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JAIL SUICIDE UPDATE

Spring 1991 Volume 3, Number 4

MODEL SUICIDE PREVENTION PROGRAMS

PART 4

*When our readers were asked last year what particular topics should be included in future issues of the **Jail Suicide Update,** many responses echoed the interest in learning more about successful suicide prevention programs, policy design and screening/risk assessment. Responses included: "We need a detailed description of successful programs at all levels of care" and "Especially useful is how jails have handled the problems and what prevention programs they have set up, and whether these programs have been successful." As such, and while keeping our readers abreast of research, training and litigation issues in the field of jail suicide, we continue our special series on model jail suicide prevention programs.*

General awareness of jail suicide prevention has greatly expanded over the past several years, and programmatic accomplishments have resulted in the identification of essential program elements which experts believe will dramatically reduce incidents of jail suicide. In January 1987, the National Commission on Correctional Health Care (NCCHC) revised their jail standards to include the provision that facilities have a written plan for identifying and responding to suicidal inmates. The standard (J-58) contained 11 suicide prevention elements, including: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, and review.

A similar revision had occurred a few years earlier with the jail standards of the American Correctional Association (ACA). In August 1984, the ACA revised Standard 2-5271-1 to include the following:

> *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. . . .Staff have a responsibility for preventing suicides through intake screening, identification, and supervision of suicide-prone inmates. They should receive training in the implementation of a suicide prevention program.*

*During the past year, **Update** staff identified various potential model suicide prevention programs operating within both large and small jails throughout the country. On-site case studies were conducted on five selected programs and, concluding with this issue, program highlights published in the **Update.** In previous issues of this special series, we highlighted the suicide prevention efforts at the Oneida County (New York) Correctional Facility, Mobile County (Alabama) Jail, and Champaign County (Illinois) Correctional Center. In this issue, programs within both the El Paso County (Colorado) Detention Facilities and Laramie County (Wyoming) Detention Center are profiled. All of the programs highlighted in the **Jail Suicide Update** were initially evaluated by the following jail suicide prevention elements:*

- *Intake screening to detect potential suicidal behavior;*
- *Suicide prevention training of officers;*
- *Training of mental health staff regarding the jail environment and criminal justice system;*
- *Access to timely assessment and treatment services, including outpatient care, psychiatric inpatient services, and detoxification services;*
- *Staff and electronic supervision of inmates;*
- *Timely medical intervention;*
- *Re-evaluation of inmates following a crisis period;*
- *Environmental/architectural jail design conducive to reducing suicide potential;*

INSIDE. . .

- El Paso County (Colorado) Detention Facilities — A Model Suicide Prevention Program
- Laramie County (Wyoming) Detention Center — A Model Suicide Prevention Program
- Resource List of Model Jail Suicide Prevention Programs

- *Alternatives to incarceration which permit high-risk inmates entry into the community mental health system; and*

- *Extended incident-free periods of suicides.*

We begin the last issue of our special series by highlighting the model suicide prevention program currently operating within the El Paso County Detention Facilities in Colorado Springs, Colorado.

El Paso County Detention Facilities

"1982 was a very bad year," stated H.D. Bradley, Captain of Detention Services with the El Paso County Sheriff's Office. Retired from the United States Army, he arrived at his new job during the year in which the department would experience 20 suicide attempts and three suicides. The problem actually started the year before when William Zeller, 35, attempted suicide in the El Paso County Jail, a facility built in 1973 with a capacity of 250 beds. He survived on a life-support system for three weeks before dying on November 7, 1981.

At 12:30 a.m. on March 27, 1982, Vincent Garcia was booked into the El Paso County Jail on several motor vehicle charges, including driving while intoxicated. He expressed fear of being housed in the general population, and was thus placed in a second floor isolation cell. Mr. Garcia, 39, hanged himself with a blanket six hours later. On April 15, 1982, Randall Wilson (26) was found hanging by a bedsheet. He had previously attempted suicide in the jail on March 7. Charged with first degree murder, Mr. Wilson's co-defendant had been convicted at trial earlier in the day. Mr. Wilson suffered severe brain damage and currently remains hospitalized in a coma. Timothy Daugherty, 23, had also been charged with first degree murder. He was also mentally ill and had attempted suicide on three previous occasions, the last of which occurred in the jail on April 12. Mr. Daugherty hanged himself with a bedsheet in an isolation cell on April 29, 1982.

Four suicides in seven months. The deaths shocked many in Colorado Springs, a community of approximately 395,000 people, who asked — What's happening in the jail? Sheriff Red Davis responded after the Randall Wilson suicide by stating to the media — "I wish somebody had an answer. I don't have it and I don't think anybody else has. Unfortunately, we're saddled with a group of people here who are prone to suicide and we don't have a solution."

A group of community leaders soon formed a committee to address the problem. Local mental health professionals, attorneys and criminal justice practitioners became involved. The El Paso County Sheriff's Office also began to take notice. According to Captain Bradley — "You turn introspective very quickly." Together with new Sheriff Bernard J. Barry, who replaced Red Davis after his death in June 1983, Captain Bradley embarked upon a pro-active approach to solving the sheriff office's problem of jail suicides. "We were living in the dark ages regarding suicide prevention. You must have command level interest in the prevention of suicides and communicate it down," said Bradley. A clinical social worker was hired soon thereafter to develop a mental health program.

Despite the self-initiative from the El Paso County Sheriff's Office and others, it is generally acknowledged that jail suicide prevention efforts were launched by ***Garcia v. Board of County Commissioners of the County of El Paso*** (U.S.D.C., District of Colorado, Civil Action No. 83-Z-222). Filed in July 1982 by Colorado Springs attorney Craig M. Cornish on behalf of Vincent Garcia's family, this lawsuit was perhaps the one piece of litigation that best exemplifies jail suicide prevention. Captain Bradley called it the "linchpin" in the El Paso County Sheriff's Office commitment to reducing suicides within their detention facilities. The lawsuit culminated in a consent judgement signed by all parties on January 14, 1985, see page 3. In addition to a $10,000 payment to the Garcia family, the El Paso County Sheriff's Office agreed to implement various suicide prevention measures — comprising screening, increased supervision, staff training, mental health services, and physical plant renovation (including the closing of isolation cells).

When she arrived in the Fall of 1983, through a contract with ARA Services' Correctional Medical Systems, Inc., Margaret M. Severson became the only mental health staff at the El Paso County Jail. And as the facility's first clinical social worker, she had an immediate challenge — development of a mental health and suicide prevention program while providing services to approximately 200 inmates. When ***Update*** staff asked Ms. Severson to highlight the suicide prevention program at the El Paso County Detention Facilities, she offered the following summary.

1) Intake Screening

Medical staff complete a comprehensive psychological assessment form on each newly incarcerated inmate (the suicide assessment component appears on page 5). No inmate leaves the intake area for a housing unit until this form is completed. The questions are designed to elicit information that research has found to be the best indicators of suicide potential. The form contains questions about mental health, suicide, polysubstance and criminal history, and the current mental status of the inmate. This form also elicits from the examiner subjectively based observations about the inmate's emotional and behavioral functioning.

Given the relationship between drug/alcohol intoxication and suicide, no inmate is assessed until he can understand and answer the questions in a reliable manner. If an inmate is under the influence of some substance and gives information to the interviewer suggestive of suicidal ideation, that inmate remains in the intake area and is re-evaluated hourly in order to gain a more clear picture of the suicide risk he presents.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 83-Z-222

PINIO GARCIA and ESTELLA GARCIA,
father and mother of decedent Vincent Garcia,
ROSE LOBATO, as Personal Representative of the
Estate of Vincent Garcia, and DON GARCIA, individually,

Plaintiffs,

v.

THE BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF EL
PASO, SHERIFF BERNARD J. BARRY, in his official capacity,

Defendants.

CONSENT JUDGMENT

ORDERED, ADJUDGED AND DECREED, upon stipulation of the parties, Rose Lobato, plaintiff, and Bernard Barry, defendant, as contained in the Stipulation to Enter Consent Judgment filed with this Court, that final judgment in favor of the plaintiffs and against the defendants is hereby granted and ordered entered as the judgment in this action as follows:

Defendant, Bernard Barry, as Sheriff of El Paso County, his agents, successors and assigns stipulate and agree to:

1. Provide intensive supervision of all recently admitted inmates during the first twenty-four hours of incarceration. Intensive supervision is to be provided in the following manner:

    a. Not less than one deputy will be assigned to supervise not more than three adjacent wards encompassing the wards designated for recently admitted inmates and inmates requiring mental health care on a 24-hour a day basis.

2. Replace the doors on all of the existing holding cells in the booking area with "Lexan" glass doors, or similar material, thereby removing the currently existing solid steel doors with the view hole.

3. Modify the existing light fixtures, ventilator covers and other protrusions in all holding cells as recommended by an expert in jail architecture to be designated and hired by the El Paso County Sheriff. Said expert shall furnish a written report of the recommended changes to the El Paso County Sheriff which report shall permanently be retained in the files of that office.

4. Create and maintain a special ward for mental health purposes in which anyone who is in need of special observation as identified by a doctor, psychologist, licensed mental health professional or jail personnel shall be confined.

5. Provide intensive and recurring suicide prevention training to all booking, intake and emergency medical technicians employed by the jail to be provided by the National Institute of Corrections (NIC) or by an expert approved by the NIC or by a licensed mental health professional on at least an annual basis. Additionally, all deputies who are assigned to the jail division shall receive recurring supplementary training in suicide prevention, crisis intervention and general mental health problem recognition from an accredited source. All training shall be comparable in length, quality and content with the training then available from or recommended by the NIC. Such training must either be approved by the NIC, or the designated instructor must certify in writing to the Sheriff of El Paso County that the training comports in length, content and quality with the training then available from NIC and that the trainer's qualifications are equivalent to those of NIC instructors.

6. Provide intensive screening of all inmates at the time of booking for risk of suicide. This screening will encompass an in-depth questionnaire which comports with current mental health and corrections standards, to be filled out at booking for all newly admitted inmates. Any individual who is identified as having special needs, i.e., those who are intoxicated, in a crisis situation, a suicide risk, or exhibiting any aberrant or unusual behavior will be placed under intensive supervision and a licensed mental health professional notified. Intensive supervision of inmates with an identified risk of suicide shall be no less than that described in paragraph 1 and shall be reasonable under the circumstances. No person who has been identified as presenting risk of suicide shall be placed in isolation without continuous visual observation, which term shall be defined as meaning not less than every 15 minutes.

7. Contract for services of an appropriately licensed mental health professional to be on call 24 hours a day to assist jail personnel involved in the booking/screening/classifying roles to identify individuals with special need for intensive supervision and for any other mental health need.

8. Close Cell 212, an isolation cell on the second floor of the El Paso County Jail, in a manner which will prevent any use of that cell for confinement of inmates. Close Cell 312, an isolation cell on the third floor of the El Paso County Jail, in a manner which will prevent any use of that cell for confinement of inmates.

9. At the time of this agreement, it is contemplated that a new jail will be constructed in El Paso County. Said new jail shall be constructed pursuant to the American Correctional Association's (ACA) standards. The facility, once constructed, will make reasonable good-faith efforts to seek ACA accreditation. The provisions of paragraphs 1 through 8, inclusive, shall apply to any county jail facility in El Paso County which acts as the receiving facility for newly admitted inmates.

10. Defendants agree that a copy of this Consent Decree will be furnished to all employees of the El Paso County Jail.

The foregoing consent judgment shall take full effect ninety days from the signing of this order. An extension of time may be granted the defendants upon application to this Court for good cause.

IT IS FURTHER ORDERED that the plaintiffs attorneys' fees and costs will be decided by the Court at future proceedings.

Judgment in favor of the plaintiffs and against the defendants in the amount of Ten Thousand Dollars ($10,000.00) shall be entered.

SO ORDERED this 14th day of January, 1985.

BY THE COURT:

ZITA L. WEINSHIENK
Federal District Judge

*(Reformatted for the **Jail Suicide Update**)*

Environmentally, our intake section is designed to minimize the threat of suicide among newly admitted inmates. Cooperative, though not necessarily sober, inmates are held in an amphitheater area located within 15 feet of the intake desk. One officer is assigned to that outer area. Inmates can use the telephone and watch television while awaiting the booking process. Disruptive or combative inmates who can not be securely held in that area are placed in cells lined with rubber-like padding. Physical restraints are utilized in rare instances when the inmate presents a threat of injury to himself or others. All inmates in the intake area are observed by the security officer on a constant basis. When housed in an intake cell, the inmate is checked by the officer at staggered 15 minute intervals. When restrained, a nurse immediately checks the restraints to ensure that the inmate is in no medical distress. Clothing that is likely to be used as a suicide instrument such as shirts, underwear, belts, and shoelaces, is removed from the inmate who is threatening suicide. (As a rule, shoelaces, belts, and socks are removed from every inmate admitted into our facilities.) The inmate is allowed to wear one layer of clothing during the intake process.

Prior to the inmate being moved to a housing unit, the inmate is also interviewed by the Classification Officer. Classification personnel ask the inmate questions about suicidal ideation and psychiatric history. This system works in such a way as to provide a double check on the inmate's propensity for suicide. Information regarding the inmate's positive responses to suicide questions is freely shared between the medical, classification, and housing staff.

If an inmate responds positively to suicide questions and is felt to be in imminent danger of hurting himself, mental health staff are immediately notified. They are on-call 24 hours daily to assist security staff in safely maintaining the inmate. If the inmate is calm, he will be left in the intake amphitheater until evaluated. If the inmate is assaultive or self-injurious, the inmate may be restrained until calmed. The medical and intake staff repeatedly check on, and talk to, the inmate in order to note any change in attitude or behavior. Mental health staff review the information gathered by security staff prior to talking with the inmate.

2) Housing Units

All inmates are assigned to intake wards for the first 24 to 48 hours of their incarceration. These "fishtank" wards are designed to provide maximum observation of newly admitted inmates. All inmates are eyeballed at a minimum of once every 15 minutes. Doors to the single cells remain open from 5:00 a.m. until 10:30 p.m. This assists the security officer in recognizing any change in behavior in an inmate due to some precipitant, such as court hearings, family problems, disappointing visits, or other upsetting news. The security officers in the fishtank wards are notified by the medical and intake staff of any peculiarities about an inmate, in particular, of their suicide risk. Those inmates identified as being suicidal are placed on a "welfare check" (i.e., suicide watch), placed on the lower level within view of the officer, and their door is left open 24 hours daily. The officer assigned to the ward documents that he has observed the inmate within each 15 minute period. Both mental health and medical staff follow-up and work with the inmate until the risk of suicide is abated.

From the fishtank wards, most inmates are assigned to permanent housing areas. If the inmate continues to present a risk of suicide, the welfare check follows the inmate to his new housing. The security officer notes in his ward log any behavior of any inmate in that ward that is of concern. Those logs are reviewed and forwarded as needed to mental health staff. This provides another method of ensuring that concerns about inmates reach mental health staff.

We maintain a mental health ward in our new facility. This ward was designed specifically to house suicidal inmates. Being aware of the prevalence of suicide incidents among inmates housed in isolation, the mental health ward was designed as an open ward without single cells. Our new detention facility was designed without bars and with minimal areas suitable for hanging. The mental health ward is utilized for inmates who are suicidal or who present signs of mental illness, but who do not require emergency hospitalization. There are particular rules designed specifically for this ward, such as a rule that requires the immediate removal of an assaultive inmate from the ward. This ensures that inmates feel an added measure of security during their incarceration, one less item to concern an already overwhelmed person.

Of course, an inmate may become suicidal anytime during his incarceration. When an inmate is identified as being suicidal, several factors are considered when reviewing the inmate's psychological and environmental needs. The inmate may remain in his current ward, with frequent contacts made by staff members. Any non-essential items which could be used for self-injury are removed from the inmate. These items typically include sheets, towels, pillowcases, underwear and socks. The inmate would be moved into a cell located within direct view of the officer and the inmate's door would remain open.

3) Accessing Mental Health Services

There are several ways that an inmate can access mental health services within the jails. At the time of the medical/ mental health intake evaluation, an inmate is asked if he wants to talk with someone. If the inmate's answer is yes, or if the medical staff believe the inmate should be contacted by mental health, the mental health staff is notified.

The security staff is encouraged to communicate with mental health and medical staff if an inmate appears to be depressed or evidences other signs indicative of mental illness and/or suicidal ideation. Signs and symptoms of mental illness and suicide are clearly reviewed in initial and annual training classes. Attorneys, judges, probation officers and other court personnel are encouraged to notify the mental health professional of their concerns regarding an inmate's well-being.

CORRECTIONAL MEDICAL SYSTEMS, Inc.

CRIMINAL JUSTICE CENTER/2739 E. LAS VEGAS/COLORADO SPRINGS, CO 80906/303-520-7143

SUICIDE ASSESSMENT SHEET

1. Have you ever attempted suicide? Yes _____ No _____, If yes, when? _____
   How? _____ Why? _____
   What happened? _____
2. Have you ever considered suicide? Yes _____ No _____ If yes, when? _____
3. Has any close friend or family member ever ATTEMPTED/COMMITTED suicide? Yes _____ No _____
   How/Why/Who _____
4. Is there anything that will make you depressed while you are in jail, aside from being in jail?
   Yes _____ No _____ If yes, what? _____
5. If you do become seriously depressed, would you be willing to talk to someone about your problem?
   Yes _____ No _____
6. Can you think of any problems which may cause you to consider hurting yourself while you are in jail?
   Yes _____ No _____ If yes, what problem? _____

OBSERVATIONS

Please circle all that apply to the detainee:

Poor eye contact	Untidy
Agitated	Antagonistic
Guilty	Sleepy
Confused	Illogical speech
Hearing voices	Rambling speech
Seeing visions	Mumbling speech
Hyperactivity	Incoherent
Hypoactivity	Homicidal
Suspicious	Anxious
Depressed	Angry
Scared	Disoriented to date/time/place
Non-communicative	Bizarre behavior (explain if Circled)

Counselor notified? Yes _____ No _____ Recommendation _____

General population _____ Segregation _____ Special assignment _____

Welfare check: 15 min. _____ 30 min. _____ 45 min. _____ 60 min. _____

_____
Interviewer's Signature

NAME (last, first, middle initial) ADMIT NUMBER RACE

Inmates, once in their housing areas, have access to material with which they may make a written request for mental health services. At all times, an inmate is free to approach the security officer to request mental health services. This information is typically logged by the officer on this report and called in to the medical staff. Many referrals come from other inmates who observe a fellow inmate to be having problems. Emergencies are handled first. Such emergencies are identified through a written request, by the assessment completed by the security or medical staff, and by actual behavior. Many inmates request routine visits by mental health staff. These are responded to promptly but always follow priority/emergency intervention needs.

Clinicians are often appointed by the Court to complete evaluations on inmates. When a clinician comes into the detention facilities, he is asked to write a brief assessment for our mental health records. We do not ask for any confidential information, rather, we ask the clinician to address suicide potential and acute or chronic mental illness. From these evaluations mental health staff will assess the inmate for the need for additional therapeutic intervention. Asking this consulting professional for this information helps our security staff be more aware of an inmate's current emotional status.

Inmates, when meeting the statutory criteria for emergency evaluations, are transferred to the Colorado State Hospital. Such admissions are available only to those inmates who are imminently dangerous by reason of mental illness to themselves or others, or who are gravely disabled. The Colorado State Hospital provides forensic evaluations, assessments for medication and treatment, and discharge coordination. Most frequently, suicidal inmates are not hospitalized due to the absence of an accompanying mental illness. Personnel at the Colorado State Hospital have toured our detention facilities and met with mental health staff in order to enhance communication and understanding about the needs of both systems. When an inmate is returned to jail from the hospital, discharge paperwork, including medications and goals for treatment, are sent back with the inmate to the jail.

4) Discharge Planning/Involvement with the Community

When an inmate is brought into either of our facilities and subsequently found to be suicidal, if that inmate is able to post bond, an M-1 (emergency mental illness application) is completed and that inmate is transported to the local crisis center prior to being released from custody. At that time, the crisis center staff is provided with the inmate's background information and determines if hospitalization or further intervention is required. This system ensures that the discharged inmate is connected to the local mental health community.

Family members, when appropriate, are also included in the discharge planning process. This may entail arranging for transportation, living quarters, and financial assistance. Not infrequently, family members of former inmates will call the mental health professional at the jail for referrals to drug/alcohol or mental health programs.

Those inmates who are known to have chronic mental illnesses are refused for intake processing until screened by the local crisis center. They may be hospitalized without being officially booked into the jail in which case a detainer is placed on that person. This system saves time and reduces the amount of energy the medical, security and mental health staff must expend on the acutely mentally ill inmate who is appropriate for hospitalization versus incarceration. In a similar vein, efforts have been made to divert appropriate inmates, once admitted to jail, to mental health systems in the community. Local judges have been cooperative in granting conditional releases to inmates who require more intensive mental health treatment than what can be offered in the jail.

Efforts have been made to form a cooperative effort with the local mental health center as well as with other community groups that exist to assist the mentally ill. Meetings between jail staff and local mental health practitioners have occurred with some frequency in order to create a working relationship between the two entities.

5) Suicide Prevention/Crisis Intervention Training for Detention Facilities' Staff

Every new employee of the El Paso County Sheriff's Office must attend 12 hours of suicide prevention and crisis intervention training. During this training, all the symptoms of suicide and depression are reviewed. These symptoms include emotional, mental, behavioral, and verbal clues. Employees are encouraged to ask questions, talk about examples, role play suicide scenarios, and examine their personal feelings about suicide. A test is administered before and after the class to determine whether the employee has learned the essentials of suicide detection and intervention. In addition, employees learn the symptoms of major mental illnesses and how to assess and intervene in crisis situations. Cutting down the hanging victim, symptoms of drug/alcohol intoxication and withdrawal, and first aid procedures are included in this training as well.

Every employee of the Detention Bureau must complete annual "update" suicide prevention training. At minimum on a yearly basis, all the symptoms of suicidal thoughts/behavior are reviewed. Suicide statistics from the prior year are discussed and compared to the national profile. Trends are identified and communicated. Litigation issues are discussed. Items that constitute "notice" of suicide potential to a staff member are reviewed in order to instill the importance of documenting and passing on critical information about inmates.

All staff members are encouraged to document any "unusual" behavior that they note about an inmate and to pass this information on to their relief person, as well as to

mental health staff. Such communication may be oral or written, although the security staff is encouraged to write their observations whenever possible.

Security staff are also encouraged to visit with mental health staff regarding their concerns about any inmate. This has proven to be a valuable learning process. Information communication between both the security and mental health staff has certainly contributed to the success of the suicide interdiction program. Teamwork is the key to preventing suicides in our facilities.

In addition to formal training, other means of communication are utilized to keep staff informed about suicides and suicide potential. For example, when a suicide occurs in another detention facility and is reported locally, a copy of that article will be sent to each member of the staff with an attached memo warning them of the increased possibility of a copycat suicide. Staff are asked to be extra diligent in their checks on inmates and to immediately report any concerns. Each holiday season a memo is delivered to staff asking them to pay close attention to those inmates who appear to be having difficulty with their incarceration. In each type of memo, a sincere thanks goes out to each staff member for their efforts in the past. We know that without a dedicated staff our success would not have been possible!

Finally, after each attempted suicide or suicidal gesture, every effort is made to debrief the staff involved in the rescue. Reviewing what occurred and the detention officer's reaction can help ease the anxiety that person may feel about his performance. Each officer is appreciated for his efforts in intervening in the suicide crisis.

6) Miscellaneous Aspects of the El Paso County Detention Facilities' Suicide Prevention Program

A. Mental Health Services for the Staff

Each employee of the Sheriff's Office is invited to talk with mental health staff about their own personal issues. Many employees take advantage of this offer. Such services, which include crisis intervention and referrals, gives the employee the sense that he is cared for as a valuable member of this team. It also assists in cutting through the attitude that the inmates get everything and the staff get nothing. Our staff are aware that their communications are confidential within the bounds of the law and that the administrators of this Department support the staff in utilizing this benefit.

B. Mental Health Professional's Role in Court

It is made clear to the inmates, attorneys and judges in this area that unless subpoenaed by the defense, the mental health professional will refuse to testify against an inmate. For over seven years this stand has been effective. Defense attorneys are encouraged not to subpoena the mental health professional as it is likely that the latter has knowledge that will hurt their client as well as knowledge that might be of assistance. There has been a great deal of cooperation in this effort. Court appearances would reduce the amount of time available to provide inmate mental health services as well as undermine the trust that inmates must have in the mental health staff. Furthermore, inmate's manipulations for positive court testimony are minimized by making clear from the start that court appearances are not part of the mental health services offered in the jails.

C. Partnership: Mental Health and Detention Staff

The success of the suicide prevention program in El Paso County is largely due to the success of the partnership between the various jail sections. Security staff's opinions are elicited and taken into consideration in mental health assessments. Often the staff will have more knowledge about an inmate's behavior, the precipitant for suicidal actions, and interactions between inmates that may give rise to a crisis, than will mental health staff. This information can be invaluable when setting up a suicide prevention plan for a particular inmate.

The message related to security staff is that they are an integral part of the success of our suicide prevention mission. Positive feedback for a job well-done is given freely. Each staff member is encouraged to take pride in their contribution to the absence of suicides in our detention facilities.

D. Psychological Autopsy

Though thankfully we have not had to put this final part of our suicide prevention program into action, we have a system in place for the completion of a psychological autopsy after an inmate suicide. Members of the Sheriff's Office involved in the suicide, administrative staff, mental health and medical staff, and professionals from the community will be asked to meet to discuss the circumstances of the suicide. This includes a "hindsight" approach to discover if there were clues about the suicide and a review of the procedures followed during the intervention. Indications for change that result from the autopsy will be discussed, and, if appropriate, will be integrated into the suicide prevention program and procedures.

Conclusion

There have been various changes in the El Paso County Jail System since the development of the suicide prevention program. First, the average daily jail population rose from 184 in 1982 to 511 in 1990. The Criminal Justice Center opened in August 1988, a direct supervision facility housing over 300 inmates. The old county facility, built in 1973 and now referred to as the Metro Jail, has been reduced to a self-imposed capacity of under 200 beds. On the day of our March 12 visit, the El Paso County Detention Facilities held a total of 499 inmates. Second, Margaret Severson left the program in December 1990 to teach social work at Louisiana State University. She has been replaced by Lorraine Staton,

also a clinical social worker. An additional part-time (i.e., 24 hours) mental health worker has also been added to the staff.

Finally, and as can be seen by Table 1, the El Paso County Detention Facilities have not had any suicides ***since*** 1982 — a period of eight years and almost 88,000 bookings. As Ms. Severson told ***Update*** staff — "We are convinced our system works. Good assessment skills and good communication between staff are key elements of any successful suicide intervention program. Teamwork is where it starts and where it ends. Every person on staff in our detention division is a member of that team."

Table 1

El Paso County Detention Facilities
Total Bookings v. Total Suicides
1982 — 1990

Number of Bookings	Year	Number of Suicides
7,956	1982	3
9,754	1983	0
10,536	1984	0
10,760	1985	0
10,942	1986	0
11,360	1987	0
11,684	1988	0
11,620	1989	0
11,301	1990	0
95,913	1982-1990	3

During our March tour of the old El Paso County Jail, ***Update*** staff walked past Vincent Garcia's second floor isolation cell. It was almost nine years to the day after his death and the cell door, pursuant to the consent judgement, was locked and sealed by a padlock. A sign on the door read — **"CLOSED PERMANENTLY BY ORDER OF THE SHERIFF."** It was an eerie feeling and, in retrospect, perhaps symbolized the county's commitment to reducing jail suicides. It would be our opinion that El Paso County best exemplifies jail suicide prevention programming in the United States.

For more information on suicide prevention efforts at the El Paso County Detention Facilities, contact Sheriff Bernard J. Barry, El Paso County Sheriff's Office, 15 East Cucharras Street, Colorado Springs, Colorado 80903, (719/520-7100); or Margaret M. Severson, Assistant Professor, School of Social Work, Louisiana State University, Baton Rouge, Louisiana 70803, (504/388-1108).

LARAMIE COUNTY DETENTION CENTER

Located 174 miles north of Colorado Springs on Interstate 25, the Laramie County Detention Center in Cheyenne, Wyoming exemplifies the "small jail" approach to suicide prevention. Laramie County has a population of 126,000 residents spread out over 2,650 square miles. The state population is only 678,000. The old Laramie County Jail, built in 1917, had a capacity of 111 beds for both city and county inmates. It was said to have been an antiquated and dangerous facility, with cell walls made of steel plates from the hull of a ship. Inmates were afforded little supervision due to the linear configuration. Ironically, however, the facility rarely experienced any suicides.

Rudy Restivo became Sheriff of Laramie County in 1983. He had been an officer with the Cheyenne Police Department for 21 years, and its chief since 1979. Sheriff Restivo and other officials were eventually able to convince the county commissioners that the old jail's deteriorating physical plant and overcrowded conditions posed a significant risk of liability. A 10.85 million dollar multi-purpose law enforcement center was eventually authorized, and included a 112-bed capacity direct supervision jail facility. Opened in July 1989, the new Laramie County Detention Center quickly became the pride of county jails within the state of Wyoming. On the day of our March 13 visit, the facility held 87 inmates — 44 county, 20 city and 23 U.S. Marshall/Bureau of Prison holds (via a contract). A total of 3,168 inmates were booked through the Laramie County Detention Center during 1990, and the average daily jail population was 90.2 inmates.

In November 1987, Sheriff Restivo hired Rod V. Bottoms as his jail administrator. Captain Bottoms had the added responsibility of planning and implementing the transition between the old and new facilities, a position similar to that which he left in Larimer County (Fort Collins), Colorado. When he arrived, Captain Bottoms was also faced with an old facility lacking both written jail policy and mental health services. He eventually convinced the county commissioners to earmark $20,000 to the Southeast Wyoming Mental Health Center (SEWMHC) for psychological services to the jail. And while awaiting the new facility's opening, Captain Bottoms and his staff first began to develop written jail policy, to include procedures regarding suicidal inmates. "Good sound philosophy will improve any type of facility, regardless of its condition," he stated. The philosophy adopted by Sheriff Restivo and his staff within the Laramie County Sheriff's Department became simple — "At minimum, no inmate shall leave the detention center in worse physical or mental condition than when they were admitted."

According to Captain Bottoms, "All detention facilities face the possibiity of some litigation in many different areas, however, litigatin araising from a successful jail suicide is far more damaging to the facility than a monetary award. A successful suicide is viewed as the failure' of staff, management, and the department as a whole. It is, therefore the moral and legal obligation of any detention facility to provide a suicide prevention program." The Laramie County Sheriff's Department's suicide prevention policy was as straightforward as its philosophy on jail operations — "Close observation, appropriate medical referral and treatment necessary will be given to any person who, while incarcerated in this facility, experiences or begins to develop suicidal problems. Ongoing staff training in the implementation of suicide prevention and intervention is required." In conjunction with this new policy, Jeannie Koepplinger (a licensed practical nurse) was hired as a full-time medical supervisor to supplement the part-time services of Arnold Krause, M.D., the facility's physician; and 20-hour per week psychological services of Dr. William Fairbanks from the SEWMHC were initiated.

The Program

According to our interviews with these staff, as well as review of procedures, when an arrestee is brought into the Laramie County Detention Center, the booking officer completes a screening form which includes asking the individual if he has a history of suicide attempts. Positive responses and/or unusual behavior are immediately brought to the attention of the medical and/or mental health staff. Suicide behavior may also be identified through other sources such as family members or the arresting officer. To ensure appropriate housing assignments and observation levels, all inmates are housed in the intake section of the facility up to the first 72 hours of their incarceration.

Once identified, a suicidal inmate is immediately referred to Dr. Fairbanks who conducts an evaluation of the inmate as soon as possible. In the interim, a special watch (detailed below) is placed on the inmate by either medical or mental health staff. Detention facility staff are encouraged to write reports on inmates whose behavior indicates emotional instability. In addition, Ms. Koepplinger or another full-time nurse conducts a medical assessment within eight hours after admission, maintains daily rounds on inmates suspected of suicidal behavior, and confers with Dr. Fairbanks every morning to "triage" appropriate cases. Finally, suicidal inmates are observed by detention facility staff under one of the following three levels of supervision.

Level 1 — Constant Supervision

Level 1 observation is for an inmate who is in imminent danger to himself. Although detention facility, medical and mental health staff can authorize Level 1 observation, only Dr. Fairbanks or another psychologist from the Southeast Wyoming Mental Health Center can discontinue this or any other observation level. The inmate is housed in either a holding cell near the booking office, on a mattress in the general population dayroom, or in one of four infirmary rooms under medical supervision. He is under continuous observation by detention staff. The Level 1 inmate is only permitted a mattress and paper gown, with all other items removed from his possession. Detention facility staff will document the inmate's behavior at least once every hour using an observation log sheet. Medical and mental health staff will evaluate the inmate at least once a day. Should the inmate's behavior remain stabilized for a period of between 24 to 36 hours, mental health staff will normally authorize Level 2 observation.

Level 2 — 15 Minute Emotional Stability

Level 2 observation is for an inmate whose behavior indicates emotional instability. Observation will be initiated when the inmate makes a suicidal gesture or statement. The inmate is housed in either a holding cell near the booking office or on a mattress in the dayroom, although he may go inside his open cell during the day. The Level 2 inmate is permitted clothing and bedding, with all other non-essential items removed from his possession. Detention facility staff will document his behavior at 15 minute intervals on the observation log sheet. Medical and mental health staff will evaluate the inmate at least once a day. Should the inmate's behavior remain stabilized for a period of 24 hours, mental health staff will normally authorize Level 3 observation.

Level 3 — 30 Minute Observation

Level 3 observation is for an inmate whose behavior indicates the need for further observation based upon any of the following circumstances — under the influence of alcohol and/or drugs; use of temporary restraints; or undiagnosed medical condition. The inmate is placed in any appropriate housing area and restrictions on clothing and bedding are determined by the classification board. Documentation of observation vary from case to case but occur no more than at 30 minute intervals. Medical staff will evaluate the inmate at least once a day. When an inmate is no longer intoxicated, he will be re-evaluated. The inmate will be removed from Level 3 following 24 hours of emotional stability. Should the inmate begin to display unstable behavior, observation may be upgraded to Level 2 or 1.

The case of Frank Howard (a pseudonym) is indicative of suicide prevention efforts in the Laramie County Detention Center. Mr. Howard entered the facility on February 8, 1990 following his arrest on a firearms charge. He also had a detainer pending from the U.S. Marshall's Service for a probation violation. During the

intake process, Mr. Howard admitted to the booking officer that he had had previous mental health treatment, but denied any current or prior suicidal ideation. He did, however, receive medication after telling staff he felt depressed. Following several days of stable behavior, Mr. Howard was assigned to a general housing unit on February 13.

On February 19, Mr. Howard attempted suicide by tying his blanket to the cell bar. The blanket loosened, however, and he fell to the floor, fracturing his foot. He was transported to the local hospital for medical treatment and returned to the Laramie County Detention Center the same day. Mr. Howard was given a paper gown and placed in the infirmary under Level 1 observation. Dr. Fairbanks evaluated him the next day and Mr. Howard stated legal and family problems, as well as a physical disability, led him to attempt suicide. He was shaking and began to cry, and appeared "non-focused" to Dr. Fairbanks. Level 1 observation was continued. Mr. Howard's behavior improved by February 22, his clothes were returned, and he was placed in a close observation section of the facility under Level 1. His behavior continued to improve and Level 3 observation was authorized by Dr. Fairbanks the following day. Soon thereafter, Mr. Howard's federal charges dictated a transfer to a Bureau of Prisons facility.

On April 5, 1990, Mr. Howard returned to the Laramie County Detention Center to resolve his state charges. He was placed in the intake section of the facility on Level 3 observation for 72 hours. Although his psychotropic medication had been increased while under the jurisdiction of federal authorities, Mr. Howard's behavior appeared normal to staff. He was transferred to general population on April 8. During the next few weeks he remained on Level 3 observation and was allowed contact visits with his wife. On April 26, however, Mr. Howard returned from a court hearing to discover that his wife had filed for divorce. He was placed on Level 2 observation after detention facility staff noticed Mr. Howard displaying violent mood swings. His behavior was eventually stabilized and he was transferred to general housing the following week. Mr. Howard remained on Level 3 observation until his May 22 sentencing hearing, whereupon he was again transferred to federal authorities.

During his three month incarceration at the Laramie County Detention Center, Mr. Howard was seen daily by medical staff and more than three times a week by Dr. Fairbanks. "This extended care case typifies what we do here," stated Ms. Koepplinger. "We treat the whole person, a holistic approach involving both medical and mental health staff." Yet, she admits, "If it wasn't for the detention staff, my job would be impossible. As seen in Mr. Howard's case, training has enabled them to be more perceptive regarding potentially suicidal behavior."

Training is a big part of suicide prevention efforts at the Laramie County Detention Center. Security staff receive initial training through the Detention Officer's Basic Course sponsored by the Wyoming Law Enforcement Academy. Four hours of suicide prevention training are provided through this course. The Laramie County Sheriff's Department supplements this instruction with a 360-hour field training program regarding all jail operations and services. As emphasized within the Detention Center's policy statement —

> The effective operation of the detention center is dependent on highly motivated, well-trained staff who continually strive to improve both their individual job performances and their areas of responsibility. To encourage professional growth, staff are provided with training within the department and are given opportunities to attend outside training. To facilitate the effective operation of the detention center, staff are encouraged to actively contribute to management decisions through regular meetings designed for problem-solving and proposing improvments. Such contributions are essential to the successful operation of the detention center.

Conclusion

Rod Bottoms has never had a jail suicide in a facility he administered. He quickly attributes the track record to the dedication of staff. "Suicide prevention is the result of shift briefings, increased awareness and additional training," he stated. "It comes down to the attitude of your staff, their pride and professionalism." Sheriff Restivo concludes — "Few suicides are spontaneous or impulsive, and the jail environment often provides the mechanism to manifest frustration. If you pay attention to screening and have checks and balances, you will probably not have a suicide."

The Laramie County Detention Center typifies a small jail approach to suicide prevention — limited resources and budget coupled with a high energy level of staff. For more information on suicide prevention efforts at the Laramie County Detention Center, contact Rod V. Bottoms, Detention Bureau Commander, Laramie County Sheriff's Department, 1910 Pioneer Avenue, Cheyenne, Wyoming 82001, (307/778-3700).

WE'RE LOOKING FOR A FEW GOOD PROGRAMS

If you believe your jail facility operates a model suicide prevention program, and would like it considered as a possible case study in an upcoming issue of the ***Jail Suicide Update,*** please contact:

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40 Lantern Lane
Mansfield, Massachusetts 02048
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RESOURCE LIST OF MODEL JAIL SUICIDE PREVENTION PROGRAMS

During the past year, staff of the ***Jail Suicide Update*** have identified and highlighted five model suicide prevention programs operating within both large and small jails throughout the country. This issue concludes our model program focus and we hope our readers have found this special series to be useful. For more information regarding model jail suicide prevention programs, readers are encouraged to contact ***Update*** staff, or any of the following resources:

1) Daniel G. Middaugh, Captain
   Oneida County Correctional Facility
   Law Enforcement Building
   Oriskany, New York 13424
   (315) 768-7804

2) Rhoda Manning, Director of Nursing
   Mobile County Sheriff's Department
   P.O. Box 113
   Mobile, Alabama 36601
   (205) 690-8670

3) Gary R. Turner, Captain
   Champaign County Sheriff's Office
   204 East Main Street
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4) Bernard J. Barry, Sheriff
   El Paso County Sheriff's Office
   15 East Cucharras Street
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   School of Social Work
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5) Rod V. Bottoms, Detention Bureau Commander
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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.

This project is supported by grant number 90J01GHI0 from the National Institute of Corrections (NIC), U.S. Department of Justice. Points of view or opinions stated in this document are those of the author(s) and do not necessarily represent the official position or policies of the U.S. Department of Justice.

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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 and 2)

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

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