicide in its facilities since January 1978. Police officials believed, however, that despite the low number of suicides, the Department was vulnerable to future incidents and the resulting liability if it did

not provide written suicide prevention policies, intake screening of its detainees, and training of its staff. The ***Monroe*** lawsuit did not mandate changes, yet the settlement agreement allowed the Maui County Police Department to improve and streamline its suicide prevention practices. Such a pro-active approach is commendable, and will result in the Maui County Police Department positioning itself to more adequately respond to incidents of suicidal behavior in the future.

For more information on suicide prevention efforts at the Maui County Police Department, contact Howard Tagomori, Chief of Police, or Sergeant Lawrence Hudson, Planning and Training Division, Maui County Police Department, 55 Mahalani Street, Wailuku, Maui, Hawaii 96793, (808/244-6300).

REPORT: ASSESSMENT OF MENTAL HEALTH IN LOUISIANA JAILS

Beginning in January 1991, and under order of the Honorable Frank Polozola, United States District Court of the Middle District of Louisiana, a consulting team comprising three faculty members of Louisiana State University's School of Social Work has been conducting an assessment of mental health needs and services within Louisiana parish jail and prison facilities. The duel systems have been subjected to federal court intervention since 1983. The team (including Margaret M. Severson, J.D.; Dorinda N. Noble, Ph.D.; and David N. Pugh, Ph.D.) was asked by Judge Polozola "to act not as inspectors, but rather to gather impressions and ideas that could contribute to a meaningful mental health plan."

The consulting team visited 15 parish jails, 8 state prisons, and 2 federal facilities with the aim toward talking with a variety of both mental health and correctional personnel about mental health needs in their respective facilities. As a result, "our assessment is a collage of information provided by a wide variety of informants. We found that many jails in this state differ radically from one another; some are extremely rural with populations consisting of mostly long-time community residents, while other jails are urban and deal with many transients and homeless people. The physical structures vary from quite modern to decidedly decrepit; philosophies of jail administrators and staffs range from a rehabilitative/change-agent stance to a strict people-warehousing perspective. Some jails are progressive in training staff and in seeking links with national correctional bodies; some have little interest and/or resources to pursue enhancements."

*The team recently compiled their findings in a document entitled — **Report: Assessment of Mental Health in Louisiana Jails.** Presented below are excerpts from Chapter 3 of the report regarding the team's overall assessment of current mental health needs and services. Report recommendations are also summarized.*

Prevalence and Types of Mental Health Problems

Most of the staff we contacted stated that, in their facilities, mentally ill or retarded inmates presented significant management and security problems, either periodically or frequently. Because facilities defined "mental illness" in different ways, and because facilities across the state deal with very different populations, the percentage of inmates considered to be mentally ill ranged from almost 0% in a very few facilities to over 50% in a number of jails. When asked about drug/alcohol abuse among inmates, jailers frequently estimated a prevalence rate of 70%-80%.

On the average, the majority of jails reported that about one-fourth of their inmates were mentally dysfunctional and in need of special attention. The most commonly reported source of these problems was drug/alcohol abuse, and the behaviors that signaled mental illness were behaviors that made it difficult for the inmate to relate appropriately to others. Behaviors such as throwing body wastes, hearing strange voices, aggressive actions, inability to understand directions and rules, and self-mutilation were among the frequently given indications of mental illness.

Many jail personnel wondered whether some of these behaviors were manipulative and willful, rather than indicative of mental dysfunction. Regardless of the root cause, however, it was clear that such behaviors created problems in the jails.

Access to Mental Health Resources

Many of the staff explained that they and other jail personnel were ill-equipped to handle people with mental problems, due to lack of qualified mental health professionals in the jail, lack of security staff to handle the special needs created by these inmates, and lack of appropriate secure housing areas for retarded/mentally ill inmates. Many expressed dismay that jails have become the community's "facility of last resort" to handle people who might be better served in mental institutions. The great majority of jail staff with whom we talked expressed frustration that in-patient psychiatric and retardation facilities had limited beds to serve mentally ill/retarded persons, and that such people who either needed to be protected from society or from whom society needed protection ultimately ended up in jail. We found a few instances of mentally ill individuals being held without charges or being held on misdemeanor charges for well over a year. Jail personnel often were clearly troubled by these situations but felt that the lack of mental health services in the community/state forced them into a "care-taker" role for both the inmate and the society.

Numerous jail staff lamented the lack of community resources, such as halfway houses, shelters, or group homes for mentally ill or retarded inmates who could live in the community with supervision. A number of jails also reported that they had recurrent "customers," people who were periodically homeless due to mental dysfunction and who committed petty crimes in order to get shelter in the jail. Another difficulty they cited was that they perceived that existing mental hospitals and group homes were very reluctant to deal with mentally ill felons.

The Forensic Facility. One recurrent comment centered around the Feliciana Forensic Facility (FFF). Many jail staff stated that, once an inmate was judicially committed to this facility, a wait of at least several months to secure a bed at FFF was not uncommon. However, many jail staff also commented that the situation was somewhat better than it had been in the recent past. Transporting prisoners to and from FFF meant stretching already limited jail staff resources. Furthermore, a number of jails reported that when the inmate at FFF was transported back to the local jail for a hearing, it was sometimes difficult to get the inmate back into FFF, as the bed may have been filled in the interim. On the other hand, it appears that sometimes local jails are slow to pick up an inmate from FFF who has been restored to competency. In short, transportation issues appeared to aggravate the bed-shortage problem.

Local Resources. While many jails had access to local community mental health centers if an inmate needed to be seen by a mental health professional, the same issues of transportation and staff time to handle these needs were problems for many jails. A number of jails reported that the local mental health centers were also short-staffed and busy, resulting in long waits for inmates and jail personnel upon arriving at the mental health clinic. Furthermore, local in-patient facilities were often short of beds or could not handle the security needs posed by hospitalizing an inmate. Further, some jail officials indicated that they perceived most mental health professionals as having little expertise in dealing with criminals.

On the positive side, however, a number of jails reported that they work well with their local community mental health centers and/or in-patient facilities. A few reported that they were able to provide some regular mental health assessment and treatment inside the jail using staff of local state or private mental health centers or agencies. Those who told these success stories also stated that they worked hard to maintain these good working relationships and found them to be very valuable.

> *"The state has made a commitment to help these people, but they aren't doing a very thorough job of it. You can't get a guy into a hospital or group home, particularly if he's a felon."*
> *— A Louisiana warden*

Use of Mental Health Professionals

Only a few jails reported having hired mental health professionals (certified psychiatrist, social worker, psychologist, or licensed professional counselor). Some jails relied on health care professionals, such as physicians or nurses, or members of the clergy to deal with disturbed inmates.

Misuse of Professionals. In a few jails, we found that mental health professionals were being poorly used. Staff who have been trained in assessment and treatment of mental illness, but who were used to handle inmates' commissary privileges or handle paperwork for inmates' appeals, were forced to waste their clinical skills. In a number of jails this team found that those staff who were trained to deal with mentally ill inmates were under-used; jail staff did not refer inmates in need to them, or provide support (such as interview rooms) for these employees to do the jobs they were trained to do. Some jail situations were complicated by staff in-fighting, resulting in poor communication between the various mental health professionals, lack of rapport between security staff and mental health staff, and inadequate or nonexistent referrals of inmates to other mental health professionals. As a result of all these problems, some promising mental health programs were severely compromised; they served very few of the potential inmates who could be helped by the programs. The consequence was poorer mental health care and a waste of money for the facility.

Types of Mental Health Professionals. A few facilities indicated that they thought they must have a licensed psychiatrist to deal with the mentally ill or retarded. In fact, other mental health professionals, such as social workers or psychologists, may be easier to hire and are well trained to address the problems of the mentally ill. Dealing with the mentally ill using a purely medical model of treatment may, in fact, limit the range of treatment options that are available. Medication is not the only answer — indeed, may not be any of the answer — for some inmates. Dispensing medication also creates security problems in jails. This team encourages jail personnel to acquaint themselves with the variety of mental health professionals who may be available in the community or area, and the types of services they can provide.

Training for Mental Health Professionals. Some jail personnel questioned whether the mental health professionals in their area were trained to deal with criminals. Indeed, specific training on dealing with the mentally ill in the jail setting is helpful to any mental health professional hired into correctional systems. Such training is available through national correctional organizations as well as through university programs in social work, criminal justice, and psychology. Though this training is theoretically available, it may not be financially or logistically available for all mental health professionals dealing with parish jails. This team encourages the development of more readily accessible training opportunities for mental health professionals working with inmates.

Suicide

The majority of staff seemed to believe that genuine suicide attempts were rare and that most jail suicide attempts were attention-getting behaviors. However, a few reported that such cries for attention had become competed suicides, and, regardless of whether the attempts were seen as real or manipulative, the majority of staff appeared to take suicide attempts seriously, both from a human viewpoint and an administrative stance. Some jails reported a suicide watch of 30-minute intervals; some reported continuous suicide watches; the majority reported 15-minute interval watches.

Many jails reported placing potentially suicidal inmates in isolation, a practice that is not supported by current research. In addition, some jail seemed to be unaware of the fact that

there is a higher risk of suicide when inmates are placed in holding cells than when housed in general population. Indications across the nation are that a person is less likely to suicide if placed in a situation where he/she enjoys human companionship. Though most jails reported that their staff had some training on suicide prevention, most of the jail personnel with whom we talked stated that further training, particularly in-house training, would be helpful.

Inmate Screening

Mental health screening of new inmates varied widely. Some jails reported that they had only recently begun to include screening of the inmate's psychiatric and suicide histories. Other jails used long-standing and more detailed instruments to identify in-coming inmates who might present problems. This team believes that many jails might benefit by more thorough screening at the time of booking to identify people who may need special mental health attention. This is particularly important in light of the fact that a number of jail suicides in Louisiana have taken place in holding cells before the inmate is placed into population.

> *"Sometimes my new staff people are not patient with these disturbed inmates. They don't know how to handle them very well, either in jail or on the streets, and we can't always get them trained before they get into dangerous situations. That's bad; someone can get hurt."*
>
> *— A Louisiana sheriff*

Environmental Conditions Affecting Mental Health

The physical facilities of jails in this state run the gamut from very clean, well-lit, and well-ventilated institutions to some facilities that are reminiscent of Hollywood's 1930s-era prison movies. We have talked to a number of wardens who quickly acknowledged the deficits of their physical plants but who are unable to make major changes due to lack of local funding. Jail facilities that operate with dark, dingy, dungeon-like cells; constant high noise levels; leaky roofs; overcrowded conditions; lack of temperature controls; no or few recreation facilities; and other substandard conditions are at much higher risk for inmates to become depressed or angry than those jails that can provide less oppressive living conditions.

Further, less primitive surroundings enhance the mental health of jail staff. Some jails in the state are so environmentally oppressive that it is easy to understand their difficulties in recruiting and retaining staff of any kind, including professional mental health staff. The living conditions of inmates are also the living conditions of staff during their duty hours. Consequently, if conditions are depressing and harsh for inmates, staff will also suffer the same sorts of fatigue and discomfort for a good portion of their day. Living and working in some of the situations we have seen can only contribute to poor interpersonal relationships, low morale, and resulting security risks.

Staff Training and Attitudes

This team has no illusions that mental health issues are, or even should be, of paramount importance in jails. It is our contention, in fact, that security of both staff and inmates is the most important consideration in a detention facility, and that security is a very important component of mental health. If people inside the jail do not feel safe, they suffer a diminution of mental health.

Consequently, it was neither surprising nor inappropriate when we heard many jail personnel state that, while they saw some importance in mental health issues, they did not see those issues as a first priority. Further, it was appropriate to hear, as we frequently did, that jail staff are not experts in mental health — nor should they be.

However, while mental health issues may not be paramount in corrections, they are important. Inmates (or staff, for that matter) who suffer from problems such as drug abuse, paranoia, schizophrenia, uncontrolled anger, debilitating depression, or any other serious impediment to clear thinking and controlled actions ultimately cost jails valuable staff time, money, aggravation, potential legal action, and all sorts of other grief, both obvious and subtle. While many of the people with whom we talked seem to recognize this reality, a number of jails were unable to verify whether jail employees could secure mental health counseling for themselves or their dependents.

Summary of Recommendations

1) Communication between inmates and jail staff should be enhanced through the use of comprehensive medical and mental health intake screening instruments. Access to an inmate's confidential mental health information should be limited to appropriate staff members. Interagency transfer forms should be used to communicate necessary information about the inmate to the receiving agency.

2) Changes in the physical environment and security procedures within the jail should allow for better supervision of suicidal and/or mentally ill inmates. Isolation should be avoided for these inmates. All newly admitted inmates should be under close observation for the first 48 hours of their incarceration. Jails who hold female inmates should employ a sufficient number of female security officers to provide for 24-hour daily supervision.

3) A comprehensive jail-based mental health program should include access to a variety of visitation, educational, substance abuse, and recreational activities.

4) A comprehensive jail-based mental health program should take into consideration the mental welfare of jail employees. Improved insurance benefits, access to the mental health professional, encouragement to pursue physical exercise, and an ongoing program of staff in-service training will result in better mental health among staff members.

5) The Department of Corrections should make available acute psychiatric beds, in a convenient location, for sentenced inmates within its custody.

6) The Department of Health and Hospitals, Division of Mental Health, should be of assistance to sheriffs by securing the services of more clinical staff in community mental health centers and by dedicating psychiatric beds for use by pretrial inmates.

7) Admissions and discharges from the Feliciana Forensic Facility should take place in a more streamlined, efficient, and timely manner due to more appropriate use of clinical staff and enhanced communication between authorities at the Forensic Facility and the sheriffs' departments.

8) Licensed mental health professionals should provide mental health assessment and treatment services in jail-based programs. Security officers and other employees of the sheriffs' department should have training in crisis intervention techniques. Discharge planning services should become an inherent part of the jail-based mental health program.

9) Exploration and adoption of alternative methods to evaluate defendants for competence to stand trial and sanity should have the positive impact of reducing the waiting list for admission to the Feliciana Forensic Facility.

10) Security officers, mental health professionals, jail physicians, and jail administrators should attend annual training in a variety of subject areas (e.g., suicide prevention, recognition of mental health problems, crisis intervention, etc.) which will enhance their clinical interpersonal communication skills.

Conclusion

The consulting team concluded that — "Our assessment revealed that in many jails, administrative and security staff are concerned about the mental disordered inmate, both from an operational viewpoint and from humanitarian concerns. Nevertheless, many jails, for a variety of financial, logistical, and philosophical reasons, are struggling against great odds to provide even minimal mental health care. We have attempted to provide recommendations that will help jails consider and develop procedures, training, and programs that will enhance the delivery of mental health services in jails.

Many of our recommendations are relatively low-cost and simple; some recommendations are more far-reaching. We firmly believe that giving more thoughtful attention to mental health needs will pay big dividends in making jails safer and more tolerable for inmates and staff alike. Protection from adverse legal action, better recruiting potential, the ability to retain capable staff, and an enhanced capability to break the cyclical nature of criminality are benefits likely to result from the implementation of these recommendations."

For more information on the 68-page ***Report: Assessment of Mental Health in Louisiana Jails,*** *contact the consulting team at: Louisiana State University, School of Social Work, 311 Huey P. Long Field House, Baton Rouge, Louisiana 70809, (504/388-1351).*

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 (Volumes 1, 2 and 3)

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

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