



August 2011

Jail Suicide Prevention: Review of Previous Committee Work

Prepared by Sheri Scurr, Staff Research Analyst

Initial Study: 2007-2008 Interim

The 2007 Legislature passed four interim study resolutions that encompassed, to varying degrees, mental health treatment for justice-involved adults and juveniles. All four of these studies were assigned to the Law and Justice Interim Committee (LJIC). HJR 26 specifically requested an examination of mental health treatment and diversion alternatives for incarcerated adults.

Scope of the Problem

While undertaking these assigned studies, the LJIC learned of a series of tragic jail suicides. In 2005 (prior to the 2007 session), Ravalli County was reeling from three jail suicides in two months. Family members, who said the sheriff had been alerted to the suicidal tendencies of their loved ones, were outraged and demanded answers. In 2007, a young mother, Tia Henriksen, hung herself at the Cascade County Detention Center in the same manner as a previous inmate who also committed suicide. The county was sued for negligence. Also in 2007, in the Custer County Detention Center, Linda Wilson, a mother and wife, who had been vocal about her intention to kill herself, was left unobserved in an unlocked cell and hung herself with a telephone cord. Her family filed a civil lawsuit for wrongful death.

Eighth Amendment Rights

The 2007-2008 LJIC began its examination by reviewing the constitutional rights of detained and incarcerated persons under the Eighth Amendment of the U.S. Constitution. The Eighth Amendment reads: "*Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.*"

The LJIC learned that courts have identified six constitutionally required components of mental health care for incarcerated persons. Failure to meet these

minimum standards constitutes evidence of "*deliberate indifference to serious medical needs*". One of these minimum requirements is a "*basic program of identification, treatment, and supervision of prisoners with suicidal tendencies*." (See Attachment A for a legal memorandum on the Eighth Amendment.)

Examination of Other States - The Kentucky Model

Part of the 2007-2008 legislative study involved examining what other states have done to reduce jail suicide rates. Kentucky's response was found to be nationally recognized as most effective.

In 2004, responding to a series of highly publicized jail suicides, the Kentucky Legislature enacted and funded a jail suicide screening and prevention program that reduced Kentucky's jail suicide rate by 80%. Kentucky's program requires:

- standardized screening instruments at intake;
- 24/7 telephonic triage system providing direct telephone access to mental health professionals who perform interviews and provide evaluations;
- standardized suicide risk management protocols; and
- follow-up measures for those identified as being at high risk of suicide.

(See Attachment B for more information on Kentucky's program.)

Subcommittee on Jail Standards and Suicide Prevention

To drill down on the issue and develop specific recommendations for Montana, the LJIC established a subcommittee on jail standards and suicide prevention. This subcommittee considered various options and heard from various stakeholders, including:

- Capt. Dennis McCave, Yellowstone County Detention Center and Montana Sheriffs and Peace Officers Association (MSPOA);
- Jim Smith, MSPOA;
- Sheriff Cashell, Gallatin County;
- Deb Mattuecci, Department of Public Health and Human Services (DPHHS)/Department of Corrections;

- Roland Mena, Montana Board of Crime Control;
- Jan Dwyer, American Civil Liberties Union;
- Matt Kuntz, National Alliance for the Mentally Ill - Montana; and
- Charley McCarthy, Disability Rights Montana.

The subcommittee recommended a bill draft to enact a pilot program in Montana that would involve:

- standardized screening at intake;
- interviews by mental health professionals using remote electronic access if necessary (i.e., video conferencing or telephonic communications);
- determination of suicide risk by a mental health professional;
- management protocols based on the inmates suicide risk; and
- appropriate followup counseling or treatment.

Committee Recommendation - HB 60 Pilot Project

The LJIC's bill recommendation to the 2009 Legislature was HB 60, which created a two-year pilot program to establish a mental health triage system for a sample of small, medium, and large population counties.

Rep. Ebinger carried the bill and added a grant program to assist detention centers with costs of participation in the pilot project. HB 60 was approved by House Judiciary 14 to 4. The full House passed the bill on second reading 55 to 45. The bill was then referred to House Appropriations, where it was tabled. *(See Attachment C for a copy of the bill and the fiscal note.)*

Follow-up During the 2009-2010 Interim

The high rate of suicide in Montana jails continued. In 2009, four more jail suicides made headlines. The 2009-2010 LJIC requested that legal staff examine the MSPOA's progress in addressing jail suicides. Responding to this request, David Niss conducted an extensive review of MSPOA's voluntary standards and peer review efforts. A memorandum dated June 18, 2010, presented the findings, noting several concerns. *(See Attachment D.)*

After considering the staff findings and listening to the MSPOA response as well as comments from other stakeholders, the LJIC requested that staff draft a committee study resolution to continue the LJIC's work to address Montana's high jail suicide rate. However, the study resolution was withdrawn in favor of a notation in the committee' final report recommending that the 2011-2012 LJIC continue to examine jail suicide in the context of its on-going oversight responsibilities.

LEGAL MEMORANDUM

TO: Law and Justice Interim Committee

FROM: David S. Niss, Staff Attorney

DATE: September 14, 2007

RE: Constitutional and Federal Law Requirements for Mental Health Care
for Convicted Offenders, Jailed Persons, and Detainees in Montana

I INTRODUCTION

There has been much litigation over the years concerning a government's duty to care for the health, including the mental health, of prisoners in its custody,¹ so much litigation, in fact, that it's now exceedingly clear from reported federal and state judicial opinions that governmental entities operating prisons for persons convicted of criminal offenses are under a constitutionally required duty to provide mental health care to a prisoner with a serious mental illness. This requirement springs from the Eighth Amendment to the U.S. Constitution,² and similar language in state constitutions,³ prohibiting the government from inflicting cruel and unusual punishment upon persons convicted of criminal offenses. Additionally, the duty of a government to provide mental health care to detainees, persons in jails, and those discharged or about to be discharged from confinement, pursuant to the Eighth Amendment and the Due Process Clause of the U.S. Constitution, is a developing area of the law.⁴

Fortunately or unfortunately, Montana courts have not been the source of many judicial opinions on the subject of the application of the Eighth Amendment or the comparable provision in the Montana Constitution to physical or mental health care in Montana

¹A short but excellent history of the litigation against state and federal prison systems that established a prisoner's right to mental health care appears in *Class Action Litigation in Correctional Psychiatry*, Metzner, 30 *Journal of the American Academy of Psychiatry and the Law*, No. 1, p. 19 (2002). In the article, Metzner explains that in 1988, at least one prison in each of 21 states was the subject of a court-certified class action lawsuit involving the provision of mental health services for inmates.

²The Eighth Amendment provides that "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."

³See, e.g., Art. II, sec. 22, Mont. Const., that provides: "Excessive bail shall not be required, or excessive fines imposed, or cruel and unusual punishments inflicted."

⁴See sections II D and II F of this memorandum.

prisons or jails. In fact, research has disclosed only one opinion, Walker v. State, 2003 MT 134, 316 M 103, 68 P3d 872 (2003), dealing materially with this subject. In that case, the Court held that certain disciplinary treatment of a mentally ill prisoner, along with certain living conditions at the Montana State Prison, constituted cruel and unusual punishment in violation of the Montana Constitution. The opinion in Walker is further discussed in section II F of this memorandum.

Because of the lack of judicial opinions from Montana courts on which to rely for guidance regarding constitutionally required mental health care for prisoners in Montana, nearly all of the requirements reviewed in this memorandum come from judicial opinions from other jurisdictions. However, for reasons discussed in section II F of this memorandum, reported judicial opinions from other jurisdictions are highly relevant to the law in Montana and those decisions may even be viewed as either minimal constitutional requirements in this state or even requirements that do not meet the minimal standards contained in the Montana Constitution.

In evaluating an existing or proposed treatment program for convicted individuals who are not free to see their own mental health professional,⁵ the question of not only whether the program meets the standards of the Eighth Amendment, but also whether the program meets Montana constitutional standards must be asked.

II DISCUSSION

A. Eighth Amendment Standard for Mental Health Care in Prisons

In Estelle v. Gamble, 429 U.S. 97 (1976), the United States Supreme Court held that a complaint evidencing "deliberate indifference to serious medical needs" of a prison inmate stated a cause of action under 42 U.S.C. 1983, the federal statute under which most federal constitutional rights may be enforced against a state or political subdivision of a state in state or federal court. Since the Supreme Court's opinion in Estelle, numerous federal appellate courts have applied the holding to mental health care.⁶ Some of the earlier cases after Estelle sought to flesh out the definitions of what constituted "deliberate indifference" and what constituted a "serious mental illness".

⁵Language in some judicial opinions decided under the Eighth Amendment indicate that the standards of the Eighth Amendment for a treatment system apply when the convicted offender is unable to secure mental health care "on his own behalf". See discussion of Wakefield v. Thompson, 177 F.3d 1160 (9th Cir. 1999), infra, at page 5.

⁶See, e.g., Bowring v. Godwin, 551 F.2d 44 (4th Cir. 1977), Brown v. Zavaras, 63 F.3d 967 (10th Cir. 1995), and Gates v. Cook, 376 F.3d 323 (5th Cir. 2004).

Various courts have arrived at working definitions.⁷

Most importantly, the courts have gradually, through expert testimony used in legal actions challenging penal mental health care practices, adopted working standards for a prison mental health treatment system that comply with the requirements of the Eighth Amendment. One of the more well-known criteria for a constitutional mental health care system was announced in Ruiz v. Estelle, 503 F. Supp. 1265 (S.D. Tex. 1980), in which the federal District Court held that the following constitute those minimal requirements under the Eighth Amendment:

(1) First, there must be a systematic program for screening and evaluation of inmates in order to identify those who require mental health treatment for a serious mental disorder.

(2) Treatment must entail more than segregation and close supervision of inmates suffering from serious mental disorders.

(3) Treatment requires participation by trained mental health professionals,

⁷See, e.g., Tillery v. Owens, 719 F. Supp. 1256 (W.D. Pa. 1989), in which the court defined a "serious mental illness" as one "that has caused significant disruption in an inmate's everyday life and which prevents his functioning in the general population without disturbing or endangering others or himself". Also, several federal circuit courts have held that repeated acts of simple negligence may in some instances be used to prove deliberate indifference. See Todaro v. Ward, 565 F.2d 48 (2nd Cir. 1977), and Wellman v. Faulkner, 715 F.2d 269 (7th Cir. 1983). The Supreme Court itself clarified "deliberate indifference" in Farmer v. Brennan, 511 U.S. 825 (1994), holding that deliberate indifference is something like criminal recklessness and that actual knowledge of a prisoner's mental condition may be attributed to prison officials based upon circumstantial evidence.

Cohen, in his book, The Mentally Disordered Inmate and the Law (1998) (hereafter "Cohen"), includes a list of those factors, largely taken from case law, that are indicators of a serious mental disorder. Those factors are:

- (1) The diagnostic test is one of medical or psychiatric necessity.
- (2) Minor aches, pains, or distress will not establish necessity for treatment.
- (3) A desire to achieve rehabilitation from alcohol or drug abuse, or to lose weight to simply look or feel better, will not suffice.
- (4) A diagnosis based upon professional judgment and resting on some acceptable diagnosis tool (e.g., DSM-IV) is presumptively valid.
- (5) By the same token, a decision by a mental health professional that mental illness is not present is also presumptively valid.
- (6) While "mere depression" or behavioral or emotional problems alone do not qualify as serious mental illness, acute depression, paranoid schizophrenia, "nervous collapse" and suicidal tendencies do qualify. (Cohen, p. 4-36)

Regarding the sixth category, Cohen notes that "it is actually the clinician's choice of the diagnostic terminology that will move these cases from no care to discretionary care or to mandated care". (Cohen, p. 4-36) Cohen also notes that most opinions on the subject have not mandated treatment for transsexualism or mental retardation. (Cohen, pp. 4-33 through 4-36)

employed in sufficient numbers to identify and treat, on an individual basis, treatable inmates suffering from serious mental disorders.

(4) Accurate, complete, and confidential records of the mental health treatment process must be maintained.

(5) Administration of behavior-altering drugs in dangerous amounts by dangerous methods or without appropriate supervision or evaluation is an unacceptable method of treatment.

(6) A basic program of identification, treatment, and supervision of prisoners with suicidal tendencies is a necessary component of the mental health treatment system.

Other writers have provided a somewhat larger list of criteria.⁸

B. Scope of the Requirement for Treatment of Convicted Prisoners

A considerable body of case law has developed on each of these standards and others, applied to various institutions or entire penal systems on a case-by-case basis. Those cases make clear that the existence or nonexistence of any of the foregoing six components of a prison mental health treatment system announced in Ruiz is not the only issue that must be considered; the quality, extent, timeliness, and even the location of one or more of the six components set forth above are also issues within the purview of the Eighth Amendment. Thus, the following holdings are examples of cases applying the type of criteria listed above:

(1) Inordinate delays in providing treatment for mental illnesses are prohibited by the Eighth Amendment. Coleman v. Wilson, 912 F. Supp 1282 (E.D. Cal. 1995).

(2) The requirements of the Eighth Amendment also apply to persons sentenced to county or municipal jails and to those facilities. Inmates of Allegheny County Jail v. Pierce, 612 F.2d 754 (3rd Cir. 1979); Feliciano v. Colon, 697 F. Supp. 37 (P.R. 1988); Young v. Augusta, 59 F.3d 1160 (11th Cir. 1995); Hamilton v. Morial, (D.La. 1995) (unpublished).

⁸Cohen adds the additional criteria of (7) adequate physical facilities, expressed often as bed/treatment space, to meet varying treatment needs; (8) a human and clinically sound approach to mechanical restraints; and (9) the absence of brutality toward inmates with mental illness. While the author provides no case citations, it's likely that judicial opinions from some jurisdictions exist in which these additional criteria can be found. (Cohen, p. 4-27) Judicial opinions in other cases have included even lengthier lists of criteria or deficiencies. See, e.g., Cody v. Hillard, 599 F. Supp. 1025 (D.S.D. 1984), Langley v. Coughlin, 715 F. Supp. 522 (S.D.N.Y. 1989), and Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995).

(3) The requirements of the Eighth Amendment also apply to juveniles and to facilities holding juveniles. Viero v. Bufano, 901 F. Supp. 1387 (N.D. Ill. 1995).

(4) The requirements of the Eighth Amendment also apply to those prisoners being released or soon to be released from confinement, to require the prison or jail to provide some medications upon discharge. Wakefield v. Thompson, 177 F.3d 1160 (9th Cir. 1999). The basis for this holding, as explained in the opinion, is that while an inmate is in custody, the inmate cannot act for himself or herself, but must depend upon the prison staff to provide care for the inmate. Similar reasoning appears in DeShaney v. Winnebago County Dept. of Social Services, 489 U.S. 189 (1989).

(5) A private health care provider, acting under contract with a state, may be held liable pursuant to 42 U.S.C. 1983 and the Eighth Amendment for violating a state prison inmate's constitutional right to be free from cruel and unusual punishments. Ancata v. Prison Health Services, Inc., 769 F.2d 700 (11th Cir. 1985); West v. Atkins, 487 U.S. 42 (1988).

C. Other Topics Within the Purview of the Eighth Amendment

The duty to care for mentally ill inmates imposed by the Eighth Amendment has ramifications for the seriously mentally ill and a prison and prison staff throughout a prison system. Some of the aspects of a prison system, as those aspects relate to persons with severe mental illnesses, that are touched by the Eighth Amendment are listed below. A more complete description of how the Eighth Amendment impacts these parts of a prison system can be researched and discussed at a future date, as the Committee reaches the following topics in its study:

- (1) substance abuse programs;
- (2) effect of isolation or "supermax";
- (3) use of bodily restraints or excessive force;
- (4) disciplinary proceedings;
- (5) mentally retarded offenders;
- (6) transfer of inmates to other facilities for treatment (including the extent to which treatment services may be provided "off site"); and
- (7) sex offender treatment.

D. The Due Process Clause Requirements for Treatment

The foregoing pages have shown that an inmate in a state prison or local jail who has been convicted of (or plead guilty to) an offense has a constitutional right to treatment for a serious mental illness. More recent cases have established the proposition that

the Due Process Clause of the U.S. Constitution⁹ contains a requirement that pretrial detainees, to whom the Eighth Amendment does not apply because there has been no conviction (or plea of guilty), also must be treated for serious mental illnesses to at least the same extent as convicted offenders. Bell v. Wolfish, 441 U.S. 520 (1979); City of Revere v. Mass. General Hospital, 463 U.S. 239 (1983); Thomas v. Kipperman, 846 F.2d 1009 (5th Cir. 1988); Benjamin v. Fraser, 161 F. Supp. 2d 151 (S.D.N.Y. 2001); Woodward v. Correctional Medical Services, 368 F.3d 917 (7th Cir. 2004).

Case law also establishes that the purpose and scope of treatment for mental illness for pretrial detainees under the Due Process Clause is roughly equal to the purpose and scope of treatment of prisoners under the Eighth Amendment. Dawson v. Kendrick, 527 F. Supp. 1252 (S.D. W. Va. 1981); Calderon-Ortiz v. Laboy-Alvarado, 300 F.3d 60 (1st Cir. 2002). Therefore, the six-part test for a mental health treatment system used by the court in Ruiz is applicable to a city or county jail used for the detention of pretrial detainees. Thus, for example, in Jones v. Wittenberg, 509 F. Supp. 653 (N.D. Ohio 1980), an inmate challenged the mental health services in the Lucas County, Ohio, jail because of the lack of availability of a jail psychiatrist, among other conditions at the jail. The court held that while other special services were provided, the lack of a psychiatrist was a constitutional violation.

E. Federal Statutory Law

In Pennsylvania Dept. of Corrections v. Yeskey, 524 U.S. 206 (1998), the U.S. Supreme Court affirmed an opinion of the Third Circuit Court of Appeals, holding that the Americans With Disabilities Act of 1990 (ADA)¹⁰ applied to state prisons. Thus, in Armstrong v. Davis, 275 F.3d 849 (9th Cir. 2001), the Ninth Circuit Court of Appeals affirmed a U.S. District Court order holding that the ADA and the Rehabilitation Act of 1973¹¹ apply to inmates in a state prison system, affirmed findings that the California agency in charge of paroling prisoners from state prisons routinely violated both federal acts by discriminating against disabled persons in making the processes of the parole board insufficiently available to those disabled persons (by, for example, requiring that the hands of a deaf person be shackled during a parole board hearing, prohibiting the person from communicating with the board by sign language) and affirmed injunctive relief against the board to enforce the provisions of the ADA. Whether there are rules

⁹Amendment V to the U.S. Constitution provides: "No person shall be . . . compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law. . .".

¹⁰42 U.S.C. 12101, et seq. Section 42 U.S.C. 12132 prohibits a "public entity" from discriminating against a "qualified individual with a disability".

¹¹29 U.S.C. 794. The Rehabilitation Act of 1973 prohibits discrimination against disabled individuals "under any program or activity receiving Federal financial assistance".

expect that in future cases, the Montana Supreme Court will hold that a mental health care system or component of the system that is minimally adequate under the Eighth Amendment in another jurisdiction is not adequate in Montana. Put another way, because of its holding in Walker, the Montana Supreme Court may well hold in the future that the components of a treatment system as required in Ruiz are below the minimum requirements of the Montana Constitution for a mental health treatment system in Montana for persons convicted of offenses. It is also possible that the same rationale and result would apply to the Montana Constitutional requirements that would apply an Eighth Amendment standard to the treatment of pretrial detainees, or other persons in the Montana criminal justice system, that have not yet been convicted.¹⁴

III CONCLUSION

Beginning in 1976, case law from other jurisdictions has consistently demonstrated that there is a constitutional requirement for mental health treatment in prisons for individuals, both adults and juveniles, convicted of criminal offenses who have a serious mental illness. The law now also requires treatment for individuals, both adults and juveniles, jailed pending trial for an offense. Because Montana has almost no case law on this subject, the parameters of a constitutionally sufficient mental health program for these persons in the criminal justice system must be gleaned from the case law of other jurisdictions applying the Eighth Amendment or the Due Process Clause of the U.S. Constitution or equivalent state constitutional provisions. These opinions demonstrate that there are at least six basic components of a constitutionally sufficient mental health treatment system. However, because of the Montana Supreme Court's holding in Walker, the Montana Supreme Court has strongly indicated that a mental health care system that is minimally constitutionally sufficient in a jurisdiction other than Montana may not be constitutionally sufficient in Montana. Only subsequent opinions of the Montana Supreme Court will further determine exactly what mental health treatment practices in the administration of Montana prisons and jails fall below the higher constitutional standard recognized in the Walker opinion.

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and that those programmatic differences did not rise to the same level as the poor conditions of care at issue in the Walker case.

¹⁴Like the requirements of Art. II, sec. 22, Mont. Const., when read together with the individual dignity provisions of Art. II, sec. 4, Mont. Const., as those requirements apply to convicted persons, the Montana Supreme Court might hold that the Due Process Clause in Art. II, sec. 17, Mont. Const., when read together with the individual dignity provisions of Art. II, sec. 4, Mont. Const., provides more protection from cruel and unusual punishment for Montanans held in pretrial confinement than does the Due Process Clause of the U.S. Constitution. At this time, there are no opinions of the Montana Supreme Court to this effect.

HOUSE BILL NO. 60

INTRODUCED BY B. EBINGER

BY REQUEST OF THE LAW AND JUSTICE INTERIM COMMITTEE

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO CONTRACT FOR THE CREATION AND OPERATION OF A PILOT PROGRAM FOR THE REDUCTION OF RISK OF INMATE SUICIDES IN CERTAIN DETENTION FACILITIES; PROVIDING FOR THE CONTENT OF THE PROGRAM AND THE DUTIES OF THE DEPARTMENT; REQUIRING RULEMAKING; PROVIDING AN APPROPRIATION; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Short title.** [Sections 1 through 7] may be cited as the "Linda Wilson Memorial Jail Suicide Prevention Act of 2009".

NEW SECTION. **Section 2. Legislative finding and intent.** An examination of inmate suicides occurring in detention centers in Montana has demonstrated to the legislature that while the number of yearly suicides in those facilities is no more than an average of 3.6 per year, the rate of those suicides compared to other states, when compared on the basis of the number of inmates in detention centers, warrants the creation of a pilot program designed to reduce the risk of suicides in those centers. The intent of the legislature in enacting [sections 1 through 7] is to create a time-limited pilot project based upon the Kentucky jail mental health crisis network established pursuant to Kentucky Revised Statutes 210.365. It is the intent of the legislature that the pilot program be conducted in detention centers representing a mixture of both small and large detention centers, by inmate population, in order to demonstrate the viability of a permanent program to reduce the risk of inmate suicide within detention centers in all counties of the state. It is also the intent of the legislature that in creating and operating the pilot program, the department shall consider the creation and operation of the Kentucky jail mental health crisis network for guidance.

NEW SECTION. **Section 3. Definitions.** As used in [sections 1 through 7], the following definitions apply:



Attachment C

1 (1) "Department" means the department of public health and human services established in 2-15-2201.

2 (2) "Detention center" means a detention center, as defined in 7-32-2120, that is operated by a local
3 government.

4 (3) "Inmate" means a person who is confined in a detention center.

5 (4) "Management protocol" means a rule providing the best management practices in the subject areas
6 of housing, supervision, clothing, property, and food for an inmate at risk of suicide.

7 (5) "Mental health professional" has the meaning provided in 53-21-102.

8 (6) "Rule" has the meaning provided in 2-4-102.

9 (7) "Screening instrument" means a written or electronic series of questions designed to determine the
10 degree of likelihood or risk that an inmate may commit suicide.

11
12 **NEW SECTION. Section 4. Pilot program for reduction of inmate suicide risk in certain detention**
13 **centers -- design and content -- inmate screening required.** (1) The department shall contract to create a

14 program for the reduction of likelihood or risk that an inmate in any of the detention centers within the state may
15 commit suicide. The program must include the use of:

16 (a) one or more screening instruments for which the department's goal should be uniformity in all
17 instruments for all detention centers and for other individuals who may be required to complete or respond to the
18 questions in the screening instrument;

19 (b) an interview of one or more detention officers in a detention center in which the inmate is located or
20 an interview of the inmate, or both, by electronic means or otherwise, by a mental health professional;

21 (c) a determination by the mental health professional participating in the program of the degree of
22 likelihood or risk that an inmate may attempt to commit suicide;

23 (d) management protocols to be used by the detention facility as indicated by the degree of likelihood
24 or risk of inmate suicide determined by the mental health professional and as provided in this section and by the
25 rules of the department; and

26 (e) appropriate followup counseling or treatment by a mental health professional for an inmate
27 determined to be at risk for suicide as provided in this section in order to reduce that risk.

28 (2) Each inmate, upon admittance to a detention facility represented in the program provided for in this
29 section and at such other times as determined by the rules of the department, must be screened for a degree of
30 likelihood or risk that the inmate may attempt to commit suicide. Screening, management, and followup

1 counseling or treatment of an inmate must occur as provided for in subsection (1). An inmate in a detention center
2 included in the program who cannot be safely housed in the detention center by the use of management
3 protocols, counseling, treatment, or any combination of those procedures and who must be treated for a serious
4 mental illness in order to reduce the inmate's risk of suicide may not be treated in a detention center.

5
6 **NEW SECTION. Section 5. Contracting or consultation and department rulemaking.** (1) In
7 developing the program provided for in [sections 1 through 7], the department, an entity that the department
8 contracts with, or either of them may contract or consult with operators of any similar program in the country.

9 (2) The department shall adopt rules to implement [sections 1 through 7]. In creating and maintaining
10 the program provided for in [sections 1 through 7] and in adopting management protocols and other rules to
11 implement [sections 1 through 7], the department shall consult with the suicide prevention officer appointed
12 pursuant to 53-21-1101, the Montana sheriffs and peace officers association, the mental health ombudsman
13 appointed pursuant to 2-15-210, and the mental health oversight advisory council appointed pursuant to
14 53-21-702 and may consult with other appropriate groups and individuals.

15 (3) The program administered by the department must include a grant program that pays those expenses
16 incurred by a detention center participating in the program that are determined by the department to be
17 appropriately payable. If an insufficient number of detention centers apply to participate in the pilot program, the
18 department shall by rule designate the detention centers that are required to participate.

19
20 **NEW SECTION. Section 6. Data collection.** The department shall, as part of the program provided
21 in [sections 1 through 7], collect data concerning inmates at risk of suicide in detention centers included in the
22 program and the treatment of inmates in those detention centers. County sheriffs and detention center personnel
23 shall cooperate with the department in providing data to the department.

24
25 **NEW SECTION. Section 7. Report to committee required.** Before January 1, 2011, the department
26 shall provide to the law and justice interim committee, provided for in 5-5-226, a report on the program provided
27 for in [section 1 through 7]. The report must include:

28 (1) an assessment by the department of the degree of success of the program and a recommendation
29 by the department as to whether that program should be continued as a pilot program, be made permanent, or
30 be allowed to terminate;

1 (2) an assessment of:

2 (a) the collateral impacts of the program, such as whether the program places unacceptable pressure
3 on other parts of the state or local mental health treatment system;

4 (b) whether the program causes or should require additional diversions to community crisis centers; and

5 (c) whether the program causes or should require additional transportation operations to the Montana
6 state hospital; and

7 (3) any draft legislation that the department considers necessary to implement any recommendation of
8 the department.

9

10 **NEW SECTION. Section 8. Appropriation.** There is appropriated from the general fund to the
11 department of public health and human services the following amounts in the fiscal years indicated for the
12 purposes of [sections 1 through 7]:

13 Fiscal Year 2010: \$264,000

14 Fiscal Year 2011: \$189,000

15

16 **NEW SECTION. Section 9. Effective dates.** (1) Except as provided in subsections (2) and (3), [this
17 act] is effective October 1, 2009.

18 (2) [Sections 5(1) and 8 and this section] are effective on passage and approval.

19 (3) [Section 4(1)] is effective July 1, 2009.

20

21 **NEW SECTION. Section 10. Termination.** [This act] terminates July 1, 2011.

22

- END -



GOVERNOR'S OFFICE OF
BUDGET AND PROGRAM PLANNING

Fiscal Note 2011 Biennium

Bill # HB0060

Title: Jail mental health crisis network standards pilot program

Primary Sponsor: Ebinger, Bob

Status: As Introduced

- | | | |
|---|--|--|
| <input type="checkbox"/> Significant Local Gov Impact | <input checked="" type="checkbox"/> Needs to be included in HB 2 | <input checked="" type="checkbox"/> Technical Concerns |
| <input type="checkbox"/> Included in the Executive Budget | <input type="checkbox"/> Significant Long-Term Impacts | <input type="checkbox"/> Dedicated Revenue Form Attached |

FISCAL SUMMARY

	<u>FY 2010 Difference</u>	<u>FY 2011 Difference</u>	<u>FY 2012 Difference</u>	<u>FY 2013 Difference</u>
Expenditures:				
General Fund	\$226,123	\$208,354	\$0	\$0
Revenue:				
General Fund	\$0	\$0	\$0	\$0
Net Impact-General Fund Balance	<u>(\$226,123)</u>	<u>(\$208,354)</u>	<u>\$0</u>	<u>\$0</u>

Description of fiscal impact:

HB 60 will provide funding to coordinate a pilot program to screen inmates entering detention facilities for suicidal risk, provide funding for participating detention centers for necessary safety equipment and staffing to help administer the program, acquire management software, and contract with mental health centers to provide suicide evaluation services to inmates identified to be at risk. In addition, this bill will provide funding for one FTE to develop and coordinate the program

FISCAL ANALYSIS

Assumptions:

Department of Public Health and Human Services

Addictive & Mental Disorders Division

1. Contracted services will be provided at each of the three detention facilities chosen, for the screening and monitoring of inmates. This is estimated to cost \$40,000 annually per detention center, or \$120,000 per year in total starting in FY 2011.
2. Professional clinical services will be provided through the mental health centers to evaluate inmates entering incarceration for suicidal risk. The cost for these evaluations and follow-up will be \$1,440 in FY 2010 (3 months), and \$5,400 each year thereafter. (\$120 per evaluation for 15 evaluations at 3 each of the sites annually)
3. Contracts will be entered into with detention centers to procure safety equipment (Safety chairs and smocks) in the amount of \$39,000 in FY 2010.
4. Contracts with the mental health centers will begin 4/1/2010. One time costs are expected to be \$5,000 each for three centers, of which \$3,000 will be spent in FY 2010, and the balance of \$12,000 being spent in FY 2011. These one time costs will pay for incremental costs of developing the program through the mental health centers.
5. The procurement of software will be a one-time cost of \$125,000 in FY 2010. The software is proprietary software that was developed and being used by the state of Kentucky. The Department of Public Health and Human Services will procure the rights to use this software for screening, data collection, and management and statistical reporting. This cost includes trainers from Kentucky to come out and train state of Montana employees on the use of the software.
6. Addictive & Mental Disorder Division (AMDD) will need a contract administrator for this pilot program. AMDD will need .75 FTE in FY 2010 and 1.00 FTE in FY 2011. This position will be Program officer, pay band 6, and will have an estimated start date of 10/1/09. This individual will write a Request for Proposal to determine needs and interest of county detention facilities across the state (anticipated completion 1/1/2010), to draft administrative rules (anticipated completion 3/31/2010), provide appropriate training to detention staff, and to bring the program operational by 4/1/2010.
7. The new employee will require an office setup package (desk/chair/file cabinet) and a computer, for a total of \$2,600 in FY 2010.

Director's Office

8. Legal Services, within the Director's Office, will incur expenditures for legal fees for work on rules and contract preparation and review, in addition to filing fees.
9. The department's legal staff is working at capacity, therefore, these services will need to be contracted out through temp services and using Agency Legal Services through the Department of Justice.
10. It is estimated that the total legal costs are \$6,720 for Legal fees (\$84 x 80 Agency Legal Services hours) and \$750 in filing fees (15 pages x \$50/ page filing fee), and, for a total of \$7,470 in FY 2010.

Funding

11. All expenditures for this program will be funded with general funds.
12. The pilot program terminates July 1, 2011.

Fiscal Note Request – As Introduced

(continued)

	<u>FY 2010 Difference</u>	<u>FY 2011 Difference</u>	<u>FY 2012 Difference</u>	<u>FY 2013 Difference</u>
<u>Fiscal Impact:</u>				
FTE	0.75	1.00	0.00	0.00
<u>Expenditures:</u>				
Personal Services	\$47,613	\$63,484	\$0	\$0
Operating Expenses	\$178,510	\$137,400	\$0	\$0
TOTAL Expenditures	<u>\$226,123</u>	<u>\$200,884</u>	<u>\$0</u>	<u>\$0</u>
<u>Funding of Expenditures:</u>				
General Fund (01)	\$226,123	\$200,884	\$0	\$0
TOTAL Funding of Exp.	<u>\$226,123</u>	<u>\$200,884</u>	<u>\$0</u>	<u>\$0</u>
<u>Net Impact to Fund Balance (Revenue minus Funding of Expenditures):</u>				
General Fund (01)	(\$226,123)	(\$200,884)	\$0	\$0

Technical Notes:

1. In FY 2010, the expenditure estimate stated in this fiscal note is less than the proposed appropriation in HB 60. In FY 2011, the expenditure estimate stated in this fiscal note exceeds the proposed appropriation in HB 60.

Sponsor's Initials

Date

Budget Director's Initials

Date

**No. 4 - Kentucky Jail Mental Health Crisis Network
Executive Bullets**

- * The state of Kentucky has enacted the Kentucky Jail Mental Health Crisis Network, taking the mental health and suicide screening out of the hands of local jail staff and placing that evaluation in the hands of trained mental health clinicians, who are reachable by a toll-free telephone number.
- * The Network uses written and electronic screening instruments to be completed by the arresting officer and the jail detention staff, use of the toll-free consultation, application of jail detention policies designed to prevent inmates from committing suicide, and followup care.
- * Statistics indicate that the creation of the program has reduced the incidents of suicide in Kentucky jails.
- * Issues and options are listed for the Committee's consideration.

Attachment B



Montana Legislative Services Division

Legal Services Office

PO BOX 201706
Helena, MT 59620-1706
(406) 444-3064
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TO: Law and Justice Interim Committee

FROM: David S. Niss, Staff Attorney

RE: No. 4 - Kentucky Jail Mental Health Crisis Network, Issues and Options

DATE: June 13, 2008

I INTRODUCTION

In February of 2002, a Kentucky newspaper ran a series of articles about suicides in Kentucky jails. In response, the Kentucky Legislature enacted legislation requiring 4 hours of training of all detention officers in mental health issues. However, detention officers made it clear that what was needed was not just training but a different kind of service, providing professional mental health screening of arrestees. As a result, in 2004, the Kentucky Legislature funded a screening program, the Kentucky Jail Mental Health Crisis Network (Kentucky program), for use by any Kentucky jail through which any of them have access to professional mental health screening of arrestees through a toll-free number to the professional mental health staff of the Bluegrass Regional Mental Health-Mental Retardation Board, Inc. Through a series of questions asked by the mental health professionals over the telephone, the arrestees are triaged as to their potential to commit suicide while in jail. Suicide rates in Kentucky jail have now dropped by 80%. This memorandum and an article from Behavioral Healthcare (attached) explain the program.

II DISCUSSION

a. The Kentucky program

The purpose of the Kentucky program is to prevent jail suicides by taking the suicide screening function and suicide prevention decisionmaking out of the hands of Kentucky detention officers, particularly those in jails in rural counties with small staffs, and placing both in the hands of trained mental health professionals. According to much literature on the subject, the process of screening arrestees for predicting suicide is a critical process in preventing suicides. In Kentucky, the Lexington Fayette County Detention Center had already developed such a screening program. Under that screening program, the County was able to reduce the number of suicides in the jail from 10 in a 13-year period to none in the 12 years after the screening program was implemented. The Kentucky program used the lessons learned from that detention

center as the basis for a successful five-jail pilot program and then the statewide program. Of Kentucky's 96 detention centers, only 4 have not joined the program. The program's \$2.2 million annual cost is funded through a \$5 court fee. The Kentucky program has four component parts: (1) standardized screening instruments; (2) telephone triage; (3) jail management protocols; and (4) mental health care followup.

Standardized Screening Instruments. The Kentucky program uses two initial screening forms. One screening form is completed by every arresting officer in a participating jurisdiction (the officer answers a short list of yes or no questions), and the other form is completed by the booking officer at the jail (both questionnaires attached). Prior to adoption of the program by the Kentucky Legislature, the implementing law for which requires standard screening tools, there were many different screening forms being used by the many jails, a situation that some claim developed from Kentucky electing its jailers. A positive response to any of certain questions on the two screening forms must result in a toll-free call to the mental health professional (copy of two screening forms used in the Kentucky program attached).

Telephone Triage. When the mental health professional receives a telephone call pursuant to responses on the two screening forms, the mental health professional takes the detention officer (and sometimes the arrestee) through a computer program containing a validated risk assessment tool developed in software just for the Kentucky program. The mental health professional answering the toll-free telephone call takes the detention officer, and sometimes the arrestee, through a guided interview provided by a validated, proprietary computer program and uses the program and the clinician's professional judgment to score the arrestee as a low, moderate, high, or critical suicide risk. The guided interview takes about 5 minutes. Then, depending upon how the arrestee is scored by the clinician and the computer program, the jail applies written management protocols to safeguard the arrestee until the arrestee can be provided with mental health counseling.

Jail Management Protocols. The risk level provided by the computer program and the mental health professional then results in the application of protocols to manage the arrestee until further followup mental health care is provided, paid for by the Network. The protocols represent best management practices designed to lower the arrestee's risk of suicide while in jail and can generally be described as protocols for housing the inmate, the level of supervision of the inmate by the detention staff, and management of the inmate's property, clothing, and food.

Followup Mental Health Treatment. The Kentucky program requires a followup consultation between a mental health professional and the inmate for any arrestee (who has then become an inmate) who was scored "critical" or "high" by the mental health professional conducting the telephone triage. At that followup consultation, the mental health professional determines whether the triage category assigned to the inmate, and the corresponding detention management protocols being used for that inmate, need to be changed. In Kentucky, this consultation function is carried out by the community

mental health center closest to the inmate that is able to provide the service in a timely fashion.

I discussed with Ms. Connie Milligan, who is the Regional Director of Intake and Emergency Services for the Bluegrass Regional Mental Health-Mental Retardation Board, Inc., and the Director of the Kentucky Jail Mental Health Crisis Network, the issue of suicide risk assessment of arrestees who are under the influence of alcohol or drugs. She explained that that assessment had to be done because a high number of arrestees are under the influence and that national data shows that a high number of suicide victims are under the influence. She pointed out that what is being assessed is not an arrestee's suitability for treatment but whether the arrestee is at risk for suicide, which she felt was a much different standard.

Ms. Milligan also said that she has said that she has so much confidence in the ability of the Network to correctly score an arrestee, even an intoxicated arrestee, for suicide risk that she would offer the services of the Network on a fee for services basis to a pilot program in Montana.

b. General Issues

1. Whether a program like the Kentucky Jail Mental Health Crisis Network, or any part of it, is needed in Montana?
2. Whether the number of suicides in Montana jails warrants an investment of public money in a program like the Kentucky Jail Mental Health Crisis Network, or any part of it, in Montana?
3. How much it would cost to implement a program like the Kentucky Jail Mental Health Crisis Network, or any part of it, in Montana?

c. Specific Issues

1. Should city officers and county deputies be required to use the arresting officer questionnaire?
2. Should detention officers be required to complete the booking officer questionnaire?
3. What entity would provide the toll-free telephone triage system (e.g., could the 24/7 suicide crisis hotline mandated by 53-21-1103, MCA, to be staffed with paid and trained persons, be used to provide the screening service on a pilot project or other basis or would a fee for service contract with the Bluegrass Regional Mental Health-Mental Retardation Board, Inc., be a more appropriate choice)?
4. What entity would provide the followup mental health consultation?

d. Options

1. Continue to study the Kentucky Jail Mental Health Crisis Network, or any part of it.
2. Require the Department of Public Health and Human Services to study the feasibility of establishing a pilot program or a permanent program like the Kentucky Jail Mental Health Crisis Network and report back to the Committee or the Legislature.
3. Request legislation to enact a system like the Kentucky Jail Mental Health Crisis Network (Kentucky HB 157 attached), or any part of it, on a permanent or pilot project basis. The several parts of the Kentucky program are:
 - (a) arresting officer questionnaire;
 - (b) booking officer questionnaire;
 - (c) toll-free telephone triage system;
 - (d) detention management protocols; and
 - (e) followup mental health consultation for inmates.

III CONCLUSION

Based upon a successful pilot project, Kentucky has passed legislation creating the Kentucky Jail Mental Health Crisis Network. The Network's purpose is to take the evaluation of local jail inmates, including arrestees, for mental health and suicide issues out of the hands of the local jail detention staff and place the evaluation in the hands of trained mental health clinicians. The components of the program include written and electronic screening instruments, a toll-free telephone number through which jail detention staff may reach the trained mental health clinicians, jail protocols or policies used to prevent inmates from committing suicide, and followup care. Available data indicates that the use of the Network has reduced jail suicides in Kentucky.

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BEHAVIORAL HEALTHCARE

Issue Date: August 2006

Calling for help

A Kentucky program makes mental health consultants available to jails 24/7

by CONNIE MILLIGAN, LCSW and RAY SABBATINE, MA

It has become axiomatic that local jails are the front line in many communities for the assessment of acute mental illness. According to the U.S. Department of Justice, serious mental illness affects up to 16% of the incarcerated population.¹ Jails often become the de facto venue for initial assessment and treatment of individuals with serious mental illness, some of whom are arrested multiple times over a short period.

For jails, housing this population increases costs, particularly in taking steps to prevent suicides. Jails are required to provide safe management often without adequate mental health consultation or intervention. For individuals with mental illnesses, these safe management techniques may result in long periods of suffering in solitary confinement.

Across the nation, good solutions to these problems have been limited. In Kentucky, an innovative program, the Kentucky Jail Mental Health Crisis Network, provides all jails in the state with access to a system of care that identifies mental health and suicide risk and offers 24/7 mental health consultation and intervention. Since this program is fully funded through the state legislature, detention centers may use this program without incurring additional costs. More importantly, data suggest that the program has resulted in an 80% reduction in deaths of inmates in custody.

Program Development

In February 2002, a series in the *Louisville Courier-Journal* revealed that 17 individuals had committed suicide while in custody in the previous 30-month period, and two others had died while in restraints.² The Kentucky legislature responded by passing legislation that required four hours of mental health training for all detention center personnel. However, it soon became clear that services, not simply more training, were required.

Through Bluegrass Regional Mental Health-Mental Retardation Board, Inc., a large community mental health center (CMHC) in central Kentucky, the authors developed a comprehensive program to address the greater needs of the state's detention centers. The main objective was to offer immediate access to mental health consultation. In 2003, using Bluegrass's emergency and assessment call center, a Telephonic Triage program was developed and piloted with five jails. Using a toll-free telephone number with 24/7 access to licensed mental health professionals, the Telephonic Triage program uses standardized protocols to guide a mental health triage risk assessment. The identified risk level corresponds to clearly delineated best-practice jail risk-management protocols.

Based on positive responses from the pilot program jails, the Telephonic Triage program became the focal point for the development of other service components that would enhance and unify the state jails' response to people with mental illness. Standardized screening forms were developed to ensure identification of risk when someone enters a jail. Additional face-to-face services were organized through the Department of Mental Health's 14 community mental health-mental retardation regional boards to ensure the safety of and appropriate response to people with mental illness. Finally, a telephonic and electronic infrastructure was developed to create an integrated network between jails and mental health centers that centralizes the flow and collection of data.

In 2004, a funding proposal for the newly created Kentucky Jail Mental Health Crisis Network was presented to the Kentucky legislature. With the leadership of State Senate Majority Leader Dan Kelly, the program received designated funding through a \$5 increase in court costs. Participation is voluntary, and 90% of the state's 86 detention facilities are enrolled in the program with others interested in joining.

Program Components

The Kentucky Jail Mental Health Crisis Network's components are based on the tenants of proper inmate classification and the recommendations of Lindsay M. Hayes, a project director at the National Center of Institutions and Alternatives, for the reduction of suicide in jails.³ The program includes four components:

Standardized screening instruments

The use of standardized screening instruments is the foundation for assessing risk and need in most detention centers and is integral to this program's success. Two instruments have been developed, one for the arresting officer and one given to the arrestee by the booking/screening officer. The instruments, each with no more than 20 yes/no questions, have standard risk assessment questions, including those related to behavioral indicators of suicide, history of psychiatric hospitalization and mental illness, acquired brain injury, mental retardation, and reaction to the charge. (For more information on the instruments, e-mail milligan0806@behavioral.net.) A yes to any of the mental health questions triggers an automatic call to the Telephonic Triage line.

In addition to the two screening instruments, jail personnel are trained to observe mental health problems, keep mental health risk alerts from previous incarcerations, and respond to the individual's and family members' requests for mental health services. Any indication of risk or request for services triggers a call to the Telephonic Triage line.

Telephonic Triage

Telephonic Triage provides jails with 24/7 access to a licensed mental health professional, who uses a research-based assessment instrument to identify and scale an inmate's mental health risk. Telephonic Triage involves a guided telephonic interview between the mental health professional and the deputy (and, when possible, the inmate) to determine the level of risk related to four potential risk categories: (1) the charge, (2) suicide, (3) potential substance abuse withdrawal, and (4) symptoms of mental illness in four diagnostic categories. Information also is obtained on history of treatment, hospitalization, and medications.

A final summary level of risk—critical, high, moderate, or low—is assigned based on the constellation of risk variables. The mental health professional also will determine if the risk level's acuity warrants treatment or diversion, and he/she will arrange follow-up services. Diversion options include civil commitment to a psychiatric facility, referral for a competency evaluation, or working with the courts to have charges dropped. The completed Telephonic Triage form is e-mailed or faxed to the jail and to the corresponding CMHC when follow-up is indicated.

Jail risk management protocols

The summary risk level determined through Telephonic Triage corresponds to a level of jail risk management protocols that represent the industry's best practice standards. These recommended safe management techniques guide jail personnel on interventions with housing, supervision, property, clothing, and food.

These protocols' goal is to enhance the safe and humane treatment of persons with mental illness in detention facilities. The program seeks to reduce the unnecessary use of restraints and to ensure that isolation and suicide watch protocols are implemented safely on a time-limited basis. At any time, additional Telephonic Triage calls can be conducted to reassess an inmate's level of functioning and need for intervention.

Follow-up with mental health services

The final component is face-to-face follow-up services provided by the state's CMHCs. Local mental health professionals are trained and available to respond to requests for follow-up made by the Telephonic Triage clinician within specified time frames. Each risk level has a required time frame, from three hours to the next business day, for follow-up response to ensure that this service is implemented consistently across the state.

Follow-up services include a face-to-face evaluation with the inmate to provide crisis counseling and consultation to the jail. An assessment is made to determine if the risk level and jail management protocols seem appropriate and if additional services are indicated. If the inmate can be diverted from the facility to other care or have the charges dropped, the local clinician makes those arrangements. Documentation of the follow-up is sent to Bluegrass for data collection and to the jail for the inmate's file.

Results

Since the program's implementation in fall 2004, 90% of jails in the state participate in the Kentucky Jail Mental Health Crisis Network. More than 11,000 Telephonic Triages have been conducted. There has been an 80% reduction in suicides in participating jails and a 100% reduction in deaths in restraints.

Analyses of data generated by Telephonic Triage interviews reveal that 65% of people being booked in Kentucky jails have some risk related to suicide, 30% have had a psychiatric hospitalization in the past year, 38% of those triaged have substance abuse-related risk, and a staggering 77% have at least one symptom of a mental illness.

This program has been a win-win situation for everyone involved. It offers jails much needed mental health consultation, intervention, and risk reduction with no increased cost. It provides CMHCs with funding for this service and the opportunity to develop expertise with a population that traditionally has fallen through the service delivery cracks. And most importantly, people with mental illness in detention facilities now have options for services and diversion that did not exist previously.



Connie Milligan, LCSW, is the Regional Director of Intake and Emergency Services for the Bluegrass Regional Mental Health-Mental Retardation Board, Inc., and Director of the Kentucky Jail Mental Health Crisis Network.



Ray Sabbatine, MA, is a jail consultant to the Kentucky Jail Mental Health Crisis Network.

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1. Ditton PM. Mental Health and Treatment of Inmates and Probationers. BJS Special Reports. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; July 1999. Available at: <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf>.
2. Adams J, Shipley S. Locked in suffering: Kentucky's jails and the mentally ill. Four-part series. Courier- Journal [Louisville, Kentucky]. Feb. 24-Mar. 3, 2002.
3. Hayes LM. Jail suicide prevention and liability reduction. National Center on Institutions and Alternatives. Available at: <http://www.ncianet.org/cjisl.cfm>.

**Jail Intake Assessment
Arresting Officer Questions**

1. Has this arrestee engaged in any assaultive or violent behavior? **(If yes, refer to custody supervisor)**
2. Has your search of this arrestee uncovered any dangerous contraband such as drugs or weapons? **(If yes, refer to custody supervisor)**
3. Has this arrestee attempted to allude or escape from custody? **(If yes, refer to custody supervisor)**
4. Are you aware of the need to keep this arrestee separated from other persons housed in this facility? **(If yes, refer to custody supervisor)**
5. Are you aware of this arrestee's consumption or use of potentially dangerous level of alcohol or drugs? **(If yes, refer to medical)**
6. Are you aware of any acute medical condition or injury recently sustained by this arrestee that may require immediate medical attention? **(If yes, refer to medical)**
7. Has this arrestee demonstrated any behaviors that might suggest mental illness? **(if yes, call the crisis line)**
8. Has this arrestee demonstrated any behaviors that might suggest mental retardation? **(If yes, refer to custody supervisor)**
9. Has this arrestee demonstrated any behaviors that might suggest acquired brain injury? **(If yes, refer to medical)**
10. Has this arrestee demonstrated any behaviors that might suggest suicidal tendencies? **(If yes, call the crisis line)**
11. Has there been any indication that the arrestee is reacting so negatively toward their charge that they may engage in self harming behavior? **(If yes call the crisis line.)**
12. Do you have any other information that may assist this agency in the care and/or custody of this arrestee?

Jail Officers Assessment Questions

13. Are there any institutional alerts on file for this arrestee? **(alerts for mental health, suicidal, call the crisis line)**
14. Is there a need for an immediate evaluation of this arrestee by health care staff or a custody supervisor? **(If yes, refer to the appropriate person)**

Inmate Booking Screening Questions

1. Do you have a serious medical condition that may require attention while you are here? **If yes, refer to medical staff**
2. Are you currently taking a prescription medication that may need continuation while you are here? **If yes, refer to medical staff**
3. Do you have a serious mental health condition that may need attention while you are here? **If yes, call crisis line**
4. Have you recently taken or been prescribed medication for emotional problems? **If yes, refer to medical staff**
5. Have you been hospitalized for emotional problems within the last year? **If yes, call crisis line**
6. Have you ever attempted suicide? **If yes, call crisis line.**
7. Are you currently thinking about suicide? **If yes, call crisis line**
8. Have you recently ingested potentially dangerous levels of drugs and alcohol? **If yes, refer to medical staff**
9. Have you ever experienced DTs or other serious withdrawal from drugs or alcohol? **If yes, refer to medical staff**
10. Have you ever had a closed head injury that resulted in permanent disability? **If yes, refer to medical staff**
11. Do you have learning or other disability that will impact your ability to understand instructions while you are here? **If yes, refer to custody supervisor.**
12. Are you aware of any reason you should be separated from another inmate while you are here? **If yes, refer to custody supervisor.**
13. Have you ever required separation from another inmate while incarcerated in another facility? **If yes, refer to custody supervisor.**
14. Do you understand that you may request a health care provider at any time while you are here?
15. Have you understood all the questions that I have asked you? **If no, refer to custody supervisor.**
16. Have you provided us with all the information that you want us to be aware of while you are here?

Questions for the Booking Screening Officer

17. Does the screening officer feel that the arrestee is capable of understanding all the questions asked? **If no, call the crisis line if related to mental health, suicide, MR, ABI or in combination with substance abuse.**
18. Does this arrestee have any institutional history of alerts? **Call the crisis line if the alerts are related to mental health, suicidal, MR, or ABI. Notify custody supervisor or medical staff for other alerts**
19. Does this screening officer feel that his arrestee should be referred to a supervisor for review? **If yes, notify immediately.**
20. Is there any indication that the arrestee is reacting so negatively toward their charge that they may engage in self harming behavior? **(If yes call the crisis line.)**

AN ACT relating to services for individuals with brain injuries or malfunctions and making an appropriation therefor.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

Section 1. KRS 189A.050 is amended to read as follows:

- (1) All persons convicted of violation of KRS 189A.010(1)(a), (b), (c), or (d) shall be sentenced to pay a service fee of three hundred twenty-five~~two hundred fifty~~ dollars (\$325)~~(\$250)~~, which shall be in addition to all other penalties authorized by law.
- (2) The fee shall be imposed in all cases but shall be subject to the provisions of KRS 534.020 relating to the method of imposition and KRS 534.060 as to remedies for nonpayment of the fee.
- (3) The revenue collected from the service fee imposed by this section shall be utilized as follows:
 - (a) Twelve~~Fifteen~~ percent (12%)~~(15%)~~ of the amount collected shall be transferred to the Kentucky State Police forensic laboratory for the acquisition, maintenance, testing, and calibration of alcohol concentration testing instruments and the training of laboratory personnel to perform these tasks;
 - (b) Twenty~~Twenty-five~~ percent (20%)~~(25%)~~ of the service fee collected pursuant to this section shall be allocated to the Department of Public Advocacy;
 - (c) One percent (1%) shall be transferred to the Prosecutor's Advisory Council for training of prosecutors for the prosecution of persons charged with violations of this chapter and for obtaining expert witnesses in cases involving the prosecution of persons charged with violations of this chapter or any other offense in which driving under the influence is a factor in the commission of the offense charged;

(d) Sixteen percent (16%) of the amount collected shall be transferred as follows:

1. Fifty percent (50%) shall be credited to the Traumatic Brain Injury Trust Fund established under KRS 211.476; and
2. Fifty percent (50%) shall be credited to the Cabinet for Health Services, Department for Mental Health and Mental Retardation Services, for the purposes of providing direct services to individuals with brain injuries that may include long-term supportive services and training and consultation to professionals working with individuals with brain injuries. As funding becomes available under this subparagraph, the Cabinet may promulgate administrative regulations pursuant to KRS Chapter 13A to implement the services permitted by this subparagraph.

(e) Any amount specified by a specific statute shall be transferred as provided in that statute; ~~and~~

~~(f)(e)~~ Forty-six percent (46%) of the amount collected shall be transferred ~~to~~ ~~The remainder of the service fee shall~~ be utilized to fund enforcement of this chapter and for the support of jails, recordkeeping, treatment, and educational programs authorized by this chapter and by the Department of Public Advocacy; and

(g) The remainder of the amount collected shall be transferred to the general fund.

(4) The amounts specified in subsection (3)(a), (b), ~~(c), and~~ (c), and (d) of this section shall be placed in trust and agency accounts that shall not lapse.

SECTION 2. A NEW SECTION OF KRS CHAPTER 210 IS CREATED TO

READ AS FOLLOWS:

(1) As used in this section:

- (a) "Prisoner" has the same meaning as set out in KRS 441.005; and
- (b) "Qualified mental health professional" has the same meaning as set out in KRS 202A.011.
- (2) The Cabinet for Health Services shall create a telephonic behavioral health jail triage system to screen prisoners for mental health risk issues, including suicide risk. The triage system shall be designed to give the facility receiving and housing the prisoner an assessment of his or her mental health risk, with the assessment corresponding to recommended protocols for housing, supervision, and care which are designed to mitigate the mental health risks identified by the system. The triage system shall consist of:
- (a) A screening instrument which the personnel of a facility receiving a prisoner shall utilize to assess inmates for mental health, suicide, mental retardation, and acquired brain injury risk factors; and
- (b) A continuously available toll-free telephonic triage hotline staffed by a qualified mental health professional which the screening personnel may utilize if the screening instrument indicates an increased mental health risk for the assessed prisoner.
- (3) In creating and maintaining the telephonic behavioral health jail triage system, the cabinet shall consult with:
- (a) The Department of Corrections;
- (b) The Kentucky Jailers Association;
- (c) The Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses; and
- (d) The regional community mental health and mental retardation services programs created under KRS 210.370 to 210.460.
- (4) The cabinet may delegate all or a portion of the operational responsibility for the

triage system to the regional community mental health and mental retardation services programs created under KRS 210.370 to 210.460 if the regional program agrees and the cabinet remains responsible for the costs of delegated functions.

(5) The cabinet shall design into the implemented triage system the ability to screen and assess prisoners who communicate other than in English or who communicate other than through voice.

(6) The cost of operating the telephonic behavioral health jail triage system shall be borne by the cabinet.

(7) Records generated under this section shall be treated in the same manner and with the same degree of confidentiality as other medical records of the prisoner.

(8) Unless the prisoner is provided with an attorney during the screening and assessment, any statement made by the prisoner in the course of the screening or assessment shall not be admissible in a criminal trial of the prisoner, unless the trial is for a crime committed during the screening and assessment.

(9) The cabinet may, after consultation with those entities set out in subsection (3) of this section, promulgate administrative regulations for the operation of the telephonic behavioral health jail triage system and the establishment of its recommended protocols for prisoner housing, supervision, and care.

SECTION 3. A NEW SECTION OF KRS CHAPTER 441 IS CREATED TO READ AS FOLLOWS:

Every prisoner upon admittance to detention shall be screened for mental health risk issues, including mental illness, suicide, mental retardation, and acquired brain injury, by the personnel of the facility in which facility the prisoner is detained. Facilities have the discretion of using the telephonic behavioral health jail triage system created in Section 2 of this Act. Where the triage system indicates levels of behavioral health risk, the facility holding the prisoner may consider implementing the recommended protocols for housing, supervision, and care delivery that match the level of risk.

SECTION 4. A NEW SECTION OF KRS CHAPTER 23A IS CREATED TO READ AS FOLLOWS:

In addition to the twenty dollar (\$20) fee created by 2004 Ky. Acts ch. 78, sec. 1, in criminal cases a five dollar (\$5) fee shall be added to the costs imposed by KRS 23A.205 that the defendant is required to pay. The fees collected under this section shall be allocated to the Cabinet for Health Services for the implementation and operation of a telephonic behavioral health jail triage system as provided in Sections 2 and 3 of this Act.

SECTION 5. A NEW SECTION OF KRS CHAPTER 24A IS CREATED TO READ AS FOLLOWS:

In addition to the twenty dollar (\$20) fee created by 2004 Ky. Acts ch. 78, sec. 2, in criminal cases a five dollar (\$5) fee shall be added to the costs imposed by KRS 24A.175 that the defendant is required to pay. The fees collected under this section shall be allocated to the Cabinet for Health Services for the implementation and operation of a telephonic behavioral health jail triage system as provided in Sections 2 and 3 of this Act.

Section 6. The moneys received from the fines levied under subparagraphs 1. and 2. of paragraph (d) of subsection (3) of Section 1 of this Act are hereby appropriated for the purposes provided in those subparagraphs.



Law and Justice Interim Committee
61st Montana Legislature

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June 18, 2010

TO: Law and Justice Interim Committee
FROM: David S. Niss, Staff Attorney
RE: MSPOA Peer Review Program

I
Introduction

Based on a request by Representative Ebinger¹, the Law and Justice Interim Committee has asked for a report on the jail "peer review" program conducted by the Montana Sheriffs and Peace Officers Association (MSPOA)² (Rep. Ebinger was the sponsor of HB 60 in the 61st Legislature [Attachment A], creating a jail suicide prevention pilot program). The purpose of this memorandum is to present the status of the peer review program in context with other information about jail suicides obtained this legislative interim and last.

II
Discussion

a. Method of inquiry

The method of inquiry that forms the basis for this staff report was to first ask the MSPOA for a report on the status of the peer review program³ and, after the MSPOA report was received, to ask followup questions based upon the MSPOA response. All inquiries were made exclusively by e-mail in order to document the questions and responses. Unfortunately, this report is unfinished because of a lack of information and because the results of the peer reviews

¹Representative Ebinger made his oral request at the Law and Justice Interim Committee meeting on December 18, 2009, which was subsequently approved by the presiding officer of the LJIC, Representative Augare.

²This memo uses the shorthand "MSPOA" to refer to the several organizations that developed the Montana voluntary jail standards and those that conducted the peer reviews to determine compliance with the standards. These organizations are the MSPOA, the Montana Association of Counties, and the Montana Municipal Interlocal Authority.

³LJIC staff e-mail of February 16, 2010 to Dennis McCave, included in Attachment B. All staff e-mails and MSPOA responses, including attachments, are at Attachment B.

that have been done have not been made available to the Committee staff.⁴

b. Method of the peer review of jails by MSPOA

Responses by the MSPOA to the LJIC staff inquiries indicate the following method of peer review by the MSPOA:

(1) The voluntary jail standards of the MSPOA⁵ are divided into "core" and "noncore" standards, with "core" standards shown in the voluntary standards in bold print. There are approximately 113 numbered "core" standards of apparently equal weight or importance, "core" standards being those standards required by "law, ARMS, case law, professional standards."⁶ However, five of the six reviews conducted by the time of preparation of this memorandum have been "training" reviews in which only three chapters of the core standards were used for the review. These chapters were Chapters 1 (Administration), 7 (Security and Control), and 11 (Health Care Services).⁷ The MSPOA has cautioned that these "training" reviews are not to be considered full reviews.⁸

(2) For each of the 113 numbered "core" standards, the MSPOA has developed a check sheet listing the numbered standard, several "bullet points" by which compliance with the numbered standard is to be determined, including interviews with certain personnel, and a place for the reviewer to score the facility as "Compliant", "Partial compliance", "Non-compliant", or "Not applicable". Attachment C, for example is the exact scoring page to be used to determine compliance with standard number 09.07, requiring that accurate records be maintained of all meals served to inmates.

(3) The MSPOA also uses an interview form in the peer review process, specifying that certain questions be asked of the jail's staff in order to gauge compliance with any core standard. Attachment D, for example, shows the question to be asked the jail staff to help determine compliance with standard 09.07 above.

⁴The response to the staff's initial inquiry on February 16, 2010, by the MSPOA lacked detail, lacked a response to all of the staff's questions, and lacked any mention of peer reviews other than those undertaken in 2008, therefore necessitating additional staff e-mails to the MSPOA. The staff e-mails of June 7, 8, and 10 (Attachment B) to Capt. Jerome McCarthy were not answered by the time of preparation of this memorandum, other than by his e-mail on June 10, 2010, explaining that the e-mails of June 7, 8, and 10 would not be replied to until after an MSPOA committee meeting sometime during the week of June 20 (Attachment B).

⁵Montana Detention/Jail Standards for Detention and Holding Facilities, Fourth Edition, Revised September 2006.

⁶Id.

⁷See Response to Question #1, paragraph 2, "Montana Peer Review Information May 2010" (Attachment B).

⁸See Response to Question #3, Montana Peer Review Information May 2010 (Attachment B).

(4) By the date of this memorandum, the MSPOA had responded to staff inquiries stating that six jails had been the subject of a peer review on a training or non-training basis, those facilities being the jails in Custer, Cascade, Park, Butte-Silver Bow, Lewis and Clark, and Valley Counties. Of these, only Valley County had a "non-training" review. As explained, by the time of this memorandum, the MSPOA had responded that for three of the counties that received a training review, those counties had only been reviewed for compliance with the "core" standards in Chapters 1 (Administration), 7 (Security and Control), and 11 (Health Care Services). It is assumed, therefore, that the two remaining counties reported on June 4, 2010, Lewis and Clark and Butte-Silver Bow, for which training reviews were done have also been reviewed only for compliance with those three chapters. Of these chapters, Chapters 7 and 11 are particularly important to this study of the peer review program because they contain the core frequency of observation standard (standard 07.01, requiring observation, or a "cell check", of all inmates every 30 minutes) and the core requirement for suicide and, to some extent, mental health screening (standards 11.04, 11.10 and 11.11).

(5) The reviews were conducted by a team of three detention officers and detention administrators. An exit interview with the sheriff was also conducted upon completion of the review. Following the exit interview, the MSPOA sent a disk to the sheriff of the reviewed facility containing the written results of the review.⁹

c. Results of peer review program

The results of the peer review program are not yet known. The only access to those results will be by making a request to each individual sheriff as those peer reviews occur. Committee staff has requested assistance from MSPOA for this purpose.¹⁰ Because MSPOA has chosen to respond to staff inquiries by committee and because that committee had not met by the time this memorandum was prepared, that assistance in contacting individual sheriffs' offices has not yet been received.

d. Staff concerns about the peer review program

There are some very good things about the peer review program: principally, the program has begun, the MSPOA began appropriately by training the reviewers, and that training work started at a manageable level using only the core standards. However, those positive aspects of the program do not in any way decrease staff concerns about the review program, discussed below, especially in light of the suicides in county jails in 2009. MSPOA will be relied upon to more thoroughly discuss before the Committee the positive aspects of the peer review

⁹Montana Jail Standards Peer Review Advisory Committee Memorandum of Understanding April 5, 2010 (Attachment B).

¹⁰Committee staff e-mail of June 8, 2010 (Attachment B).

program. This report addresses only those aspects of the peer review program that (1) address suicide prevention because that is the context in which the LJIC 2007-2008 study of jail standards and House Bill 60 arose and (2) may need further legislative attention of some type. The staff concerns are as follows:

(1) This staff study is unfinished in that it does not present the results to date of any of the peer reviews conducted by the MSPOA peer review program.

As previously noted, the MSPOA has declined the staff request for copies of the reviews provided to sheriffs, citing its policy that only sheriffs may distribute the completed reviews. Committee staff has therefore asked the MSPOA for assistance in contacting sheriffs, but that assistance was yet to be received at the time of preparation of this memorandum.

(2) The number of jail suicides has not abated.

The 2008 final report of the LJIC noted that 14 jail inmates committed suicide between 2003 and 2007, resulting in a rate of just under 3 suicides per year, or a rate of suicides per 100,000 inmates (the method used by the U.S. Department of Justice for comparing the states) that is approximately five times the national average for jail suicides.¹¹ In 2009, there were four suicides in Montana county jails. These were as follows: Mr. Eric Jones (Hill County Jail) on February 27, 2009; Mr. August Whitedirt (Sanders County Jail) on April 9, 2009; Mr. Richard Newville (Park County Jail) on July 7, 2009; and Mr. Clifford Grandbois (Cascade County Jail) on December 30, 2009. Three of these suicides were by hanging by jail-issued bed sheets.¹²

(3) There is no method in the review program for testing sheriffs and detention personnel for a complete commitment to a zero tolerance policy for jail suicides.

The National Center on Institutions and Alternatives (NCIA) is a major contractor with the U.S. government concerning suicides in county jails. NCIA is the contractor with the U.S. Department of Justice, National Institute of Corrections (NIC), for measuring the number of county jail suicides, reporting those suicides on a national basis, and studying and reporting on ways to reduce the risk of jail suicides. In 1981 and 1986, the NIC published often-cited national reports on county jail suicides. The NCIA and NIC have now updated those previous two studies with a new study of jail suicides, the National Study of Jail Suicide, 20 Years Later

¹¹Diverting the Mentally Ill from the Justice System and Providing Involuntary Commitment Alternatives, A Report to the 61st Legislature From the Law and Justice Interim Committee, Office of Research and Policy Analysis, Legislative Services Division (January 2009), p. 17.

¹²Transcripts of Coroners' inquests regarding the suicides of Clifford Wayne Grandbois, Eric James Jones, and August C. Whitedirt. Many of the concerns raised in this memorandum would be academic if inmates didn't continue to commit suicide and, in 2009, to do it so often with instruments issued by the county jails. This number of Montana suicides by use of jail bedding appears greater than the national average, which has now been reported to be the means of suicide in 66.4% of the suicides reported and studied on a nationwide basis in the National Study of Jail Suicide, 20 Years Later (National Study), National Institute of Corrections, U.S. Department of Justice (April 2010).

(National Study), National Institute of Corrections, U.S. Department of Justice (April 2010).¹³ The NIC also previously funded for 20 years the NCIA monthly newsletter, Jail Suicide/Mental Health Update (Update), distributed free of charge to correctional and health care administrators.

Several times, the Update has published articles stressing that jail staff must be actively committed to a philosophy that does not tolerate any suicides.

In 2005, an Update contained the story of a suicide death in the Orange County Jail in Santa Ana, California and the attitude of the administrator of that jail, the now deceased Lieutenant Jarvis. The Update stated:

In January 2004, a 38-year-old male inmate committed suicide by hanging in the Central Men's Jail. It marked the first suicide in the Orange County Jail system in four years and over 250,000 admissions. Despite this death, the Orange County Sheriff's Department certainly exemplifies the best in suicide prevention programming. The immense size of the jail system does not impede the proper identification, referral and management of inmates at risk for suicide. When asked in 1998 to address the view held by many jail administrators throughout the country that inmate suicides simply cannot be prevented, the late Lieutenant Jarvis responded without hesitation: "When you begin to use excuses to justify a bad outcome, whether it be low staffing levels, inadequate funding, physical plant concerns, etc. — issues we also struggle with each day — you lack the philosophy that even one death is not acceptable. If you are going to tolerate a few deaths in your jail system, then you've already lost the battle.

In 2007, Mr. Lindsay Hayes, the Project Director of NCIA, wrote:

Experience has shown that negative attitudes often impede meaningful suicide prevention efforts. These obstacles to prevention often embody a state of mind that unconditionally implies that inmate suicides cannot be prevented (e.g., "If someone really wants to kill themselves there's generally nothing you can do about it" and/or "We did everything we could to prevent this death, but he showed no signs of suicidal behavior," etc.)

In 2010, an Update introduced the National Study with the following language:

With strong data to indicate that suicides can be prevented, [Lindsay] Hayes emphasized that "the antiquated mindset that 'inmate suicides cannot be prevented' should forever be put to rest."

The voluntary standards contain no standard regarding the commitment of jail administrators or other detention staff members to a philosophy of zero tolerance for jail suicides. It's likely that for this reason, there is no measurement in the peer reviews of the commitment of

¹³This study is believed to be the most recent national study of jail suicides done for the federal government, containing statistically based recommendations for the content and implementation of jail suicide prevention programs.

jail administrators or other staff to a zero tolerance standard.¹⁴

(4) There is no standard and therefore no review for use of suicide bedding. There is no standard for use of suicide clothing and review is therefore perfunctory unless a written suicide prevention plan requires their use.

Suicide clothing and bedding are not mentioned in the voluntary standards that serve as the basis for the peer review program. Standard 11.12 does require that each sheriff have a "written suicide prevention program" in place, which the sheriff might write to include the use of suicide clothing or bedding, and requires that the plan be approved by the facility's "qualified medical or mental health professional". However, there are no criteria in standard 11.12 that the medical professional, or a reviewer in the peer review program, may use to gauge the quality or effectiveness of that written suicide prevention program.¹⁵ The content of the suicide prevention program is therefore left to the training and experience of the qualified professional.

One of the interview questions to be asked pursuant to this standard is whether the facility uses suicide smocks, but because there is no standard requiring their use in any instance, a "no" answer appears to be just as acceptable as a "yes" answer, unless the written suicide prevention plan requires their use.

(5) There is no standard and therefore no review for the use of a suicide profile of the victim or the incident.

The NCIA has described the use of a suicide profile for a jail, containing the characteristics of the victim, but which also might include the characteristics of the suicide event, as "an important part" of jail suicide prevention.¹⁶ However, the NCIA appropriately cautions that the profiles, like suicide clothing and bedding, should not be relied on as a type of "quick fix".¹⁷ However, there is no standard in the voluntary standards for, and therefore no peer review for the use of, suicide profiles at all for the suicide incident, such as the fact that three of

¹⁴This is not to say that any detention staff don't care about jail suicides. They do care. This is only to say that there is no apparent standard requiring a commitment to a zero tolerance philosophy for jail suicides.

¹⁵The reliance upon a written suicide prevention program approved by a qualified medical or mental health professional (standard 11.12), policies and procedures regarding mental health services approved by a the facility medical authority, to include suicide screening (standard 11.04), and a suicide screening form approved by the facility medical authority (standard 11.10) might, given Montana's lack of physicians or other trained personnel in sparsely populated areas, be a major weakness in the voluntary standards. Finding a physician or other medical personnel trained and experienced in suicide prevention policies, programs, screening, and screening instruments or forms for detention facilities in sparsely populated areas, so that the approval of the suicide prevention policy and procedures and the screening form is meaningful approval, would be an even larger task. Additionally, portions of these standards are unclear as to what they require or allow and need to be rewritten. It's unclear, for example, how a detention staff member knows an individual is "suicide prone" so that the staff member knows to administer the screening instrument.

¹⁶National Study, p. 3.

¹⁷Several authors have commented that the results of a suicide profile of the victim should not be used as a "death certificate" for inmates who fit the profile but the profile must be used in conjunction with other suicide prevention tools. National Study, p. 4.

the four of 2009 suicides were committed by hanging with jail-issued bed sheets¹⁸, or of the victim. A suicide profile of Montana victims would show, if the National Study is reflective of Montana victims, that victims do not always suffer from mental illness but may feel ashamed, trapped, and desperate.¹⁹

(6) There is no standard and therefore no review for the content of ongoing suicide prevention training.

Standard 04.01, requiring a written training plan for the staff, and standard 04.03, requiring ongoing training for staff, were not used for training inspections but will be used in full operational inspections such as the one already completed in Valley County.²⁰ However, the standard for ongoing training lacks detail in its requirements.²¹ There are organizations that publish detailed guides for staff training in suicide prevention. One such organization is the NCIA that publishes both components of a successful ongoing suicide training program and a step-by-step guide for such a program.²² The NCIA and NIC recommend that initial staff training be followed by at least two hours of refresher training every year and that the refresher training include "obstacles to prevention, research, why correctional environments are conducive to suicidal behavior, potential predisposition factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, guiding principles to suicide prevention, components of an effective suicide prevention policy, critical incident staff debriefing, and liability issues."²³ The National Study now also recommends that the yearly two-hour refresher training also include any changes to the jails suicide policies and protocols and that the ongoing training discuss any recent suicides.²⁴ There is no mention of any of these topics in the training required by the voluntary standard because the standards contain no minimums at all for suicide prevention training programs. A revised standard to include some detail for a suicide prevention ongoing training program would give peer reviewers a more meaningful standard against which to judge a sheriff's ongoing suicide prevention training. Standard 11.12 requires a written suicide prevention program approved by a qualified medical or mental health professional. That program might be written to include an ongoing training program, but there are no criteria in the standard by which that medical or mental health professional might judge the effectiveness of the training program. The effectiveness of the written suicide prevention program, including the training plan, would therefore depend upon the

¹⁸See note 11.

¹⁹Id., pp. 1, 17, and 45.

²⁰MSPOA e-mail of June 4, 2010, response number 4.

²¹The standard requires "40 hours of training each year...[t]opics include...suicide precautions".

²²The NCIA lists the components of staff training as well as material for a staff training program on its website at www.ncianet.org. While somewhat dated, the actual training program provides a great deal of detail, including various slides to be used in presentations. These could be used as a basis for a more detailed standard for a jail suicide prevention training program or as a basis for an actual program.

²³Key Components of a Suicide Prevention Program, Hayes, National Center for Institutions and Alternatives (2007); National Study, p. 48.

²⁴National Study, p. 48.

training and experience of the medical or mental health professional in suicide prevention training plans because there are no objective standards by which the plan can be judged.²⁵

(7) There is a lack of detail in the standards and therefore in the review program about the content of suicide screening instruments.

Standards 11.04f and 11.10d require that jails have written policies and procedures approved by the medical authority that must include screening of suicide-prone inmates and that the findings are recorded on a form approved by the medical authority. However, the standards specify only a very minimal content regarding the policies and procedures and for the screening program, instrument, or form.²⁶ This lack of detail has led to the use of widely differing screening instruments.²⁷ What is remarkable is not that the current standards for suicide screening and suicide screening instruments result in differences between jails, but that the differences between those instruments are so great. This result may continue because there is very little in the voluntary standard that the reviewers may rely upon to specify the minimum content of the screening policy, procedure, and forms, except that they must be approved by the facility medical authority.²⁸ However, there's little in the standards that the medical authority may rely on to approve the policy and procedures regarding screening for suicide and for approving the screening instrument or form. The ability of the screening instrument to detect potential suicides therefore depends upon the training and experience of the medical authority in jail suicide prevention policies and procedures and in jail suicide prevention screening devices.²⁹

About suicide screening in general, the NCIA states:

[Suicide screening] should include inquiry regarding: past suicide ideation and/or attempts; current ideation, threat, plan; prior mental health

²⁵Regarding the effectiveness of the program or meaningfulness of the approval, see footnote 14.

²⁶Standard 11.04f provides: "The written policies and procedures shall address, at a minimum, the following: f. Screening, referral, and care of the mentally ill, suicide-prone, and disabled inmates." Standard 11.10d, e, and i provide: "The medical screening includes, at a minimum, the following: Inquiry into: d. Past or present treatment or hospitalization for mental disturbance or suicidal behavior. e. mental illness. Observation of: * * * * i. Behavior, including state of consciousness, mental status..."

²⁷In the previous interim, the LJIC and the MSPOA conducted a survey regarding suicide prevention in county jails. As part of that survey, the Committee received copies of widely differing screening devices which, although they had not been through the peer review process, demonstrate the sheriffs' widely differing interpretations of exactly the same standards in the voluntary standards for screening devices. For example, of the 17 responding counties, eleven of which stated they used "suicide screening forms", one Inmate Medical Screening Form asked only one question directly related to suicide prevention: "Does the inmate's behavior suggest risk of suicide?" By contrast, the Mineral County Sheriff's Office submitted the Mineral County Sheriff's Office Detention Facility Suicide Screening For Inmates that asks numerous questions about mental state, past attempts at suicide, previous mental health treatment, the suffering of significant personal losses, etc.

²⁸Regarding approval by the facility medical authority, see footnote number 14.

²⁹Ibid.

treatment/hospitalization; recent significant losses (job, relationship, death of family member/close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; and arresting officer/transporting officer(s) belief that inmate is currently at risk.

The NIC and NCIA now also strongly recommend that suicide screening determine whether an inmate was under any suicide precautions during any previous confinement and recommend that a series of nine specific determinations be made about the inmate during the screening process.³⁰

The foregoing recommendations, perhaps used in conjunction with another validated and standardized test for depression that requires no training in psychology to administer, such as the Beck Depression Inventory (Attachment E),³¹ could be used as the basis for a revised jail suicide screening standard so that peer reviewers would have a more detailed and therefore more meaningful and effective standard against which to review a sheriff's jail suicide screening instrument.

(8) All of the standards are voluntary standards with no apparent sanction for not adhering to those standards, and therefore peer review may cause no change in inappropriate or unconstitutional facilities, policies, or practices.

In the initial staff inquiry of February 16, 2010, the staff queried the MSPOA what the result was of a failure to abide by the voluntary standards. MSPOA responded by stating "No follow up has been done at this time to determine what effect the peer reviews have had in regards to suicide prevention." Taken at face value, this statement means that there was no followup to see if any sheriff changed his or her policies, forms, or practices after completion of a peer review, exit interview, and receipt of the results of the review.³² While the staff appreciates the fact that most of the peer reviews conducted to date were "training" reviews, failure of a sheriff to follow the MSPOA voluntary standards, especially a core standard, even

³⁰National Study, p. 48. These nine determinations that should be made by use of the jail screening instrument are:

- (1) Was the inmate a medical, mental health, or suicide risk during any prior contact and/or confinement in this facility?
- (2) Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates the inmate is currently a medical, mental health, or suicide risk?
- (3) Has the inmate ever attempted suicide?
- (4) Has the inmate ever considered suicide?
- (5) Is the inmate being treated for mental or emotional health or emotional problems, or has the inmate been treated in the past?
- (6) Has the inmate experienced a significant loss (e.g., relationship, death of family member or close friend, job)?
- (7) Does the inmate feel there is nothing to look forward to in the immediate future (i.e., is the inmate expressing helplessness and/or hopelessness)?
- (9) Is the inmate thinking of hurting/or killing himself or herself?

³¹The National Study reports that most "inmates with mental illness who later committed suicide suffered from depression or psychosis." National Study, p. 17.

³²These components are part of the peer review process. Montana Jail Standards Peer Review Advisory Committee Memorandum of Understanding April 5, 2010 (Attachment B).

after a training review, might contribute to jail suicides.³³ For example, the Cascade County jail used its own standard, both before and after³⁴ its MSPOA training review, for cell checks that required a cell check only every hour instead of every 30 minutes as voluntary standard 07.01 requires. At the end of that one-hour period cell check, Mr. Grandbois was found hanging in his jail cell. However, there is evidence suggesting that even the county's own one-hour standard for cell checks, used by Cascade County notwithstanding the 30-minute check required by standard 07.01, may not have been followed.³⁵ Whether compliance with the MSPOA standard for 30-minute cell checks after the peer review and before the suicide could have saved Mr. Grandbois will probably never be known.

III Conclusion

As previously stated, this report deals mostly with the manner in which peer reviews are being and will be conducted by the MSPOA and with staff concerns about weaknesses in the peer review program, leaving it to the MSPOA to discuss positive aspects of the program that will likely not require further legislative review or legislative direction. The conclusions that can be drawn at this point in the review program are as follows:

(1) There is no priority among the core standards and therefore in the peer review program that emphasizes suicide prevention, as opposed to, for example, application of core standard 09.07 to record meals fed to prisoners. This lack of emphasis or priority on keeping prisoners alive is unfortunate in light of the resources readily available in national studies and reports that would assist in making that emphasis and is underscored by continuing suicides in Montana county jails in 2009, in which most victims used jail-issued instruments to cause their death.

(2) There are and will be weaknesses in the peer review program that to an extent are caused by weaknesses in the voluntary standards, such as a lack of detail in the standard's requirements for ongoing suicide prevention training, use of suicide bedding or clothing, and suicide screening instruments. This lack of detail results in weaker standards and peer review for training, use of suicide garments and bedding, and screening, unless more detailed provisions have been required as part of the facility suicide plan approved by the medical or mental health professional or by the facility medical authority, a standard that is problematic in Montana and may itself benefit from further staff review.

(3) The standards are voluntary standards and the sheriffs must be depended upon for voluntary compliance. In at least one instance, a suicide occurred in a facility that failed to voluntarily comply with an important core standard both before and after a training peer review and was failing to comply with that voluntary core standard (for 30-minute cell checks) at the time the suicide was discovered.

(4) There is a range of responses that the Committee may take in reaction to this report, including:

(a) do nothing;

³³Of course, the failure of a jail to follow one of the core standards whether or not there has been a peer review may contribute to the cause of a suicide.

³⁴The MSPA training peer review for Cascade County occurred on July 11, 2008.

³⁵Transcript of coroner's inquest into the death of Mr. Clifford Grandbois, pp. 82, 89.

(b) instruct the staff to followup on the peer review program and report again to the Committee. That followup could include the staff's pending questions with MSPOA, the results of the peer reviews completed to date, inquiry into the reliance upon medical authority for approval of suicide prevention programs and suicide screening and screening forms, or further inquiry into the detail in the voluntary standards as a basis for peer review generally and in compliance determination and interview questions.

(c) request and consider a draft study resolution concerning any aspect of the voluntary standards or the peer review program based upon those standards;

(d) request and consider draft legislation requiring that sheriffs have available suicide clothing and/or bedding at a time and in a manner determined by some other body such as the Board of Crime Control or the Department of Public Health and Human Services (DPHHS);

(e) request and consider draft legislation requiring that suicide screening devices contain some questions designed to determine if the inmate is depressed or require that screening devices be approved by, or given for comment to, some other body such as DPHHS or the psychiatric staff of the Montana State Hospital (note that while any of these agencies may not have experience in the subject matter, they could become experienced and the centralization for review of screening devices would thereby benefit all of the counties);

(f) request and consider draft legislation requiring that suicide prevention programs be approved by, or given for comment to, some other body such as Board of Crime Control, DPHHS, or the psychiatric staff of the Montana State Hospital (also see note to alternative (e) above);

(g) request and consider draft legislation requiring sheriffs to report on and circulate to other sheriffs suicide profiles of prisoners and incidents through some other body such as the Board of Crime Control;

(h) request and consider legislation requiring some other body such as the Board of Crime Control to study and adopt standards for timing of cell checks for some jails or requiring the sheriffs to submit the same standards to that body for review and comment; and

(i) request and consider legislation to provide that in any system of voluntary standards used for the purposes of inspection of jails that the voluntary inspection system place the most emphasis on those standards applicable to prevention of inmate suicides.

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