McLean County, IL
Sheriff's Detention Facility

JAIL MENTAL HEALTH ASSESSMENT

"Options & Opportunities"

Technical Report #13J1032
January 6, 2013

Mike Emery, Sheriff
Bloomington, IL

Kenneth A. Ray, M.ED.
Technical Consultant

United States Department of Justice
National Institute of Corrections
Jails Division Technical Assistance Project 13J1032
Washington, DC

Technical Assistance Report

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December January 6, 2013

NIC Technical Assistance Request No. 13J1032

Kenneth A. Ray, M.ED, Technical Service Provider

DISCLAIMER

RE: NIC Technical Assistance No. 13J1032

This technical assistance activity was funded by the Jails Division of the National Institute of Corrections. The Institute is a Federal agency established to provide assistance to strengthen State and local correctional agencies by creating more effective, humane, safe and just correctional services.

The resource person who provided the onsite technical assistance did so through a cooperative agreement, at the request of the McLean County, Illinois Sheriff and through the coordination of the National Institute of Corrections. The direct onsite assistance and the subsequent report are intended to assist the agency in addressing issues outlined in the original request and in efforts to enhance the effectiveness of the agency.

The contents of this document reflect the views of Mr. Kenneth Ray. The contents do not necessarily reflect the official views or policies of the National Institute of Corrections.

CONSULTANT QUALIFICATIONS

Kenneth A. Ray, M.Ed., LMHC, NCC

The United States Department of Justice National Institute of Corrections assigned to Kenneth A. Ray this short-term technical assistance project at the specific request of County officials following a review of prospective qualified consultants.

Ken is a national expert in correctional administration, policy, and operations with more than 35 years of experience in law enforcement, corrections, security, criminal justice administration, behavioral health and consulting. He retired from county government administration in 2005 following a very successful and productive 29-year career serving in many professional and community positions including deputy sheriff, police officer and supervisor, law enforcement administrator and director; criminal justice academy director, emergency management director, jail administrator and director of medium and large county jail systems, community leader and volunteer; and has earned several local, state, and national accolades for his work in public safety, criminal justice, community and youth wellness. Ken is also a licensed mental health primary care provider and Board Certified by the National Board for Certified Counselors.

His expertise in jail mental health and suicide prevention practices and facility design has provided pivotal assistance to numerous mega, large, medium, and small jails throughout the United States. More recent projects include Dallas County, TX (8500 beds), Lake County, IN (1050 beds) St. Croix and Chippewa Counties, WI (500 beds combined) Onondaga County, NY (1000 beds), and Porter County, IN (450 beds). Ken has served as the lead compliance consultant for a Federal Jail Civil Rights Settlement Agreement at Lake County, IN since late 2010. He is the County's Liaison to the United States Department of Justice Civil Rights Division and compliance assurance coordinator. There he leads a team of national experts in the fields of correctional medicine, suicide prevention, life and fire safety, sanitation, and use of force to assist in ensuring compliance and rapid dismissal of the federal order.

Ken holds a M.Ed. in Counseling and Human Development, Bachelors and Associates degrees in Criminal Justice and Law Enforcement, and is currently pursuing a Doctorate in Behavioral Health at Arizona State University's Graduate School of Letters and Sciences. His work in mental health spans the entire length of his professional career including developing and implementing school based behavioral health services, forensic assessment and counseling, jail-based mental health services, residential and out-patient clinical primary care of individuals, families, children, and groups. He has in excess of 4000 hours professional development training, and has completed academic residencies and internships in metropolitan police administration, community policing, psychiatric prison inmate assessment and treatment, jail-based mental health services, pediatric health diagnosis and treatment, and community mental health. As an adjunct professor at public and private universities in Texas and Washington states, Ken taught graduate and undergraduate courses in criminal justice, business administration, and counseling. He has conducted over 300 professional presentations on various criminal justice, education, law enforcement, corrections, and mental health topics at the local, state, and national levels since 1986.

Ken is married with six children and one grandson, and resides in Ashland, Kentucky.

EXECUTIVE SUMMARY

The McLean County Sheriff, other government officials and community leaders remain committed to providing constitutional care of inmates afflicted with mental illness who are incarcerated within the McLean County, IL Detention Facility (MCDF). These officials and community leaders clearly recognize their moral and legal obligation to ensure that adequate health care is provided all inmates is provided and place commendably high value on collaboration among all government and community elements to meet this obligation. The overall results of this assessment are convincing evidence of a long-standing culture of government transparency and effective problem solving within and among the McLean County community.

MCDF is clearly one of the most professionally managed and forward-thinking County jails in the nation in the opinion of this Consultant. MCDF contains and is surrounded by an army of competent, compassionate, and dedicated people who seem sincerely invested in the success of facility and its mission.

In general, it appears that mentally ill inmates at MCDF are provided good care that begins at the booking process but does not end exactly at discharge. Electronic databases exist to provide adequate initial and ongoing screening and evaluation of inmate health and risk needs. Screening, evaluation, referral, and care of inmates continue during incarceration as need to ensure identification and treatment of inmate mental health problems, serious or otherwise. There is an array of quality and evidence-based general and therapeutic programs involving qualified jail staff, professionals, and community volunteers. Officials openly acknowledge and are very concerned about improving facility housing options for mentally ill inmates. Discussions to correct these housing deficiencies began before this assessment and forward movement continues. Planning is underway to create special housing capacity. Despite this single deficiency, it is MCDF policy and practice to maintain close monitoring and care of inmates housed in segregation. Licensed mental health professionals are on-site providing primary care and support. However, officials should consider increasing on-site hours to ensure consistent continuity of assessment and care. Psychotropic medications seem to be responsibly secured, prescribed, and use seems properly monitored. Mentally ill inmates are provided prescriptions for continuation of medications upon release. MCDF maintains an effective suicide prevention program providing for timely identification, response, and intervention services. Staff seems well trained in suicide prevention and MCDF officials continue to require regular training on this topic and subjects related to mental illness in corrections. MCDF officials are encouraged to review policies involving post crisis debriefing and revise them according to the current literature related to staff wellness and crisis intervention recovery. Mortality and morbidity review policies should be reviewed and revised accordingly. Officials should expand involvement of community advocacy groups such as NAMI.

Finally, McLean County has not escaped the reach of severe cut-backs in funding for mental health services. Despite its remarkable development of specialty courts and best-practices alternatives, officials will be hard-pressed to effectively manage the impact of these cut-backs without devoting additional resources to community-based interventions and treatment. However, McLean County is clearly devoted to meeting this challenge.

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I. INTRODUCTION

This report contains information about interviews, observations, document and data reviews, discussions, additional topical research, tours of the McLean County Detention Facility, conclusions and recommendations of Kenneth A. Ray, following the completion of short-term technical assistance to the McLean County Sheriff's Office Jail located in Bloomington, Illinois. The conclusions and recommendations contained in this report are based on this Consultant's understanding of concerns about mentally ill jail inmates voiced by some 40 participants including Sheriff Mike Emery and jail staff, local criminal justice, law enforcement, and government officials, local social justice and mental health community leaders, and researchers involved in local criminal justice issues from Illinois State University. A distinct and vivid unanimous desire was voiced by all participants involved in this assessment to 1) ensure adequate and constitutional care of mentally ill inmates incarcerated at the McLean County Detention Facility (MCDF); 2) improve custody housing for these inmates; 3) identify and implement additional, cost-effective and evidence-based jail diversion; jail treatment; and reentry services; and, 4) identify and engage opportunities and options for strengthening existing collaborations and partnerships. All participants were openly candid and descriptive.

A. Basics of a National Problem

Growing numbers of mentally ill offenders have strained jail's fiscal and operational capacities; many to the point of costly federal intervention and judicial oversight involving the United States Department of Justice Civil Rights Division.[1] Thousands of people with mental illness are falling through the cracks of this country's social safety net and are landing in the criminal justice system at an alarming rate. Each year, more than ten million people are booked into U.S. jails. Studies indicate that rates of mental illness among these individuals are at least three to four times higher than the rates of serious mental illness in the general population. [2]

[1] The United States Attorney is authorized by federal law to investigate and litigate violations of Constitutional Civil Rights under the Civil Rights for Institutionalized Persons Act (CRIPA). There are currently more than 30 correctional facilities under federal order to comply with Constitutional requirements for the care and protection of inmates. Most of these cases involved medical and mental health violations. *See: http://www.justice.gov/crt/about/spl/findsettle.php*
[2] *See*: http://consensusproject.org/the_report/executive-summary

The origins of the problem are complex and largely beyond the scope of this report. During the last 35 years, the mental health system has undergone tremendous change. Once based exclusively on institutional care and isolation, the system has shifted its emphasis almost entirely to the provision of community-based support for individuals with mental illness. This public policy shift has benefited millions of people, effecting the successful integration of many people with active or past diagnoses of mental illness into the community. Many clients of the mental health system, however, have difficulty obtaining access to mental health services. Overlooked, turned away, or intimidated by the mental health system, many individuals with mental illness end up disconnected from community supports. The absence of affordable housing and the crisis in public housing exacerbates the problem; most studies estimate that at least 20 to 25 percent of the single, adult homeless population has a serious mental illness.

Most troubling about the criminal justice system's response in many communities to people with mental illness is the toll it exacts on people's lives. Law enforcement officers' encounters with people with mental illness can sometimes end in violence, including the use of lethal force. Although rare, police shootings do more than end the life of one individual. Such incidents also have a profound impact on the consumer's family, the police officer, and the general community. When they are incarcerated, people with untreated mental illness are especially vulnerable to assault or other forms of intimidation by predatory inmates. In prisons and jails, which tend to be environments that exacerbate the symptoms of mental illness, inmates with mental illness are especially at risk of harming themselves or others. Once they return to the community, people with mental illness learn that providers already overwhelmed with clientele are sometimes reluctant to treat someone with a criminal record.

Given the dimensions and complexity of this issue, the demands upon the criminal justice system to respond to this problem are overwhelming. Police departments dedicate thousands of hours each year transporting people with mental illness to hospitals and community mental health centers where staff often have to turn away the individual or quickly return him or her to the streets. Jails and prisons are swollen with people suffering some form of mental illness; on any given day, the Los Angeles County Jail system and detention centers hold more people with mental illness than any state hospital or mental health institution in the United States.

Not surprisingly, the McLean County criminal justice system has encountered people with mental illness with increasing frequency. Calls for crackdowns on quality-of-life crimes and offenses such as the possession of illegal substances have netted many people with mental illness, especially those with co-occurring substance abuse disorders. Ill-equipped to provide the comprehensive array of services that these individuals need, corrections administrators often watch the health of people with mental illness deteriorate further, prompting behavior and disciplinary infractions that only prolong their involvement in the criminal justice system.

According to a study published in 2006 by the United States Bureau of Justice Statistics, at midyear 2005, more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in State prisons, 78,800 in Federal prisons, and 479,900 in local jails. These estimates represented 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates. In addition, this research states that "people with mental illnesses are overrepresented in probation and parole populations at estimated rates ranging from two to four times the general population". These findings serve as a *clarion wake-up call* to local officials for taking immediate action, and provide guidance for developing cogent response plans, not only to avoid expensive federal intervention, but to rally community leaders and partners to address psycho-social and criminogenic characteristics among this inmate population. [3] Overall, jail inmates reportedly have higher mental health problems those inmates in state or federal prisons (64.2%, 56.2%, and 44.8% respectively). This makes perfect sense when considering the fact that all state and federal inmates typically begin incarceration in a local jail. Simply stated, not all jail inmates go to prison but all state prison inmates are initially booked into a local jail.

B. Psycho-Social and Criminogenic Characteristics of Mentally Ill Inmates

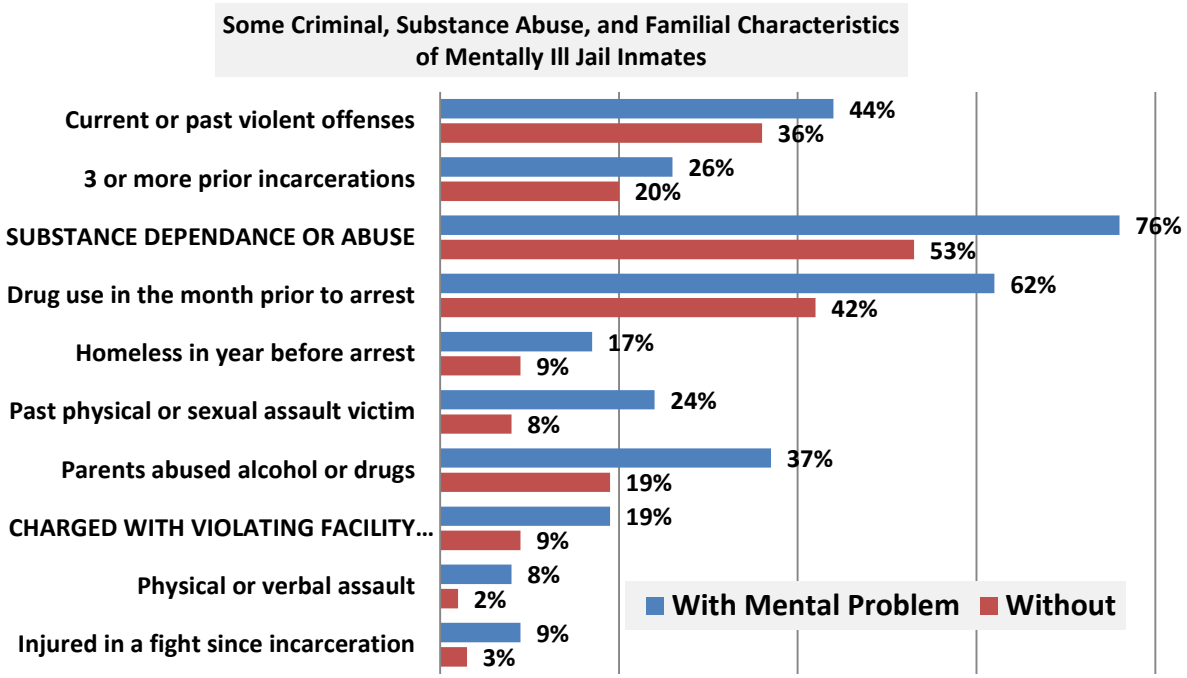
Local government, criminal justice, and community leaders are best served by interpreting the needs of their mentally ill inmates as a reflection of the needs in the overall community. Mentally ill inmates are no less citizens or constituency than are the mentally well. Yet, the debilitating stigma of being labeled "mentally ill" worsens when the label "offender" or "inmate" is added.

Staggering moral and financial issues, added to the high liability risks surrounding the incarceration of this community population drives a salient and unending obligation for community leaders to focus special attention and dedicate resources toward adequate care and management. A good first step for this attention can be to focus resources on establishing a data-driven and compassionate understanding of factors that place the mentally ill at risk of criminal justice involvement and incarceration. Understanding the relevant psycho-social and criminogenic risk factors specific to McLean County's mentally ill population is a formative basis for good response planning.

Compared to non-mentally ill jail inmates, mentally ill inmates are more likely to have a current or past violent offense and three or more prior incarcerations. They are much more likely to have substance dependence or abuse issues and are more likely to report drug use a month before their arrest. Mentally ill inmates are almost twice as likely to be homeless and three times more likely to have a history of being victims of physical or sexual abuse. They are more likely to have parents who abused drugs or alcohol. Regarding jail behavior, mentally ill inmates are twice as likely to violate jail rules, engage in physical or verbal assaults at a rate of four times more often,

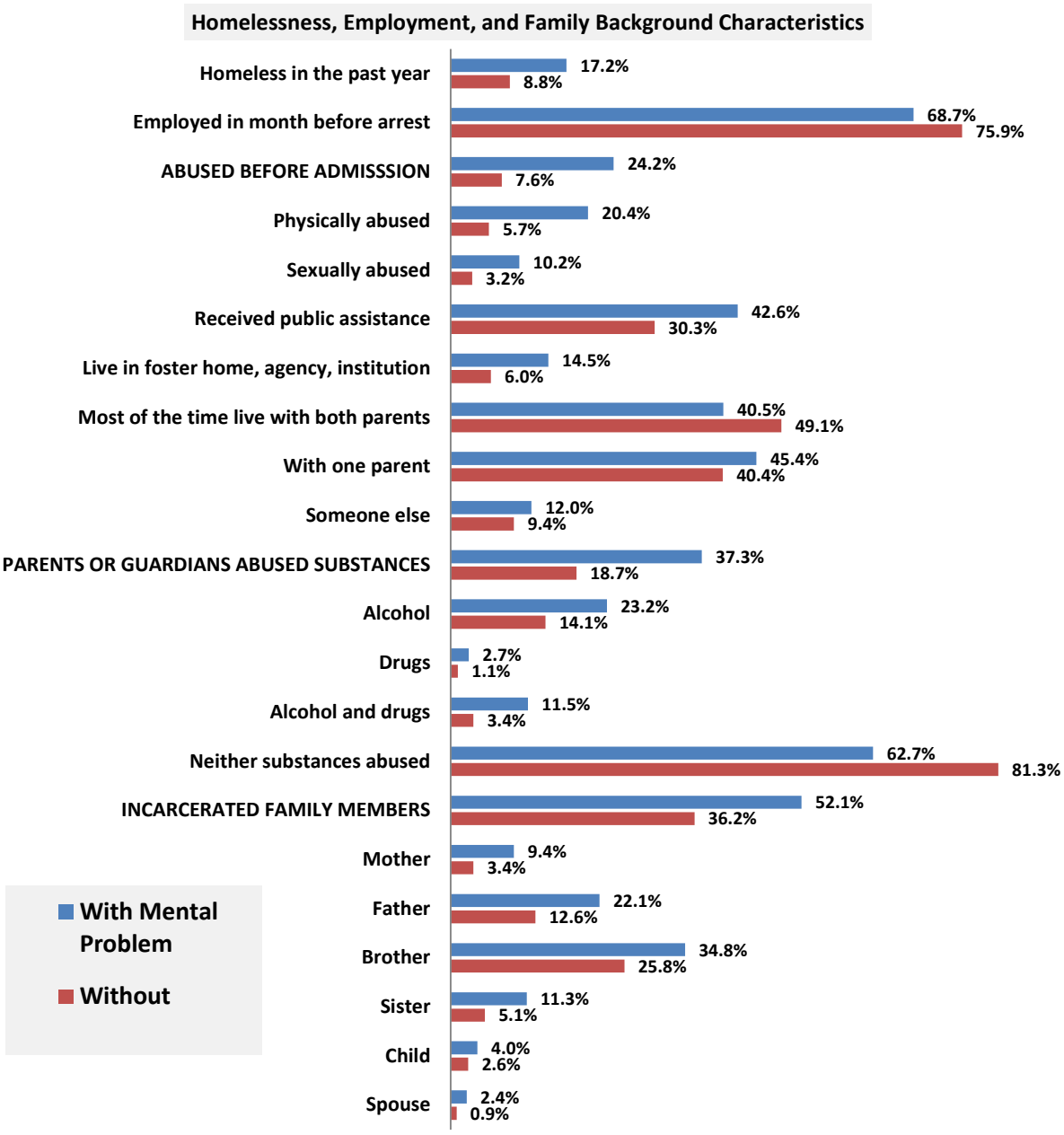
[3] *See*: http://www.bjs.gov/content/pub/pdf/mhppji.pdf

are three times more likely to be injured in a fight during incarceration than non-mentally ill inmates.



McLean County leaders should drill even deeper into these factors in order to target jail-based and community interventions so that resources are focused strategically. Homeless, employment, and family background information can provide a better understanding for this process.

As stated above, mentally ill jail inmates were found to be homeless at almost twice the rate of the non-mentally ill and less likely to be employed in the month of their arrest. They are four times more likely to be victims of physical abuse and three times more likely to be victims of sexual abuse. While growing up, they are more likely to receive public assistance and twice as likely to live in foster care, an agency or institution. Regarding family background, mentally ill inmates lived with both parents slightly less often than their counterparts but were more likely to live with one parent or someone else. Twice as many mentally ill inmates have parents who abused substances and less likely to have parents who do not. They are significantly more likely to have parents, siblings, and children who have been incarcerated.



McLean County continues to look very closely at the clinical mental health and substance abuse and dependence characteristics of its mentally ill offender population to determine its capacity for treatment and programming before, during, and after incarceration. The BJS study provides further insight into these issues.

Gender, race, and age are also important factors for targeting custody and community intervention services and program capacity to inmates with mental illness. This means that interventions must use evidence-based programming specific to the salient demographic characteristics. Programs should be qualified, culturally competent, gender sensitive, and age

specific. Regarding these characteristics, the BJS study found several program development indicators.

II. PURPOSE OF ASSISTANCE

McLean County Sheriff Mike Emery, and on behalf of his department and McLean County states in his request this technical assistance,

> *"This correspondence is a request to ask for technical assistance in regards to housing inmates with mental health issues. Currently, the trend seems to be that McLean County is providing long term housing for inmates unfit for trial due to the unavailability of beds at state [psychiatric inpatient] facilities. McLean County recognizes that housing and treatment of inmates in need of mental health services will escalate and a technical assistance assessment will provide information on how to proceed in order to address this before it becomes a crisis.*
>
> *In support of this request are Chief Judge of the 11th Judicial Circuit and Chairperson of the McLean County Criminal Justice Coordinating Council, Judge Elizabeth Robb, Judge Rebecca Foley, Mr. Matt Sorensen, Chairman of the McLean County Board and McLean County Administrator, Mr. William Wasson"*[4]

[4] Request letter from Sheriff Emery to Fran Zandi, NIC Jail Division Technical Assistance Manager dated 10/15/12

III. SCOPE OF WORK

This technical assistance project includes activities performed prior to November 16th thru December 29, 2012. On-site work was performed November 16, and December 3-7, 2012. Project activities included pre on-site preparation, on-site assessment, post-visit follow-up, and report writing.[5]

A. Pre-On-Site Activities Included:

1. Contact with Sheriff Emery and discuss the scope and intent of this technical assistance request.
2. Based on that discussion, develop an outline of the work requested and develop an itinerary of tasks to be completed.
3. Develop a comprehensive list of documents and statistics required and submit them to the Sheriff.
4. Review statistics available through their contact with Illinois State University as they pertain to the mental health population of their jail.
5. Review current policies/procedures and practices for the mental health population.

B. On-Site Activities Included:

November 16:

1. Attend the CJCC planning meeting; concentrate on the jail planning expectations as they pertain to enrichment of current mental health programs.
2. Note any plans for expansion of external components that may be addressed at the meeting.
3. Meet with Sheriff Emery for any additional requests as it may impact the on-site visit at the meeting.

December 3-7:

1. Meet with primary administrators as designated by the sheriff to outline the agenda and plans for the assessment.
2. Discuss the expectations at the November 16 jail planning session.
3. Review the population and capacity usage data relevant to implementing best practices for inmates with mental illness.
4. Conduct prescheduled meetings and interview local government officials and community partners involved with the mental health population.
5. Assess existing usable jail capacity available for renovation for the housing of mentally ill inmates within the jail.
6. Assess existing space for new construction and provide options for best use applying the integrated approach to special needs inmates' incarceration and care.
7. Hold a preliminary exit meeting outlining provisional observations and findings.

[5] NIC TA authorization letter Statement of Work dated 10/31/12

While on-site, this consultant met with several MCDF staff, County legal and risk management officials, jail contract medical and mental health treatment providers, and inmates. Participants in this activity are listed below:

1. Sheriff Mike Emery, McLean County
2. Greg Allen, Superintendent for Adult Detention Facility
3. Jamey Kessinger, Assistant Superintendent
4. Diane Hughes, Operations Officer
5. Karen Zangerle , Director of PATH
6. Cara Rebe-Hemp, Professor Criminal Justice Sciences at Illinois State University
7. Elizabeth Hall, National Alliance on Mental Health (NAMI)
8. Ken Hall, National Alliance on Mental health (NAMI)
9. Jason Chambers, McLean County State's Attorney
10. Randy McKinley, Bloomington Police Chief
11. Melinda Fellner, Jail Assessment Supervising Specialist
12. Jackie Mathias, Jail Assessment Specialist
13. Sheri Day, Jail Program Director
14. Kim Campbell, McLean County Public Defender
15. Dr. Laurie Bergner, League of Women Voters – Justice Options Committee
16. Bob Sutherland , ACLU – Jail Review Committee
17. Jack Porter, LWV – Justice Options Committee (JOC)
18. Mark Benson, Real Change Clinical Services (RCCS)
19. Chris Chasen, Real Change Clinical Services (RCCS)
20. Joan Naour, Director of Jail Nursing
21. Lori McCormick, Director of McLean County Court Services (Probation)
22. Dr. Carl Alaimo, Past Director and Chief Psychologist Mental Health Services Cook County Jail
23. Michelle Rock, Director, Illinois Center of Excellence for Behavior Health and Justice
24. Walt Howe, Director of McLean County Health Department
25. Beth Whisman, WJBC Radio Bloomington
26. Dr. Jessie Krienert, Professor of Criminal Justice Sciences at Illinois State University, Chairperson of Jail Review Committee (JRC)
27. Dr. Frank Beck, Stevenson Center, Illinois State University
28. Dr. Edward Wells, Stevenson Center, Illinois State University

C. On-site Activity Agenda:

Monday December 3, 2012	Participant	Representing	Location
08:30 to 16:30	Greg Allen Jamey Kessinger Diane Hughes Sergeant	Jail Division Administration	Sheriff's Training Room
08:30 to 9:30	Karen Zangerle	PATH	Sheriff's Training Room
10:00 to 11:00	Jason Chambers	Prosecutor	Sheriff's Training Room
11:15 to 12:15	Aaron Woodruff	Chief of ISU PD	Sheriff's Training Room
12:40 to 13:00	Beth Whisman	WJBC Radio	Radio Bloomington
13:00 to 17:00	As scheduled		
Tuesday December 4, 2012			
08:30 to 16:30	Melinda Fellner, Shift Supervision Jackie Mathias Sheri Day	Jail Division	Sheriff's Training Room
08:30 to 09:30	Jessie Krienert, Professor	Illinois State Univ	Sheriff's Training Room
10:00 to 11:00	Ms. Kim Campbell,	Public Defender	Sheriff's Training Room
11:00 to 12:00	Judy Buchanan,	Advocate MH	Sheriff's Training Room
14:00 to 15:00	Chief Rick Bleichner	Normal PD	
15:15 to 16:15	Dr. Laurie Bergner Mr. Bob Sutherland Mr. Jack Porter	JOC JOC JRC	
Wednesday December 5, 2012			
08:30 to 11:00	Mark Benson, QMHP	Jail Mental Health Srvcs	Sheriff's Training Room
09:30 to 10:30	Lori McCormick	Probation	Sheriff's Training Room
11:00 to 12:00	Elizabeth and Ken Hall	NAMI	Sheriff's Training Room
11:00 to 12:00	Joan Naour	Jail Medical	Sheriff's Training Room
14:00 to 15:00	Matt Sorensen, County Board Chairman Bill Wasson, County Admin Hannah Eisner , Asst. County Administrator Pablo Eves, States Attorney	McLean County	County Gov't Bldg.
12:00 to 16:30	Judge's Meeting	Courts	Room 503 / Jury Assembly
Thursday December 6, 2012			
08:30 to 10:00	Walt Howe	MCHD	Sheriff's Training Room
10:00 to 14:00	Dr. Alaimo	State IDHS	Sheriff's Training Room
14:15 to 15:15	Michelle Rock	COEBJ	Sheriff's Training Room
	Chief Randy McKinley	BPD	Sheriff's Training Room
Friday December 7, 2012			
08:30 to 16:30	Wrap-Up / Exit Prep		Sheriff's Training Room
		Exit Presentation	Gov't Bldg.

It is important to note that ALL McLean County officials and service providers were exceptionally professional, helpful, motivated, and cooperative during this assessment process. This Consultant observed positive, active and deliberate efforts to develop, provide, and maintain

effective inmate medical, mental health and suicide prevention services by all MCDF, County officials and services providers involved in this work.

IV. DOCUMENT REVIEW

More than 500 pages of documents were provided by McLean County officials for this assessment process:

Studies/Government Documents:

1. McLean County Jail Bi-Annual Jail Review Committee 2012 Annual Report [survey of jail conditions and inmate perceptions]. McLean County, IL. March 26, 2010. (57 pages)

2. United States Department of Corrections National Institute of Corrections. *Explaining Jail Crowding: An Analysis of Changes in the Number of Bookings/Admissions & Average Length of Inmate Stays in the McLean County, IL Jail System* (Robert C. Cushman) and, *Mclean County Jail, Detention Facility Bed Utilization Analysis for October/November 2003 & 2008* (Mark Cunniff) Technical report no. NIC TA # 09J1024. Washington, DC: USDOJ NIC, 2008. (136 pages)

3. *Illinois Project for Local Assessment of Need: IPLAN Community Health Plan and Needs Assessment*. Research report no. 2012-2017. Bloomington, IL: McLean County Health Department, 2012. (128 pages)

4. Peoria, IL, LZT Associates Architects, Planners, & Engineers. *McLean County, IL Detention Facility Report*. Boulder, CO: Cihacek Associates, Justice Research & Forecasting, 2000. (37 pages)

5. Department of Corrections Jail and Detention Standards Unit, Illinois Jail Standards, (Ill.). (60 pages)

6. IL Department of Corrections, comp. *McLean County Jail Inspection Reports 2006-2012*. Springfield, IL: Jail and Detention Standards Unit, n.d. (38 pages)

Manuals/Policies:

7. McLean Justice System Information Management System, E* Justice System User's Manual (Version 2.1, October 1998, 219 pages)

8. McLean County Jail Policy and Procedure Manual (139 pages):

   Operations:
   9. 208: Minimum Staffing Requirements
   10. 240: Custodial Sexual Misconduct
   11. 316: Rated Bed Capacity

12. 502: Staff Development and Training
13. 504: Training for Correctional Officers
14. 512: Administrative/Managerial Training
15. 518: Continuing Employee Education
16. 520: Training
17. 702: Admissions Booking Procedure
18. 710: Suicide Prevention Program
19. 711: Mental Health Behavioral Plan: Safety/Security Protocol for Inmates Housed in Booking/Holding Cells
20. 712: Custody Under the Influence
21. 794 Admissions and Immediate Release
22. 922: Security Ratings
23. 928: Use of Force
24. 950: Prostraint Restraint Chair
25. 1102 Classification Procedure
26. 1104: Classification Review Board
27. 1106: Custody Classification Review
28. 1108: Formal Classification Procedure
29. 1112: Special Needs Cells
30. 1114: Isolation Cells

Health Care:

31. 1201/J-A-01: Access to Care
32. 1202/J-A-02: Responsible Health Authority
33. 1203/J-A-03: Medical Autonomy
34. 1208/J-A-08: Communication on Patient's Health Needs
35. 1209/J-A-09: Privacy of Care
36. 1211/J-A-11: Grievance Mechanism for Health Complaints
37. 1219/J-C-03: Professional Development
38. 1220/J-C-04: Health Training for MCDF Correctional Officers
39. 1232/J-E-02: Receiving Screening
40. 1233/J-E-03: Transfer Screening
41. 1234/J-E-04: Health Assessment
42. 1235/J-E-05: Mental Health Screening and Evaluation
43. 1239/J-E-09: Segregated Inmates
44. 1250/J-G-04: Basic Mental Health Services
45. 1252/J-G-06: Intoxication and Withdrawal
46. 1254/J-G-08: Inmates with Alcohol or Drug Problems
47. 1259/J-H-02: Confidentiality of Health Records
48. 1261/J-H-04: Management of Health Records
49. 1262/J-I-01: Restrains and Seclusion (see #926, #950, and #1110)
50. 1263/J-I-02: Emergency Psychotropic Medication
51. 1266/J-I-05: Informed Consent and Right to Refuse
52. 1268: Suicide Attempts
53. 1402: Inmate Restriction List Sheet

54. 1403: Inmate Classification Restriction List Sheet

Other Documents and Information

55. Criminal Justice Coordinating Council 2012 Priorities for Strategic Planning Agenda (11/16/12, 1 page)
56. Classification Review Log (GP/AD SEG/ORIENTATION/FEMALE/SPECIAL NEEDS/WORK RELEASE & PERIODIC IMPRISONMENT/EAST POD/WEST POD, 11 pages)
57. McLean County Jail Inmate Program Narrative
58. 2013 Staffing Essential Learnings E-Training List of Required Courses (3 pages)
59. Current Staffing Authorization (1 page)
60. MCDF Annual Population Report (2006-2012, Nov, 7 pages)
61. Email dated 12/7/12 re: count of current inmates on psychotropic medications being treated for comorbid chronic disease (1 page)
62. MCDF Health Services Department 2011Annual / 2012 3rd Qtr. Activity Volume Reports (6 pages)
63. Mental Health Court Initiative Program Update of 12/03/12 (3 & 4 pages)
64. Six-Month Inmate Medical Services Report (2012)

Forms

65. Initial Custody Assessment Scale (1 page)
66. Custody Reassessment Scale (1 page)
67. Special Needs Housing Weekly Classification Review (2 pages)
68. EJIS - JIMS Booking Templates (17 pages, screen prints)
69. EJIS – JIMS Medical Screening Templates (17 pages, screen prints)
70. RCCS Psychiatric Referral (1 page)
71. Aramark “Fresh Favorites” inmate special incentive request form (1 page)
72. Mental Health Court Referral Form (2 pages)
73. RCCS Initial MH Contract Assessment Note (2 pages)
74. MCJ Mental Health Screening Assessment (1 page)
75. MCJ Mental Health / Behavior Plan for Inmates Housed in Booking and Holding Cells

V. METHODOLOGY

A. This short-term assessment was conducted according to NIC jail technical assistance protocols. This included pre-visit communication with client-agency officials, collection and review of relevant documents, data and other information provided by the client-agency, coordination of site visit activities and a short-term site visit.

B. The site visit included an initial meeting with key officials to discuss the assessment and to clarify expectations and outcomes. It also included several tours of MCDF, meetings and interviews with key criminal justice and law enforcement officials, community leaders and advocates, jail and health care staff, interviews with inmates, review of health care charts and other medical records, reviews of agency health care policies, procedures, protocols, staff, training and other information. An exit meeting involving many of these officials and community citizens was conducted on the last day of the site visit. This meeting included a discussion of this Consultant's general impressions and opinions; issues of concern and risk, and a general open discussion.

C. Report writing included additional research and a more in-depth examination of documents and information provided before, during and following the site visit. Additional research was conducted on salient topics and issues involved in this assessment, consultation with other professionals as needed, follow-up contact with client-agency officials to clarify specific information and findings, and completion of the report with supporting documents and references.

Special Note: McLean County officials, staff, and community members are to be highly commended for their ongoing involvement in this work. The value of this assessment is a direct result of their commitment to quality and constitutionally sound inmate healthcare at MCDF.

VI. PROGRESS AND PERCEPTIONS

A. McLean County has a long, solid track-record of tackling and effectively resolving serious and important criminal justice problems. It seems to have long established a cultural that values resolving problems using a well-informed, integrated, and collaborative approach that honors and respects intergovernmental and community involvement. A few recent examples evidencing this are the establishment of the Criminal Justice Coordinating Council (CJCC), Drug and Mental Health Courts initiatives.

This technical assistance process began with an invitation to attend the 2013 CJCC Strategic Planning Session. This four-hour planning meeting seemed well-organized and attended by CJCC members. The process was masterfully facilitated by Dr. Frank Beck and Dr. Edward Wells, Stephenson Center, Illinois State University. The agenda consisted of a cogent mix of salient topics directly related to further advancing the effectiveness of the CJCC, the McLean County Criminal Justice System, and the interplay among system elements with emphasis on public safety and community wellness. Topics pertaining to offender accountability and inmate well-being were included. The agenda and process were succinct yet allowed for full involvement among CJCC members:

Review and Establish Goals: As a group, we will discuss the priorities you provided and the parts that comprise them. You each will vote on the goals in rank order. We will quickly assemble those votes and cull the goals into a short list. The group will prioritize that list.

Review the Subcommittee Structure: In small groups, you will review the subcommittees and seek to understand their relationship to the Goals. Each group will generate a list of subcommittees needed to accomplish the Goals. We will discuss those lists as a whole.

Form Action Steps: Small groups will be used to generate a list of Action Steps for the Goals. Those will be posted on the wall. The whole will discuss for 15 minutes.

Discuss Assessment: On a "round robin" basis, groups will rotate to discuss how progress on each of the Action Steps will be measured and by whom. Decisions regarding what are "short term" and "long term" steps will be made. The Stevenson Center will compile the Goals, Action Steps, and Assessment Measures into a document for review.

Discuss Vision: Groups will be used to draft a Mission (for the next year) and a Vision for the Future (3 years out) of the CJCC.

The CJCC worked through all pre-established priorities quickly and completely. Two universal top priorities established by the CJCC included:

Case processing time and dispositions: The CJCC should work to identify those things that affect case-processing time and work to shorten case processing time. The CJCC should assess whether the case disposition standards are appropriate and being met. The CJCC should examine the length of time a person is in custody as a portion of their overall processing time and track outcomes; a goal is to manage case processing time for those in custody. Regarding disposition standards, the CJCC should consult the Center for State Courts.

Jail Usage: The CJCC should develop a vision for how to use the jail in an appropriate manner. This includes housing related to mental illness, work release, periodic imprisonment, and pre-trial versus sentenced individuals. In all, the CJCC should converse about and suggest policies that move the County toward that vision. The CJCC should continually assess the population per that vision.

Four other issues fell into a second level of importance:

Organization of organizations: The CJCC should serve as an umbrella for organizations in the criminal justice system. It will be the "glue" for the organizations. However, the Council needs to make sure the organizations at the table really need to be there. The CJCC should serve as a forum to discuss differences, facilitate communication, and assist with the pursuit of external funding and technical assistance. The CJCC can be a conduit for information sharing between our Council and others like it. The CJCC can also be a means by which new programs are explored.

Data-driven Analyses and Evidence-based Practices: The CJCC should evaluate processes and business practices to improve efficiency in relevant programs. The Council should also monitor trends and demographics of the jail population by charge severity and pre-trial, convicted, or sentenced status. This data will be made available to committees and departments. Whether managed by the CJCC or departments themselves, data will be used to evaluate programs and agencies. The CJCC should continue to seek the fine tuning of McLean County's criminal justice system.

Communication between Jail and Courts: Some suggest that incarcerating people for short term offenses leads to jail overcrowding. In response, the CJCC should develop a means for judges to know how much space is available in the jail at any given time. Regular communication between the courts and the jail could mitigate the short term overcrowding issues.

Standardize Practices: Use EJS as an information system for monitoring size and characteristics of the jail population in real time. The recording of events within the criminal justice system needs to be standardized across units. The CJCC should facilitate the standardization and make sure education and training for this purpose are provided.

Three issues fell in to a third level of importance:

Specialty Courts: The CJCC should evaluate the effectiveness of specialty courts and facilitate the expansion of them. A parallel concern is the evaluation of the juvenile courts and recidivism.

Legislation: The CJCC should serve as a conduit of information regarding the criminal justice system in McLean County and the state officials that represent us.

Community Knowledge of the Criminal Justice System: The CJCC should be the conduit of information about the criminal justice system to the general public.

Presenting this information would not typically be included in an assessment report of this type with showing significant relevance to the objectives of this assessment. In this case, this information shows very strong evidence that McLean County clearly recognizes what issues need to be addressed and how to effectively develop planning methods and strategies targeted at addressing issues individually and from a synergistic mindset. This information also shows the existence of a strong consensus to ensure continued, sustainable, and responsible use of MCDF based on evidence-based policies targeted at meeting its obligation to the citizens, system, community, and the inmates. Ironically, participants this Consultant interviewed during this assessment who are not CJCC voiced similar priorities and issues. Many of these interviewees had no knowlege or very little knowledge of CJCC priorities but concurred with them nonetheless. This further exemplifies McLean County's hybrid level of ongoing awareness and collaboration.

B. Collective Perceptions

This assessment process involved individual and group interviews, and meetings that involved in excess of 40 officials, community leaders, and community members. The following is an annotated synthesize of concerns and recommendations shared by participants.

Concerns

- Funding has been drastically cut for state and community mental health services.
- Many people have been cut off from mental health services but desperately need those services.
- The waiting list for getting services is growing and it takes longer to get services.
- Demand for community intervention and crisis services have exploded.
- Reduction in community intervention services has significantly burdened law enforcement resources.
- Law enforcement calls for services involving mentally ill people have significantly increased.

- There are few to no places to take mentally ill offenders other than to jail, even though incarceration could be a last resort.
- Lack of adequate community diversion or stabilization beds has increased the population of mentally ill inmates in the jail.
- Criminal case filings involving mentally ill defendants has significantly increased.
- Crime is down but felony filings are up and include an increase in cases involving mentally ill defendants.
- The lack of access to state forensic and restoration capacity has resulted in increased length of inmate stays in the jail and caused significant slow-downs in criminal case resolution and justice.
- Prosecution, defense, and probation lack necessary resources.
- Justice to victims is impaired when cases remain unresolved for long time periods.
- The increase in the mentally ill inmate population has severely impacted the cost and operations of the jail.
- The jail is not designed, staffed, or budgeted to sustain long range services to this increasing population's care.
- We don't have enough strategically developed jail diversion, jail-based operational methods, jail capacity options, reentry programming, or post-released community options yet in place to effectively curb this situation.
- There are no community stabilization beds or facilities for pre and post incarceration.
- The courts need additional evidence-based options.

Recommendations

- Provide mental health services and support to community members and their families who cannot afford them.
- Increase community awareness about the problem and develop momentum for change planning.
- Create collaborative and community-based stabilization beds/facility for low risk mentally ill offenders and non-offenders. Incorporate criminal justice and care services.
- Establish an integrated behavioral health services delivery system.
- Re-establish adequate funding levels to community crisis intervention services.
- Develop a support network involving all public and private sector agencies for comprehensive to planning, development, implementation, and evaluation of strategies to address all facets of community mental health and include criminal justice options.
- Train all MC law enforcement in CIT.
- Expand law enforcement notification system database to all departments.
- Provide law enforcement more options in lieu of incarceration of the mentally ill where appropriate.
- Fund crisis services intervention agencies to be able to respond to calls involving MH subjects.
- More training to MCDF staff about mental illness.
- Expand MCDF to better accommodate the numbers and needs of mentally ill inmates.
- Reconsider efficacy of the work release program in lieu of competing priorities and other options.

- Expand CJCC membership to include additional community members.
- Use the Stephenson Center to conduct a meta-summary of all community needs assessment plans and progress. Assimilate findings into a comprehensive criminal justice action plan.
- Ensure seamless transition to and between community providers and services.
- Expand criminal justice system resources to expand; develop, implement, and operate evidence-court options.
- Ensure courts have sufficient information at first appearance to make timely and prescriptive decisions about program options and defendant mental illness issues.
- Expand drug and mental health court participation and eligibility where community safety is not jeopardized.
- Reduce delays in the time it takes for unfit restoration – move the cases.
- Consider inviting bordering counties to participate in a regional stabilization facility.

The concerns and recommendations voiced by participants seem to encompass the issue of offender mental illness at a more global level and eschew narrow focus on jail issues alone. CJCC strategic planning efforts appear consistent with this sentiment. Hopefully, the perceptions articulated above can somehow assist the CJCC, other government and community officials in re-focusing efforts and resources even more prescriptively.

The next section of this report will briefly discuss the salient legal issues related to McLean County's obligation to ensure that inmates are provided with necessary and adequate care. It is intended as a primer to readers less familiar with this topic and a refresher to those who are adding updated information about related liability and intervention by the courts. It is also hoped that this information will help clarify proposed recommendations.

VII. LEGAL FRAMEWORK - INMATE RIGHTS TO ADEQUATE HEALTHCARE

The following discussion lays out a general legal foundation regarding a jail's obligation to provide adequate medical, dental and mental health care to inmates.

A. The Civil Rights of Institutionalized Persons Act (CRIPA)[6]

In an effort to stem the tide of prisoner section 1983 litigation and strike a balance between deference to state officials and the rights of the institutionalized, Congress enacted the Civil Rights of Institutionalized Persons Act ("CRIPA") in 1980. Prior to 1980, inmates who wanted to sue in court were not required to exhaust their administrative remedies. CRIPA applied only to section 1983 actions and contained the first exhaustion requirement for prisoner lawsuits. CRIPA did not require mandatory exhaustion, however, and gave judges the power to require plaintiffs to exhaust administrative remedies when "appropriate and in the interests of justice." A judge could continue a case for up to 180 days if he believed that the suit could be resolved using administrative remedies.

This discretionary exhaustion requirement offered [jail] officials the ability to resolve violations in administrative proceedings without involving the courts. The exhaustion provision of CRIPA further limited its own application by mandating that exhaustion could only be required where the administrative remedies had been certified by the Attorney General as meeting certain minimum standards. These standards required that inmates be afforded an advisory role in creating and applying a grievance procedure. The Supreme Court created a balancing test for determining when to require exhaustion under CRIPA; "federal courts must balance the interest of the individual in retaining prompt access to a federal judicial forum against countervailing institutional interests favoring exhaustion."

Beyond the exhaustion requirement, CRIPA also gave the Attorney General of the United States authority to sue state and local officials responsible for facilities exhibiting a pattern or practice of flagrant or egregious violations of constitutional rights. CRIPA also set forth guidelines for prison administrative procedures and required that states have their procedure certified by the Attorney General in order to require exhaustion of remedies. Even with this discretionary exhaustion requirement, CRIPA allowed inmates to participate in the formation of the grievance procedures and many states refrained from having their procedures certified because of this requirement. The states' refusal to adopt these provisions and alter their grievance procedures to accommodate inmates' civil rights had opposite of the intended effect and actually increased the number of prisoner suits filed and contributed to the burden on federal dockets as well as increased the costs to prisons caused by defending suits. In response, many legal scholars, politicians and judges supported a change in the system that would reduce the number of frivolous lawsuits.

[6] Civil Rights of Prisoners: The Seventh Circuit and Exhaustion of Remedies Under the Prison Litigation Reform Act, Seventh Circuit Review, Volume 1, Issue 1, Spring 2006 (www.kentlaw.edu/7cr/v1-1/mccomb.pdf)

B. The Prison Litigation Reform Act of 1995

The civil rights of inmates were again the subject of Congressional legislation in 1996 with the passage of the aptly named amendment to CRIPA, the Prisoner Litigation Reform Act ("PLRA"). Though the legislative history is minimal, the PLRA was intended to stem the tide of purportedly frivolous prisoner lawsuits and reduce judicial oversight of correctional facilities. The PLRA represented a major change in prison litigation creating barriers such as requiring physical injury in tort claims, forcing even *in forma pauperis* prisoners to pay filing fees, and creating limits on attorney's fees. Most importantly, however, the PLRA drastically modified the CRIPA's exhaustion of administrative remedies provision.

Under the PLRA, inmates are required to exhaust all administrative remedies available, mandating, "No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal Law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted." The PLRA's exhaustion requirement was more restrictive and differed from CRIPA in five important ways: First, the PLRA applies to all state, local and federal prisoners in contrast to CRIPA, which did not apply to federal prisoners or juveniles. Second, the exhaustion requirement was broadened to include pretrial detainees as well as convicted prisoners. Third, the PLRA requires dismissal of cases in which administrative remedies were not exhausted. Before the PLRA, courts continued or stayed cases until prisoners had exhausted administrative remedies.

The PLRA lacks the discretionary application of the exhaustion requirement and removes the ability of judges to determine when requiring exhaustion is appropriate. Finally, before a court could require a prisoner to use a prison's administrative grievance process, the process had to meet certain requirements. The PLRA removed the requirements that exhaustion of administrative remedies must be "appropriate and in the interests of justice" or that the administrative remedies be "plain, speedy and effective." The PLRA also removed the five statutory standards for administrative remedies and required only that the remedies be "available." The impact of the PLRA on prisoner lawsuits for constitutional violations was immediate and substantial. In the last year under CRIPA, inmates filed 41,679 civil rights petitions.

In 2000, four years after the passage of the PLRA, the number of civil rights petitions dropped to 25,504 - a reduction of 39%. Specifically, the more comprehensive and automatic exhaustion requirement greatly increased the number of inmate lawsuits that were dismissed for failure to exhaust all available administrative remedies. The Supreme Court, in interpreting the new exhaustion requirement under the PLRA, held that inmates were required to exhaust all available administrative remedies regardless of whether the claims involved general circumstances of incarceration or particular incidents, thus ensuring that the PLRA will govern all prisoner lawsuits in every state.

C. Inmate Healthcare[7]

Jail inmates have the right to receive adequate health care. The Eighth Amendment of the US Constitution guarantees the right to be free from cruel and unusual punishment, which the Supreme Court has determined to include the right of prisoners to have access to health care.[8]
The denial of necessary medical care is a Constitutional violation only if prison officials are "deliberately indifferent" to a "substantial risk of serious harm."[9] Medical, dental and mental health care would fall within the scope of these legal expectations.

In order for an inmate to successfully claim that inadequate medical care violated his constitutional rights, he must prove two things[10]: (1) that the treatment or lack of treatment resulted in "sufficiently serious"[11] harm (the objective standard), and (2) that the jail officials responsible for the harm knew of that or the possibility of a risk, by act or omission, failed to eliminate the risk [12] (the subjective standard).

The Objective Standard of Care: Generally speaking, for an injury to be considered "sufficiently serious," the harm must significantly change the prisoner's quality of life. For example, harm would be considered "sufficiently serious" if it causes degeneration or extreme pain. Some examples of medical needs that the courts have considered "sufficiently serious":

- degenerative, painful hip condition that hindered the inmate's ability to walk
- painful, obviously broken arm
- bleeding ulcer that caused abdominal pain
- inflamed appendix
- shoulder dislocation
- painful blisters in mouth and throat caused by cancer treatment
- pain, purulent draining infection, and 100 degrees or more fever, caused by an infected cyst
- cuts, severe muscular pain, and burning sensation in eyes and skin, caused by exposure to mace
- head injury caused by slip in shower
- substantial back pain
- painful fungal skin infection
- broken jaw requiring jaw to be wired shut for months

[7] http://www.washlaw.org/projects/dcprisoners_rights/medical_care.htm#objectiveStandard
[8] *Estelle v. Gamble*, 429 U.S. 97, 97 S. Ct. 285, 50 L. Ed. 2d 251 (1976).
[9] *Farmer v. Brennan*, 511 U.S. 825 (1994).
[10] Criteria summarized in A Jailhouse Lawyer's Manual (JLM), 5th edition. New York: Columbia Human Rights Law Review , 2000, p. 540.
[11] *Wilson v. Seiter*, 501 U.S. 294, 298, 115 L. Ed. 2d 271, 111 S. Ct. 2321 (1991).
[12] *Martinez v. Mancusi* 443 F.2d 921, 924 (1970). In: JLM, p. 542.

- severe chest pain caused by heart attacks

Some examples of medical needs that the courts have determined NOT to be "sufficiently serious":

- sliver of glass in palm that did not require stitches or painkillers
- pain experienced when doctor removed a partially torn-off toenail without using anesthetic
- nausea, shakes, headache, and depressed appetite caused by family situational stress
- "shaving bumps"

The Subjective Standard of Care: A jail official cannot be "deliberately indifferent" to a medical need if he is not aware of the medical problem. Thus, an inmate must make sure that jail officials know about his medical needs. If an inmate wants to see medical personnel, he must inform the corrections officers on his block. He must fill out sick call slips and, if these are not honored, he must file grievances. Once an inmate gets in to see a nurse or doctor, he should discuss symptoms and any relevant medical history.

While an inmate should do all he can to make sure that medical personnel are aware of his medical problems, medical personnel can also be held responsible for knowing information in addition to what the inmate tells them. Specifically, medical personnel are responsible for information gained by examining the inmate, reviewing the inmate's medical records, and by talking to others familiar with the inmate (guards, other doctors, and family members, for example). If a jail official knows of an inmate's medical problem, he must do what is in his power to address that problem. If a jail official knows of an inmate's substantial medical need and disregards it, he can be held accountable for violating the inmate's constitutional rights. Listed below are some common situations in which courts have held that officials were deliberately indifferent to inmates' medical needs.

Failure to Treat a Diagnosed Condition: If a jail doctor diagnoses an inmate with a certain medical condition and then fails to provide that inmate with treatment for this condition, courts are likely to find that the doctor has been deliberately indifferent to inmates' medical needs. If an inmate suffers serious harm as a result of this lack of treatment, jail officials can be held liable for violating the inmate's rights. For example, if an inmate who is diagnosed with HIV receives no drugs to inhibit the virus and as a result develops full-blown AIDS more quickly than he should have, jail medical staff can be held liable.

Similarly, jail officials other than doctors can be held liable for infringing on an inmate's rights if the official prevents an inmate from receiving treatment recommended by a doctor. For example, the 2nd Circuit Court of Appeals held that prison officials were deliberately indifferent to an inmate's medical needs when they removed him from a hospital without permission from the

doctors.[13] Jail officials without medical training do not have the right to second-guess the recommendations of doctors.

Delay in Treatment or Delay in Access to Medical Attention: Jail officials do not have to provide inmates with immediate access to non-emergent medical care. Generally speaking, jail officials can delay in providing medical care if they have a legitimate reason for doing so. For example, security concerns can justify delaying an inmate's access to medical care, as long as this delay does not make the medical problem significantly worse. On the other hand, unreasonable delays do violate the Constitution. A delay is considered to be unreasonable if it is medically unjustified and it is likely to make the medical problem worse or to result in permanent harm. For example, the 7th and 8th Circuit Courts of Appeals have ruled that 10-15 minute delays in responding to heart attacks constitute deliberate indifference.[14] Also, the 4th Circuit Court of Appeals held that prison officials were deliberately indifferent when they delayed 11 hours in examining an inmate's painfully swollen and obviously broken arm.[15]

Denial of Access to Medical Personnel: Jail officials cannot deny inmates' access to health care personnel. If an inmate requests health care attention, non-healthcare staff may not decide whether or not to allow the inmate to see health care personnel. For example, in Parrish v. Johnson, the 6th Circuit Court of Appeals ruled that a guard who failed to relay an inmate's request for health care was deliberately indifferent to the inmate's medical needs.[16] Similarly, the 11th Circuit Court of Appeals found a physician's assistant to be deliberately indifferent to an inmate's medical needs when the assistant refused to x-ray an inmate with a broken hip or to send him to a doctor for examination.[17]

*Grossly Inadequate Care***:** Negligent medical care does not generally violate the Constitution. In jails, health care malpractice, generally speaking, does not constitute a violation of prisoners' rights. On the other hand, excessively bad medical care can violate a prisoner's 8th Amendment rights. For example, a jury could find that a jail official acted with deliberate indifference if he treats a patient with a serious risk of appendicitis by simply giving him aspirin and an enema.[18]

Inadequate staffing levels have been determined by the United States Department of Justice to be a direct and indirect cause for Civil Rights violations. Insufficient staff levels create serious access to care barriers resulting in medical neglect. Additionally, assigning unqualified staff to perform medical or mental health care functions outside their scope of licensure or practice can

[13] *Martinez v. Mancusi*, 443 F.2d 921, 924 (1970). In: JLM, p. 542.
[14] *Lewis v. Wallenstein*, 769 F.2d 1173, 1183 (7th Cir. 1985) and *Tlamka v. Serrell*, 244 F.3d 628, 633-34 (8th Cir. 2001). In: Toone, p. 81
[15] *Loe v. Armistead*, 582 F.2d 1291, 1296 (4th Cir. 1978). In: Toone, p. 81
[16] 800 F.2d 600, 605 (1986). In: Toone, p. 80.
[17] *Mandel v. Doe*, 888 f.2d 783, 789-90 (1989). In: Toone, p. 80
[18] *Sherrod v. Lingele*, 223 F.3d 605, 611-12 (7th Cir. 2000). In: Toone, p. 84.

be cause for inadequate care violations as noted in a 2012 DOJ jail Investigation Findings Letter[19]:

"Our investigation found reasonable cause to believe that the Jail is denying necessary medical and mental health care, and consequently places prisoners at an unreasonable risk of serious harm, in violation of the Constitution.…

> *Many of the lapses we identify below are directly related to [the jail's] inadequate medical staffing. There is too little onsite coverage by properly licensed staff members, forcing certified nursing assistants (CNAs) to practice and provide medical care beyond their training and licensure.* ***The lack of sufficiently trained and available medical staff for the management and evaluation of serious medical conditions places prisoners at risk of unnecessary harm and is deliberately indifferent to prisoners' serious medical needs. Prison officials, including doctors, "violate the civil rights of inmates when they display 'deliberate indifference to serious medical needs.'"*** *Gordon v. Kidd, 971 F.2d 1087, 1094 (4th Cir. 1992) (citing Estelle v. Gamble, 429 U.S. 97, 104 (1976))...*
>
> *" Perhaps the most significant single concern we have with the provision of medical and mental health care at the Facility is that staff members routinely perform medical services beyond what they are trained and credentialed to do. A further concern involves "medical" security officers. We reviewed several incidents in which security staff were used to evaluate prisoner injuries, and cleared the prisoners without any medical input or consultation.* ***Any clinical support by corrections officers must be limited, must be overseen by the medical department, and must be guided by clear protocols. Corrections officials may, and, in fact, should respond to medical emergencies in acute, life-threatening situations and be properly trained to do so. They should never, however, evaluate prisoners for medical reasons, perform sick call, or provide any type of non-emergency care.*** *There are no protocols in place at [the jail] to guide corrections officers in the very limited medical tasks they may perform, and the current level of medical department oversight of officers is insufficient."*

D. Inmate Psychiatric Treatment and Mental Health Care:

It is important that jail officials and local government leaders clearly recognize and acknowledge that adequate inmate psychiatric treatment and mental health care is a fundamental constitutional obligation of the jail and, therefore, a constitutional duty of local government. Such care should be looked at no differently than medical care in terms of providing constitutionally adequate care and custody of inmates. The courts have consistently applied the same constitutional standard for inmate medical care to psychiatric and mental health services. These standards generally consist of these six (6) elements:

[19] http://www.justice.gov/crt/about/spl/documents/piedmont_findings_9-6-12.pdf

1) Timely and appropriate assessment, treatment and monitoring of inmate mental illness
2) Making appropriate provisions for an array of mental health services that is not limited to psychotropic medication only
3) Ensuring that administrative segregation and observation is used appropriately
4) Mental health records are accessible, complete and accurate
5) There is proper and adequate response to medical and laboratory orders in a timely manner
6) That adequate and ongoing quality assurance programs are in place

The Fourteenth Amendment mandates that jails must provide pre-trial inmates "at least those constitutional rights . . . enjoyed by convicted prisoners," including Eighth Amendment rights.[20] Under the Eighth Amendment, prison officials have an affirmative duty to ensure that inmates receive adequate food, clothing, shelter, and medical care.[21] The Constitution imposes a duty on jails to ensure an inmate's safety and general well-being.[22] This duty includes the duty to prevent the unreasonable risk of serious harm, even if such harm has not yet occurred.[23] Thus, jails must protect inmates not only from present and continuing harm, but also from future harm. This protection extends to the risk of suicide and self-harm.[24].

The Constitution also mandates that jails provide inmates adequate medical and **mental health care, including psychological and psychiatric services**.[25] Jail officials violate inmates' constitutional rights when the officials exhibit deliberate indifference to inmates' serious medical needs.[26]

E. Jail Staffing and the Federal Courts[27]

Court decisions define important parameters for jail operations by establishing minimum levels of service, performance objectives, prohibited practices, and specific required practices. We explore federal court decisions in this appendix, but we note that state and local courts also play an active role in evaluating and guiding jail operations. Decisions handed down by federal courts have required jails to:

[20] *Bell v. Wolfish*, 441 U.S. 520, 545 (1979).
[21] *Farmer v. Brennan*, 511 U.S. 825, 832 (1994).
[22] County of Sacramento v. Lewis, 523 U.S. 833, 851 (1998) (citing DeShaney v. Winnebago County Dep't of Soc.Servs., 489 U.S. 189, 199-200 (1989)).
[23] *Helling v. McKinney*, 509 U.S. 25, 33 (1993).
[24] *Matos v. O'Sullivan*, 335 F.3d 553, 557 (7th Cir. 2003); Hall v. Ryan, 957 F.2d 402, 406 (7th Cir. 1992)(noting that prisoners have a constitutional right "to be protected from self-destructive tendencies," including suicide)
[25] *See Farmer, 511 U.S. at 832*
[26] Estelle v. Gamble, 429 U.S. 97, 102 (1976).
[27] *See*: Excerpts from: Jail Staffing Analysis Third Edition, Jail Staffing and the Federal Courts Copyright 2009, Rod Miller, Dennis R. Liebert and John E. Wetzel. (An NIC project).

- Protect inmates from themselves, other inmates, staff, and other threats
- Maintain communication with inmates and regularly visit occupied areas
- Respond to inmate calls for assistance
- Classify and separate inmates
- Ensure the safety of staff and inmates at all times
- Make special provisions for processing and supervising female inmates
- Deliver all required inmate activities, services, and programs (medical, exercise, visits, etc.)
- Provide properly trained staff

Federal court involvement with jails goes back more than 40 years. State and federal prisons were the focus of many landmark cases in this era, and local jails soon became targets as well. Early federal decisions tackled fundamental constitutional issues in jails. Many of these pioneering decisions are still cited in current litigation.

F. Courts View Staffing Levels and Practices as Central to the Constitutional Duty to Protect

The United States Constitution imposes an extraordinary duty to protect on jails that have no counterpart in the public safety. While our duty is less visible to the public, and likely less appreciated, it rises above the constitutional responsibilities of our public safety colleagues. Even probation does not approach the duty to protect that is imposed on jails. Probation officials are not held responsible for the behavior of offenders under their supervision, nor for what happens to the offenders when they are not actually with a probation officer.

Do citizens have a *constitutional* right to be protected from crime or to have a fire extinguished? Neither of these are services that government *chooses* to provide. Whether or not to provide these services and the level of service that are delivered are discretionary decisions from a constitutional perspective. To be sure, it is politically expedient to provide fire and police protection. Because such services are discretionary, officials may vary staffing levels in response to temporary or long term staff shortages.

But a jail's duty to protect is constant, beginning when an inmate is admitted and continuing until release. Case law clearly establishes the responsibility of jail officials to protect inmates from a "risk of serious harm" at all times, and from all types of harm-- from others, from themselves, from the jail setting, from disease, and more. Because the duty to protect is constant and mandated, jails do not have the option to lower the level of care just because there is not enough staff. If a shift supervisor leaves a needed post vacant because there are not enough employees to staff all posts, he/she increases risk and exposes the agency and government to higher levels of liability.

G. Duty to Protect

In an early federal district court case in Pulaski County, Arkansas, the court described the fundamental expectations that detainees have while confined:

> *…minimally, a detainee ought to have the reasonable expectation that he would survive his period of detainment with his life; that he would not be assaulted, abused or molested during his detainment; and that his physical and mental health would be reasonably protected during this period… Hamilton v. Love*, 328 F.Supp. 1182 (D.Ark. 1971).

In a Colorado case, the federal appeals court held that a prisoner has a right to be reasonably protected from constant threats of violence and sexual assaults from other inmates, and that failure to provide an adequate level of jail security staffing, which may significantly reduce the risk of such violence and assaults, constitutes deliberate indifference to the legitimate safety needs of prisoners.

H. Staffing Levels

The first Pulaski County case produced continuing federal court involvement with jail operations. When the county was brought back to court by inmates in 1973, the county asked the court to consider their plans to build a new jail. But the judge held that, while the plans are promising, current conditions must be addressed:

> *This Court can only deal with present realities.…The most serious and patent defects in the present operation result directly from inadequate staffing. Hamilton v. Love*, 358 F.Supp. 338 (D.Ark. 1973). A federal district court judge linked Platte County (Missouri) Jail's duty to protect to staffing levels: *There shall be adequate correctional staff on duty to protect against assaults of all types by detainees upon other detainees. Ahrens v. Thomas*, 434 F.Supp. 873 (D.Mo. 1977).

In New Jersey, the federal district court required county officials to obtain an independent, professional staffing analysis addressing security staffing and training, classification, and inmate activities. The court set expectations for the plan and ordered the county to *implement* the plan:

> *The staffing analysis shall review current authorized staffing, vacancies, position descriptions, salaries, classification, and workload…[The county] must implement the plan… Essex County Jail Annex Inmates v. Treffinger*, 18 F.Supp.2d 445 (D.N.J. 1998).

I. Liability

Officials may be found to be "deliberately indifferent" if they fail to address a known risk of serious harm, or even if they *should* have known of the risk. Ignorance is not a defense. Failure to protect inmates may result in liability. Usually court intervention takes the form of orders that restrict or direct jail practices. Sometimes the courts award compensatory damages to make reparations to the plaintiffs. In more extreme situations, defendant agencies may be ordered to pay punitive damages. A U.S. Supreme Court decision held that punitive damages may even be assessed against individual defendants when indifference is demonstrated:

> *A jury may be permitted to assess punitive damages in a § 1983 action when the defendant's conduct involves reckless or callous indifference to the plaintiff's federally protected rights. Smith v. Wade*, 103 S.Ct. 1625 (1983)

J. Court Intervention

Most court decisions produce changes in jail conditions, including operations. Continuing court involvement might be prompted by a consent agreement between the parties, or by failure of the defendants to comply with court orders. The nature of court involvement may even include the review of facility plans. In a New Mexico case, the court renewed its involvement when plans to reduce staffing were challenged by the plaintiffs. The court prevented the state from reducing staffing levels at several correctional facilities:

> *..defendants will be enjoined from…reducing the authorized or approved complement of security staff…unless the minimal staffing levels identified as being necessary to provide a constitutional level of safety and security for prisoners have been achieved.. The Court also will enjoin defendants to fill existing vacancies and thus to employ at least the number of medical and mental health staff as well as the number of security staff authorized to be employed during fiscal Year… Duran v. Anaya*, 642 F.Supp. 510 (D.N.M. 1986).

Connecting Staffing Practices to Other Conditions

In the New Mexico case, the court went on to draw links between staffing levels and other aspects of facility operations, ranging from overtime to inmate idleness:

Overtime: *"...security staff will be adversely affected by excessive overtime work as a result of the understaffing of the institutions subject to the Court's orders in this litigation"*

Out of Cell Opportunity: "*…In addition, prisoners will be required to remain in their housing units for longer periods of time, and inmate idleness will increase."*

Idleness: "*Prisoner idleness…will increase as a result of staff reductions..."*

Programs and Activities: "*There is a direct, inverse correlation between the incidence of acts and threats of violence by and between inmates, on the one hand, and the types and amounts of educational, recreational, work and other programs available to inmates, on the other--i.e., acts and threats of violence tend to decrease as program availability and activity increase."*

Training: *"Reduction in security staff positions will prevent…complying with staff training requirements of the Court's order…"*

The court noted concerns by a security expert that the "*security staff reductions that are*

contemplated will result in a 'scenario at this time…very similar to the scenario that occurred prior to the 1980 disturbance'", referring to the deadly inmate riot at the New Mexico Penitentiary that claimed 33 inmate lives and injured more than 100 inmates and 7 officers.

K. Lack of Funds is Not an Excuse

Federal courts have made it clear that **lack of funds does not excuse violation of inmates' constitutional rights:**

> *Humane considerations and constitutional requirements are not, in this day, to be measured or limited by dollar considerations… Jackson v. Bishop,* 404 F.2d 571 580 (8th Cir.1968)

Courts may even restrict a jurisdiction's discretion with regard to where funds are found to make needed improvements. An appeals court held that it may restrict the sources from which monies are to be paid or transferred in order to protect the legal rights of those who have been victims of unconstitutional conduct. In a 1977 decision, Supreme Court Justice Powell observed:

> *…a federal court's order that a State pay un-appropriated funds to a locality would raise the gravest constitutional issues... But here, in a finding no longer subject to review, the State has been adjudged a participant in the constitutional violations, and the State therefore may be ordered to participate prospectively in a remedy otherwise appropriate.*

L. Recent Federal Cases

Although the basic tenets of federal court involvement with jail staffing and operations were forged many years ago, the practice has not ended, as suggested in these more recent cases:

Cavalieri v. Shepard, 321 F.3d 616 (7th Cir. 2003). The court noted that the detainee's right to be free from deliberate indifference to the risk that he would attempt suicide was clearly established.

Wever v. Lincoln County, Nebraska, 388 F.3d 601 (8th Cir. 2004). The court held that the arrestee had a clearly established Fourteenth Amendment right to be protected from the known risks of suicide.

Estate of Adbollahi v. County of Sacramento, 405 F.Supp.2d 1194 (E.D.Cal.2005). The court held that summary judgment was precluded by material issues of fact as to whether the county knowingly established a policy of providing an inadequate number of cell inspections and of falsifying logs showing completion of cell inspections, creating a substantial risk of harm to suicide-prone cell occupants.

Hearns v. Terhune, 413 F.3d 1036 (9th Cir. 2005). The court held that the inmate's allegations stated a claim that prison officials failed to protect him from attacks by other inmates. The

inmate alleged that an officer was not present when he was attacked even though inmates were not allowed in the chapel without supervision.

Velez v. Johnson, 395 F.3d 732 (7th Cir. 2005). The court held that the detainee had a clearly established Fourteenth Amendment right to be free from the officer's deliberate indifference to an assault by another inmate.

Smith v. Brevard County, 461 F.Supp.2d 1243 (M.D.Fla. 2006). Violation of the detainee's constitutional rights was the result of the sheriff's failure to provide adequate staffing and safe housing for suicidal inmates, and in light of the sheriff's knowledge that inmate suicide was a problem, his failure to address any policies that were causing suicides constituted deliberate indifference to the constitutional rights of inmates.

VIII. ASSESSMENT OF MCDF MENTAL HEALTH PRACTICES
Findings / Conclusions / Recommendations

Federal court precedent has established specific fundamental elements for an effective and constitutionally-sound jail mental health care program.[28] All of these elements are typically found in national standards for jail health care (NCCHC, ACA, and AJA).[29] Illinois State Jail Standards also includes these concepts in meeting requirements for operating a county jail.[30]

MCDF mental health practices were assessed according to these standards and elements.

Constitutional Right #1: There must be an adequate and systematic program for screening, evaluation, and monitoring inmates in order to identify those needing mental health services.

General Discussion

An adequate and systematic inmate mental health screening and evaluation program involves three primary components. The primary objective of these components is to 1) determine inmate mental health needs in order to provide adequate housing and care; 2) protect a mentally ill inmate from themselves and others if and as indicated; 3) ensure mentally ill inmate reasonable access to jail services and programs required by law.

Screening and evaluation are ongoing processes throughout the length of incarceration. These processes begin during the intake process and end at discharge. The intake process should include collecting information from the arresting officer about the inmate's demeanor and specifically ask the officer about behavior that indicates possible mental illness or suicide risk. This information must be documented and maintained permanently by the jail for future reference in case the inmate again is incarcerated in the facility. A structured initial screening is used by jail staff to identify potential urgent care needs and, if determined, urgent care protocols are used to provide necessary care. For example, an inmate who presents with a history of severe mental illness but who has been off prescribed psychotropic medications for more than a week should be considered a possible urgent care case. This inmate is immediately referred for a crisis evaluation for medication and stabilization services to prevent the inmate from decompensating. The inmate should be transported to the nearest hospital under emergent cases and returned to the jail only if and when the inmate stabilizes to a level that is within the jail's capacity to provide ongoing care.

[28] *Ruiz v. Estelle*, 503 F.Supp. 1265 (S.D. Texas 1980)
[29] Refers to the National Commission on Correctional Health Care, American Correctional Association, and the American Jail Association.
[30] Illinois County Jail Standards Title 20 I-F Part 701

Screening evaluation is ongoing during incarceration for all inmates. Inmates identified as mentally ill during the intake process are monitored and evaluated to maintain stability and provide needed care. Inmates not found to be mentally ill at intake are monitored for signs and symptoms of decompensating mental health. The stressors of incarnation, changes in court schedules and case status, family problems, the fear and shame of being locked up, etc. are only a small few examples of circumstances that can trigger a mental health problem with this population. An adequate screening and evaluation process is based on the understanding that any inmate can develop a mental health problem during incarceration and proactively promotes reasonable access to mental health care services according to need as determined by qualified medical or mental health professionals.

A discharge screening or evaluation is completed before a mentally ill inmate is released from the jail as is reasonably possible. This is intended to determine inmate mental health status and readiness for freedom, and to counsel the inmate about medication compliance. It can also provide the opportunity to connect the inmate to community mental health care agencies and services. In many cases, mentally ill inmates are released without a screening or evaluation due to time constraints, inadequate resources, or because the inmate refuses the assessment, Regardless of potential barriers, every reasonable effort should be made to offer and complete a discharge assessment with mentally ill inmates before they are released.

FINDING(S): MCDF uses a multi-layered, very comprehensive and systematic screening, evaluation, and monitoring process to identify inmates who need mental health services before incarceration through to discharge.

MCDF written policies and procedures clearly require adequate screening and evaluation of all persons being admitted into the jail. The intake process consists of collecting relevant information from the arresting officer to determine potential medical, mental illness, suicide risk, and urgent care needs. This information is given verbally to the jail booking officer by the arresting officer, documented, and permanently maintained. A detailed screening is performed by the booking officer once the inmate is accepted from the arresting officer. Adequate policies, procedures, and protocols exist to guide the booking officer in dealing with urgent care needs. The detailed intake screening process involves a series of medical, mental health, and suicide risk questions asked to the arrestee using a series of intake screening templates in the electronic jail information system (EJIS). This Consultant's review of the electronic intake templates found them to contain adequate and essential screening elements needed for the booking officer to make informed decisions about inmate medical, mental health, and suicide prevention risks and needs.

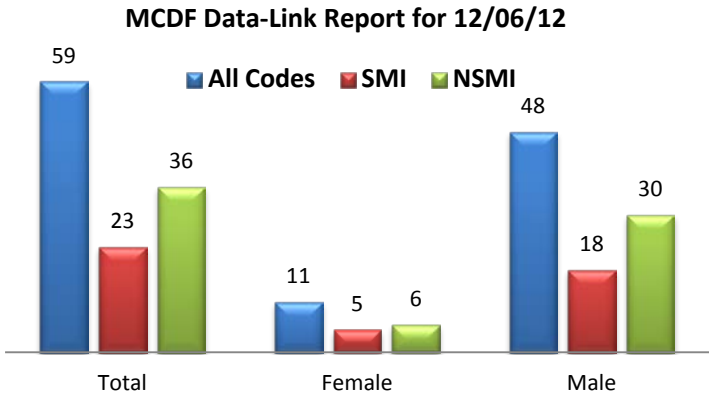
In addition to the above intake screening process, all newly booked inmates are electronically cross-referenced automatically with the Illinois State Jail Data-Link data-base system. The Jail

Data-Link system contains the names and diagnoses of all inmates who have a history of mental illness treatment and services. This includes any type of mental health service during their lifetime from publicly funded MH agencies in Illinois. Information provided assists jail Inmate Services staff and other health care professionals to quickly know which inmates have known histories of serious mental illness (TA=SMI) and those with histories of diagnosed non-serious illness (EA=NSMI). This information is reviewed daily by jail staff and follow-services are initiated. This Consultant reviewed the Jail Data-Link report for 12/06/12 to gain a better understanding about the prevalence of inmate mental illness, and for the data's value to the intake screening process and jail mental health program.

The Data-Link report for 12/06/12 showed that there were 64 inmates currently in custody who had histories of mental health services.[31] The total in-house inmate population for 12/06/12 was estimated at 230 (12% female, 88% male). Sixty-four inmates reported in Data-Link accounted for approximately 28% of the in-house population, 11 female and 53 males. Approximately 17% of the Data-Link population was female, 83% male. However, females represented a higher percentage of their in-house cohort than did males at 40% and 26% respective. These findings are relatively consistent with national research regarding jail and mental illness and gender.

MCDF DATA-LINK 12/06/12	Population	Female	Male
Total Jail Count	230	28	202
% Jail Count	100%	12%	88%
Total Data-Link Count	64	11	53
% Data-Link of Ttl Jail Count	28%	40%	26%
% Gender Data-Link	100%	17%	83%

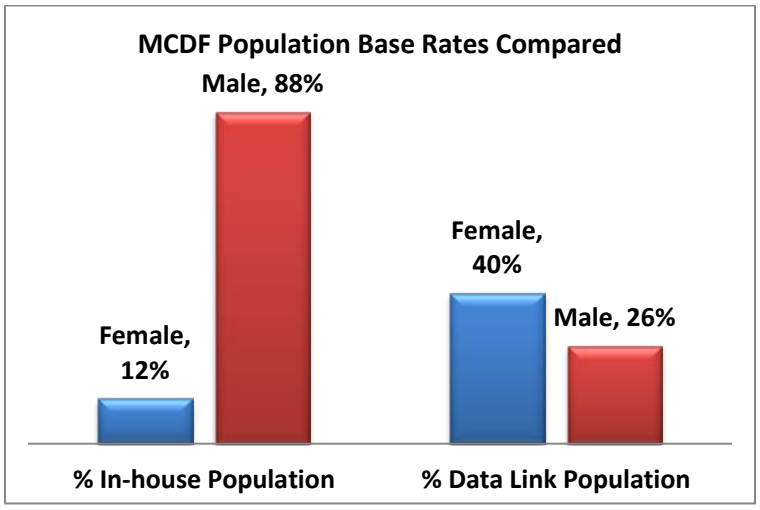
Diagnosis codes were reported for 59 (90%) of the 64 names, 11 (19%) female and 48 male (81%). Twenty-three (39%) inmates had SMI diagnosis codes and 36 (61%) had NSMI diagnoses.



[31] Data-Link uses EA to identify inmates with an "eligible diagnosis" and TA for "Target Diagnosis. EA is considered non-SMI with a less serious Axis I diagnosis. TA includes SMI Axis I diagnosis as defined by USDHHSA. There were no diagnosis codes for six of the 64 names for the data reported.

Nearly one-third of male and less than one-tenth of female inmates accounted for the SMI diagnosis group; whereas about one-half of male and one-tenth of the female inmates had NSMI diagnoses codes. However, comparing gender prevalence base-rates reveals a much different interpretation of the data.

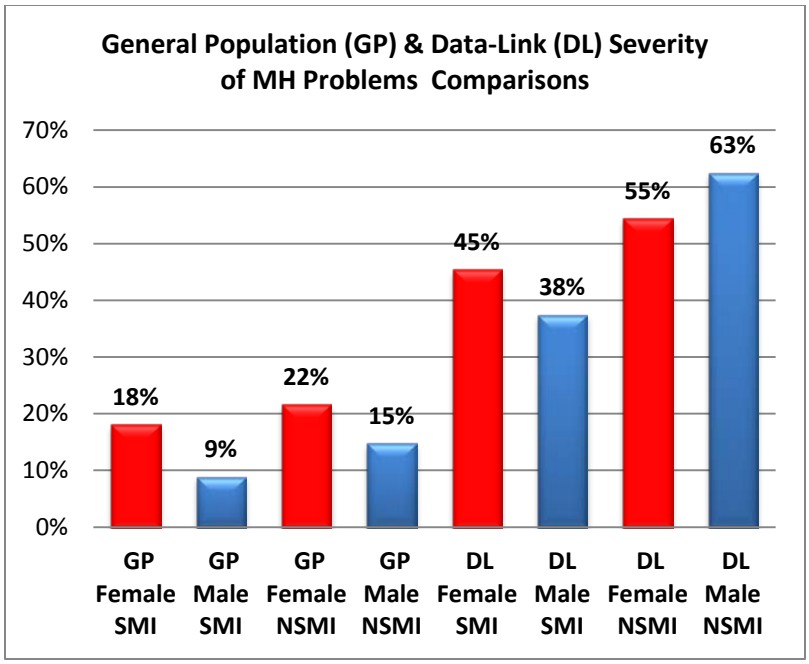
Comparing in-jail and Data-Link populations for 12/06/12 shows a distinct difference in the prevalence of mental health problems between female and male inmates. Although women represented only 12% of the in-house population, 40% of them had a reported mental health diagnosis code. Men, however, represented about 88% of the in-house population but only 26% of them had a reported diagnosis.



These differences are generally consistent with the literature comparing prevalence rates for mental health problems between female and male local jail inmates. The United States Bureau of Justice Statistics reported for 2006 that jail inmate populations were at about 88% male and 12% female, and a prevalence of mental health problems among jails inmates at approximately 75% for female and 63% for males.[32]

Among the MCDF general population, prevalence of serious mental illness (SMI) was two-times higher among female inmates than males, 18% and 9% respectively, and somewhat higher for non-serious problems (NSMI), 22% and 15% respectively. Females also showed higher prevalence for SMI in the Data-Link group compared to males (45% to 38%) but lower rates for NSMI (55% to 63%).

[32] See: http://bjs.ojp.usdoj.gov/content/pub/pdf/jim10st.pdf, and http://www.bjs.gov/index.cfm?ty=pbdetail&iid=789



The multi-layered intake screening and evaluation process used at MCDF appears comprehensive, reliable, and valid. Information collected by booking officers is cross-referenced with Data-Link in a timely manner. This process provides custody and care staff reasonably accurate information about the prevalence of mental illness among all inmates.

MCDF continues screening, evaluation, and monitoring processes following intake using four primary methods: 1) follow-up evaluation and care of Data-Link inmates; 2) inmate or staff initiated requests for mental health services; 3) a Custody Reassessment review; and 4) the 14-Day Health History and Physical assessment.

Follow-up Evaluation: Follow-up services are proactively initiated by Inmate Services and Qualified Mental Health Professional (QMHP) staff for all Data-Link inmates within 48 hours of incarnation, or sooner if needed. Staff reviews the reported history of mental illness and initiates inmate contact for additional assessment and care services as indicated by the reported history and assessed needs. These inmates are regularly monitored during incarceration as indicated by presented or reported need.

Inmate/Staff Initiated: Inmates and staff are encouraged to initiate screening, evaluation, and monitoring for all inmates at booking and during incarceration. Inmates are able to report personal needs verbally or in writing using a sick call request. Inmates can also report concerns about other inmates, and all staff having contact with inmates are required to report concerns they have about an inmate's mental wellness to their supervisors, Inmate Services Staff or QMHP staff, or other health care staff. The same process used for the Data-Link population is used for follow-up, care, and monitoring for these reporting methods.

Custody Assessments: All inmates booked in to MCDF receive an initial Custody Assessment for classification, care, and housing purposes. The initial assessment is followed by a similar reassessment conducted periodically. Both assessments follow a structured methodology that monitors and scores status changes for the following conditions:

MCDF Initial Assessment / Reassessment Custody Scale

Custody Evaluation	• Severity of charges and convictions • Serious offense history • Escape history • Institutional disciplinary history • Prior felony convictions • Alcohol and drug abuse • Stability factors (age, employment, residence)
Special Management Issues	• Protective custody • Psychological impairment • Mental deficiencies • Escape threat • Serious violence threat • Known gang affiliation • Substance abuse problem • Known management problem • Suspected drug trafficker • Suicide risk • Medical impairment • Physical impairment • Other as specified

14-Day Health Assessment: The 14-day Health History and Physical Assessment (14-day H&P) protocol is the third method used by MCDF to ensure adequate screening, evaluation, and monitoring inmates for mental health needs. As required by Illinois State and recommended by other national correctional health standards, all MCDF inmates are required to have a Health History and Physical Assessment within 14 days of admission into the jail. This assessment is performed by qualified medical staff using a comprehensive and structured health assessment form that assesses medical and psychiatric conditions and needs. Inmates assessed with psychiatric or mental health conditions or needs are referred for follow-up assessment, care, and monitoring similar to those previously discussed.

CONCLUSION(S): Overall, MCDF appears to meet the constitutional requirements for screening, evaluation, and monitoring of inmates to determine need for mental health services and care. This process appears to be a model in many ways based on this Consultant's professional experience.

RECOMMENDATION(S):

1. Continue use of current screening and evaluation systems and processes.
2. Develop a Continuous Quality Assurance program using specific data elements from the EJIS and Data-Link systems to establish qualitative and quantitative measures for housing and monitoring mentally ill inmates.
3. Continue the recently established practice of maintaining statistical data on all inmates with mental illness.
4. Involve designated system and CJCC components to participate in establishing CQA measures.
5. Collect, compare, and report monthly EJIS and Data Link information to better understand mentally ill inmate volume.
6. Maintain a daily "case load" report for SMI and NSMI populations from Data Link and other sources.
7. Continue collecting data on the mentally ill inmate population that will aid in making decisions for expanding and developing diversion and reentry strategic plans.

Constitutional Requirement #2: There must be a mental health treatment program that involves more than segregation and close supervision.

General Discussion

Generally speaking, it is unlawful (and inhumane) for jail officials to restrict mentally ill inmates from access to services that are available to inmates without mental health problems. Unfortunately, this happens all too often for many seemingly legitimate reasons resulting in expensive litigation against local governments. Lack of resources (treatment and care services) and/or jail capacity (housing) are indefensible arguments for disparate treatment of the mentally ill inmate population. The following is the "short list" of failed defenses in Civil Rights cases involving inadequate mental health care violations:

- *The County can't afford any or more qualified staff to screen, evaluate, and care for these inmates.*
- *The County can't afford mental health medications.*
- *Segregation cells are all we have available for these inmates.*
- *We can't afford to hire more officers to move inmates to programs or provide security while these inmates are participating in their programs.*
- *We didn't know what we were supposed to do.*
- *Our staff is not trained in how to manage these inmates.*
- *It's the mentally ill inmate's fault if he/she ends up living in segregation because he/she won't get along with other inmates in general population.*

- *This population is too unpredictable and dangerous.*
- *Our community has no services to help us.*

Court response to these and other unsuccessful defenses has been expensive and consistent. Two recent cases resulted in hiring mandates of as many as 400 officers in one Illinois county jail and 30 in an Indiana facility. The same Indiana County was also required by the United States Department of Justice to increase qualified mental health staff levels from five to 21 FTEs, increase on-site psychiatric provider services from four to 40 hours per week, and to ensure that all staff (FT, PT, government, and contract) having contact with inmates complete pre-service and annual training on suicide prevention and mental illness. Both jurisdictions are also currently engaged in construction and renovation of jail facilities to ensure adequate care of mentally ill inmates. On January 2, 2013 a U.S. District Court Judge found the Indiana State Department of Corrections to act with "deliberate Indifference" to the constitutional rights of mentally ill inmates. U.S. District Judge Tanya Walton Pratt ruled that the Indiana Department of Corrections violated mentally ill prisoners' constitutional right against cruel and unusual punishment by keeping them separate (segregated) from other inmates and failed to provide them with adequate treatment:[33]

> *"The Court finds that mentally ill prisoners within the IDOC segregation units are not receiving minimally adequate mental health care in terms of scope, intensity, and duration and the IDOC has been deliberately indifferent,"*
>
> *"The pervasive function of mental health staff within the IDOC has become a mixture of responding to crises and responding to prisoner requests to be seen," she added."*
>
> *"In practice, however, mental health treatment is principally limited to issuance of medication, prisoner conversations with the mental health staff, and mental health staff's response to incidents of actual and attempted self-harm," Pratt wrote in her 37-page opinion issued in federal court in Indianapolis more than a year after a July 2011 bench trial."*

The federal court found both the practice of unreasonable use of segregation and lack of adequate funding to ensure appropriate care to these mentally ill inmates the primary culprit in this case.

Adherence to this Constitutional requirement involves providing assessment, treatment, services, and housing programming that meets the special health needs of mentally ill inmates while protecting all inmates and staff from risk of harm. Specifically, adherence requires jail officials to provide an array of services that allow mentally ill inmates access to basic jail services (food,

[33] NWI Times 01/02/2012 at: http://www.nwitimes.com/news/state-and-regional/indiana/judge-ind-indifferent-to-mentally-ill-inmates/article

clothing, recreation, protection, etc.), as well as providing treatment for their mental illness that is generally consistent with community standards of care. This would include medications indicated for specific diagnosis and symptoms, crisis intervention and stabilization services, evidence-based individual and group therapy, and other reasonable accommodations designed to aid in alleviating illness. Programs and services should be appropriate to age, gender, and illness. For example, individual or group insight therapy would not be an appropriate treatment modality for severely psychotic inmates but social rehabilitation might. Group Cognitive Behavioral Therapy for female inmates diagnosed with PTSD stemming from a history of sexual assault may be appropriate but should be conducted separately from a treatment group for male inmates with a similar diagnosis and abuse history. Additionally, services should be culturally competent and sensitive. Some reasonable accommodations may include allowing these inmates to keep their program materials in their housing units, have reasonably unrestricted access to showers, be housed in special units with dayrooms, and provided other resources that promote stability, etc.

As a general rule, inmates with mental illness must be provided reasonable access to basic jail services similar to those available to inmates who do not have mental illness, and be provided treatment, services, and resources specific to their mental health needs.

FINDING(S): As a general rule, it is the policy of MCDF to provide parity in access to basic jails services to mentally ill inmates with the exception of housing. A review of operations and health care policies, procedures, assessment and monitoring forms, interviews with staff, facility tours, and review of jail services indicates that MCDF generally excels in its efforts to provide programs for all inmates, including the mentally ill. MCDF does not discriminate in allowing inmates with mental illness access to programs that are available to other inmates. Access to programs is based on risk, need, and appropriateness.

General Programs

MCDF maintains structured rehabilitative and treatment programs for ALL inmates requesting participation, including general education, substance abuse, individual and group counseling, religious, recreation, work and educational release programs. All of the programs are available to all inmates regardless of sex, race, origin, religion, political views, disabilities or legal status. It is the policy of the MCDF to use volunteers to enhance and expand the services and programs offered to the inmates. The jail's volunteer program encourages increased personal contact for the inmate, broadens community resources for the jail and increases public awareness of the functions and responsibilities of the MCDF. Volunteers are used effectively in such program areas as education, religious activities, and specialized programs such as substance abuse. Volunteer services provide superior services in an economical way and foster community support. The MCDF Inmate Program Supervisor is responsible for the recruiting, orientation and training of all volunteers. The jail's staff is responsible for transporting inmates to and from

programs and providing security for the inmates and volunteers when programs are in session. MCDF has 87 active volunteers enrolled as of the date of this assessment.

- *Alcoholics Anonymous* meetings were offered to inmates at MCDF in 2011. There were 557 inmates attending this program in 2011 compared to 504 in 2010. Volunteers conduct meetings on a weekly basis for AA. While there are various factors that have a role in the number of inmates that participate each week, overall inmate population and class size restrictions are still the largest factors.

- *GED (General Equivalency Diploma)* classes are offered to inmates 5 days a week. As with all programs, males and females have separate classes. The teacher for the GED program for 2010 was contracted through Heartland Community College. Obtaining a GED certificate while in MCDF is done at no cost to the inmate. The goal always is that when inmates leave the jail they will continue their education and be able to become gainfully employed or maintain steady employment. Inmates that are unable to complete the program while incarcerated are provided information about where in the community they can continue their GED education. The number of inmates attending GED classes was 945 in 2010 and 1026 in 2011. Twenty-four inmates took the GED test and 19 passed.

- *The Storybook Program* provides an opportunity for inmates to communicate with their children while incarcerated. This program promotes individual as well as family literacy. Inmates are allowed to pick out a storybook suitable for their child and their own reading level. The inmate will record the book on cassette tape with a volunteer present, the tape will be transferred to a CD and then the book and CD will be mailed to the child at no cost to the inmate. STAR Adult Literacy, through the Regional Office of Education, has written and received a grant each year from the Secretary of State office to fund this program. The Mid-State and Illinois Reading Councils have also donated materials and staff time for the program. In 2011, 211 inmates participated in the Storybook Program.

  The Illinois State Board of Education and the Illinois Reading Council selected this program to be a pilot program for the State of Illinois. They funded a film crew to film a training video at MCDF on how to start this type of program in other facilities. Several state and local agencies have had interest in this program and some have implemented the program based on the provided information. The video has reached facilities across the nation through the work of the Illinois Reading Council's collaborative efforts with the Mid-State Reading Council.

- *Bible Study and Church Services* operate as non-denominational programs. Volunteers work with inmates, as well as with the individuals released back into the community. The Jail Chaplain oversees the scheduling of these programs. Churches and volunteers in the community assist the facility by making donations of Bibles and other religious materials as needed. For 2011, the following literature was used: Gifts of Freedom (15), Bible Study guides (40), Koran 8, Jehovah Witness (4), Tanaks (2), James Gill's Books (30), Daily Bread (500), My Heart-Christ Home (40), CEV/GNT/Gideon Bibles (445), and Celebrate Recovery (265).

- *Life Skills Classes* are geared towards providing inmates with the tools to help individuals improve basic work skills or develop skills needed to stay in or enter the work force upon release back into the community. The classes encourage use of the library and other resources available in the community. *Life Skills* assists participants with finding the right job based on their education, skills and interests, as well as teaching networking skills while looking for a job. The classes also educate inmates on what documents they may need after their release (birth certificate, social security card) and how to obtain them, as well as where to go in the community to find affordable housing based on income and transitional housing or other assistance programs for basic living needs and community and government services available. Inmates can learn basic budgeting and money management. Issues regarding basic hygiene and health care are also addressed. Computers with various educational software programs are provided to assist with individuals learning needs and to help learn or improve keyboarding skills. While *Life Skills* classes are generally geared towards the specific needs of an individual, group discussions are also promoted. Profits from the sale of inmate phone cards pay for this contract. Attendance for 2010 was 552 with 719 participating in 2011, an increase of 30%.

- *Women's Informational Support Group* is provided by the YWCA / Stepping Stones, started a program entitled Women's Informational Support Group. The support group focuses on various aspects of relationships. The group addresses how to choose positive relationships, avoid or get out of abusive relationships, empowering women, and teaching them about making alternative choices in life and improving and maintaining positive relationships with their children. There are 8 volunteers with two volunteers running each group session. The Stepping Stones program runs in six-week sessions and up to 12 females can attend each week. Attendance for 2011 was 161.

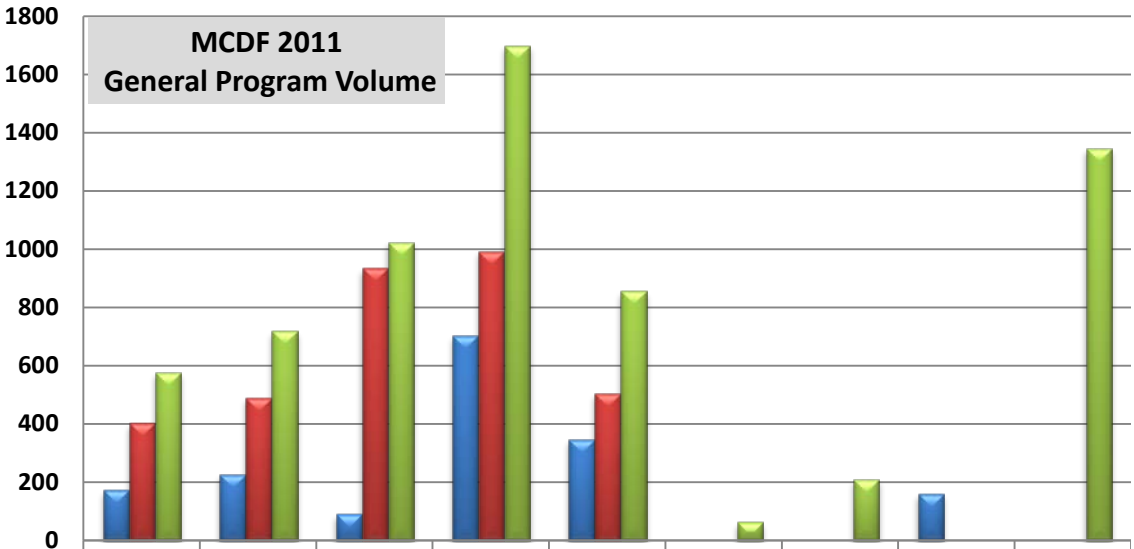
- *The Mentoring Children of Prisoners Program* also began in 2009 and is run by Big Brothers Big Sisters. This program is not unlike any other mentoring program offered by Big Brothers Big Sisters and focuses on children between the ages of 5-14 who have one or both parents who are incarcerated in a local, state or federal correctional facility. A mentor, who is a screened and trained community member, agrees to spend

consistent time with a child to develop a caring and trusting relationship. Big Brothers Big Sisters works in coordination with MCDF staff to identify prisoners who would like to request services for their children. By signing a waiver/release of information form we will be able to share information between Big Brothers Big Sisters and the MCDF in order to coordinate efforts to reach the caregiver and child to offer services. The child's caretaker must agree to participate in order for the child to be accepted into the program. The mentor will spend 3-4 times a month meeting with the child doing a variety of activities outside of the child's home and school. The agency also makes an effort to help the child connect with the incarcerated parent through letters, cards, phone calls and visits when appropriate but only with the consent of the child's caregiver and when appropriate. The Mentoring Children of Prisoners Program continues to reach out to families.

- *Celebrate Recovery* is a recovery program that deals with all aspects in life with a primary focus on dealing with drug addictions and co-dependence. Currently, 3 volunteers help orchestrate the program. This program is for men and women and meets every other Friday. Attendance for 2011 was 204.

- *Commissary* is provided to inmates once each week. The MCDF commissary contains hygiene items, correspondence materials, limited undergarments, shoes, snack and food items and phone cards. Inmates are permitted to purchase from the commissary if they have funds in their Inmate Trust Fund Account. All profits from commissary are used for detainee welfare. Proceeds of the Inmate Commissary and phone card sales also help support and maintain jail programs along with community and limited County budget contributions.

- *Job Partnership* brings together local and area businesses and churches to train, equip and employ citizens in the McLean County area. The primary goal is to bring program participants from dependency to self-sufficiency. Participants become productive, taxpaying citizens who help strengthen the local community.

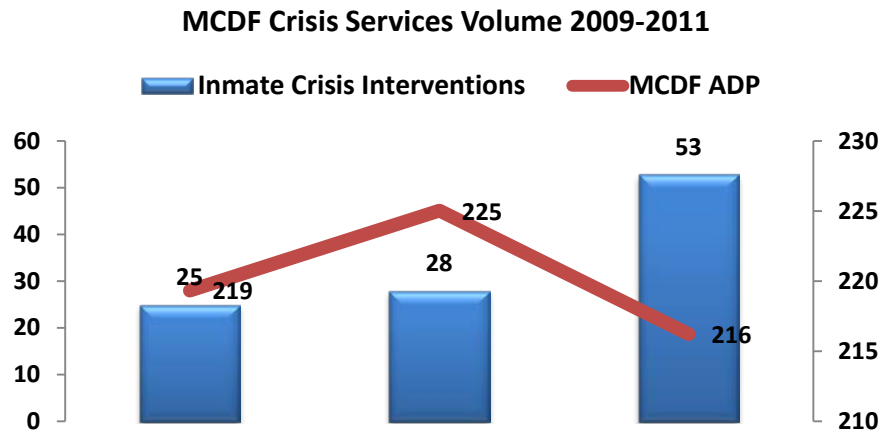


	AA	Life Skills	GED	Bible Study	Church Services	Chaplin Visits	Story Book	Womens Support Group	Bibles Given
Females	174	229	91	704	348			161	
Males	403	490	935	995	507				
Total	577	719	1026	1699	855	64	211		1346

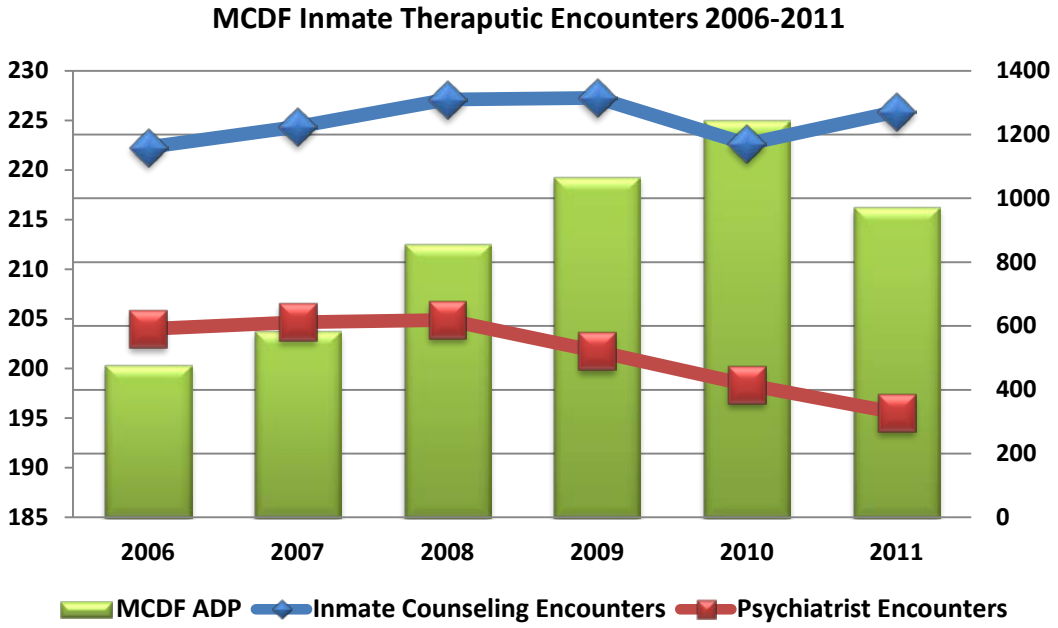
Therapeutic Programs and Services

Therapeutic services are provided to mentally ill inmates and inmates who experience situational mental health problems. According to interviews of MCDF officials, these services are provided onsite by 16- hour per week private licensed mental health practitioners, two hours per-week by a psychiatrist, and other qualified MCDF staff. This Consultant found these MCDF staff to be very personable, competent, qualified, and compassionate. Programs and services include an array of assessment and treatment activities aimed specifically toward inmates with mental illness or mental health problems. Services include a crisis response team, psycho-social assessment, individual and group treatment, and psychiatric medication.

Inmate crisis interventions more than doubled from 2009 to 2011, yet the ADP for those years remained relatively unchanged. There were 25 crisis interventions in 2009, 28 in 2010, and 53 in 2011. This increase is mainly due to policy that requires the Crisis Team to respond to all events involving the use of the restraint chair. The policy has since been adjusted to require this response only as needed to ensure that inmate mental health needs that are in question are assessed and to provide care orders as needed.



There was an overall increase in inmate counseling encounters between 2006 and 2011 but psychiatrist encounters decreased during that same time period. Psychiatric encounters are of particular concern and interest. These encounter data suggest that the need for psychiatric medications decreased. MCDF officials explained that this decrease was very temporary and during a brief period while transitioning to a new provider. Officials also explained that some of the increase in counseling encounters was due, in part, to an increase in proactive encounters to compensate for this temporary change in psychiatric providers.



Housing

As a general rule, it is the policy of MCDF to provide parity in access to basic jail services to mentally ill inmates with the exception of housing. MCHF makes every effort to allow mentally ill inmates the opportunity to live in general population housing units. Many with serious mental

illness are segregated from other inmates in single cells in the booking area or directly across from the intake booth and supervisors office. MCDF officials stated this is done for two specific reasons. First, the single cells across from booking booth are used for inmates who are on suicide precautions so they can be closely monitored. Second, mentally ill inmates are segregated in single cells in the booking area simply because the facility does not have adequate bed capacity to manage these inmates appropriately elsewhere, but fully desires to make necessary changes to do so.

Segregating mentally ill inmates does not by itself create a violation of inmates civil rights. There can be several legitimate justifications for such a practice. Examples may include when an inmate's mental illness cannot be stabilized in general population; when close monitoring by medical staff is needed following a change in medications; or even because the inmate has specifically requested segregation and that the request is determined by jail officials to be in the best interest of the inmate. There are several possibilities. However, such housing practices can violate inmate civil rights where doing so unreasonably restricts access to basic and therapeutic programs and services, exacerbates illness or contributes to a lack of mental health improvement, or simply because the facility does not have the resources or capacity to otherwise provide appropriate services or housing options.

MCDF maintains an exceptionally clean and orderly facility. The single cells segregating mentally ill inmates are no exception. Jail officials stated that cell sanitation and inmate hygiene is very important and given particular attention to ensure cleanliness and health. This Consultant's inspection of all jail areas, including segregation cells, found this to be true.

Specific and ongoing monitoring of mentally ill inmates housed in segregation is provided by additional wellness checks and written formal Mental Health Behavior Plan for inmates housed in the booking and holding cells involving a multidisciplinary team. This Plan is documented and accessible to all staff involved in the care and custody of the mentally ill inmate. The Plan is written and includes mental health orders related to risk and needs, reasons for the housing decision, property allowed, observation frequency, security restrictions, and additional comments. Additionally, Inmate Services and health care staff perform ongoing mental health status assessments of the inmates to monitor the effects of segregation and care needs.

McLean County officials are very concerned about the practice of segregating mentally ill inmates in single cells and fully intend to make reasonable changes to correct this practice. The fundamental reason given by MCDF officials for this practice, a lack of adequate housing options, is not defensible despite the added quality of care and attention given these inmates. Continuing this practice is unhealthy for these inmates who have special needs and exposes McLean County to significant risk of civil liability. Furthermore, booking and intake cells were not meant nor designed to be permanent housing units. This practice has virtually eliminated all

use of these cells for their intended purpose, severely impairing the intake and booking process. Therefore, the sheriff has proposed renovating one 2100 square foot recreation area into a special housing unit for mentally ill inmates. Although further study is required to determine the feasibility of the proposal, the area appears to provide adequate capacity for between 10-18 inmates, depending on the types of inmates housed in this area and levels of programming. Interviews conducted during this assessment indicate strong consensus and support for the sheriff's proposal.

CONCLUSION(S): MCDF officials are very concerned about the practice of segregating mentally ill inmates in booking and intake cells and fully intend to correct this practice quickly, as stated above. On the other hand, MCDF provides what appears to be an exceptional array of integrated general and therapeutic inmate programs and services involving a host of highly qualified, caring, and competent staff and volunteers. The variety of these programs and services appear to address many personal, social, and criminogenic needs and factors among inmates. MCDF officials are to be commended for applying this integrated approach, and for the variety and volume of these activities.

RECOMMENDATION(S):

1. Determine the feasibility to renovate the available recreation space into a special mental health unit. This should begin with an engineering study to determine if this area can access needed utilities, can handle the additional surface weights, and provide for basic living requirements for intended use and designs concepts.
2. Request additional Technical Assistance from the National Institute of Corrections to help in programing and design development planning.
3. Current basic and therapeutic program philosophies, programs and services should continue.
4. Begin developing ideas and concepts for determining types and volume of services that would be provided if a special housing unit for mentally ill inmates is constructed.
5. Begin developing program policies concepts for implementation of the special unit.
6. Review the literature regarding evidence-based treatment programs for jail-based mental health services to determine what, if any, modifications or changes should be made to current services. See the NIC Library at: http://nicic.gov/.
7. Review the literature on Writing a Recovery Treatment Plan (WRAP) program to determine if and how this program can be assimilated into current jail-based services to prepare mentally ill inmates for community reentry and linking. See at: http://www.mentalhealthrecovery.com/wrap/.
8. Add local NAMI representatives to the current list of community volunteers and advocates. Consider providing office space in MCDF to allow NAMI representatives to add their expertise and resources to managing mentally ill inmates and for assistance in

linking released inmates to community services and providers. Take full advantage of local, state, and national NAMI expertise and resources.

Constitutional Requirement #3: There must be trained Mental Health Professionals in sufficient numbers to provide for the identification and treatment services in an individualized manner to treatable inmates suffering a serious mental disorder.

FINDING(S): MCDF provides 16 hours per week of mental health services by two licensed mental health practitioners and a psychiatrist four hours bi-weekly. Based on interviews with one of these clinicians and review of documents and inmate charts, it appears that these professionals are very competent and knowledgeable in dealing with this population. MCDF officials intend to increase weekly on-site time to 20 hours per week for these practitioners but voiced no decision to increase psychiatrist hours.

CONCLUSION(S): MCDF has well qualified and trained mental health professionals on-site to provide competent identification, assessment, and treatment of inmate mental illness. They work as part of an integrated behavioral health care team consisting of staff from Inmate Services, Custody, Medical, and management. Overall, these clinicians and this team seem very productive and dedicated. However, based on the data provided for inmate population and prevalence rates for inmate mental illness, the hours appropriated for both the psychiatrist and the mental health clinicians seems inadequate.

RECOMMENDATION(S):

1. On-site psychiatrist hours appear to be inadequate. MCDF officials should consider increasing this time to a minimum of six hours per week. Use of a psychiatric nurse practitioner can be a cost-effective way to increase on-site hours if allowed by state law.
2. On-site licensed mental health professional hours appear to be inadequate. MCDF officials should consider increasing this time to a minimum of 40 hours per week to include regular weekend coverage.
3. Continue to provide specific training in dealing with mentally ill inmate populations to all staff who work with these inmates.

Constitutional Requirement #4: There must be maintenance of accurate, complete and confidential records.

FINDING(S): Except for screening and assessment information collected at booking in the electronic jail information management system (EJIS), MCDF primarily maintains a "paper" health records system. Records area maintained in a secure location and maintaining records confidentiality was reported as a high priority by the Nursing Director and jail administration

officials. A review of 18 charts involving inmates with mental illness found these paper charts to appear well organized and complete. All required screening, assessment, treatment, consultation records appeared in appropriate chronological order and each chart was easily reviewed.
Medical officials indicated that they were interested in procuring an electronic health records system (EMR) in the near future and were currently investigating several systems.

CONCLUSIONS(S): MCDF appears to maintain accurate, complete, and confidential inmate health records in a secured location. Procurement of an electronic medical records and medication administration system(s) seems appropriate and necessary.

Constitutional Requirement #5: Treatment by prescription and administration of behavior-altering medications in dangerous amounts and by dangerous methods or without appropriate supervision and periodic evaluation is an unacceptable method of treatment and must not be present.

FINDING(S): Based on interviews with health care and jail officials, a review of the medication administration records and medical charts of mentally ill inmates, there appears to be no evidence that MCDF prescribes psychotropic medications in dangerous amounts, uses dangerous methods, or fails to provide appropriate supervision and routine evaluation of medications prescribed. As a general rule, inmates are continued on the verified prescription medications they were on before incarceration unless otherwise indicated by illness.

It is also the policy and practice of MCDF to provide inmates with psychotropic medications upon release. Medical staff places a telephone order to a local pharmacy for medications and provides the necessary information necessary to verify the identification of the inmate picking up the order. Released inmates do not have to pay for this or any other medication or health care provided while incarcerated.

CONCLUSION(S): MCDF appears to take the utmost care in prescribing and treating inmates with psychotropic medications. This is evidenced by the interviews conducted and the review of medication administration and health records.

As a matter of policy and practice, it is very atypical for a local jail not to charge inmates for health care or medications. The reason given by several jail officials for not charging inmates for these services is even more extraordinary in this Consultant's experience. Officials stated that they do not what to impose additional economic barriers to a person's successful reentry into the community.

RECOMMENDATION(S):

1. Implement an electronic health records system that fully and reliably interfaces with the jail information management software. Include an electronic medication administration record component as part of the EMR or as a separate interfacing system.

Constitutional Requirement #6: There must be a suicide identification, treatment and supervision program. There must be a basic program for identification, treatment and supervision of inmates who evidence suicidal tendencies (and mental health problems).

General Discussion

MCDF officials report that there have been on three successful suicides in the facility over the past 30 years. This is considered extraordinarily low but not atypical for a facility that operates at the level of professionalism as witnessed by this Consultant. All aforementioned program elements are either directly or indirectly connected, maintaining effective jail suicide prevention.

Current National Perspective

A recently published national study on jail suicide reports that "*Suicide continues to be a leading cause of death in jails across the county; the rate of suicide in county jails is estimated to be several times greater than that in the general population."*[34] This study goes on to describe many of the salient factors and influences associated with jail suicides. Although it appears that the base-rate for jail suicides is decreasing, certain factors found 20 years ago have changed. The significant findings in this study are in bold and italics below:

Suicide Victims:

- 67% were white.
- 93% were male.
- The average age was 35.
- 42% were single.
- 43% were held on a personal and/or violent charge.
- 47% had a history of substance abuse.
- 28% had a history of medical problems.
- ***38% had a history of mental illness.***
- 20% had a history of taking psychotropic medication.
- ***34% had a history of suicidal behavior.***

[34] Lindsay Hayes, "National Study of Jail Suicide 20 Years Later", DOJ/NIC AN 024308, April 2010.

Characteristics of Suicides:

- ***Deaths were evenly distributed throughout the year; certain seasons and/or holidays did not account for more suicides.***
- 32% occurred between 3:00pm and 9:00pm.
- ***24% occurred within the first 24 hours, 27% between 2 and 14 days, and 20% between 1 and 4 months.***
- 20% of the victims were intoxicated at the time of death.
- ***93% of the victims used hanging as the method***.
- 66% of the victims used bedding as the instrument.
- 30% of the victims used a bed or bunk as the anchoring device.
- 31% of the victims were found dead more than 1 hour after the last observation.
- ***CPR was not administered in 37% of incidents***.
- 38% of the victims were held in isolation.
- 8% of the victims were on suicide watch at the time of death.
- No-harm contracts were used in 13% of cases.
- ***35% of deaths occurred close to the date of a court hearing, with 69% occurring in less than 2 days.***
- ***22% occurred close to the date of a telephone call or visit, with 67% occurring in less than 1 day.***

Characteristics of the Jail Facilities:

- 84% percent were administered by county, 13% by municipal, 2% by private, and less than 2% by state or regional agencies.
- 77% provided intake screening to identify suicide risk, but only 27% verified the victim's suicide risk during prior confinement, and only 31% verified whether the arresting officer believed the victim was a suicide risk.
- 62% provided suicide prevention training, but 63% either did not provide training or did not provide it on an annual basis.
- 93% provided a protocol for suicide watch, but less than 2% had the option for constant observation; most (87%) used 15-minute observation periods.
- 32% maintained safe housing for suicidal inmates.
- 35% maintained a mortality review process.
- ***85% maintained a written suicide prevention policy, but as shown above, suicide prevention programming was not comprehensive***.

Finally, the suicide rate in detention facilities during 2006 was calculated to be ***38*** deaths per 100,000 inmates, a rate approximately three times greater than that of the general population. This rate, however, represents a dramatic decrease in the rate of suicide in detention facilities

during the past 20 years. The almost three-fold decrease from a previously reported ***107*** suicides in 1986 is extraordinary. Absent in-depth scientific inquiry, there may be several explanations for the reduced suicide rate. During the past several years, prior national studies of jail suicide have given a face to this long-standing and often ignored public health issue within our nation's jails. Findings from the studies have been widely distributed throughout the country and eventually incorporated into suicide prevention training curricula. The increased awareness to inmate suicide is also reflected in national correctional standards that now require comprehensive suicide prevention programming, better training of jail staff, and more in-depth inquiry of suicide risk factors during the intake process. Finally, jail suicide litigation has persuaded (or forced) jurisdictions and facility administrators to take corrective actions in reducing the opportunity for future deaths. Therefore, the antiquated mindset that "inmate suicides cannot be prevented" should forever be put to rest.[35]

Twenty years later, this national study of jail suicides found substantial changes in the demographic characteristics of inmates who committed suicide during 2005–06. The table below shows that some of these changes are stark. For example, suicide victims once characterized as being confined on "minor other" offenses were most recently confined on "personal and/or violent" charges. Intoxication was previously viewed as a leading precipitant to inmate suicide, yet recent data indicate that it is now found in far fewer cases. Previously, more than half of all jail suicide victims were dead within the first 24 hours of confinement; current data suggest that less than one-quarter of all victims commit suicide during this time period, with an equal number of deaths occurring between 2 and 14 days of confinement. In addition, it appears that inmates who committed suicide were far less likely to be housed in isolation than previously reported, yet for unknown reasons it was less likely that they would be found within 15 minutes of the last observation by staff. Finally, more jail facilities that experienced inmate suicides had both written suicide-prevention policies and an intake screening process to identify suicide risk than in previous years, although as noted above, the comprehensiveness of programming remains questionable.[36]

Changing face of Jail Suicide Victims		
Variables	**1985-1986**	**2005-2006**
Facility Type	70% Detention	88% Detention
Race	72% White	67% White
Sex	94% Male	93% Male
Age	30	35
Marital Status	52% Single	42% Single
Most Serious Charge	29% Minor Other	43% Violent/Personal
Jail Status	89% Detained	91% Detained

[35] Lindsay Hayes, "National Study of Jail Suicide 20 Years Later", DOJ/NIC AN 024308, April 2010.

[36] Hayes Study

Intoxication at Death	60%	20%
Time of Suicide	30% between 12:00am and 6:00am	32% between 3:00 pm and 9:00pm
Length of Confinement	51% within 1st 24 hours	23% within 1st 24 hours
Method	94% Hanging	93% Hanging
Instrument	48% Bedding	66% Bedding
Time Span (between last observation and finding victim)	42% found within 15 minutes	21% found within 15 minutes
Isolation	67%	38%
Known History of Suicidal Behavior	16%	34%
Known History of Mental Illness	19%	38%
Intake Screening of Suicide Risk	30%	77%
Written Suicide Prevention Policy	51%	85%

The study concluded that "*findings… create a formidable challenge for both correctional and health care officials, as well as their respective staffs. While our knowledge base continues to increase, seemingly corresponding to a dramatic reduction in the rate of inmate suicide in detention facilities, much work lies ahead. The data indicates that inmate suicide is no longer centralized to the first 24 hours of confinement and can occur at any time during an inmate's confinement. As such, because roughly the same number of deaths occurred within the first few hours of custody as in more than several months of confinement, information gathered regarding current suicide risk during intake screening should be viewed as time-limited. Instead, because inmates can be at risk at any point during confinement, the biggest challenge for those who work in the corrections system will be to conceptualize the issue as requiring a continuum of comprehensive suicide prevention services aimed at the collaborative identification, continued assessment, and safe management of inmates at risk for self-harm.*"[37]

MCDF Suicide Prevention Program

An effective and reasonably reliable jail suicide prevention program relies fundamentally upon 8 key components. These include: 1) Staff Training, 2) Intake Screening and Assessment, 3) Communication, 4) Housing, 5) Levels of Supervision, 6) Intervention, 7) Notification, and 8) Mortality/Morbidity Review Process. The MCDF suicide prevention program was examined according to these 8 elements. The program seems to possess all components. Therefore, the following recommendations are considered advisory and intended to provide MCDF officials additional information for further maintaining what appears to be a solid program.

[37] Hayes Study

Critical Component #1: Staff Training:

The key to any successful suicide prevention program is properly trained jail staff. Trained jail officers are often the staff most likely to recognize signs and symptoms of suicidal behavior. Often the focus of suicide prevention plans is the initial 48 to 72 hours of incarceration, but it is important to stress that suicides can and do occur at any time during incarceration. Staff and other inmates often recognize inmates who have destabilized or are reacting with hopelessness to recent losses, problems at home, or the reality of the disposition of their legal situation. Simply stated, because jail officers are often the only staff in the jail 24 hours per day they form the front line of defense in suicide prevention. Jail staff cannot effectively or consistently detect, make an assessment, or prevent a suicide for which they have no training.

FINDING(S): All MCDF officers complete both orientation (basic state certification training) and in-service training on suicide prevention as indicated above. Additionally, MCDF officials have subscribed to a qualified E-learning provider for basic, intermediate, and advanced training topics that directly or indirectly benefit the care and custody of inmate mental illness and suicide prevention purposes. The 2013 training schedule includes the following courses:

1. Civil Liability in Disciplinary Process in Corrections
2. Corrections and Mental Illness: An Overview of Correctional Officers
3. Cultural Awareness in Corrections
4. Maintaining Security Part 1
5. Maintaining Security Part 2
6. Discrimination and Security Harassment in Correctional Facilities
7. Professional Ethics in Corrections
8. Sexual Harassment in Correctional Settings
9. Sexual Misconduct in Correctional Settings
10. Stress Management in the Workplace
11. Suicide Prevention in Jails Part 1: Common Myths and Reactions
12. Suicide Prevention in Jails Part 2: Prevention
13. Suicide Prevention in Jails Part 3: Identifying Suicidal Offenders
14. Suicide Prevention in Jails Part 4: Managing Suicidal Offenders
15. Suicide Prevention in Jails Part 5: Responding to Suicides
16. Supervising Mentally Offenders
17. Understanding Mental Health Treatment in Correctional Settings

RECOMMENDATION(S):

- *Ensure suicide prevention policies and procedures include clear guidance and expectations about training. The following include essential elements of adequate training policies and procedures:*

  - *All staff (including correctional, medical, and mental health personnel) that have regular contact with inmates shall be initially trained in the identification and management of suicidal inmates, as well as in the eight components of a suicide prevention program. Initial training shall encompass eight (8) hours of instruction. New employees shall receive such instruction through the training academy. Current staff shall receive such instruction through scheduled training workshops.*

  - *The initial training should include inmate suicide research, why the environments of correctional facilities are conducive to suicidal behavior, staff attitudes about suicide, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite their denial of risk, components of the suicide prevention policy, case studies of recent suicides and/or serious suicide attempts, and liability issues associated with inmate suicide.*

  - *All staff who has regular contact with inmates shall receive two (2) hours of annual suicide prevention training. The two-hour training workshop shall include a review of predisposing risk factors, warning signs and symptoms, identifying suicidal inmates despite their denial of risk, and review of any changes to the suicide prevention program. The annual training shall also include general discussion of any recent suicides and/or serious suicide attempts in the Jail.*

  - *All staff who has regular contact with inmates shall receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff shall be trained to use emergency equipment located in each for responding. In an effort to ensure an efficient emergency response to suicide attempts, "mock drills" shall be incorporated into both initial and refresher training for all staff.*

- *Subscribing to a web-based training program to supplement current training program is commendable.*

- *Review orientation and in-service training lesson plans at least annually to ensure the training remains current and contemporary.*

- *It is also important to include information about mental health disorders and appropriate jail-based management interventions in both pre-service and refresher training for all*

who have regular contact with inmates.[38]*The MCDF 2013 online training includes this topic in several contexts.*

- *MCDF should access the online Jail Suicide/Mental Health Update newsletter, a quarterly publication available at no charge and devoted to suicide prevention and mental health services within detention and correctional facilities.*[39]

- *Both medical and mental health staff should also consider subscribing to the newsletter mentioned above. In addition, they may seek further information from the NIC information center about providing suicide prevention practices in a jail facility.*

Critical Component #2: Intake Screening/Assessment:

Identification is also critical to any effective jail suicide prevention program. Research in the area of jail suicides has identified a number of characteristics that are strongly related to suicide including: intoxication, emotional state, family history of suicide, recent significant loss, lack of social support, psychiatric history, and various "stressors of confinement". Most importantly, prior research has consistently reported that at least two-thirds of all suicide victims communicate their intent some time prior to death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than most of those who have never made an attempt. The key to identifying potentially suicidal behavior in inmates is to inquire not only during admission to MCDF, but at other key risk periods during incarceration.

Screening should inquire about past suicidal ideation or attempts, current ideation, threat or plan, prior mental health treatment including hospitalizations, recent significant loss (job, relationship, death of family member/close other), suicide risk during prior confinement, and arresting / transporting officer's belief that inmate is currently at risk. Given the strong association between inmate suicide and special management (i.e., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit should receive a written assessment for suicide risk by mental health staff upon admission to the special housing placement. In addition, the inmate's healthcare records should be thoroughly reviewed to ensure that the placement is not contraindicated or requires special treatment.

FINDING(S): MCDF intake and assessment policies and practices appear adequate and effective as previously discussed in this assessment. Electronic and paper screening and assessment forms appear adequate as previously stated and booking staff seem to understand the

[38] Instructors Materials, Behavioral Health Needs in Local Jails: A Cross Training Program, KY NAMI; Department of Mental Health and Retardation; Department of Corrections; and Commission on Services and Supports of Individuals with Mental Illness, Alcohol and other Drug Abuse Disorders and Dual Diagnosis.
[39] Funded by National Institute of Corrections; published by Lindsay M. Hayes, National Center on Institutions and Alternatives. Access at http://www.ncianet.org/suicideprevention/publications/update/index.asp

importance of this screening process. A review of screenings documents indicates that consistently completed.

RECOMMENDATION(S):

- *Continue to administer the comprehensive mental health/suicide risk intake screening upon entry in the jail and prior to placement in any housing unit. The screening should be administered during the admission and booking process by a Registered Nurse (RN) or other qualified and designated medical/mental health staff in their absence. Every effort shall be made to ensure this screening is conducted in a reasonably private and confidential location within the booking area.*

- *Mental health/suicide risk intake screening Form includes inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; prior/current psychotropic medication; recent significant loss (job, relationship, death of family member/close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; arresting/transporting officer(s) belief that the detainee is currently at risk; and brief mental status examination.*

- *A Registered Nurse (RN) or other qualified staff in their absence shall question the arresting and/or transporting officer(s) regarding their assessment of the inmate's medical, mental health or suicide risk.*

- *A Registered Nurse (RN) or other designated staff in their absence shall determine through the review of the electronic medical record (i.e., "Past Medical History Screen") whether the inmate was a medical, mental health or suicide risk during any prior confinement.*

- *A Registered (RN) or other designated staff in their absence shall make all appropriate observations, and ask all questions and appropriate follow-up questions, as contained on the screening instrument.*

- *Although an inmate's verbal responses during the intake screening process are critically important to assessing the risk of suicide, staff should not exclusively rely on an inmate's denial that they are suicidal and/or have a history of mental illness and suicidal behavior, particularly when their behavior and/or actions or even previous confinement suggest otherwise.*

- *Following completion of screening, the Registered Nurse (RN) and only other qualified medical / mental health staff in their absence shall confer with the Corrections Shift Supervisor for appropriate disposition.*

- *If identified as a risk for suicide, the inmate shall be immediately placed on "Suicide Precautions" and then referred to a qualified mental health professional for further assessment.*

- *The assessment of suicide risk by mental health staff shall include, but not be limited to, the following: description of the antecedent events and precipitating factors; suicidal indicators; mental status examination; previous psychiatric and suicide risk history, level of lethality; current medication and diagnosis; and recommendations/treatment plan. Findings from the assessment shall be documented on the Suicide Risk Assessment of the electronic medical record.*

- *Although any designated supervisory correctional, medical, or mental health staff may place an inmate on Suicide Precautions and/or upgrade those precautions, only licensed qualified mental health professional staff should downgrade and/or discontinue Suicide Precautions following a comprehensive suicide risk assessment and following consultation jail medical and custody officials.*

- *A completed screening assessment should be performed on all inmates prior to assignment to a housing unit, except under the following circumstances: a) Inmate refuses to comply with process; b) Inmate is severely intoxicated or otherwise incapacitated; or c) Inmate is violent or otherwise belligerent.*

- *For inmates listed, a Registered Nurse (RN) or other designated staff in their absence shall still complete all non-questionnaire sections of the Mental Health/Suicide Risk Intake Screening and make a document notation regarding why the inmate was unable to answer the questionnaire section. The Corrections Shift Supervisor shall then make the appropriate Disposition. A continuing, but reasonable effort shall be made to complete the entire Mental Health/Suicide Risk Intake Screening Form on inmates listed above at least every two (2) hours.*

- *The Mental Health Director or clinical supervisor shall review each completed mental health screening for accuracy and completeness within 24 business hours.*

- *All inmates shall be asked to sign a release of information form authorizing the disclosure of health records from outside providers. Medical and mental health staff shall make a reasonable effort to obtain records of previous medical and mental health treatment, including both in-patient and out-patient treatment services.*

- *Any inmate who screens positive for mental illness or suicidal ideation during the intake screening process, or who is otherwise referred for mental health services, shall receive a comprehensive mental health evaluation in a timely manner from a licensed qualified mental health professional according to the following timetable: immediate for an Emergent issue; within 24 hours for an Urgent issue; and within 72 hours for a Routine issue. The comprehensive evaluation shall include a recorded diagnosis section, including a standard five-Axis diagnosis from DSM-IV-TR, or subsequent Diagnostic and Statistical Manual of the American Psychiatric Association. If the QMHP finds a serious mental illness, they shall refer the inmate for appropriate treatment. Findings from the assessment shall be documented on either on the evaluation form or Psychiatric evaluation forms in the inmate's medical record.*

- *Given the strong association between inmate suicide and segregation, Qualified Mental Health, medical, and custody staff shall make regular rounds in segregation. Documentation of the rounds shall be made in the segregation log, with any significant findings documented in the inmate's electronic medical record. Inmates with serious mental illness who are placed in segregation shall be immediately and regularly evaluated by a QMHP to determine the inmate's mental health status, which shall include an assessment of the potential effect of segregation on the inmate's mental health. Following these regular assessments, qualified staff shall evaluate whether continued segregation is appropriate for that inmate, considering the QMHP assessment, or whether the inmate would be appropriate for graduated alternatives.*

- *See previous recommendations on staffing increases.*

- *The assessment of suicide risk should not be viewed as a single event, but as an ongoing process. Because an inmate may become suicidal at any point during confinement, suicide prevention should begin at the point of arrest and continue until the inmate is released from MCDF. In addition, once an inmate has been successfully managed on and discharged from suicide precautions they should remain on a mental health caseload and assessed periodically until released from MCDF.*

- *Screening for suicide during the initial booking and intake process should be viewed as something similar to taking one's temperature – it can identify a current fever but not a future cold. The shelf life of behavior that is observed and/or self-reported during intake screening is time-limited, and we often place far too much weight upon this initial data collection stage. Following an inmate suicide, it is not unusual for the mortality review process to focus exclusively upon whether the victim threatened suicide during the booking and intake stage, a time period that could be far removed from the date of suicide. If the victim had answered in the negative to suicide risk during the booking stage, there is often a sense of relief expressed by participants of the mortality review process, as well as a misguided conclusion that the death was not preventable. Although the intake screening form remains a valuable prevention tool, the more important determination of suicide risk is the current behavior expressed and/or displayed by the inmate.*

- *Prior risk of suicide is strongly related to future risk. At a minimum, if an inmate had been placed on suicide precautions during a previous confinement in MCDF, such information should be accessible to both correctional and health care personnel when determining whether the inmate might be at risk during their current confinement.*

- *MCDF should not rely exclusively on the direct statements of an inmate who denies that they are suicidal and/or have a prior history of suicidal behavior, particularly when their behavior, actions and/or history suggest otherwise. Often, despite an inmate's denial of suicidal ideation, their behavior, actions, and/or history speak louder than their words.*[40]

[40] Lindsay Hayes, www.ncianet.org/suicideprevention/publications/guidingprinciples.asp

- *Additionally, suicide and mental health policies should be reviewed regularly by staff and provided annual training on these policies as previously recommended.*

Critical Component #3: Communication:

The screening and assessment process, coupled with staff training, will only be successful if an effective method of communication is in place.

It is not enough to identify inmates who are at risk for suicide. It is essential that this information be communicated. There are essentially three levels of communication in preventing inmate suicides: 1) communication between the arresting or transporting officer and the jail receiving staff; 2) communication between and among facility staff including medical and mental health personnel; and 3) communication between facility staff and the suicidal inmate. It is also critically important for jail staff to maintain open lines of communication with family members who often have pertinent information regarding the mental health status of inmates. Officers should recognize that they are an integral part of the mental health team and often the key factor in preventing suicide.

Communication cannot stop at receiving or during the early hours and days of incarceration. There are a number of key risk periods/points including crisis precipitated by court services such as new/additional charges, separation, divorce, child removal or custody, or protection from abuse orders. Also sentencing, especially unexpected harsh or lengthy sentences can precipitate suicidal crises. A little explained but fairly common phenomenon is a suicide immediately prior to release.

FINDING(S): MCDF seems to place exceptionally high value on open communication among staff at all levels. This was very noticeable and quite impressive. Leadership provides ongoing training materials and coaching to subordinate leaders that further encourage open communication with and between line staff and other jail employees.

There appears to be good verbal and written communication at the intake process between intake officers and admitting law enforcement personnel. Overall communication between and among facility staff regarding this critical element seems equally appropriate and effective.

RECOMMENDATION(S):

- Continue to grow current communication between all staff participating in inmate suicide detection, prevention, intervention, and aftercare services. Post information that explains the purpose for suicide watch placement, reasons for lengths of stay on suicide watch, and where

and how to receive help following return to general population and before release from the jail.

- Updated training on effective communication with inmates, special needs offenders, and manipulative inmates should be provided at pre- and in-service intervals. Custody, medical and mental health staff should train together on subjects of mutual interest and concern as a means to increase inter-function reliance, support and communication. The inmate handbook should clearly explain the signs and symptoms of suicide / mental health problems and how to access help while incarcerated. MCDF should post information in the visiting areas that encourages visitors to communicate any concerns about inmate suicide / mental health to staff as soon as possible.

- Jail managers and supervisors should make regular rounds of all housing areas and when so doing inquire about problems the inmates are experiencing, as well as invite suggestions for improving conditions of confinement. These rounds will demonstrate to both staff and inmates that jail administration is concerned about the well-being of the inmates and open improved dialogue between inmates and custody staff.

- Revise current policies and procedures to include comprehensive guidance and expectations for suicide prevention communication purposes. Minimum policy elements are listed below:

    - All staff shall maintain awareness, share information and make appropriate referrals regarding potentially suicidal inmates to mental health staff.

    - All staff shall use various communication skills with the suicidal inmate, including active listening, staying with the inmate if they suspect immediate danger, and maintaining contact through conversation, eye contact, and body language.

    - All incidents of suicidal behavior shall be documented on an observation sheet, which shall also be utilized to document all physical cell checks of suicidal inmates.

    - The Corrections Shift Supervisor shall maintain a suicide precaution monitoring log of all inmates on Suicide Precautions. The sheet shall be updated daily, designate each inmate's level of observation, and be distributed to appropriate correctional, medical, and mental health personnel.

    - The Corrections Shift Supervisor shall ensure that appropriate staff is properly informed of the status of each inmate placed on Suicide Precautions. The Corrections Shift Supervisor shall also be responsible for briefing the incoming Corrections Shift Supervisor regarding the status of all inmates on Suicide Precautions.

    - Should an inmate be returned to the facility following temporary transfer to the hospital or other facility for suicide risk assessment and/or treatment, the Corrections Shift Supervisor shall inquire of medical and/or mental health officials what further prevention measures, if any, are recommended for the housing and supervising the returning inmate.

- Authorization for Suicide Precautions, reassessment and any changes in Suicide Precautions shall be documented on the precautions log and distributed to appropriate staff.

- Multidisciplinary case management team meetings (to include MCDF officials and available medical and mental health personnel) shall occur on a weekly basis to discuss the status of inmates on Suicide Precautions.

Critical Component # 4: Housing:

It is essential that the least restrictive housing commensurate with classification and risk for suicide be assigned for all inmates. It is important to maintain inmates in a safe and secure housing unit that is maximally designed to eliminate suicide attempts and behaviors as long as their risk level requires special housing. Regular assessment of inmates' suicide risk and movement to the least restrictive housing when the inmate is stabilized must be provided. Housing assignments should be based on the ability to maximize staff interaction with the inmate, avoiding assignments that heighten the depersonalizing aspects of incarceration. All cells designated to house suicidal inmates should be suicide-resistant, free of all obvious protrusions, and provide full visibility.

FINDING(S): MCDF staff currently use constant or close direct physical observations of persons on suicide watch as part of their daily rounds. Camera monitoring is used only as a supplement to direct observation according to policy and practice.

MCDF inmate housing policy prohibits the use of disciplinary segregation for inmates presenting a credible risk of self-harm. This policy clearly acknowledges the mental and emotional well-being of inmates placed in disciplinary segregation and specifies segregation time limits. MCDF administrative segregation policies are applied to inmates presenting symptoms of suicidal risk and/or mental illness. This policy further prohibits any punitive restrictions to food, correspondence, attorney or clergy visits. Cells used for this purpose appeared to be relatively free of protrusions, clean and well-kept.

RECOMMENDATION(S):

- MCDF policy and practice appears to embrace a least restrictive approach to managing such at-risk inmates. Written policy appears to be complete and thorough on the subject. Close supervision of at-risk inmates is required and recorded electronically and in writing. MCDF policy prohibits the use of disciplinary segregation for at-risk inmates. Administrative segregation policies seem appropriate and fair.

- MCDF should develop policy to audit the written close supervision logs to the electronic logs to ensure compliance, accuracy and consistency. This audit should be conducted no less than quarterly.

- Revise current policies and procedures to include comprehensive guidance and expectations for suicide prevention housing purposes. Minimum policy elements are listed below:

    - Any inmate placed on Suicide Precautions shall be housed in a designated suicide-resistant cell.

    - The decision to remove the clothing and mattress from a suicidal inmate and issuance of a safety smock shall only be done with the approval of a QMHP or Qualified Medical Professional in their absence, and only following a face-to-face direct assessment of the inmate by the qualified health care provider in-person or by telephone-contact with the inmate, when said qualified staff are not on duty. A reliable and secure telemedicine system may be used for a face-to-face assessment in cases where no QMHP is available on-site. In most instances, the removal of clothing of an inmate on Constant Observation status should not be necessary. Documentation of the decision shall be in both the Suicide Risk Assessment and the Observation Sheet.

    - Unless contraindicated in writing by a QMHP or Qualified Medical Professional in their absence, each inmate on Suicide Precautions shall continue to receive regular privileges (e.g., showers, telephone, visiting, recreation, etc.) commensurate with their security level. Documentation of the decision shall be in both the Suicide Risk Assessment and the Observation Sheet. It is understood that loss of such privileges, unless necessary for security and the personal safety of the inmate, can be counterproductive to the goals of suicide prevention efforts and should, therefore be avoided unless otherwise necessary.

    - The use of any physical restraints (e.g., restraint chairs or bunks, leather straps, etc.) shall be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-injurious behavior. A Qualified Medical Professional shall be immediately notified to monitor and assess the need for further restraint. Metal handcuffs shall never be utilized for restraint.

    - Regardless of whether restraints are initiated by custody or health care personnel, the use of any restraints shall include adherence to the following minimal guidelines:

        - Restraints shall not be used for punitive purposes;
        - Restraints require an order by a Qualified Medical Professional (physician, nurse practitioner, or physician's assistant);
        - Only a Restraint Chair shall be authorized for restraints. The restrained inmate shall be immediately transported via the restraint chair to the 4th floor medical/mental health unit for further assessment and observation.

- The restrained inmate shall be seen immediately by Qualified Medical Staff, as well as receive a face-to-face assessment by a physician or Licensed Independent Practitioner (LIP) within four (4) hours of initial restraint;
- Inmates shall never be restrained in an unnatural position;
- Restraint equipment must be medically appropriate;
- Inmates placed in restraints shall be under the constant observation of a Crisis Stabilization Technician or designated correctional staff in their absence;
- Vital signs of inmates placed in restraints shall be assessed every 2 hours by nursing staff;
- Each restrained limb shall be untied for at least 10 minutes every two hours to allow for proper circulation;
- Restrained inmates shall be allowed bathroom privileges as soon as practical;
- Restrained inmates shall be reassessed by a physician, LIP, or registered nurse every 2 hours after the initial assessment, and must be reduced as quickly as possible to the level of least restriction necessary to protect the inmate and others; and
- Restraint orders shall be automatically terminated after 12 hours and, if the inmate remains in a highly agitated state after 12 hours that they cannot be released because of physical danger to self or others, they shall be transferred to the hospital.

o Each Jail housing unit shall contain various emergency equipment, including a first aid kit; CPR pocket mask or Ambu-bag; and emergency rescue tool (to quickly cut through fibrous material). The Corrections Shift Supervisor staff should ensure that such equipment is in working order on a regular basis.

Critical Component # 5: Levels of Supervision:

Inmates who are at risk of suicide require increased levels of observation, communication, and interaction with custody and healthcare staff. These staff must be available and unencumbered by other assignments that would interfere with a suicide prevention priority. The incarceration experience is a very dehumanizing experience for all inmates and the inmate's primary contact with the outside world is through their access to correctional staff.

Differing levels of suicide risk, mental illness, and vulnerability requires different levels of observation and management. Experience shows that prompt, effective emergency medical and other health care services can save lives and mitigate the adverse impact of incarceration on suicidal and mentally ill inmates.

FINDING(S): MCDF uses graduated levels of supervision that provide for initial risk management monitoring (close/constant watch), stabilization, and return to less restrictive supervision based on an integrated-decision making approach involving custody, medical, and mental health staff.

RECOMMENDATION(S):

- MCDF staff is to be commended for their professional interactions with inmates and are encouraged to continue practicing such interactions.

- Develop a "step-down" housing unit and process that increases social interaction and privileges for inmates who have been assessed as stable or stabilizing. Each inmate placed on suicide precautions should have an integrated treatment plan that involves a multi-disciplinary team in its development and implementation. The plan should specifically define "stabilized" in descriptive behavioral terms to help ensure that staff understands when an inmate may be eligible for the step-down environment. The plan should be behavior-based with incentives, and it should be shared with the inmate.

Critical Component #6: Intervention:

Following a suicide attempt, the degree and promptness of intervention provided by staff often foretells whether the victim will survive. It is essential to balance the safety of officers and the inmates. It is also imperative that all officers understand that brain injury can occur within four minutes and that death can occur within five to six minutes from asphyxiation by hanging. Crime scene protection should not outweigh saving lives.

Provided below is a listing of the applicable national correctional standards relating to emergency response within correctional facilities. Unless otherwise indicated, these standards apply to adult correctional facilities.[41]

American Correctional Association

Performance-Based Standards for Adult Local Detention Facilities, 4th Edition, June 2004, *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions*, 1st Edition, January 2002

Emergency Response

Correctional and health care personnel are trained to respond to health-related situations within a *four-minute response time* (emphasis added). The training program is conducted on an annual basis and is established by the responsible health authority in cooperation with MCDF or program administrator and includes instruction on the following:

- recognition of signs and symptoms and knowledge of action that is required in potential emergency situations.
- administration of basic first aid certification in cardiopulmonary resuscitation (CPR) in accordance with the recommendations of the certifying health organization.
- methods of obtaining assistance

[41] http://www.ncianet.org/suicideprevention/publications/update/Winter%202008.pdf

- signs and symptoms of mental illness, violent behavior, and acute chemical intoxication and withdrawal
- procedures for patient transfers to appropriate medical facilities or health care providers
- suicide intervention

Comment: MCDF administrator and the health care authority may designate those correctional officers who have responsibility for responding to health care emergencies. Staff not physically able to perform CPR is exempt from the expected practice.

National Commission on Correctional Health Care

Standards for Health Services in Jails, 7th Edition, 2003, *Standards for Health Services in Prisons*, 5th Edition, 2003

Training for Correctional Officers

A training program, established or approved by the responsible health authority in cooperation with MCDF administrator, guides the health-related training of all correctional officers who work with inmates.

Compliance Indicators

All aspects of the standard are addressed by written policy and defined procedures. Correctional officers who work with inmates receive health-related training at least every 2 years, which includes at minimum:

- administration of first aid;
- recognizing the need for emergency care and intervention in life-threatening situations (e.g., heart attack);
- recognizing acute manifestations of certain chronic illnesses (e.g., asthma,
- seizures), intoxication and withdrawal, and adverse reaction to medication);
- recognizing signs and symptoms of mental illness;
- procedures for suicide prevention;
- procedures for appropriate referral of inmates with health complaints to health staff;
- precautions and procedures with respect to infectious and communicable diseases; and
- cardiopulmonary resuscitation.

The appropriateness of the health-related training is verified by an outline of the course content and the length of the course.

A certificate or other evidence of attendance is kept on site for each employee.
While it is expected that 100% of the correctional staff who work with inmates are trained in all of these areas, compliance with the standard requires that at least 75% of the staff present on each shift are current in their health related training.

Discussion: This standard intends to promote the training of correctional officers to recognize when the need to refer an inmate to a qualified health care professional occurs and to provide emergency care until he/she arrives. Because correctional personnel are often

the first to respond to problems, they must be aware of the potential for emergencies that may arise, know the proper response to life-threatening situations, and understand their part in the early detection of illness and injury.

Emergency Services

MCDF provides 24-hour emergency medical, mental health, and dental services

Compliance Indicators

A written plan includes arrangements for the following, which are carried out when necessary:

- emergency transport of the patient from MCDF;
- use of an emergency medical vehicle; use of one or more designated hospital emergency departments or other appropriate facilities;
- emergency on-call physician, mental health, and dental services when the emergency healthcare facility is not located nearby;
- security procedures for the immediate transfer of patients for emergency medical care and notification to the person legally responsible for MCDF.
- Emergency drugs, supplies, and medical equipment are regularly maintained.

Discussion: This standard intends that sufficient emergency health planning occurs and is put into effect when necessary. Planning ahead for emergencies can help minimize bad outcomes. Policy and procedures address, for example, which facility on-call staff need to be notified, arranging for an ambulance, and alerting the community emergency room. The choice of basic emergency equipment depends on the size of MCDF, its distance from the nearest emergency department, and the level of staff training.

FINDING(S): MCDF staff are provided training for intervening in suicidal ideation and attempts. Training is also provided in CPR and first response techniques. A review of all medical staff files indicated that all CPR/First Aid certifications are current.

RECOMMENDATION(S):

- Ensure that all staff having contact with an inmate is provided ongoing and updated training on these policies. Also ensure that all CPR certifications are kept up-to-date.

- Establish a multidisciplinary morbidity review process to review all serious suicide attempts. The review process should include officials from custody, medical, and mental health.

- Revise current policies and procedures to include comprehensive guidance and expectations for suicide prevention intervention purposes. Minimum policy elements are listed below:

    - All correctional and medical staff shall be trained (and maintain certification) in standard first aid and cardiopulmonary resuscitation (CPR).

- All correctional and medical staff shall participate in annual "mock drill" training to ensure a prompt emergency response to all suicide attempts.

- All housing units shall contain an emergency response bag that includes a first aid kit; CPR pocket mask or Ambu-bag; latex gloves; and emergency rescue tool. All staff who comes into regular contact with inmates shall know the location of this emergency response bag and be trained in its use.

- Any staff member who discovers an inmate attempting suicide will immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for the facility's medical personnel, and bring the emergency response bag to the cell. If the suicide attempt is life-threatening, Central Control personnel will be instructed to immediately notify outside ("911") Emergency Medical Services (EMS). The exact nature (e.g., "hanging attempt") and location of the emergency will be communicated to both facility medical staff and EMS personnel.

- Following appropriate notification of the emergency, the First Responding Officer shall use his/her professional discretion in regard to entering the cell without waiting for backup staff to arrive. With no exceptions, if cell entry is not immediate, it shall occur no later than four (4) minutes from initial notification of the emergency. Correctional staff will *never* wait for medical personnel to arrive before entering a cell or before initiating appropriate life-saving measures (e.g., first aid and CPR).

- Upon entering the cell, correctional staff shall *never* presume that the victim is dead, rather life-saving measures shall be initiated immediately. In hanging attempts, the victim shall first be released from the ligature (using the emergency rescue tool if necessary). Staff shall assume a neck/spinal cord injury and carefully place the victim on the floor. Should the victim lack vital signs, CPR will be initiated immediately. All life-saving measures shall be continued by correctional staff until relieved by medical personnel.

- The Corrections Shift Supervisor shall ensure that both arriving jail medical staff and EMS personnel have unimpeded access to the scene in order to provide prompt medical services to, and evacuation of, the victim.

- Although the scene of the emergency shall be preserved as much as possible, the first priority shall always be to provide immediate life-saving measures to the victim. Scene preservation shall receive secondary priority.

- Automated External Defibrillators (AEDs) are positioned in various locations within the jail. All medical and correctional staff shall be trained in their use. The jail Medical Director or Designee shall provide direct oversight of AED use and maintenance.

- The Medical Director or Designee shall ensure that all equipment utilized in the response to medical emergencies (e.g., emergency response bag, crash cart, oxygen tank, AED, etc.) is inspected and in proper working order on a regular basis.

- All affected staff and inmates involved in the incident shall be offered critical incident stress debriefing.

- Although not all suicide attempts require emergency medical intervention, all suicide attempts shall result in the inmate receiving immediate intervention and assessment by a QMHP.

Critical Component #7: Reporting and Notification:

In the event of a suicide attempt or suicide, all appropriate correctional officials should be notified through the chain of command. Following the incident, the victim's family should be immediately notified, as well as appropriate outside authorities. All staff that came into contact with the victim prior to the incident should be required to submit a statement including their full knowledge of the inmate and incident.

FINDING(S): The active suicide prevention policy includes necessary reporting and notification language to effective carry out this component of an effective suicide prevention program.

RECOMMENDATION(S): None

Critical Component #8: Follow-up/Mortality Review:

Experience has demonstrated that jail systems that carefully review suicides and serious suicide attempts will reduce the likelihood of future suicides.

FINDING(S): MCDF conducts thorough investigations for inmate death incidents and involves out-side law enforcement in those investigations. However, current policies and procedures are brief and do not include guidance for mortality or morbidity reviews (for serious suicide attempts).

RECOMMENDATION(S):

- A full mortality review should include key members of administration and department heads, and key medical and mental health staff. Additionally, regular (monthly) reviews of inmate self-harm and suicide attempts should be conducted to learn from this information how to improve prevention and management efforts. A review of policy and protocol is indicated.

- Revise current policies and procedures to include comprehensive guidance and expectations for suicide prevention intervention purposes. Minimum policy elements are listed below.

- An effective and complete mortality/morbidity review process should include the following elements:

- Every completed suicide, as well as serious suicide attempt, shall be examined by a multidisciplinary Morbidity-Mortality Review Team that includes representatives of both line and management level staff from the corrections, medical and mental health divisions. The Mental Health Director shall chair the committee.

- The Morbidity-Mortality Review process shall comprise a critical inquiry of: a) circumstances surrounding the incident; b) facility procedures relevant to the incident; c) all relevant training received by involved staff; d) pertinent medical and mental health services/reports involving the victim; e) possible precipitating factors leading to the suicide; and f) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. The inquiry shall follow the outline described in the Morbidity-Mortality Review Checklist.

- The mortality review report should include the following minimum components:

- day, date and time of incarceration,
- arrest reports
- intake and assessment documents
- date, time, and location of death;
- inmate personal information and demographics
- apparent and actual cause of death
- death modality
- review of staff interactions previous to death
- inmate healthcare records
- current medications and administration activity
- inmate medical and mental status during incarceration and preceding death
- food service records relevant to inmate diet and eating habits
- autopsy report if applicable
- interviews with cell-mates
- review of any and all documentation associated with inmate's incarceration
- visitation logs
- inmate mail
- photographs of inmate cell and location of death
- review of health care and suicide protocols
- other information needed to provide a clear understanding of the inmate's activities while incarcerated

Critical Incident Debriefing:

A shift from rehabilitation to a more custodial approach, an increase in long-term sentences, overcrowding, and more violent and mentally ill offenders led Cheek and Miller (1979) to examine the effects of stress in staff and inmates in the New Jersey Department of Corrections.

Cheek & Miller (1982) also investigated the strategies that the Department implemented to reduce those stressors. Brodsky (1982) conducted one of the earlier analyses of correctional stress from an organizational and cultural perspective. The evidence indicated that correctional employees experience a significant amount of stress in their work, which may lead to high job turnover, high rates of sick leave and troubled relationships with inmates, other staff, and family members. Lindquist and Whitehead (1986) investigated burnout, job stress and job satisfaction among southern correctional officers. They found that 20% to 39% experienced burnout and stress but that only 16% expressed job dissatisfaction. It was suggested that correctional officers mask their dissatisfaction to prevent facing job changes. There was no analysis or implication regarding the effect this could have on families.

Stohr (1994) and associates studied stress in contemporary jails by examining jails in five areas across the U.S. They found that stress in workers was a serious problem and approaching dangerous levels in some facilities. The contributing factors were primarily related to management and organizational methods. There was less stress when fair compensation, investment in employee development and participatory management practices were employed. Similarly, Wright, Saylor, Gilman and Camp (1997) in a study of U.S. Federal Bureau of Prisons' employees, found lower job-related stress a factor when workers were involved in decision making.

Although not new to correctional employees on the front line, workplace violence was identified as having a negative impact on employees' wellness in the 1990s. The National Crime Victimization Survey (NCVS) report for 1992-1996 (U.S. Dept. of Justice, 1998) revealed that the field of Law Enforcement was the second largest group in the nation to experience workplace violence. Prison guards experienced non-fatal workplace violence at the rate of 117.3 per 1,000 workers. Additional investigations of staff victimization have been cited in the literature (Andring, 1993; Dowd, 1996; Seymour & English, 1996; VandenBlos & Bulatao, 1996).

From November 21 through December 4, 1987, prisoners rioted and took hostages in Federal Prisons in Oakdale, Louisiana and Atlanta, Georgia (National Victim Center [NVC], 1997). Bales (1988) reported about the stressors and follow-up for the hostages including a family resource center. There was no indication of pre-incident stress inoculation or family support planning. Additional hostage situations which reached national media attention were Attica, New York, 1971, Wyoming State Penitentiary, 1988, and Pennsylvania State Correctional Institution, Camp Hill, 1989, (NVC, 1997).

Throughout the 1980s and 1990s the recognition of the need for crisis intervention after a critical incident became apparent. The earliest crisis intervention programs for correctional employees were conducted post-incident. Bergman and Queen (1987) credited the retention of employees after the riot at Kirkland Correctional Institution Columbia, South Carolina to the "critical

incident debriefing" (Mitchell, 1983; Mitchell & Everly, 1993) conducted immediately after the incident. Van Fleet (1991) also referred to debriefing traumatized correctional staff to mitigate stress that could lead to posttraumatic stress disorder (PTSD). Training workshops and training guides/manuals became available (Concerns of Police Survivors [COPS], 1996; Finn & Tomz, 1997; NVC, 1997; U.S. Office of Personnel Management, 1998). Directly or indirectly, the resources referred to Critical Incident Stress Management (CISM) (Everly & Mitchell, 1997). Traditionally, in the correctional field any type of assistance offered to employees' and their families was post-incident, usually at the employees or families' request and in the form of referrals to the agency's Employees Assistance Program or private contractors. Little mention is made of preventive or stress inoculation programs for employees and families at the front end or when entering correctional employment. On the other hand, police (COPS, 1996; National Institute of Justice [NIJ], 1997) and fire-fighting agencies have initiated family awareness and educational programs, which range from a few hours to several weeks.

An Introduction to Critical Incident Stress Management[42]

A critical incident is defined as "any event which has a stressful impact sufficient enough to overwhelm the usually effective coping skills of either an individual or a group are typically sudden, powerful events outside of the range of ordinary human experiences" (Mitchell & Everly, 1993). Most employees entering the criminal justice system recognize that verbal and minimal physical abuse from those in their care, custody, and control is a reality of the job. Critical incidents and stressors experienced by employees in correctional, prison, forensic settings include: held hostage, riot, physical/sexual assault, death or serious injury in line of duty, suicide of inmate or employee, use of lethal force on inmate, participation in execution and witness to any of the above.

Historically, the approaches to help staff deal with critical incidents and stressors fall into three broad categories including:

(1) Employee Assistance Program (EAP), a contracted service with the state, agency or facility. Traditionally, the EAP provider is typically an individual mental health clinician (i.e., counselor, social worker, and psychologist). Since employees in these settings tend to be cautious and somewhat suspicious of mental health providers and outsiders, a few EAP programs include clinician-trained peer support personnel selected from the employees likely to be represented in an event.

(2) Peer Support Program (PSP) which consists of non-clinician employees, who are representative of the workforce, and trained in crisis intervention...

(3) Critical Incident Stress Management (CISM) Program, the International Critical

[42] http://www.aaets.org/article88.htm

Incident Stress Foundation (ICISF) model. The CISM Team is "described as a partnership between professional support personnel (mental health professionals and clergy) and peer support personnel (employees) who have received training to intervene in stress reactions" (Mitchell & Everly, 1993). Professional support personnel are required to have academic training at the master's degree or higher level and/or recognition of their training and skills through certification or licensure. They must also have education, training and experience in critical incident stress intervention.

Components of a Comprehensive CISM Program

A comprehensive CISM program is multi-faceted (Mitchell & Everly, 1993; PDOC, 1992). Pre-incident prevention and stress inoculation are essential. All employees receive education and training in everyday and work-related stress awareness and stress management techniques as well as how to access the EAP program and CISM team, when necessary, while attending Basic Training Academy. Employees whose job requires direct contact with inmates/patients attend biannual refresher stress management classes. Managers receive training in recognition of employee stress and referral procedures. Families and significant others are provided similar stress awareness and coping skills and how to access referral services at the Family Academy.

CISM team development, member selection and training needs to be well-planned and foster a partnership between employees, management and labor relations. A CISM Program policy/standards and procedures manual, applicable to the agency, must be established. Best results are achieved if team membership is voluntary. A selection committee comprised of management and employees/ labor representatives should develop an application form and include an interview in the selection process. Team members, professional and peer, must be trusted and accepted by their fellow employees. Peer members must be representative of the employee population including custody, maintenance, counseling, education, medical, clerical, etc. It is recommended that each facility have a team available for rapid deployment. In order to respond to major events, in large systems, regional teams composed of members from various facilities are also suggested. Although there are similarities in the training programs available, this article and model adheres closely to the ICISF standards. All team members should be required to complete ICISF Basic Critical Incident Stress Debriefing Training. Peer Support/Crisis Intervention Strategies is also recommended. All members should also have an understanding of Incident Command system, if used in their setting, and specialized units such as Emergency Response, Hostage Recovery and Hostage Negotiation Teams. The CISM team and specialty teams should participate in joint training exercises at least once annually.

The CISM Program services should include:

1. On-scene support (usually provided by peer support members during a major/prolonged event).

2. Demobilization or de-escalation (brief intervention to assist employees in making the

transition from the traumatic event back to routine or stand-by duty, formal debriefing to follow in several days).

3. Defusing (a three-phase group crisis intervention provided immediately or within twelve hours after the event to mitigate the effects of the stressors and promote recovery, usually twenty to forty-five minutes in duration).

4. Debriefing (a seven-phase group crisis intervention process to help employees work through their thoughts, reactions, and symptoms followed by training in coping techniques, usually lasting one and one-half to two hours).

5. One-on-one support (individual intervention if a single or small event and a group intervention is not possible or additional individual assistance is deemed necessary after a group process).

6. Significant other/family defusing/debriefing (services may be provided separately from traumatized employees).

7. Line-of-duty death support (defusing provided immediately after event for staff, team assists family, and a debriefing provided for staff after the funeral).

8. Referrals (team member recommends and instructs employee to access additional support/treatment through EAP or other resources).

9. Follow-up (team leader or designated member contacts employee(s) and/or employee(s) supervisor a few days after team services).

Records and Program Evaluation

Client(s) confidentiality must be maintained. However, in order to maintain service continuity and program quality improvement minimal record keeping is necessary. A request for service form including time of event, nature of incident, number of personnel involved, contact person and contact number will assist the team leader in selecting team members and establishing meeting location and time. The service provided form should include information from the request form and a summary or themes of reactions, thoughts, and symptoms presented, educational material provided, and coping techniques recommended and if referrals were made. Individual(s) names and comments are not recorded. The team leader may, with the majority consensus and participants' permission, provide administrative staff with a report of recommendations to improve conditions or remedy situations that led to the critical event. In most situations consumer satisfaction will be determined informally through follow-up with the participants and from supervisory staff. However, after major events, a participant's satisfaction questionnaire is recommended. A combination of checklist, multiple choice and general comment format works best in this employment setting.

Interagency and Community Support

Traditionally correctional facilities are scattered through the state and many times located in rural areas. Correctional CISM Teams can be a resource for smaller counties and municipalities and provide services for jails, probation and parole agencies, police and community emergency responders. The Correctional CISM Team professionals may act as consultants or supplement communities volunteer peer teams. The CISM teams can, along with other correctional special response teams, assist communities affected by a disaster. The Correctional CISM Teams may also work very effectively with other State agencies such as state police and probation and parole.

FINDING(S): There does not appear to be a formal policy or practice for CISM, in part due to very few jail deaths within the past 30 years. Additionally, there does not appear to be a coordinated policy with local community mental health services to provide CISM services.

RECOMMENDATION(S):

- Develop and implement comprehensive CISM policies and procedures.

- This procedure is not the same as mortality review de-briefing. Instead, this refers to a formalized opportunity for involved or affected staff members to talk about their thoughts and feelings about a possibly difficult critical incident, such as a death or suicide attempt, so as to try to deal more effectively with their difficult or troubling feelings. Policy should indicate that this opportunity is available and should indicate who has the responsibility for planning and implementing it. Policies and procedures should be developed to coordinate both internal and external CISM services.

- Traditionally, a critical incident debriefing focuses on the experiences and needs of staff involved in the stressful event. Inmates can also experience post-event trauma. It is important to recognize that inmates who are exposed to suicides or other serious trauma while incarcerated may suffer temporary and/or long term psycho-emotional harm. It is therefore important that a comprehensive critical incident debriefing policy and action plan includes providing similar services to appropriate inmates. Again, policies and procedures should be developed to coordinate both internal and external CISM services and include services for inmates.

IX. RELATED ISSUES & RECOMMENDATIONS

A. Data Collection and Information Management

Effective jail management requires accurate and easily accessible data[43]

In the past, managing jails was considered to be so basic that there was nothing to it. However, with increased court intervention in correctional matters, demands for better management of correctional facilities increased in the 1970s. The courts discovered that often the difference between a "constitutional jail" and an "unconstitutional jail" was the way in which the jail was managed. Since good management relies strongly on good information, sheriffs and jail administrators found that their organizational world had become a much more complex place in which to work. As a result, "professional management" arrived in correctional facilities. Sheriffs and jail administrators were introduced to a number of techniques, such as cost benefit analysis, Total Quality Management, and organizational development that were designed to help them improve organizational performance. Sometimes these techniques were very helpful, and sometimes they were not. In analyzing their relative successes and failures, the ability of the organization to generate good, valid information about its problems emerged as a critical variable. So what is management?

Management is mostly about mobilizing an organization's resources, in this case the jail's, to solve or avoid problems. In many cases, problems are not solved in the sense that they go away, but the organization finds a way to manage them more effectively. Regardless of the complexity of the problem, a basic management formula applies to analyzing a situation. It consists of five steps:

1. Facts are gathered.
2. Facts are interpreted in light of the organization's mission and values.
3. Alternative solutions are developed.
4. A decision is made.
5. Action is taken.

Easy and timely access to good jail data is pivotal to effective jail management. Valid data are absolutely needed to safely and effectively operate the jail at all levels and can significantly improve jail performance in all functional areas.

FINDING(S): The current MCDF data management system appears to collect the necessary jail data elements to develop a useful set of jail operational reports. The system appears fairly easy to extract data from and should afford MCDF the opportunity to become more "data driven". In doing so, MCDF may find fiscal and operational decision making more efficient and effective.

[43] Gail Elias, http://nicic.gov/Library/021826

Additionally, MCDF regularly collects and reviews population and health care-related data relevant to jail services and management.

RECOMMENDATION(S):

- Consider the creation of a jail information and reporting team to determine exactly what data are needed to better support decision making at all levels of the jail. The teams should decide specifically how the various functions of the jail can use better data and consult with those areas to clarify and document needs. Outside professional consultation should be considered.

- Once the data team determines what data elements are needed, they should consult with current jail management system technical support for assistance. It is likely that much of the information desired already exists in the jail management system data base and accessing may be as simple as being trained by the provider on how to most efficiently query the data. The data may then be reformatted into workable spreadsheets for simple, clear and ongoing review and analysis.

B. Cross-Discipline Staff Meetings

Regular meetings among staff who work with the inmates can greatly improve communication and build a team-based response to working with the inmates who require mental health services.

FINDING(S): MCDF currently holds regular health care meetings involving jail administration and health care staff. Although this is a great opportunity to discuss issues and resolve problems, the topics and discussions may be limited to the scope of information brought to the meeting.

RECOMMENDATION(S):

- MCDF leadership is to be commended for its open communication philosophy. MCDF is encouraged to continue this process.

C. Involve Advocates[44]:

Numerous advocacy groups throughout the greater McLean area and region may be able to assist the jail in securing the mental health resources that are needed and for informing the public about the problems of inmates with mental illnesses in the jail. Many jails that have found little to no public or financial support for jail mental health services have discovered that advocates have the interest, mission and power to force changes and support that benefits the jail.

[44] Op Cit: La Crosse County NIC TA # 06B5007

Mental health advocacy groups and coalitions are interested in supporting appropriate mental health services in the jail. There is a view within the mental health community, the advocates, and the families, that the jail should be more treatment-oriented. As in many communities, the public is often confused about the discrete role of the jail in the criminal justice system. The jailer is often "blamed" for much of the perceived "unfairness" of incarceration as well as other components of the criminal justice system. There are paradoxical perceptions that criminals "should be locked away in harsh punitive correctional environments" until that "criminal" is someone that you know or is related. When a friend or relative is incarcerated there is recognition that much of the jail population is pre-trial and not convicted criminals. The perception shifts to "he/she is still a human being and the jail environment should be humane." These conflicting perceptions can result in a confused correctional philosophy that impacts funding for jail design, staffing, and programming. Even among the advocates (both family and agency) there are mixed perceptions of the jail and a willingness to believe that "jailers do not care." Unfortunately, jailers are stigmatized by public perception based on media stereotypes. I would encourage McLean advocates to consider whether or not their perceptions are based on reality or media-driven stereotypes that stigmatize the very difficult jobs of jail personnel. If they are based on stereotypes, what can be done to further understanding and advocacy for jail personnel and inmates?

RECOMMENDATION(S): Engage or develop a mental health coalition to become a voice to advocate for an appropriate level of mental health services at the jail. Current services cannot meet obvious growing mental health needs. The mental health coalition could become a strong force to ensure that programs are put into place in the jail. Build stronger relationships the members of an existing mental health supports, with NAMI of McLean County, and other consumer advocacy groups. Contact the advocacy groups that provide services in the McLean area. These would include local/regional chapters of National Alliance for Mentally Ill (NAMI) and other consumer groups. Each of the advocacy groups, whether they advocate for families or consumers, has their own mission. Study their missions, and contact the appropriate advocacy groups for each problem to be solved. Using the expertise of advocates often goes far in educating the public, the mental health system, and county funders about the problems providing services to the vast and growing numbers of inmates who have mental illnesses who are arrested and incarcerated in county jails. While there is public acknowledgment that mental health has lost funding across the country, there is minimal understanding that those funds were not transferred to the criminal justice system to treat the growing numbers of people with mental illnesses in jails. Advocates, once informed, are often an active voice that educates the public and mental health service providers about the limitations of jails. Jails are not and were never intended to be a treatment facility for people who have mental illnesses. These advocacy groups can stress the importance of diversion and alternatives to incarceration for people who have serious mental illnesses.

CONCLUSION

Based on this assessment, this Consultant is convinced that the MCDF is, overall, a well-managed and professional correctional facility. Despite the need to create adequate housing options for managing mentally ill inmates, McLean County officials, staff, community leaders and advocates continue to focus on doing the very best they possibly can within their limit fiscal realities. It is hoped that this document will be of meaningful assistance to McLean County officials in their continuing efforts to ensure constitutional and quality inmate health care services.

Special thanks are extended to Sheriff Emery, his entire jail staff, and all the County officials who participated in this short-term technical assistance study. I especially wish to thank Jail Superintendent Greg Allen for his help and support in this work.

In conclusion, I want to take this opportunity to thank the National Institute of Corrections for providing this professional assistance to the McLean, Illinois Sheriff's Department. Doing this work was truly a privileged and an honor.