Suicide Prevention Action Network: Organization Proposal

PUP 4941 Public Policy Capstone

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Executive Summary

Pinellas County Jail – Suicide Prevention Action Network

This report is a proposal for a non-profit 501(c)(3) organization, named the Suicide Prevention Action Network (SPAN). The organization aims to bridge the gap between the Pinellas County Jail and mental health care for post-release inmates, particularly those at risk of suicidal ideations. The situation in Pinellas County, Florida, mirrors the situation across the country. Mental health evaluations and treatments are conducted in county jails, and many communities offer low-to-no-cost mental health assistance through non-profit organizations. However, there is little collaboration between the two entities, leaving post-release inmates to navigate the system independently. SPAN will offer immediate assistance to post-release inmates in urgent need and help them navigate the system to gain a full and meaningful life. Four programs will be available to formerly incarcerated individuals including a hotline, mental health counseling, continuing medication, and a peer-to-peer support community. The programs will be accessed by clients in the order listed previously, as a sequential continuum of care. SPAN will be based in Clearwater, Florida and will be fully operational by January 1, 2023.

Introduction

Pinellas County Jail – Suicide Prevention Action Network

This report was compiled as a requisite for completion of the Public Policy and Administration Bachelor of Science degree program at St. Petersburg College in the Spring of 2021. On February 14, 2020, my father James Keith Lewis, committed suicide at his home in Evansville, Indiana. My father had suffered from various mental health disorders for an unknown number of years and had multiple encounters with law enforcement and the legal system over the previous five years. On February 11, 2020, my father was released on his own recognizance from Vandergburgh County Jail after an arrest for violation of probation. According to his nephew, a detective on the Evansville Police Department, my father was instructed by the judge to seek mental health counseling through the local Veterans Affairs hospital.

For this reason, the issue is very personal to me; however, I believe I have and will continue to approach the subject with objectivity. In my father's case, I hold no one at fault. I simply see a gap in the system that needs attention. Vanderburgh County is not Pinellas County, but my research has shown that this gap is present in most counties across the United States. Therefore, I plan to address the issue where I live, but hope to create a solution that can be applied to systems nationwide. All human beings are deserving of dignity and life. Once the debt to society has been paid by a criminal, they are no longer indebted. They deserve the help we would gladly offer any other person.

ISSUE: A proposal to create a suicide prevention program for post-release inmates from the Pinellas County Jail.

History and Laws

Pinellas County Jail – Suicide Prevention Action Network

The Pinellas County Sheriff's Office was approved by county voters and established in 1912. In 1959, Sheriff Don Genung began modernizing the department, which included establishing a centralized jail facility. The Pinellas County Jail is now located on 49th street between Roosevelt Blvd. and Ulmerton Rd., adjacent to the Criminal Justice Center. The Sheriff is a constitutional officer in the State of Florida and is governed by Chapter 30 of the Florida Statutes. The office of Sheriff is currently held by Bob Gualtieri (Pinellas County Sherrif's Office, 2014).

The Department of Detentions and Corrections operates the jail and is commanded by Colonel Sean McGillen. The Pinellas County Jail is the 28th largest in the nation and houses an average of 3,000 inmates daily on 54 acres of land. In 2007, funded by the Penny for Pinellas tax, the Medical Section was opened. The jail operates 432 beds in a 162,000 square foot centralized facility for inmates' medical needs, including a mental health clinic. Major Paul Carey oversees Inmate Healthcare as the Commander of Support and Health Services Bureau (PCSO, 2014).

Multiple non-profit and not-for-profit organizations offer low or no-cost mental health services to Pinellas County residents, including formerly incarcerated individuals. The Crisis Center of Tampa Bay was established in 1972 as a crisis and suicide hotline under the name Hillsborough County Crisis Center. The organization has expanded greatly since, operating the 211 hotlines in Hillsborough County, and offering multiple services for victims of sexual assault and trauma. In Pinellas County, 211 is answered by a smaller organization, 211 Tampa Bay Cares (Crisis Center of Tampa Bay, 2021).

Personal Enrichment through Mental Health Services (PEMHS) was founded in 1981 and offers services such as a suicide hotline, outpatient counseling, and inpatient trauma services with 45 adult beds and 15 children's beds. PEMHS has a distinctive family orientation (Personal Enrichment through Mental Health Services, n.d.).

The Suncoast Center was established in 1943 in St. Petersburg, Florida. A wide variety of counseling and psychiatric services are offered at the Suncoast Center's four locations in Pinellas County. Many of those services are dedicated to victims of sexual assault and children, but the organization provides all general mental health services (Suncoast Center Inc, 2019).

Directions for Living began serving the community of Clearwater, Florida in 1982 and today serves individuals in need across four counties. The organization is committed to helping low-income and at-risk populations, such as the homeless population (Directions for Living, 2021).

A study in *American Jails* found that 6.4% of male inmates and 12.2% of female inmates released from jail or prison suffer from a current severe mental illness (Kirkman et al., 2005). Another study, in *Contemporary Clinical Trials,* found that 10% of all suicides in the United States can be attributed to a recent legal stressor (Johnson et al., 2020). Furthermore, United States congressional findings state that over 16% of incarcerated adults and 20% of incarcerated juveniles suffer from a severe mental illness, while 40% of adults with a mental illness will encounter the criminal justice system in their lifetime (Publ Law No. 108-414, 2004).

The Mentally Ill Offender Treatment and Crime Reduction Act of 2004 addresses the issue of how the national will foster local collaborations, which will ensure that resources are effectively and efficiently used within the criminal and juvenile justice systems. The law provides that, "In general.--The Attorney General, in consultation with the Secretary, may award

nonrenewable grants to eligible applicants to prepare a comprehensive plan for and implement an adult or juvenile collaboration program, which targets preliminarily qualified offenders in order to promote public safety and public health" (Publ Law No. 108-414, 2004).

Previously, the Community Mental Health Act of 1963, provided grant funds to be made available:

> for project grants to assist in meeting the costs of construction of facilities for research, or research and related purposes, relating to human development, whether biological, medical, social, or behavioral, which may assist in finding the causes, and means of prevention, of mental retardation, or in finding means of ameliorating the effects of mental retardation (Publ Law No. 88-164, 1963).

In Florida, a 2019 agreement between the Florida Department of Corrections and Disability Rights Florida, requires the creation of individually tailored Individual Service Plans (ISPs) for all inmates with a mental illness, and Multidisciplinary Service Teams that must meet regularly to discuss the inmates' treatment plan. The agreement was reached in mediation with the assistance of federal judge Harvey Schlesinger (Case No. 3:18-cv-00179, 2019).

Jails and prisons in the United States have not always dealt with such high proportions of mentally ill inmates. Prior to the 1970s, asylums and state hospitals were operated specifically to house those with sever mental illness. Deinstitutionalization began with three major court cases.

> In *Lake v. Cameron*, a 1966 D.C. Court of Appeals case, the concept of "least restrictive setting" was introduced, requiring hospitals to discharge patients to an environment less restrictive than a hospital if at all possible. In the 1975 case of *O'Connor v. Donaldson*, the U.S. Supreme Court declared that a person had to be a danger to him- or herself or to others for confinement to be constitutional. The 1999 U.S. Supreme Court decision

in *Olmstead v. L.C.* stated that mental illness was a disability and covered under the Americans with Disabilities Act. All governmental agencies, not just the state hospitals, were to be required thereafter to make "reasonable accommodations" to move people with mental illness into community-based treatment to end unnecessary institutionalization (Yohanna, 2013).

Title XXXII, Chapter 491 Clinical, Counseling and Psychotherapy services governs licensing of mental health practitioners, registration of interns, the practice of sex therapy, misconduct, and various other mental health practices. Title XLVII Criminal Procedure and Corrections governs all jails and prisons in the state. Chapter 916 Mentally Ill and Intellectually Disabled Defendants, Section 17 governs Conditional Release. Chapter 951 governs County and Municipal Prisoners. Section 032 governs Financial Responsibility for Medical Expenses (Florida Legislature, 2021).

Stakeholders and Perspectives

Pinellas County Jail – Suicide Prevention Action Network

STAKEHOLDERS	PERSPECTIVES
Inmates	Roughly 10% of all suicides in the United States are related to a recent criminal stressor. Nearly half of all incarcerated individuals report ideations of suicide (Johnson et al., 2020). Following incarceration, individuals experience numerous hardships that can significantly increase stress levels, ultimately leading to negative mental health outcomes and suicides. These individuals often feel as if there is no help available to address their mental health. While these people broke the law, and are likely still paying their debt, they deserve the opportunity to live, and to live full and meaningful lives. Most of these individuals desire no-cost, accessible counseling, and medication.
Pinellas County Sheriff's Office/Sheriff Bob Gualtieri	The Sheriff's Office operates the county jail. The Sheriff's Office provides medical services, including mental health services, to incarcerated individuals. However, the Sheriff's Office does not currently run a mental health program for post-release inmates. The exception is Safe Harbor, the Sheriff's Office's homeless shelter, where services are available only to current residents. The Sheriff's Office is focused on law enforcement, detention, and corrections. Corrections include rehabilitation and reform. Allowing people with serious mental illness to return to society untreated is costly to the community and the department. Sheriff Gualtieri does not want to see anyone die unnecessarily, from suicide or any other means (PCSO, 2014).
Pinellas County Jail Medical Section	"The Medical Section provides health care services for all inmates. Inmate Health Care is staffed by professionally trained, licensed and certified medical personnel and adheres to the Standards for Health Services in Jails, set by the National Commission on Correctional Health Care. Paid for by Penny for Pinellas, the facility opened in 2007 providing 432

	beds and consolidating all inmate medical care under one roof at the Pinellas County Jail" (PCSO, 2014). I spoke with John Martinelli, the Health Services Administrator for the PCSO Health Section, on February 2, 2021 at 10:00 a.m. According to Martinelli, inmates generally come into the jail with interrupted care or without ever having received care for mental health conditions. While the jail does identify those mental health conditions and start them on medication, when they leave, they are on their own. The stress of finding care, in addition to the mental health disorders themselves, can greatly increase the risk of suicide. The Health Section does provide a medication voucher, but it only covers three days and requires the individual to find a pharmacy and use the voucher. If the individual has no access to a doctor, after three days they have no access to medication (J. Martinelli, personal communication, February 2, 2021). As clinicians (psychiatrists, APRNs, LMHCs, and LCSWs) the staff in Inmate Healthcare is dedicated to treating and helping those inmates and does not wish to see the inmates suffer or commit suicide after release (PCSO, 2014).
Local Police Departments (Clearwater PD, Largo PD, Tarpon Springs PD, St. Petersburg PD, Pinellas Park PD)	Local police departments deal with the costs (time, resources, and collateral damage) of the actions of released inmates with mental health disorders, whether that is the commission of crime or suicide. In their mission to serve and protect the community, local police departments seek to reduce both these outcomes. As part of the law enforcement network, local police departments are in a unique position with access to these individuals. I spoke with Officer James Frederick of the Clearwater Police Department on January 28, 2021. "I truly do believe in setting them up with a counseling session when the inmate gets out, and then with his or her family that is willing to participate, a face-to-face to get them the resources, not just telling them to make a

	phone call and see if they can help you out" (J. Frederick, personal communication, January 28, 2021).
Crisis Center of Tampa Bay	"The mission of the Crisis Center is to ensure that no one in our community has to face crisis alone" (Crisis Center, 2021). The Crisis Center operates the National Suicide Prevention Hotline, 211, that provides intervention for those needing immediate support. The 211 hotlines also assist with coordinating care and follow-up telephone services until consistent treatment is obtained (Crisis Center, 2021). I spoke with Dr. Roger Boothroyd, former Chair of the USF Department of Mental Health Law and Policy and currently a member of the Board of Directors at the Crisis Center of Tampa Bay on February 4, 2021. Dr. Boothroyd suggested that a simple, effective measure would be to provide all individuals with a card for 211 when they are released from county jail (R. Boothroyd, personal communication, February 4, 2021). The Crisis Center of Tampa Bay also collaborates with other community-based partners to raise awareness for mental health and suicide.
Other Mental Health Non-Profits (Suncoast Center, Directions, PEHMS)	The mission statement for the Suncoast Center is, "Strengthening, protecting, and restoring lives for a health community" (Suncoast, 2019). The mission statement for Directions for Living is, "Our mission is to be a welcoming and compassionate provider, advocate, and partner to children, adults, and families in need of integrated healthcare, social support, safety, and hope for the future" (Directions, 2021). The mission statement of Personal Enrichment through Mental Health Services says, "PEMHS is committed to serving as a collaborative partner in the system of care to ensure immediate interventions and supportive recovery are accessible to community members for optimal behavioral health." (PEHMS, n.d.). The mission statement of the Pinellas Ex-Offender Re-Entry Coalition is, "The mission of the Pinellas Ex-offender Re-entry Coalition

	(PERC) is to help the offender become and remain an ex-offender, reunited with family through advocacy, education, programming, and comprehensive service delivery and referral" (PERC, 2017). These organizations are all committed to improving the community through mental health services. They are all non-profit, and thus are perhaps more motivated to collaborate than private sector organizations may be.
Private Health Care Systems (BayCare, Advent, Bayfront, St. Petersburg General, Tampa General, Bay Pines VA)	While St. Petersburg General Hospital (part of for-profit Hospital Corporation of America) is a for-profit hospital, Tampa General Hospital and Advent Health Systems are non-profit, while BayCare Health Systems is not-for-profit. Still, these are large institutions with large operating costs that may be less willing to offer free services.
Pinellas County Residents	County residents may be more concerned with recidivism rates as they are more visible to victims of crime and are an indicator of crime rates. However, one suicide costs an average of $1,329,553 due to lost productivity and medical costs (SPRC, n.d.). Much of these costs ultimately are shouldered by taxpayers. Pinellas County residents already pay for the Pinellas County Jail Inmate Healthcare center through the Penny for Pinellas tax. Residents will benefit from a suicide-prevention program for post-release inmates through reduced costs due to suicide and reduced recidivism as a by-product of mental health services provided to inmates after release.
Inmates families	Families of inmates in most cases wish to see their family members recover from whatever may ail them, to be reformed, to be reintroduced to society, and to remain alive (not commit suicide). My research has indicated that families are a valuable resource for individuals when they are reintegrated to society.
Homeless Outreach/Shelters (Homeless Leadership Alliance, HEP, St. Vincent DePaul, Safe Harbor)	The mission statement for the Homeless Leadership Alliance is, "The mission of the Homeless Leadership Alliance is to coordinate all community partners, systems

	and resources available with the goal of helping individuals and families to prevent, divert, and end homelessness in Pinellas County (Homeless, 2020). The mission statement for the Homeless Empowerment Program is, "Since 1986, our Mission has been to provide homeless and low-income families and individuals, including Veterans, with housing, food, clothing, and support services necessary to obtain self-sufficiency and improved quality of life" (HEP, 2021). The mission statement for the Society of Saint Vincent de Paul includes, "The Society collaborates with other people of good will in relieving need and addressing its causes, making no distinction in those served because, in them, Vincentians see the face of Christ" (Society, 2011). These organizations are not focused specifically on recently released inmates nor suicide prevention. However, the people they serve often are recently released inmates and/or suffer from ideations of suicide.
Mental Health Clinicians	Clinicians work in the mental health field for a living. They have various motivations for choosing this field, and for many this involves charity and community.
Students	Students, particularly high school students, often need community service hours and would make a great base of volunteers. College students are generally an altruistic group and would also present many readily available volunteers more capable of sensitive work with clients. Interns majoring in social work, psychology, and criminal justice would also be a premium source for staff.
Pinellas County Board of County Commissioners/City Councils	The BCC and the various city councils are political bodies. Those members who are not retiring at the end of their term must stand for re-election. Socially popular programs may aid in that re-election bid among liberal voters and fiscal restraint may aid among more conservative voters. The individual commissioners and council members are also human beings with compassion and empathy.

Florida Department of Law Enforcement/Florida Department of Public Health/U.S. Department of Health and Human Services/U.S. Department of Justice	The various state and federal level agencies have funds to disperse in the form of grants. These agencies are administrative and less political than the commissions and councils, but not entirely apolitical. Positive programs supported by these agencies bode well for the executives in power. These agencies also benefit from reduced costs when services are provided by local governments and organizations to address negative outcomes such as suicide.
Myself/Other families of those who have committed suicide after release from a county jail	Families do not want to lose loved ones to suicide after incarceration.
Formulated February 1, 2021 by James Harrison Lewis in Clearwater, Florida	

Recommendation

Pinellas County Jail – Suicide Prevention Action Network

A gap between inmate healthcare and mental health care in the community exists for inmates following release from county jail. The county loses track of the inmates, while the inmates struggle to access the help that is available. The available mental health assistance should be made more accessible to post-release inmates immediately upon release.

County jail inmates are at greater risk than the general public of suffering suicidal ideations and attempting or committing suicide. Furthermore, people with severe mental illness are at a greater chance of encountering the criminal justice system and passing through the county jail.

Post-release inmates have paid their debt to society. As members of the community, they deserve the chance to live full and meaningful lives, made possible by access to mental health assistance. When mental illness is treated, the likelihood of recidivism is reduced, benefiting the community as a whole. For those with previous severe mental illness, their crimes may not entirely be their fault and release from county jail may be an opportunity for recovery with access to the proper services.

I recommend that a non-profit 501(c)(3) organization, the Suicide Prevention Action Network, be established to bridge the gap between the county jail and mental health assistance. I further recommend that the Pinellas County Board of County Commissioners appropriate funds to provide a grant to the organization for start-up and operating costs.

I recommend that the organization offer four services to accomplish its mission. First, a dedicated suicide prevention hotline for post-release inmates. Second, free therapy and counseling through volunteer mental health clinicians. Third, a prescription medication cost assistance program. Fourth, a peer-to-peer support network.

Expert Interviews

Pinellas County Jail – Suicide Prevention Action Network

Officer James Frederick

Clearwater Police Department – Community Liaison

Q: Do you think there is an increased likelihood with former inmates committing suicide after they are released from jail, whether here in Pinellas County or in general?

A: Absolutely, I mean when you were convicted of a crime and you spend some time in jail or prison you might feel down about what happened. It is difficult to get back out into society and try to get a job and take care of yourself, so it can be a concern.

Q: Are you aware of any services that the jail or the County or the city provides for inmates while they are in custody to assist with any mental health disorders such as depression or anxiety?

A: I know we do not really handle the jails; the Sheriff's Office takes care of that for as long as they are in jail, but I do not know of any offhand, I cannot say. I thought that the Salvation Army offers things under the health program, but do not quote me on that, I guess.

Q: You're not aware of anything after people are released either then? I found, and not just here, going through my research there were some studies on mental health with inmates and when they are released that focused on recidivism rates not a lot focused on you know any negative outcomes for the inmates after the release. For things like suicide, I found maybe one

scholarly article that kind of addressed it, but it does not seem like nationwide there's a whole lot of programs that address it.

A: No there is not, and you know I applaud Hillsborough County Sheriff's Office when they did something with veterans, and they have like a veteran support which they specifically offer veterans in jail. They offer them services both in jail and on the other end. They also kind of help them to go through the legal system to protect a lot of veterans, so I would be curious as if they have programs when they get out. I know they do help them while they are in which is a wonderful thing for our veterans. I think it has been going on for a couple of years, but Chad Chronister is big on helping the veterans.

Q: What role do you think the families of inmates should play in mental health support and reintegration?

A: I think that family plays a big role in an inmate's life. You know that is the closest thing to that inmate, but you also must understand that there is a difficulty with the inmate coming back and reorienting himself with his family and society. We must see whether the children are still involved. Oftentimes, these inmates come back to nothing, you know, they may have to live with their parents or there are no family, and they may have to go shack up with a friend, which furthers their trouble. The family plays an important role, being available in support, but you also know the family they are also going through something themselves personally. They may be bringing in their concern or their issues, and it may be drug issues or alcohol dependency issues, and then it kind of furthers the problem, so it would be wonderful to have programs not only just to help the actual inmate but to help them if he is going to go home and stay with his mom or whoever it might be to help the whole family as a unit.

Q: Do you have any ideas of what law enforcement or local governments could do to support the families who are available and willing to help?

A: I can simply say offer services, but what I hear a lot of in the community is that people are told call 211. Alright, now if you ever call 211, or you go online sometimes you must wait for a long time, and sometimes you know they are just like the catch all. You call them, they kind of have all the information and they just supply it for you. I truly do believe in setting them up with maybe like a counseling session once the inmate gets out, and making a personal session for the individual and then a personal session with his or her family that wants to come in. Having a face-to-face to be able to give them the resources, not just tell the inmate to make a phone call. Guys get on the phone for like 30 minutes, and he is kind of discouraged, and he may get a representative that may be tired that day or does not supply the information that he needs and then he is kind of like lost in the system. Having a face-to-face counseling session with someone to help him, I think that will be wonderful to him or her.

Q: I basically just see like a little gap right there in between the county jail when the inmates released and then there are you know organizations out there that help with mental health and suicide prevention for people who cannot afford an expensive therapist, you have got Crisis Center of Tampa Bay, Suncoast Center, 211 hotlines, but there is like this gap in between connecting people when they are released and with the help that they need. So, that is what I am looking to hopefully develop a program that can help bridge that gap.

A: I think it needs to be done, I really do, because sometimes the jails are in the business of, you are here, you're only here for less than two years, and then you know you're kind of sent back out. The prison system, it is even worse, there is no other thing for them to go back to, so it is very discouraging. Again, a lot of these people have felony records, so it is not as easy as

going out and trying to find a job quickly. Also, there's resources that they need if they do find a job. I mean it takes a lot, you have deposits for apartments and food and so many of these factors that that they need. As they step out, they are doomed to fail unless you got a few thousand dollars that kind of gets you going. So, then that can lead into the more suicide and depression and things like that, absolutely.

Q: A hotline would help, but what about counseling or medication provided at low to no cost for these people.

A: Wonderful, I mean if they would take it. I wonder sometimes, when they get out, a lot of them are on probation and a lot of her mom for role and they must check in with probation officers so that might be a resource as a part of their probation. Well, as I say that I kind of backtrack, because sometimes when you are out of the system, when you want to get out of jail, the probation officer is just there to check in and do what you must do. So, it is not like they want to do that, or the inmate does not want to go and check in, so you might want to keep that separate. Just be sure that the inmate knows that this service is available, and require him to go to it, but it is just one session and then he can get all the information that he needs, and it is away from the court system. A lot of times inmates may not want to talk openly around a probation officer, they may just want to have that private. If it is something that happened, it is never going to happen again, they really want to be able to break free from that as much as they can.

Q: Have you have you found that you often or frequently with people who are awaiting adjudication that there is a mental health aspect?

A: I do not know if you can assess it that quickly in the transitional period awaiting because a lot of times, they could be in there for a day and they are out or they wait for their bail

bondsman they're out pretty quickly. So, it is hard to really assess whether that person is like really seeking help or just trying to get out of jail because, 'hey it's screwed up.' When you have the inmate there, I am thinking he is thinking to himself, 'I made a mistake I did this I did that,' he's having to just evaluate his life and he thinks he's just going to get out and everything's going to be fine and then he will go back to doing the same thing. So, I think the longer they stay you know it might be better to find what services might be needed.

Q: One final question for you, it might be a little more abstract. One study I found showed that increased arrests and incarcerations in a concentrated area increased the crime rate and destabilized the area, because families are missing family members that provide income support. Then there is a culture of hostility created between the community and law enforcement, and those released inmates struggle with mental health and finding employment. It kind of seems counter intuitive, you know higher arrest rates hopefully would bring down crime rates. Do you give any credence to that?

A: Yeah, I would have to agree with that, I mean I have been doing this job for four years as a community liaison officer. I was having this conversation with someone the other day, and I can agree with that. The more arrests that go up, you truly are destabilizing the area. Not only are more crimes being committed, and we must address those people that do crime, there is evil in our world, but it really does make a difficulty for the neighborhood. You got a guy that gets arrested for a felony, and he is the breadwinner for his family bringing money home to his family, his grandmother, he has got a son there or there is a child with a disability, so many different factors. The officer sometimes just thinks one thing, I must make the arrest by the book, 'I got to take you to jail.' I have seen arrest devastate a family, and I have seen arrest devastate a generation, so it's very difficult. I will say that is a problem, that is something that I

hope in the future that law enforcement would look at, that we do not turn a blind eye to crime, but we also really must understand you know when we make an arrest what that does to a family. I know sometimes, there is like in California, if they arrest someone, they release them with the bond being so low or no bond and sometimes they go out there and do the same thing that they did before. I believe there should be more resources in communities, whether it be mental health, and those resources should come from the county, but also should be involved with law enforcement. Many other different agencies offer these resources. From the people that I have seen in the neighborhood, they are not all bad, they have made a mistake and like we talked about the inmates that might have gotten arrested for whether it be a felony or drug charge that is all, so they know. So, when you got a guy that gets out, is convicted of a felony you know, this is a list of jobs that I have seen that they will hire felons, but it is difficult it is not that easy. The guy he has got to make enough money to get caught up, so it is that you are putting them in a hole, but you do not give a few thousand dollars to get him started. So, you know it is just the cycle then. He does not find a job, or he quits the job, and he goes back to what he knows right. Then he sees the same officer that arrested him a couple months ago, or a year or two ago, and it is the same cycle. Then the young boy who is living in the house with the dad or not seeing that example or seeing police officers in a certain way they do the same exact thing. A lot of it has to do with poverty. They do not have much, they must live in these neighborhoods because they cannot afford anything else. You know, me and you, I am sure you live in a decent neighborhood. I live in a decent neighborhood. We do not have police riding around our neighborhoods all the time, they do. I have seen kids who will not even speak to me because the badge arrested their father. That is devastating as that child grows up, he grows to hate police officers, so when he is 13 and 14 years old, he just does the same

thing. So, there really needs to be more resources in these communities, and I think that the counties and the police departments and fire, all these entities really need to throw money into a pot to give people opportunities. I work with the United Way often, and they do a lot of stuff in North Greenwood, but we need to kind of expand a lot of their services or a lot of services out there so people can get the help. When you call a lot of places, they are busy right, you get an intake coordinator that says, 'everything is full right now call in two weeks.' I mean, do you know the feeling of someone who really needs help, and you tell them to call in two weeks? I mean that is devastating. Even if you tell him to call on a weekly basis, most people need those services within a day or two. When they are calling, they need it, but when you push him off for two weeks it may or may not show up and then it is kind of just it is that same cycle you know. We must be able to give those people the resources right when they need, because you could pretty much could save them from something that might devastate them, and I have seen it happen. I have seen it happen where people have been waiting for services and they get in trouble again they get in trouble for something serious and so we just need more. You need more opportunity; we need more help there (J. Frederick, personal communication, January 28, 2021).

Gianluca Martinelli

Pinellas County Sheriff's Office – Health Services Administrator

Is there an increased likelihood of negative mental health outcomes that would lead to suicide among inmates after release from jail, whether in Pinellas County or in general? Yes, I think a lot of it has to do with access to care. When it comes to mental health needs and mental health services, at least in the county, a lot of our individuals that come in have had interrupted services or have never had services. So, we identified a lot of individuals with mental health

issues, started them on medication, and when they leave here, they are kind of unfortunately almost on their own. Lack of accessibility to care certainly adds to the risk of possible suicide or additional mental health problems. We provide services in the jail with mental health or any mention medication. Anybody who gets booked into the jail gets screened by my nurses and there is a component of that piece, the psychiatric screening that is done by our psychiatrist, so we have a significant psychiatric component within the medical division. We have a full-time psychiatrist, a psych APRN, and five licensed either mental health counselors or LCS providers. Once they are screened at booking, and there is a history of mental health services, or previous attempts of suicide, or any history of depression, anything related to mental health with their own medication then they are referred to the mental health team. Obviously, if their suicidal, they are uncooperative, or there is bizarre behavior or those type of things they are put on statuses. Our highest status being like an SR1, which is our single cell, on camera, suicide risk with a one-on-one deputy watching them. Then you go down to the lower level, which is an SR2, which is most of our individuals. They may voice suicidal ideations, but they have no real plan or realistic plan when it comes to it. One example, we differentiate, if somebody says, 'I'm suicidal, I'm going to run into traffic.' Well, that is not really feasible here, versus somebody said, 'I'll hang myself.' It is a little bit more precise, and they have a plan. So, we have statuses, you have your close observation and all these levels, there is a level of intervention. We have a mental health transition, where the individuals that are cleared off the statuses, but they are still not quite ready to go into general population or a psych unit type thing, so they need something a little smaller a little more you know more individual, more geared to their own type of behaviors, so they are not the oddball, or they do not stand out as much. It has been highly successful and a good transition point for people to go from a single

cell on a status to more of an open-door type living arrangement, so each one has a level of assistance that they receive from us. If they need medication, if there is a history of medication, we can verify that through Surescripts verification system with all the pharmacies and see if they have any active medication. So, that helps us be able to continue them on medication right away. If they do need medication, we need licensed mental health counselors to refer them over the psychiatrists, and we reinitiate medication. We have a good robust process. Where it gets a little difficult is when these people get released and they could be released in the middle of the night we have no idea when they come and go. We have a voucher system where we will pay for three days of medication if they accept the voucher take it and take it over to one of our pharmacies out in the community, but you know, unfortunately it is an underutilized process by inmates when they leave. So, if they leave, they do not follow up with medication right away, or they do not have a psychiatrist, or are not able to go to Directions or Suncoast and see a provider right away. Most likely they are going to fall off the medication and you know whatever stability that might have developed overtime while they have been here it kind of tends to fall apart. They go back to their behaviors and possibly end up back here and then we start over.

Q: I know you guys have Safe Harbor; I believe it is run directly by the Sheriff's Office right now. I know that they have some mental health counseling in there, but that wouldn't be accessible to anyone who is not a resident, correct?

A: They would have to be basically residents there, yes. I mean a lot of our patients here do go to Safe Harbor, and you know there is a lot of community partnerships there, so they are able to follow up with them, but you know again it is a voluntary system, they have to want to go there. So, yes Safe Harbor does get a lot of our patients and you know there is the clinic

upfront, Bayside Clinic with the County health plan system with the help of Department of Health and Human Services provides a lot of assistance. So, we have partnerships with other community partners

Q: How much does all this cost?

A: That's kind of hard to tell, obviously the services that we provide are you know it is tax dollar money, all the money for the jail comes through the Sheriff's Office, comes through the Board of County Commissioners, and the cost of staff, medication, housing them in the jail. Because they have been arrested and, if they are unable to bond or be released and then they stay here, it is kind of hard to put a figure on the cost of just the site services, because it is part of their services delivered while in jail. I am not sure if I can put a dollar amount on that.

Q: What role do you think the family of these inmates plays in reintegration once they are released?

A: If they do have family, and if they are involved, and they are also adults, you have that component where there is a privacy factor involved that these are adults and family members do not necessarily have the rights like a parent of a juvenile where they are responsible for them. A lot of it is the individual that happens to be willing and motivated and willing to give permission to the family. I think if there is family support, and they can help I think they can help him get the services that they need in the community and there is a lot of agencies involved in the county. There is a lot of procedural things, there is always the money factor involved, so the more support they have the better, but ultimately unless they are voluntary it is hard to get services, Unless they are a Baker Act or Marchman Act. Family support certainly can help.

Q: Final question, I found one study in my research showing that an increase of arrest and incarceration rates in concentrated areas increases the crime rate and destabilized the area because families are missing members who may be the breadwinner or support systems.

A: Anytime somebody gets arrested it does impact the community and the family. If they had a job, they could lose their job which impacts the income and impacts where they live. Importantly, if the individual does have mental health issues that are not being addressed, they struggle in everything in their life. There are struggles in the community, they can be out of control, commit crime, it is a repetitive process. So, yeah it does impact it. You know when I think family gets involved is because they committed a crime or somebody makes a phone call saying hey there is this individual on my property or whatever there is not a lot of options available for the law enforcement, hospitals, psych hospitals and facilities like there used to be. So, there are limited options of what to do with everyone.

Q: The project I am working on is trying to kind of bridge the gap between the county jail and the health services and places like Suncoast or Directions that provide that service they need. What insight do you have on accomplishing this?

A: Prior to working here, I worked at the health Department and I was involved with establishing the county blue card. It is just a coverage for individuals for medical and psychiatric and even some dental services for the ones that are uninsured, do not have Medicaid and that sort of stuff. So, heavily involved with that and the primary care clinics over at the health Department that provides services such as mental health transport the mobile medical units. So, I am familiar with that I worked at PEMHS before, so I think the access to care once they are on their own out of the facility that kind of stuff, I think that's the biggest at least in my eyes is the biggest obstacle to overcome. We see it because they leave us and they

are somewhat stable, but we cannot always stay in contact with them when they leave here. They may happen to leave in the middle of the night. We can Baker Act them, they go to PEMHS but if they leave and their stable or they are doing better, and they are not able to continue with counseling with medication that sort of stuff we see that the repetitiveness of them eventually coming back to us because there is nowhere else that they end up (J. Martinelli, personal communication, February 2, 2021).

Dr. Roger Boothroyd

Board of Directors Member – Crisis Center of Tampa Bay

Former Chair Department of Mental Health Law and Policy at USF

Q: In the research I have been doing, I have found that there are very few programs that exist specifically catered to those post release inmates, so I want to work on bridging the gap between the county jail and a program like Directions or the Crisis Center, do you have any thoughts on that?

A: Yeah, Roger Peters who is still at the university in the Department of Mental Health Law and Policy, he presented before the U.S. Congress about the need for reintegration for offenders coming out of jails and prisons primarily around substance abuse because so many of them need special services. There is a lack of services available to them as they transition out of prisons and jails and come back into society, so his focus on his testimony had a lot to do with the need for substance abuse services. That was one of the things I noticed in a little bit of reading I did this morning, well there is a lot of suicide due to substance abuse issues primarily because a lot of them have lost their sensitivity to the drug use, if they have been in prison or jail then they go back on the streets and they start up and you know there is a lot of that. So, he would be a good one talk to also, you know, and I can make a connection if you

want after we talk. You are right that there is this gap in terms of programs for reintegration after incarceration.

Q (from Dr. Boothroyd): So, what are you thinking of in terms of programmatic kinds of services?

A: I am thinking of a nonprofit organization type approach that helps connect these people coming out of jail with clinicians, therapists, counselors, and psychiatrists. Also, trying to find some way to help if they have medication that they are on whether in jail or that they were on previously, trying to continue to have some continuity in that medication. Also, some sort of a hotline.

A: I mean, if they dial 211, you know 211 exists everywhere and at least at the Crisis Center of Tampa Bay there is someone available 24 hours-a-day, seven days-a-week, 365 days-a-year and they have been trained specifically to deal with cases of suicide. They are incredibly talented in terms of talking with people who feel that life is not worth living, and that is not true, no matter how bad things may be that there is hope that everybody's life is worth living and things can get better. They are very good at delivering that message to people in the most desperate of situations that people may feel that they're in and so you know one of the things the Crisis Center has, it looks like a little credit card, but does have the 211 on it, and would be nice if everybody coming out no matter what jail they were leaving or what person they were leaving with. Give them this little card with the 211 number. At the Crisis Center they have 3600 service providers that they can make referrals to, not just for mental health counseling, but for housing, for all kinds of services. It's a hotline that can connect people to any kind of service that they need, and so particularly I think for someone who's reintegrating into society that may come up against a number of barriers particularly because of their record that may get

frustrated and turned down because someone says, 'Oh well, you committed a crime we don't want you living here, or we don't want to hire you, or we don't want you whatever.' The stress and strain that they may put on them and no one wants to give them a second chance, they can call 211 and they can get referrals to places that will help them overcome those problems, whether it be a housing need or food or whatever is next. That could be a quite simple thing that when they leave jail or prison. That would be a very simple thing that someone can put in their pocket or their wallet that they would at least know they can make a simple call and there is someone there that can talk with them about how to get something for anything that might arise. That is something that should be pretty feasible to do just when they're being released and here's their personal effects, you put it in your wallet in the car with the number to call if you need any help.

Q: Where would someone go about getting you know like a large quantity of those cards?

A: Well, I would call in 211 and talk with someone there. I can put you in touch with the person that overseas that, her name is Sunny Hall. I will send an email to her saying that we had a conversation, and I will CC you on that and you can talk with her also about your project. She is the Vice President for Clinical Services there and you can talk to her about getting some.

Q: What role do you think the families of inmates does or should play in mental health support and reintegration?

A: Well, families are always critical. I know, having worked in the mental health one of the real issues tend to be just isolation from families. Individuals with mental health problems tend to get very isolated from their families and that becomes a real barrier to treatment and stuff like that. I know less about that in terms of individuals who have been incarcerated but my

guess is to the extent that they become isolated from their families you know you just lose support. To the extent that families remain engaged with family members who are incarcerated and help provide support that's always a plus and other support systems are critical. I think to the success of anybody that has any kind of needs and finding any kind of barriers in life, and what is unfortunate is that when family members have problems that tends to cause stress in families and tends to alienate family members sometimes from that person. So, I mean having support to the extent that any program can help re-engage families with you know individuals who are trying to reintegrate into society that way, that is a great thing. It can be difficult though, particularly if they have been impacted by the persons criminal activity, you have distance between people and that can take time you know there is a healing process. There is a healing process that needs to take place so as part of the program maybe there is a way to build in how to you know heal those relationships and try to mend those relationships, but those relationships are important absolutely (R. Boothroyd, personal communication, February 4, 2021).

Sunny Hall

Vice President of Clinical Services – Crisis Center of Tampa Bay

Q: Can you give me a synopsis of what the Crisis Center does?

A: The Crisis Center started 40 years ago. It started as a suicide hotline and then merged with the forensic sector; it is called the nurse examiners program. They kind of merged with some nurses who were trying to provide sexual assault exams and rape kits because the hospitals, Tampa General, Saint Joseph's Hospital, at the time said we do not want rape victims in the emergency rooms. This was back in the late 70's early 80's, so the county started to fund an opportunity to be able to operate a hotline and then do a little bit around trying to respond to

crisis. Through the years it has grown obviously tremendously, we incorporated the name of Crisis Center Tampa Bay probably 15 years ago and really expanded our focus to helping people in crisis. So, we have grown to about a $15 million budget. We have taken on projects that directly connect with serving people in crisis such as suicide, sexual assault, and veterans. We have started up a veteran's hotline about five or six years ago and have funding to expand that statewide. A lot of it is really focused on veterans in crisis, so not all veterans need us, but we hired veterans to answer those lines and to work with those veterans past the first phone call. Then we opened probably 15 years ago as well an on-site forensic sexual assault clinic so now people who are sexually assaulted can come directly to us without having to go to hospitals. We have trained nurses on-call, trained advocates on-call, who do the exams, collect the evidence for law enforcement and then work with the victims of sexual assault afterwards to help them find care. Also, we have a Baker Act transportation system where when folks need involuntary commitment rather than going in the back of a police car the police or private providers can call us and we will transport them in a van with a trained staff member, mental health technician, or in an ambulance if they need it. Then we also run an ambulance program to answer 911 calls for the City of Tampa, so I mean there is basically three divisions, there's the corporate trauma center which is our mental health and sexual assault and then there is the gateway, which is 211 and all of our helplines. Then there's Transcare, which is our ambulance and behavioral health transportation system. We get 50,000 requests for help every year through the phone bank, through the ambulance service, through the mental health service after the sexual assault response. The frontline staff, the people who interact with those folks do amazing work

Q: When I spoke with Dr. Boothroyd, he suggested getting a 211 business card to every inmate as they are released so they know who to call when they need help. What other suggestions would you have for my program, or what other things could your agency collaborate on with me to address this issue?

Well, in Pinellas County, 211 does not come to us, it goes to 211 Tampa Bay Cares, which is an accredited 211. What we do beyond what they do, is that part you are talking about, that gap. So, when someone calls us just in the normal course of the day, if someone calls us and indicates suicidality, we do a safety assessment on that person and we help them establish a safety plan in the immediate. We make sure they do not need you know intervention outside of the safety plan and then we give them the option of having one of our prevention counselors follow up and so we have three people who their only job is to take all those follow-ups and make telephone calls to those folks who say, "yes I need ongoing support." Then they not only call them, but they do some more assessment to figure out exactly what is a good fit for them for treatment, is it trauma therapy which we provide, or is it a more in-depth mental health treatment that requires medication for psychiatric services, and we help get them connected to those services. We work with them, we call them every day, whatever the plan is set up with the person. It is really focused on what the person thinks they need and want, and then we work with them and establish that relationship and continue working with them until we hand them off to a longer-term provider. We fill that gap for veterans, for teens, for adults, for every population. Now, what is interesting is in Pinellas, 211 Tampa Bay Cares does not have that component. They do have a hotline component, so it is still a good plan that says if you want immediately somebody to talk to, call us. For us, Hillsborough County funds our plan because they realize that about 60,000 people every day based on research in Hillsborough County are

considering suicide at any given time, and so the idea of prevention is that when people do call us there is a window. If people do not call us and take their life, that window has already closed, but if the window opens and someone reaches out to us there is an opportunity there to connect. To connect immediately, that connectedness based on all the research is really the key. Now, what you are talking about, for peer-to-peer is a perfect next step, it is also the most challenging because finding funding, and I am going to talk funding because that is what I do is I try to make sure everybody gets paid and then we still have money coming in to pay for services. One of the primary funders for us is victims of crime money, it comes from the federal government through the state, and we get a lot of victims of crime money. The drawback to that is victims of crime will not pay for victims who have been incarcerated, who have a criminal history. We protested that because even in jails, if someone reports a sexual assault we respond to the jail and we do a sexual assault exam and we do sexual assault intervention. We cannot bill for that to the state, we cannot bill to that like we normally do to get paid for it because victims of crime money will not allow people with criminal records to receive services. So, that is a challenge. If a local entity funds us, like the county does not ask us if people are calling us or recently incarcerated or not, they do not really care. So, you know it does open an opportunity to say how do we recruit someone who has been through this, we call it lived experience. That is what we do with our veterans in the interview process, if you want to be a follow-up coordinator for our veterans program you must talk about your lived experience not as a veteran only but as a behavioral health consumer. You must be able to talk about how you access services and then talk about your journey and then we help you establish a safety plan and work with you and your support plan and at the end of the day it is very effective, it's extremely effective. So, finding someone to do that peer-to-peer mentorship with

folks who have been incarcerated, I suspect will have a tremendous impact. I have not seen the research on it, but I can guarantee you it is going to be a positive outcome. The last thing is the clinicians, you know there are clinicians who would have to donate their time for the most part until a person may or may not get connected to health insurance. Even the Affordable Care Act is not as robust for mental health counseling, but I do think it is possible. I think it is I think it is doable for people who for instance if there is a program that has interns you know we don't charge when interns do therapy, so it is possible that there are some folks who would be willing to utilize interns to do that and to be able to help the intern gain some experience at the same time giving the individual opportunities to get some therapy. I would say that probably most of them will need a trauma assessment because our research tells us that a huge majority of the people who are incarcerated have experienced trauma in their lives and it is manifesting itself through mental health symptoms, through behavioral health symptoms, substance abuse, and other types of behaviors that will eventually land them in jail. So yeah, and then the ongoing mentorship, you know the peer-to-peer counseling thing to bridge the gap, I think is important but also it is kind of like a 12-step model, you know where you keep going back and you keep checking in and you keep having that opportunity especially for people who have expressed suicidal ideations. I think the challenge for me is like how would be able to say they were suicidal or have a history of suicidal ideations.

Q: I think, most importantly probably would be working with the Sheriff's Office and their inmate healthcare division, of course they do health evaluation and screening, they are not always going to get honest answers there either, but they do have like a triage, certain levels that they will assign people based on level of risk. Or the Sheriff's Office would have someone responsible for compiling some kind of list or sending out a notification as people are released

with all that information, or they would have to be willing to allow someone from you know like if I had an established non-profit who could go in and have access to that information. Between all the legal things that I would certainly not understand myself, that is complicated. Do you have any thoughts on how to connect with the people who need help?

A: Yeah, getting people willing to consent, you know you are right it would be a process, but it is not undoable (S. Hall, personal communication, February 26, 2021).

Dr. Roger Peters

Former Chair – USF Mental Health Law and Policy

Q: Do you think that there is an increased likelihood or increased ideations of suicide in people once they are released from jails and if so, why do you think that is?

A: Sure, on release there are people at high risk for suicide, you know obviously, mental health issues, depression specifically, but other mental disorders. I do not know exactly what the steps are, you probably know better than I do, what the rates are of general population at suicide risk, or people who are at the exit point. You know, similar to a crisis situation, really for a lot of them they are going back to situation whether they're homeless, or don't have financial resources, or they don't have family supports.

Q: So, what do you think we could and should be doing to kind of help address that issue? If, you know if I were to start some sort of collaboration or an organization what would be the best approach in your mind?

A: Clearly you need to identify people before they leave who are at elevated risk for suicide, so there needs to be a universal screen provided at the jail. I mean, ideally it would be a universal screening, the Columbia Suicide Severity Rating Scale is one example but there's a

number of other evidence-based screens for suicide. Or it could be simpler like a just a checklist or a couple questions, recognizing that time is limited. I do not know what their discharge numbers are, but I guess in the range of a few 100 people a day, so that is a lot of manpower to do a screening. I think you need to do that and prioritize people for services based on that and recognizing that some people are not going to honestly respond to your questions. It might be helpful to provide something such as universal education materials to everyone about this. I think you could view everyone leaving the jail as being at high risk for suicide even if they are not honestly sharing information with you. Another thing to consider is possibly peer supports. So, you are creating a program that may not exist right? You are projecting some needs or trying to create a proposal for a program that might be helpful with different layers perhaps one layer might be peer support services connected with people before they leave the jail. So, they might go to the jail in person, or they might at least have a phone contact, but think of it like a you know a 12-step group, having a sponsor. This kind of thing is typical for veteran's treatment courts where there is a veteran peer who has had a substance abuse problem and or involved in the criminal justice system. Typically, someone who is successful in recovery and stable in their functioning and can help people just navigating different issues that come up, they can be part of the relapse prevention network. The peers would need to be aware of resources e for mental health counseling and obviously other kinds of 12 step groups. I know there are programs that you are aware of, these continuity of care for mental health services in jails and outside jail, so there are types of strategies that could be borrowed from that approach. Some of those include looking at the rosters, people who have recently been in let us say crisis stabilization units and matching those lists to people who are currently in the jail to identify people are at greatest risk. A smartphone approach might be

another idea, even without a case manager to have a smartphone app for people who are at risk and who have suicidal thoughts where they can get in touch with somebody or take a screen themselves for what their current risk is for suicide, it might have resources available such as a contact, kind of 800 numbers or 211. I mean the ideal program might be to have a person from one of the mental health centers who could do routine screenings for everyone leaving the jail, not just for suicide but also further mental health and perhaps substance abuse needs (R. Peters, personal communication, February 10, 2021).

Cost Benefit Analysis

Pinellas County Jail – Suicide Prevention Action Network

COST BENEFIT ANALYSIS CHART					
PROPOSED ACTION / ALTERNATIVE	BENEFITS	BENEFIT IMPACT VERY HIGH=5 HIGH=4 MEDIUM=3 LOW=2 VERY LOW=1	COSTS	COSTS IMPACT VERY HIGH=5 HIGH=4 MEDIUM=3 LOW=2 VERY LOW=1	RATIO BENEFITS / COSTS
Hotline dedicated to post-release inmates from the Pinellas County Jail.	A study of suicide prevention hotline users in Taiwan found that callers experienced a significant reduction in emotional disturbance and suicidal tendency during their call. Therefore, the hotline is a useful suicide prevention and crisis intervention tool (Shaw & Chiang, 2019). An earlier study found that hotline interventions reduced depressive mood by 14%	4	An automatic call distribution system (ACD) will be used for the hotline. The ACD routes calls to available agents without a prerecorded message or answering tree. The ACD system, CallShaper, costs $75.00 per line, per month. Lines will be added as demand increases. A basic management information system (MIS) would cost $500 for startup and	2	2:1

	of callers, reduced suicidal urgency by 27%, and secured contracts (agreements not to commit suicide and seek long-term counseling) in 68% of callers (Mishara & Daigle, 1997).		approximately $250 per year for updates. Training courses offered by Zero Suicide Institute for assessing and managing suicide risk (AMSR) costs $160/per person plus travel and per diem. Calls can be answered from home by volunteers.		
No-cost counseling/therapy for post-release inmates from the Pinellas County Jail.	A study of outpatient psychotherapy for veterans revealed that patients experienced a 50% reduction in severity of suicidal tendencies on the Scale of Suicidal Ideation. The study also found an 81% increase in veterans experiencing a moderate-to-strong will to live, and a 71% decrease in those reporting a weak will to live. Finally,	5	The minimum cost of this program could be as low as spending the time connecting volunteer clinicians whom have available office space with released inmates. On the high end, SPAN could be responsible for rent of office space, utilities, and licensed mental health counselor's salaries. The office space may run	2.5	2:1

	the study found that 66.6% and 70.6% were positive for suicidal ideations before treatment, and 32.4% and 42.1% were positive for suicidal ideations after treatment (Roush et al., 2020). A meta-analysis conducted at the University of Manchester found a highly significant positive effect of cognitive behavioral therapy on suicidal ideations and attempts (Tarrier et al., 2008).		approximately $7500 per year or more plus utilities. The average salary for a LMHC is $49,000 per year or $32 per hour.		
No-cost continuation of psychiatric medication for post-release inmates from the Pinellas County Jail.	A series of studies has shown that suicide prevalence was reduced from 2.63% per year without lithium usage to 0.435% per year with lithium usage. The anti-suicidal properties of lithium are not	3	At the low end, generic anti-depressant medications can be provided for approximately $10 per month, if a psychiatrist is willing to volunteer to handle patients and provide	1	3:1

	entirely well understood but are considered to be neurobiological substances with distinct bipolar disorder treating properties (Del Matto et al., 2020). Lithium is regarded as so successful at reducing suicide incidents that it has been proposed as an additive in drinking water in order to address suicide as a public health issue (Ng et al., 2019). However, the use of pharmacology in the treatment of suicidal ideations is relatively new and multiple studies have found that any effect is not statistically significant and may in fact increase the likelihood of suicide in the early phases of treatment. This		prescriptions. At the high end, SPAN may have to pay a psychiatrist's office visits, which may be around $100 per visit. A three-month supply of lithium costs $18(Huskamp, 2005).		

	same study reported that all suicide intervention approaches produce similar insignificant outcomes (Fox et al., 2020).				
Peer-to-peer support network for post-release inmates from the Pinellas County Jail.	Research on peer-to-peer suicide prevention programs is limited. However, "developing and testing peer-led suicide prevention interventions is consistent with the National Strategy for Suicide Prevention, which states peers 'can help promote hope and motivation for recovery; provide support for addressing specific stressors, such as the loss of a job; and help foster a sense of meaning, purpose, and hope'" (Lapidos et al., 2019).	3	The main costs of this program will be paying the peers a wage. SPAN will opt for a paid peer structure as a means of providing employment and income to released inmates. The peers will work part-time (no more than 18 hours per week) at $15/hour. Peers will also complete a AMSR training, costing $160 per trainee.	1	3:1

Provide 211 cards to inmates when they are released from the Pinellas County Jail.	Benefits are similar to the post-release inmate specific hotline. However, as indicated by Clearwater Police Department Officer James Frederik, 211 is often ineffective because it is so large and wait times can be lengthy in Pinellas County (J. Frederik, personal communication, January 28, 2021). Furthermore, ensuring that the cards are distributed to inmates upon release may be beyond SPAN's control.	2	The Crisis Center of Tampa Bay will provide the cards and the hotline service. The cost for SPAN will be negligible; however, it may be significant and is unknown for The Crisis Center. The costs of training deputies and ensuring the cards are distributed to inmates will also be negligible in monetary terms for SPAN; however, it will require a significant investment of time and other resources.	2	1:1
Do nothing.	None.	1	One suicide has adverse effects on seven to ten people. Those effects include depression, post-traumatic stress, risk of suicide, physical disorders, and	5	1:5

			social stigma (Lukas & Seiden, 2007). One suicide costs an average of $1,329,553 due to lost productivity and medical costs (SPRC, n.d.).		

Formulated February 1, 2021 by James Harrison Lewis in Clearwater, Florida

Public-Private Comparison

Pinellas County Jail – Suicide Prevention Action Network

OVERVIEW

CAPABILITIES

- **Private:** Public healthcare systems tend to be noisier and busier. This may decrease the likelihood that clinicians will involve patients in their own treatment. However, a study in Peru found no statistically significant difference between public and private hospitals as far as patient involvement is concerned. Perceptions of increased patient involvement in private settings may be due to clinicians' preconceived notions about sociocultural status and willingness to be involved. (Mongilardi et al., 2013).
- **Public:** To bridge the gap between inpatient care and return to society non-profits, such as the Robert Wood Johnson Foundation, have stepped in to provide centrally administered financial, social, and clinical services. Such programs are critical to ensuring continuity of care. In many local health care systems, such programs are not available. As a result, continuity of care does not occur in those communities without a case management system in place (Dorwart & Hoover, 1994). It may often fall to public institutions to bridge that gap between patients and case management systems, and even to provide the case management systems entirely when private institutions do not find it profitable.
- **Public:** A New York state study found that public specialty hospitals provide more adequate discharge planning than do private general hospitals (Dorwart & Hoover, 1994).
- **Private:** A Harvard University advisory committee rejected an offer by Hospital Corporation of America (HCA) to purchase Harvard's McLean Hospital, citing the physician communities' contestations that hospitals should not be influenced by the motivation for profit. The committee ruled that allowing the sale to a for-profit corporation would constitute a breach of the public trust (Bickman & Dokecki, 1989).
- **Private:** Proponents of private healthcare systems argue that competition will drive physicians to increase the quality of care and drive costs down, particularly if the physicians themselves are investors or owners. Opponents claims that the board of directors' desire to show a profit will outweigh more important values such as quality of care and accessibility to care (Bickman & Dokecki, 1989). The profit potential in post-release inmate mental healthcare may be considered low and/or fixed. This creates an environment unattractive to private healthcare systems because profits cannot be maximized. This may also lead advocates to distrust private institutions because the path of least resistance to maximizing profits are likely unethical.
- **Private:** Private hospitals were found to have a significantly increased use of strategic human resource management (SHRM); however, that distinction diminished when compared at the private for-profit and the private not-for-profit level. SHRM, through selection and training, has a positive effect on employee attitudinal responses, which in turn has a positive association with patient satisfaction and quality of care (Oppel et al., 2019).

MOTIVES

- **Private:** Despite broad consensus on the need for transitional care services, there is considerable variation in the ability and willingness to provide such services. Financial concerns seem to be critical (Dorwart & Hoover, 1994).
- **Private:** Restructuring funding to include more public monies through capitation, network, and managed care system payments will provide incentives to provide transitional services (Dorwart & Hoover, 1994).
- **Public:** Beginning in the 1960s, private corporate mental healthcare ballooned in response to the policy of deinstitutionalization, which was the closing of state psychiatric hospitals (Bickman & Dokecki, 1989). In his book *The Cycles of American History,* Arthur M. Schlesinger Jr., in 1986, wrote that, "Epochs of private interest breed contradictions too. Such periods are characterized by undercurrents of dissatisfaction, criticism, ferment, protest .... Problems neglected become acute, thereafter to become unmanageable and demand remedy .... The vacation from public responsibility replenishes the national energies and recharges the national batteries" (p. 28-29).
- **Public:** Recognition of the need for an organized public mental healthcare system emerged around the 1830s, before which mental health was a local, private matter. State and local governments responded by establishing psychiatric asylums. After the first 25 years of operation, the quality of care and maintenance of these asylums significantly declined. After World War II, the federal government became involved in improving conditions. The result was a decrease in inpatient populations, shifting many mentally ill individuals to outpatient service at private general hospitals. Thus, mental health care has cycled from a private service to a public service, and has transitioned back to a largely private matter through deinstitutionalization and a shift to community service programs (Bickman & Dokecki, 1989).
- **Private:** According to the National Association of Private Psychiatric Hospitals, the share of freestanding psychiatric hospitals operated by investor-owned chains increased from 25% in 1980 to 43% in 1982. In 1981, chains increased the number of beds managed by 257% and increased the number of units owned by 100% (Bickman & Dokecki, 1989).
- **Public:** In a review of 29 separate comparative studies, Baarspul and Wilderom found that the only significant directional difference in individual employee behavior is an increased level of community service in public sector (government bureau) employees compared to private sector business employees (2011).

GOALS AND OBJECTIVES

- **Public:** After the mass closure of psychiatric hospitals in the 1970s and the introduction of seriously mentally ill patients to general hospitals, policy makers observed that availability of care had been confused with access to care. In response, a predominantly public mental health care system was transitioned to a predominantly private health care system in the 1980s. Since that time, many questions have been raised about the quality and accessibility of care for those with chronic disorders and the uninsured (Dorwart & Hoover, 1994).

- **Public:** Better transitional care can reduce recidivism rates and lower costs (Dorwart & Hoover, 1994).
- **Private:** There is a phenomenon in private hospitals known as "cream skimming." The theory is that private hospitals offer the most profitable services to the most well-paying patients, leaving the rest to not-for-profit institutions, if they are available (Bickman & Dokecki, 1989). By this theory, private institutions have no objective or little interest in treating the population that is recently released from jail. While mental health may be a high profit field, the recently released inmate population is certainly not considered well paying.

COSTS

- **Private:** Mental health care providers, particularly in private hospitals and privately funded clinics, are increasingly under pressure to economize (Dorwart & Hoover, 1994).
- **Public:** 70% of mental health money was spent on hospitalization in the 1980s (Kiesler, 1982).
- **Private:** Arnold Relman has argued that the typical market forces do not operate in health care as patients are generally less knowledgeable about the service than they would be about other products and services, they lack access to the knowledge needed for consumer choices, and in most situations are less concerned about costs compared to health or survival (particularly when they are covered by insurance). These conditions are exacerbated by the growing belief that healthcare is a basic human right (Relman, 1980).

Formulated February 1, 2021 by James Harrison Lewis in Clearwater, Florida

Diplomacy/Public Relations Plan

Pinellas County Jail - Suicide Prevention Action Network

DIPLOMACY	
Goals	**Objectives**
Gain access to all inmates as they are released from the Pinellas County Jail.	Build a relationship with the Pinellas County Sheriff's Office and the Pinellas County Board of County Commissioners by seeking those stakeholders' input while creating and operating this program. We will consult with the PCSO Health Division and present our plan to the BCC at a regular meeting.
Build a staff of credentialed, volunteer mental health clinicians to provide therapy, counseling, and prescriptions for medications.	Host a series of collaborative meetings with local mental health non-profits and health systems to gain input from professionals and build a system that works for volunteer clinicians. Solicit volunteers directly by visiting their offices after setting an appointment over the phone or through e-mail

Target Audience

- Governmental organizations in Pinellas County.
- Pinellas County Sheriff's Office Inmate Healthcare
- Pinellas County Board of County Commissioners
- Clearwater City Council, St. Petersburg City Council, Largo City Commission
- Mental Health Nonprofits: Crisis Center of Tampa Bay, Directions for Living, Suncoast Center
- Health Systems: BayCare, Advent, St. Pete General, Advent, Bay Pines VA

Media Targets

- Direct e-mail
- Direct phone calls
- The Prison Journal - SAGE
- Journal of Correctional Healthcare
- Society and Mental Health – SAGE
- American Journal of Psychiatry
- State and Local Government Review – SAGE

- Local Government Studies

PUBLIC RELATIONS	
Goals	**Objectives**
Establish SPAN as a trusted member of the community.	Work with hyper local organizations, such as neighborhood associations, fraternal orders, schools, and churches. Host events that function as fundraisers and community experiences. Seek out and organize symposiums, lectures, and conferences in the community related to mental health, criminal justice, and equity.
Connect SPAN and our clients with the clients' families.	Market the organization as a family-oriented program. Ask successful clients and their family members to serve as ambassadors. Create a sense of family among peer-to-peer members and clients.
Target Audience	
• Community conscious county residents: age 45-65, male/female, high income, high education • Clients families: age 35-55, female, minority, low income, low education	
Media Targets	
• WMNF 88.5 (Sean Kinane) • Tampa Bay Times (Lane DeGregory) • Spectrum Bay News 9 (Erica Riggins) • WUSF 89.7 (Daylina Miller – former classmate) • WFLA (Marco Villareal)	

- WTSP (Jabari Thomas)
- WFTS (Wendi Lane)
- Creative Loafing (Deb Kent)
- Facebook, Twitter, Snapchat, TikTok, Instagram
- 970 WFLA (Jack Harris)

Formulated February 1, 2021 by James Harrison Lewis in Clearwater, Florida

PRESS RELEASE

FOR RELEASE MAY 30, 2021

Local Program Aims to Save Lives Often Overlooked

Clearwater, FL – The Suicide Prevention Action Network (SPAN) is lobbying local governmental organizations to provide funding and access to post-release inmates who are at risk of suicide. SPAN will present a proposal tomorrow, May 30, at 6 p.m. at the Pinellas County Board of County Commissioners located at 315 Court St. # 501 in Clearwater. The public is welcome to attend in person or virtually.

The risks of suicide are greatly increased after release from jail. A study in *Contemporary Clinical Trials* found that 10% of all suicides in the U.S. follow a legal stressor. The introduction of the Mentally Ill Offender Treatment and Crime Reduction Act states that 16% of all U.S. prisoners have a serious mental illness, and over 40% of adults with a serious mental illness will encounter the criminal justice system. SPAN is a 501(c)(3) non-profit organization, our mission is to provide dignity to men and women who have recently been incarcerated, or are awaiting adjudication, to prevent incidents of suicide.

We accomplish this by bringing these men and women together with compassionate community volunteers, professional treatment, and supplemental medication. SPAN operates a 24-hour hotline dedicated specifically to post-release inmates struggling with mental health and suicidal tendencies. We provide counseling and therapy for our clients as well as their families, whom are an integral role in the recovery process. We also organize a peer-to-peer support system that brings together former inmates who have survived mental health struggles and suicidal ideations with recently released inmates in a mentorship relationship.

We at SPAN look forward to working and growing in the Pinellas County community. We hope that we will win the trust of the people, our clients, and their families while we work to help those who need it most.

###

Press Inquiries:

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(720)492-2306

jamesharrisonlewis@gmail.com

Stakeholder Survey

Pinellas County Jail – Suicide Prevention Action Network

PARAMETERS
PURPOSE
The primary purpose of this survey is to determine whether incarceration in county jail increases the chances of suicide after release. The secondary purpose of this survey is to determine if mitigation techniques were used by the county jail, and to what effect. Through a Likert scale, non-random, cross-sectional, stratified survey I attempted to ascertain data on the frequency and severity of suicidal tendencies in post-release inmates from county jail as well as their experience with county provided assistance, familial assistance, and individually attained assistance. This data will help me to identify whether incarceration does increase the likelihood of suicide after release, and if so, how counties and municipalities can mitigate that likelihood. This will be done by identifying barriers to individuals and deficiencies in existing systems.
DESIGN
A Likert scale survey has been chosen because frequency is a critical factor for many of the questions. A question of scale is perhaps easier to answer than a yes/no question when the subject is emotionally sensitive. An experimental design would have been prohibitively impractical and certainly unethical, as an experimental design would likely require following cases to the result of death. The survey is cross-sectional, as it was administered to each participant once; however, it does have some longitudinal characteristics, as it asks questions about past and continuing events.
POPULATION
The population for this survey was all inmates on a given day in January 2021, when the average daily population of Pinellas County Jail was 2,727 (Inch, 2021). The survey was administered in January. The sample size was .005% or 14 post-release inmates who were incarcerated at Pinellas County Jail in the past. The sample size was stratified to ensure a proportionate representation of adults, juveniles, males, females, felony offenders, misdemeanor offenders and minorities. Demographics were not reported for confidentiality purposes. The sampling was nonrandom.
ADMINISTRATION

The survey was performed in person with individuals who were at bus stops along 49th street near the county jail, courthouse, and Pinellas Safe Harbor. The scale anchors were all be 5-point, including frequency, likelihood, desirability, and monetary quantity, excluding one yes or no question. A pilot test was conducted using paper surveys administered to post-release inmates at bus stops along 49th Street in front of the Pinellas County Jail. The pilot test identified errors in the survey, and established validity and reliability through control comparison. The timeline for administering the survey was three weeks, including 5 visits to the survey sight for a total of 10 hours.

CONCLUSIONS

SCALES

All survey items are Likert scales. Responses will be analyzed by finding the mean, adding all values and dividing by the number of responses. The mode will also be found for all items, by categorizing responses by answer per item and finding the most frequent response. The reliability of the scale will be determined by the extent to which the mean and mode align. Statistical test: multiple regression

RESULTS

- Response Rate: 36% (14 respondents out of 39 individuals solicited)

1. After your release from the County Correctional Facility, how often have you experienced thoughts of suicide?

   1: Never

   2: Once a month

   3: Once a week

   4: 2-3 times per week

   5: Every day

   Mean: 2.43

   Mode: 2

2. Before your time in county jail, how often did you think of suicide?

   1: Never

2: Once a month

3: Once a week

4: 2-3 times per week

5: Every day

Mean: 1.21

Mode: 1

3. During your time in the county jail how often were you provided assistance with your mental health?

1: Never

2: Once during my incarceration

3: Once a month

4: Once a week

5: Once a day

Mean: 2.07

Mode: 2

4. During your incarceration how often were you asked if you had thoughts of suicide?

1: Never

2: Once during my incarceration

3: Once a month

4: Once a week

5: Once a day

Mean: 1.36

Mode: 1

5. After your release from county jail have you been offered mental health assistance by the county?

1:Yes

2:No

Mean: 1.43

Mode: 1

6. How likely are you to voluntarily seek mental health counseling?

    1: Not likely

    2: Somewhat likely

    3: Likely

    4: Very likely

    5: I have sought mental health counseling

    Mean: 3.36

    Mode: 4

7. Would you consider court provided mental health counseling?

    1: Would not consider

    2: Might consider

    3: Would probably consider

    4: Would definitely consider

    5: I have received court appointed or mandated mental health counseling

    Mean: 1.36

    Mode: 1

8. How helpful has your family been with your mental health after your release?

    1: I don't have family

    2: Not helpful

    3: Somewhat helpful

    4: Helpful

    5: Very helpful

    Mean: 3.57

    Mode: 5

9. On a monthly basis, how much could you afford for mental health counseling?

    1: $0

    2: $1-9

    3: $10-$25

4: $26-$99

5: $100+

Mean: 1.07

Mode: 1

10. How long did you spend in county jail?
    1: <24 hours
    2: 2-30 days
    3: 1-3 months
    4: 4-11 months
    5: 1+ years
    Mean: 3.14
    Mode: 3

Independent Variable 1: Suicidal tendencies	Descriptive Research Question 1: Does the post-release inmate experience thoughts of suicide?	5 respondents never have suicidal ideations after release. 5 experience suicidal ideations once a month. 3 experience daily ideations and 1 experiences ideations 2-3 times per week.
Dependent Variable 1: County jail mitigating factors	Descriptive Research Question 2: What mitigating practices does the County implement to prevent suicide in post-release inmates?	5 respondents reported never being offered assistance with mental health while in the county jail. 6 respondents reported being offered mental health assistance once, and 4 respondents indicated they were offered assistance once a month. 10 respondents reported they were never asked if they had thoughts of suicide. 3 respondents being asked once, and 1 reported being asked once a month. 8 respondents reported they were offered mental health assistance by the county after their release, of those 7 also reported some likelihood of

		seeking mental health assistance. 6 reported not being offered assistance after their release. 7 respondents reported spending 1-3 months being incarcerated in the county jail. 2 reported being incarcerated for 1+ years, 2 reported being incarcerated 4-11 months, 2 reported being incarcerated 2-30 days and 1 reported being incarcerated for less than 24 hours.
Control Variable 1: Prior suicidal tendencies	Descriptive Research Question 3: Does incarceration in county jail increase the likelihood of suicidal tendencies in post-release inmates?	9 respondents reported never experiencing suicidal ideations before their incarceration, of those 6 experienced some frequency of ideations after release.
Relating to Dependent Variable 1: Personal mitigating factors	Descriptive Research Question 4: What mitigating practices does the post-release inmate take to improve their mental health and prevent suicide?	5 respondents reported that they have sought mental health counseling. 4 respondents reported they were very likely to seek mental health counseling, 4 reported they were not likely to seek mental health counseling and 1 reported being somewhat likely. 9 respondents reported they would not consider court provided mental health counseling. 5 respondents reported they might consider. 8 respondents reported that their family was very helpful with their mental health after their release. 4 respondents reported not having any family. 1 respondent reported their family was

		helpful and 1 respondent reported their family was not helpful. 13 respondents reported they could afford $0 per month for mental health counseling. 1 respondent reported they could afford $1-9 per month.

SIGNIFICANT FINDINGS

Perhaps most significantly, we found that 67% of respondents who never experienced suicidal ideations before their incarceration did experience some level of suicidal tendencies after their release. Further research is warranted in this area, but it is possible and supported by expert interviews that incarceration can increase the likelihood of suicide. We also found a link between the likelihood to seek mental health counseling and recognition that assistance was provided by the county. Of those who reported being offered mental health assistance by the county after release, 87% reported some likelihood of seeking mental health counseling, or had sought counseling. While a program offered to inmates immediately upon release is not known to exists, those who desire and seek assistance seem to have the perception that it is available. Other significant observations are that all but one respondent, 93%, reported they could afford $0 per month on mental health counseling. Families seemed to be a significant factor for post-release inmates mental health, with 64% reporting that their families were very helpful or helpful with their mental health, while 29% reported having no family. Only 7% reported their family was not helpful. Responses tended to find the extremes of either no family or helpful family; therefore, families may be a valuable resource in stabilizing and reintegrating inmates.

Formulated February 7, 2021 by James Harrison Lewis in Clearwater, Florida

References

Pinellas County Jail – Suicide Prevention Action Network

Baarspul, H., & Wilderom, C. M. (2011). Do Employees Behave Differently In Public- Vs Private-Sector Organizations? *Public Management Review, 13*(7), 967–1002. https://doi.org/10.1080/14719037.2011.589614

Bickman, L., & Dokecki, P. R. (1989). Public and private responsibility for mental health services. *American Psychologist, 44*(8), 1133–1137. https://doi.org/10.1037/0003-066X.44.8.1133

Community Mental Health Act, Publ Law No. 88-164 (1963). https://www.govinfo.gov/content/pkg/STATUTE-77/pdf/STATUTE-77-Pg282.pdf

Crisis Center of Tampa Bay. (2021). Mission. https://www.crisiscenter.com/about-us/mission/

Directions for Living. (2021). About Us. http://directionsforliving.org/about-us/

Disability Rights Florida v. Jones, U.S.D.C. (M.D. Fla.), Case No. 3:18-cv-00179-HES-JRK.

Dorwart, R. A., & Hoover, C. W. (1994). A National Study of Transitional Hospital Services in Mental Health. *American Journal of Public Health, 84*(8), 1229. https://doi.org/10.2105/AJPH.84.8.1229

Florida Legislature. (2021). The 2020 Florida Statutes. *Online Sunshine. http://www.leg.state.fl.us/statutes/*

Fox, K. R., Huang, X., Guzmán, E. M., Funsch, K. M., Cha, C. B., Ribeiro, J. D., & Franklin, J. C. (2020). Interventions for suicide and self-injury: A meta-analysis of randomized controlled trials across nearly 50 years of research. *Psychological Bulletin, 146*(12), 1117–1145. https://doi.org/10.1037/bul0000305.supp

Homeless Empowerment Program. (2021). About HEP. https://www.hepempowers.org/about/

Homeless Leadership Alliance. (2020). Pinellas Continuum of Care. https://www.pinellashomeless.org/about-us

Huskamp H. A. (2005). Pharmaceutical cost management and access to psychotropic drugs: the U.S. context. *International Journal of Law and Psychiatry, 28*(5), 484–495. https://doi.org/10.1016/j.ijlp.2005.08.004

Inch, M. (2021). Florida County Detention Facilities Average Inmate Population. *Florida Department of Corrections Bureau of Research and Data Analysis.* http://www.dc.state.fl.us/pub/jails/2021/jails-2021-01.pdf

Johnson, J. E., Jones, R., Miller, T., Miller, I., Stanley, B., Brown, G., Arias, S. A., Cerbo, L., Rexroth, J., Fitting, H., Russell, D., Kubiak, S., Stein, M., Matkovic, C., Yen, S., Gaudiano, B., & Weinstock, L. M. (2020). Study protocol: A randomized controlled trial of suicide risk reduction in the year following jail release (the SPIRIT Trial). *Contemporary Clinical Trials*, 94. https://doi.org/10.1016/j.cct.2020.106003

Kirkman, A., Schatzel, L., & Osher, F. (2005). The National GAINS Center reentry checklist: A practical tool for transition planning for detainees with mental illness. *American Jails, 19*(4), 34.

L. Del Matto, M. Muscas, A. Murru, N. Verdolini, G. Anmella, G. Fico, F. Corponi, A.F. Carvalho, L. Samalin, B. Carpiniello, A. Fagiolini, E. Vieta, I. Pacchiarotti. (2020). Lithium and suicide prevention in mood disorders and in the general population: A systematic review. *Neuroscience & Biobehavioral Reviews*, 116, 142-153.

Lukas, C., & Seiden, H. (2007, November 1). Silent grief; living in the wake of suicide, rev. ed. Reference & Research Book News.

Mentally Ill Offender Treatment and Crime Reduction Act, Publ Law No. 108-414 (2004). https://www.congress.gov/bill/108th-congress/senate-bill/1194/text

Mishara, B. L., & Daigle, M. S. (1997). Effects of different telephone intervention styles with suicidal callers at two suicide prevention centers: an empirical investigation. American *Journal of Community Psychology, 25*(6), 861.

Mongilardi, N., Montori, V., Riveros, A., Bernabé-Ortiz, A., Loza, J., & Málaga, G. (2013). Clinicians' Involvement of Patients in Decision Making. A Video Based Comparison of Their Behavior in Public vs. Private Practice. *PLOS ONE, 8*(3), 1–4. https://doi.org/10.1371/journal.pone.0058085

Ng, J., Sjöstrand, M., & Eyal, N. (2019). Adding Lithium to Drinking Water for Suicide Prevention—The Ethics. *Public Health Ethics, 12*(3), 274–286. https://doi.org/10.1093/phe/phz002

Oppel, E.-M., Winter, V., & Schreyögg, J. (2019). Examining the relationship between strategic HRM and hospital employees' work attitudes: an analysis across occupational groups in public and private hospitals. *International Journal of Human Resource Management, 30*(5), 794–814. https://doi.org/10.1080/09585192.2016.1254104

Personal Enrichment through Mental Health Services. (n.d.) About Us. https://pemhs.org/about-us/

Pinellas County Sheriff's Office. (2014). History.

https://www.pcsoweb.com/history

Pinellas County Sheriff's Office. (2014). Inmate Healthcare. https://www.pcsoweb.com/inmate-healthcare

Pinellas Ex-Offender Re-Entry Coalition. (2017). About Us. https://www.exoffender.org/about-us/

Relman, A. (1980). The new medical-industrial complex. *New England Journal of Medicine, 303*, 963-970.

Roush, J. F., O'Brien, K. M., & Ruha, A. L. (2020). Evaluating a recovery-oriented intensive outpatient program for veterans at risk for suicide. Crisis: *The Journal of Crisis Intervention and Suicide Prevention*. https://doi.org/10.1027/0227-5910/a000703

Shaw, F., & Chiang, W. (2019). An evaluation of suicide prevention hotline results in Taiwan: Caller profiles and the effect on emotional distress and suicide risk. *Journal of Affective Disorders, 244*, 16-20.

Schlesinger, A. M., Jr. (1986). The cycles of American histo~ Boston: Houghton Mifflin.

Society of Saint Vincent de Paul. (2011). Central Council of St. Petersburg Diocese: Mission. http://www.svdpccsp.org/mission.htm

Suicide Prevention Resource Center. (n.d.) Costs of Suicide. https://www.sprc.org/about-suicide/costs

Suncoast Center Inc. (2019) About Us. https://www.suncoastcenter.org/about-us

Tarrier, N., Taylor, K., & Gooding, P. (2008). Cognitive-Behavioral Interventions to Reduce Suicide Behavior: A Systematic Review and Meta-Analysis. *Behavior Modification, 32*(1), 77–108. https://doi.org/10.1177/0145445507304728

Yohanna, D. (2013, October). Deinstitutionalization of People with Mental Illness: Causes and Consequences. *American Medical Association Journal of Ethics, 15*(10). https://journalofethics.ama-assn.org/article/deinstitutionalization-people-mental-illness-causes-and-consequences/2013-10

Governmental Entity Observation/Participation Form
Student Name ______________________________ ______________
Date
Student ID # ______________________________
Name of the City/County ____
Name of the Presiding Officer____
List each of the City/County Council/Commission members and describe their personalities & interests

____

Complete 4-Step Policy Analysis: (use separate sheets of paper – attach same) Who is the proponent and what is their stake in the issue?

____

What are the stakeholders seeking from the Council/Commission?

____

Detail each Commissioner/Councilmember's response

____

____

What was the result of today's meeting?

____

Appendix A

Resume

James Harrison Lewis

Public Policy and Administration, Student

616 Lake Forest Rd.
Clearwater, FL 33765

(720)462-2306

jamesharrisonlewis@gmail.com

OBJECTIVE

As a student of public policy and administration, with passion and interests in planning, social services and sustainability, I am seeking an opening in municipal government. An ideal position would be one in which I can make a difference, grow, and bring my education to improve the municipality for which I work.

EDUCATION

St. Petersburg College
Clearwater, FL
B.S Public Policy and Administration
Fall 2019-Spring 2021
Current GPA: 4.0

University of South Florida
Tampa, FL
B.A. Mass Communications
Spring 2010-Fall 2013
(Incomplete)
SGA Senator, President SPJ, Phi Sigma Pi Officer
Overall GPA: 3.67

EXPERIENCE

January 2021 – Current
Parks Maintenance Technician • City of Safety Harbor

December 2019 – Current
Benefits Specialist Assistant • Homeless Empowerment Project

November 2019 – December 2020
Kitchen Manager • Benedict's

Summer 2012
Political Reporting Intern • The Tampa Tribune

I have held numerous food service management positions over the past sixteen years from high school, through college and in between. My responsibilities in these positions include ensuring the business is successful by providing a quality product to guests in a timely manner while providing superior hospitality. Additionally, I was responsible for monitoring labor costs, safe food handling and restaurant cleanliness. I was responsible for coordinating shift leaders, writing daily deployments, organizing all crew training, running management meetings, performing inventory, truck orders, scheduling, hiring, financials and cash deposits. A separate resume detailing my food service career is available.

KEYSKILLS

Collaboration
Press Relations
Policy Analysis
Social Media
Microsoft Office
Organization
Project Management
Small Team Leadership

REFERENCES

Jeffery [illegible]
Instructor in Charge
SPC Public Policy and Administration
(727) 394-6205

Personal Action Plan

James Harrison Lewis

Upon completion of the Public Policy and Administration Bachelor of Science degree program at St. Petersburg College I have several plans and goals.

First, I will apply to the Master of Public Administration at the University of South Florida by June 1, 2021. If accepted I will begin that program in the fall of 2021.

Second, I plan to continue my employment with the City of Safety Harbor in the Parks Department, while advancing into a full-time position if one becomes available. Furthermore, I will continue to watch for other positions to open within the city where I can better apply the skills I have gained in this program.

Third, I will continue volunteering with the Homeless Empowerment Program where I began as an intern in January 2019. If offered, I would consider taking a paid position with the organization.

Finally, I am exploring the idea of running for an open seat on the Clearwater City Council in 2022. This would require fundraising and a large time investment. I have been in contact with one current city council member, precinct captains in my district, and several neighborhood associations about the possibilities of a run.

Strategic Action Plan

Pinellas County Jail - Suicide Prevention Action Network

ABOUT US

VISION

We envision a near future when paying a debt to society does not include the debtor feeling the need to end their own life because help was out of reach.

MISSION

Our mission is to provide dignity to men and women who have recently been incarcerated, or are awaiting adjudication, to prevent incidents of suicide. We accomplish this by bringing these men and women together with compassionate community volunteers, professional treatment, and supplemental medication.

CORE VALUES

- Compassion
- Dignity
- Justice
- Philanthropy
- Restoration

GOALS

LONG-TERM GOALS

- Operate a 24-hour hotline specifically for post-release inmates.
- Collaborate with community physicians, psychiatrists, and therapists to provide no-cost mental health care for post-release inmates.
- Offer funding for any needed medications with a prescription to treat mental illness in post-release inmates.
- Coordinate a peer-to-peer support system. Former inmates who have recovered from suicidal ideations will counsel and sponsor post-release inmates who are struggling with suicidal tendencies.

SHORT-TERM GOALS

- Obtain Federal Employer Identification Number
- File Non-Profit Articles of Incorporation
- Write Bylaws
- File Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code (Raise $600 for filing fee).
- File Charitable Organizations/Sponsors Registration Application
- File Application for Consumer's Certificate of Exemption
- Collaborate with Pinellas County Sheriff's Office, Pinellas County Board of Commissioners, Pinellas County Homeless Leadership Board.
- Recruit volunteers, including physicians, psychiatrists, and therapists.
- Recruit board members.
- Fundraise for resources.

MEASUREMENTS OF SUCCESS

- Approval to work with the Pinellas County Sheriff's Office or access granted to post-release inmates.
- Acquisition of volunteers.
- Determination of 501(c)(3) status.
- Funds raised in any amount.
- Every person who asks for help and receives it.

STRATEGY

RESOURCE ASSESSMENT

- E-mail account
- Website (domain name, hosting, website builder)
- Social Media (Facebook, Twitter, Instagram, Mobilize, LinkedIn, Snapchat, TikTok)
- Phone line
- Bank account
- Technological hardware: Phones, computers, internet, phone service.
- Technological software: Microsoft office, hotline service (CallShaper, Five9, Ring Central), call list application (APK, PhoneSlate).
- Community volunteers
- Clinicians: therapists, counselors, psychiatrists

IMPLEMENTATION - plan what will be done along with completion deadlines

- Collect a minimum of 20 survey responses by February 1, 2021
- Compile, clean, analyze and create display of survey data by February 3, 2021
- Create a marketing plan by February 5, 2021
- Complete a public-private comparison by February 7, 2021
- Create a collaborative partnership plan by February 10, 2021
- Complete a cost-benefit analysis by February 13, 2021
- Create a diplomacy/public relations plan by February 18, 2021
- Create an organization overview by February 22, 2021
- Create a resume draft by February 28, 2021
- Complete a team dynamics overview by March 6, 2021
- Submit case study project report draft by March 14, 2021
- Complete final resume by March 18, 2021
- Complete personal action plan by March 21, 2021
- Submit final case study project report by March 28, 2021
- Present case study to PP&A panel April 12, 2021
- Establish e-mail and social media accounts by May 1, 2021
- Present proposal to Pinellas County BCC, PCSO Dept. of Detention and Corrections, Pinellas Homeless Leadership Alliance and CPD Chief Slaughter by May 30, 2021
- Obtain FEIN by May 14, 2021
- File Non-profit Articles of Incorporation by June 1, 2021
- Write Bylaws by June 14, 2021
- File Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code (Raise $600 for filing fee). By August 1, 2021
- Open bank account upon determination of 501(c)(3) status.
- File Charitable Organizations/Sponsors Registration Application by August 14, 2021
- File Application for Consumer's Certificate of Exemption by September 1, 2021
- Recruit volunteers, including physicians, psychiatrists, and therapists by January 1, 2022
- Recruit board members by January 1, 2022
- Begin fundraising for resources by February 1, 2022
- Begin volunteer phone bank by March 1, 2022

- Open hotline by May 1, 2022
- Begin peer-to-peer program by September 1, 2022
- Open prescription drug funding assistance program by January 1, 2023

DISSEMINATION

- Present proposal for collaboration to the Pinellas County Board of Commissioners, Pinellas Homeless Leadership Board, Pinellas County Sheriff's Office Department of Detention and Corrections.
- Submit grant proposals to the William Stamps Farish Fund, The Spurlino Foundation, the Carron Family Foundation, Mary Jane Hillard Jones Foundation, Biddinger Family Foundation, Campane Charitable Trust, Eckerd Family Foundation, Baycare, Pinellas County, State of Florida, Free Family foundation, Mueller Family Foundation, Pinellas Community Foundation, Community Foundation of Tampa Bay, Tampa Bay Lightning Foundation, Florida Blue Foundation, Criminal Justice Center, Clearwater Free Clinic, Largo Medical Center, Calvary Baptist Church, St. Michael's Catholic Church, Countryside Christian Center, Rotary Club of Clearwater, Clearwater Masonic Lodge, Knights of Columbus Father Lopez Council,

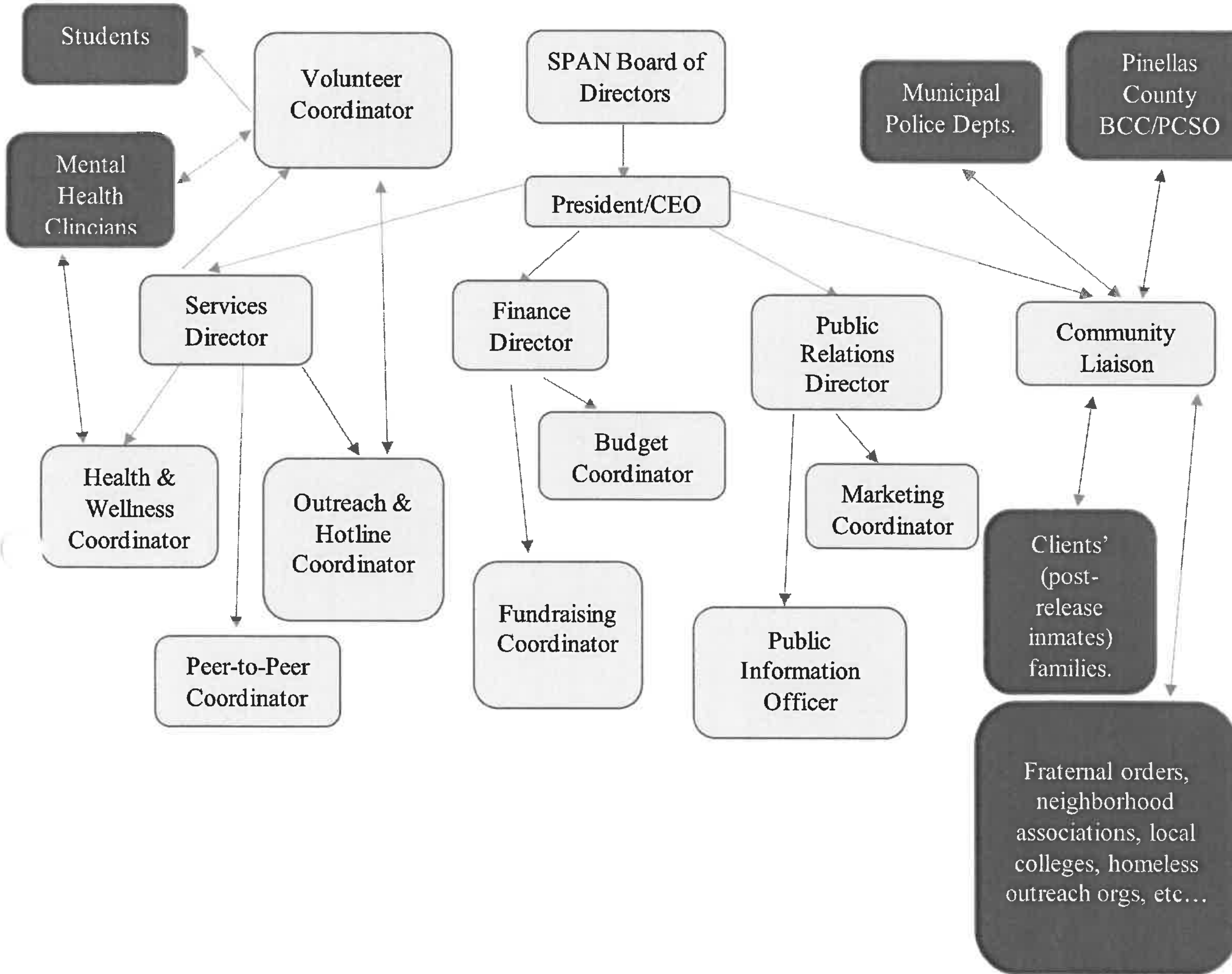
PROGRESS ASSESSMENT PLAN

- Services assessments administered to clients after reception of care.
- Annual review and report conducted by Board of Directors

Formulated January 23, 2021 by James Harrison Lewis in Clearwater, Florida

Organization Overview

Pinellas County Jail – Suicide Prevention Action Network



Formulated February 24, 2021 by James Harrison Lewis in Clearwater, Florida

Marketing Plan

Pinellas County Jail – Suicide Prevention Action Network

OVERVIEW

EXECUTIVE SUMMARY

At SPAN, we provide a service. That service is suicide prevention through mental health services, for individuals recently released from the Pinellas County Jail. As a 501(c)(3), SPAN is focused on two customer bases. The first are our clients, the post-release inmates in need of mental health services and suicide prevention services. The second are our donors and volunteers: local governments, churches, clinicians, students and charitable trusts or foundations. We reach the clients primarily through partnerships with law enforcement, homeless shelters, and churches. We also utilize social media, as well as traditional flyers and posters. We reach our donors through grant proposals, speaking engagements, quarterly fundraising events, and social media. As a non-profit offering a public service, volunteers are the crucial life blood of our organization. We reach future volunteers through social media, recruitment events, and flyers. The yearly marketing budget is $4,533.

VISION

We envision a near future when paying a debt to society does not include the debtor feeling the need to end their own life because help was out of reach.

MISSION

Our mission is to provide dignity to men and women who have recently been incarcerated, or are awaiting adjudication, to prevent incidents of suicide. We accomplish this by bringing these men and women together with compassionate community volunteers, professional treatment, and supplemental medication.

SITUATION ANALYSIS

PRODUCT/SERVICE

- A 24-hour hotline specifically for post-release inmates, staffed by community volunteers, and funded through private donations and public grants.
- No-cost mental health care for post-release inmates. SPAN will connect clients with licensed therapists, counselors, and psychiatrists who volunteer their services in the community.
- Funding for any needed medications with a prescription to treat mental illness in post-release inmates, made possible by private donations and public grants.

UNIQUE SELLING PROPOSITION

SPAN is filling an empty space in Pinellas County. A gap has widened between the county jail system and the mental health providers. Mental health services are provided to inmates during their incarceration. Numerous organizations offer mental health counseling, therapy, and medication to the community for low-to-no-cost. However, no organization is focused solely on post-release inmates. There is no organization that is readily available and seeks out individuals after release from county jail to ensure their mental health needs are met. SPAN is here to bridge that gap. We do not have competitors. We have untapped collaborators in local governments, non-profits, and willing community volunteers.

BEST PRACTICES

- We approach all clients with respect and treat all people with dignity.
- We approach all contributors, volunteers, and collaborators with a spirit of equity, inclusion, and shared ownership.

MARKETING OBJECTIVES AND PERFORMANCE – S.M.A.R.T. GOALS

SPAN utilizes marketing to reach clients who will benefit from our services, and to reach donors and volunteers in the community who are interested in joining our mission. Getting our message to potential clients is best accomplished by having a significant, accessible, and open presence within the Pinellas County Jail system including Safe Harbor, on social media, and within the community. Raising funds to support the services SPAN provides is best accomplished through grant proposals to local governments, churches and charitable trusts or foundations. Recruiting volunteers is best accomplished through direct appeals to licensed counselors, therapists, and psychiatrists, social media, colleges, high schools, churches, and fraternal orders.

SWOT ANALYSIS

STRENGHTS: SPAN addresses an unfulfilled need. This need is recognized, and our efforts to address it are recognized and supported by local law enforcement, local government, and community mental health clinicians.	WEAKNESSES: SPAN does not have any initial investments nor investors. This lack of funding gives potential donors a fear of risk and a lack of certainty as to the seriousness and dedication of the organization.
OPPORTUNITIES: We believe that the recent economic, social, cultural, and public health crises will lead to an increase in funding from the federal and state level to the county and city levels. SPAN is confident these funds can be tapped to provide the critical services we offer to the clients we serve.	THREATS: Mental health and suicide are sensitive areas, both ethically and legally. SPAN requires properly licensed clinicians, insurance, and the ability to assure Pinellas County and PCSO that our services are offered in a responsible and qualified manner. These are tall orders, but not insurmountable.

STRATEGY

TARGET MARKET

- Local government entities
- Recently released inmates from Pinellas County Jail
- Charitable trusts and foundations
- Churches
- Fraternal orders
- Educational institutions
-

BUYER PERSONAS

- Present proposal for collaboration to the Pinellas County Board of Commissioners, Pinellas Homeless Leadership Board, Pinellas County Sheriffs Office Department of Detention and Corrections, Clearwater Police Department Chief Dan Slaughter, BayCare Health Systems, Suncoast Center, Crisis Center of Tampa Bay, Pinellas Safe Harbor, Largo Police Department, St. Petersburg Police Department, Pinellas Park Police Department, Tarpon Springs Police Department, Largo Medical Center, Advent Health, St. Petersburg General Hospital
- Submit grant proposals to the William Stamps Farish Fund, The Spurlino Foundation, the Carron Family Foundation, Mary Jane Hillard Jones Foundation, Biddinger Family Foundation, Campane Charitable Trust, Eckerd Family Foundation, Baycare, Pinellas County, State of Florida, Free Family foundation, Mueller Family Foundation, Pinellas Community Foundation, Community Foundation of Tampa Bay, Tampa Bay Lightning Foundation, Florida Blue Foundation, Criminal Justice Center, Clearwater Free Clinic, Largo Medical Center, Calvary Baptist Church, St. Michael's Catholic Church, Countryside Christian Center, Rotary Club of Clearwater, Clearwater Masonic Lodge, Knights of Columbus Father Lopez Council.

DISTRIBUTION

- Advertise SPAN services on Facebook, Twitter, Instagram, Snapchat, and TikTok in a manner that links to PCSO, Pinellas Safe Harbor, HEP, St. Vincent de Paul and other organizations that inmates may already be in contact with.
- Recruit volunteers on Facebook, Twitter, Instagram, Snapchat, and TikTok in a manner that links to the United Way, Big Brother Big Sister, the Salvation Army, Goodwill, and other organizations that would appeal to people who would be willing to volunteer with our organization.
- Place flyers, posters, and business cards on the campuses of Pinellas County Jail, Pinellas Safe Harbor, HEP, St. Vincent de Paul, SPC, USF, and churches.

- Host volunteer drives at job/career fairs and on the campuses of educational institutions and churches.
- Host fundraising events such as fun runs, dinners, festivals, concerts, and art shows.

PROMOTION – TRACTION CHANNELS

- Social and display ads
- Search Engine Optimization
- Affiliate programs
- Speaking engagements
- Trade shows/job fairs
- Speaking engagements
- Fundraising events

BUDGET

Marketing Expenses = $4,533/year

1. spanpinellas.com domain name = $12/year
2. Constant Contact (e-mail marketing/website builder/Facebook, Instagram/Google ads/online donation platform = $240/year
3. CallShaper (hotline service) = $1800/year
4. Avaya Management Information System = $250/year
5. Assessing and Managing Suicide Risk training = $160/year (price per trainee)
6. Flyers (2000) = $106/year
7. Business cards (500) = $75/year
8. Posters (10) = $160/year
9. Recruitment station (tent, table, chairs) = $200
10. FunRun = $1000/year
11. Catered fundraising dinner = $1500/year
12. Art show = $500/year
13. Concert = $500/year

Core Expenses = $8,944

14. Office space ($15/sq. ft. x 500 sq. ft.) = $7,500/year
15. Internet = $600/year
16. Phone line = $144/year
17. Computer (desktop, printer, keyboard, mouse) = $600
18. Management Information System = $500
19. Phone (3 phones, 2 wireless) = $100

Formulated January 28, 2021 by James Harrison Lewis in Clearwater, Florida

Outside Experts

Pinellas County Jail – Suicide Prevention Action Network

Major Paul Carey

Pinellas County Sheriff's Office

Commander of Support and Health Services Bureau

pcarey@pcsonet.com

(727)453-7212

Chrissie Parris

Bay Care Health Systems

Program Coordinator Community Health Activation Team

(727)820-8200

linkedin.com/in/chrissie-parris-997bb64

Sergeant Lauren Ayers, LCSW

Pinellas County Sheriff's Office

Social Work Pinellas Safe Harbor

(727) 453-7520

Officer James Frederick

Clearwater Police Department

Greenwood Liaison Officer

(727) 224-7249
james.frederick@myclearwater.com

Laurie Elbow, LMHC

Suncoast Center

Director of Clinical Services

(727)327-7656

linkedin.com/in/laurie-elbow-0b89828

LaVerne Feaster, LCSW

Personal Enrichment through Mental Health Services

Social Worker/Therapist – Member Board of Directors

(727) 478-3029

Rosalie Bousher, LMHC, RN

National Alliance on Mental Health – Pinellas

Peer Supervisor

727-826-0807

rbousher@nami-pinellas.org

Dr. Dae Sheridan, Ph.D., LMHC, CRC

Crisis Center of Tampa Bay

Member – Board of Directors

DrDae@DrDae.com
(813) 431-8292

Dr. Roger Boothroyd

University of South Florida

Chair – Department of Mental Health Law and Policy

(813) 974-1915

(813) 949-9046

boothroy@fmhi.usf.edu

Collaboration Plan

Pinellas County Jail – Suicide Prevention Action Plan

The Suicide Prevention Action Network requires buy-in, support, and collaboration from multiple stakeholders. To successfully lead this collaboration, SPAN will approach each stakeholder or a representative of the stakeholder class to build value in the program and gauge the stakeholders' willingness to participate. Next, all the stakeholders or their representatives will be brought together for a series of collaborative meetings. It is imperative that SPAN play a facilitating role in this phase, that all participants feel a sense of ownership, respect, and appreciation. Finally, the Board of Directors shall be composed of representatives from all the stakeholder groups.

For this program to be successful, SPAN needs access to inmates when they are released. Therefore, we will collaborate with the Pinellas County Board of County Commissioners, the Pinellas County Sheriff's Office, Pinellas Safe Harbor, local police departments, and city councils. It is important at this phase to emphasize the success that these organizations have had with the programs they offer while highlighting the need to bridge the gap between them and mental health services in the community.

The mental health services will be provided at no cost to the clients. Therefore, the program will need clinicians, non-profit mental health organization, and mental health systems to volunteer their time, energy, and resources. At this phase it is critical to emphasize the altruistic nature of the program and the benefit of improving mental health outcomes for these individuals as it affects the broader community.

Expenses will still be incurred such as, office space, web hosting, promotional material, etc. As a 501(c)(3), SPAN will look to donors to cover these expenses. At this phase, we will look to state and federal agencies, homeless coalitions, fraternal orders, and county residents

with charitable trusts or foundations. Bringing these people together with those doing the work and those receiving the benefits will give the donors a sense of purpose, accomplishment, and ownership.

The families of the clients will play a critical role in the services provided to the clients. Collaboration with the families will occur on a rolling basis. This will consist of a counseling session with a clinician followed by counseling sessions with the client.

Lastly, but most importantly, the post-release inmates, our clients. At the start-up of the organization this will consists of inviting in former inmates who struggled with mental health and suicidal tendencies. They will provide valuable input and feedback and in exchange will be given ownership and an opportunity to make a difference. The clients will be included on an ongoing basis, as they are released and requests services, they will be included in their plan of care. In this way, they will feel like a part of the solution, rather than as the problem.

Formulated February 1, 2021 by James Harrison Lewis in Clearwater, Florida

Anticipated Team Dynamics

Pinellas County Jail - Suicide Prevention Action Network

TEAM MEMBERS and STAKEHOLDERS			
SHARED GOALS AND OBJECTIVES			
Inmates	Law Enforcement	Mental Health Industry	Local Governments
As human beings, inmates desire adequate health care, including mental health assistance. In general, inmates want to live (despite periods of suicidal ideations) and thrive after they have served their sentences.	Police officers and jail guards are concerned with recidivism, they do not want to see former convicts committing new crimes. Addressing the mental health needs of former inmates will reduce the recidivism rate.	Most mental health professionals pursued their careers out of a sense of compassion. These professionals want to deliver proper care to those who need it. Mental health clinicians want to reduce incidences of suicide.	Local governments are charged with promoting the health, safety, and well-being of their constituents. Providing necessary mental health care meets these responsibilities. Reducing suicide and recidivism rates is also a cost saving accomplishment for local governments.
POINTS OF CONFLICT			
Inmates	Law Enforcement	Mental Health Industry	Local Governments
Inmates have been through a traumatic experience of incarceration (even if this is a consequence of their own making). They are often disgruntled and feel neglected. Meeting their demands is difficult and often met with	A unique perspective has developed among law enforcement. While not exclusive nor absolute, many law enforcement members view inmates as a burden on society, entirely responsible for their own situation and	In contrast with law enforcement, many mental health professionals view the offenses committed by inmates as a symptom of the inmates' mental illness, and thus not something they can be held responsible for. They often view	Local governments are run by both elected officials, responsible to their constituents, and bureaucrats responsible to elected officials. The constituents of a community may include high numbers of former inmates or many

frustration and a lack of gratitude.	undeserving of public assistance.	law enforcement as cold and callus in their treatment of convicts and inmates.	tough on crime voters. This will cause elected officials to side with inmates and mental health professionals or with law enforcement. Bureaucrats may follow the elected officials lead, or their own conscience.

Formulated March 6, 2021 by James Harrison Lewis in Clearwater, Florida

Appendix B

Florida Statutes Title XXXII Chapter 491

Title XXXII
REGULATION OF PROFESSIONS AND OCCUPATIONS
Chapter 491
CLINICAL, COUNSELING, AND PSYCHOTHERAPY SERVICES
View Entire Chapter

CHAPTER 491

CLINICAL, COUNSELING, AND PSYCHOTHERAPY SERVICES

491.002 Intent.

491.003 Definitions.

491.004 Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.

491.0045 Intern registration; requirements.

491.0046 Provisional license; requirements.

491.005 Licensure by examination.

491.0057 Dual licensure as a marriage and family therapist.

491.006 Licensure or certification by endorsement.

491.0065 Requirement for instruction on HIV and AIDS.

491.007 Renewal of license, registration, or certificate.

491.008 Inactive status; reactivation of licenses; fees.

491.0085 Continuing education and laws and rules courses; approval of providers, programs, and courses; proof of completion.

491.009 Discipline.

491.0111 Sexual misconduct.

491.0112 Sexual misconduct by a psychotherapist; penalties.

491.012 Violations; penalty; injunction.

491.014 Exemptions.

491.0141 Practice of hypnosis.

491.0143 Practice of sex therapy.

491.0144 The practice of juvenile sexual offender therapy.

491.0145 Certified master social worker.

491.0147 Confidentiality and privileged communications.

491.0148 Records.

491.0149 Display of license; use of professional title on promotional materials.

491.015 Duties of the department as to certified master social workers.

491.016 Social work; use of title.

491.002 **Intent.**—The Legislature finds that as society becomes increasingly complex, emotional survival is equal in importance to physical survival. Therefore, in order to preserve the health, safety, and welfare of the public, the Legislature must provide privileged communication for members of the public or those acting on their behalf to encourage needed or desired counseling, clinical and psychotherapy services, or certain other services of a psychological nature to be sought out. The Legislature further finds that, since such services assist the public primarily with emotional survival, which in turn affects physical and psychophysical survival, the practice of clinical social work, marriage and family therapy, and mental health counseling by persons not qualified to practice such professions presents a danger to public health, safety, and welfare. The Legislature finds that, to further secure the health, safety, and welfare of the public and also to encourage professional cooperation among all qualified professionals, the Legislature must assist the public in making informed choices of such services by establishing minimum qualifications for entering into and remaining in the respective professions.

History.—ss. 15, 19, ch. 87-252; ss. 19, 20, ch. 90-263; s. 4, ch. 91-429.

491.003 **Definitions.**—As used in this chapter:

(1) "Board" means the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.

(2) "Clinical social worker" means a person licensed under this chapter to practice clinical social work.

(3) "Clinical social work experience" is defined as a period during which the applicant provides clinical social work services, including assessment, diagnosis, treatment, and evaluation of clients; provided that at least 50 percent of the hours worked consist of providing psychotherapy and counseling services directly to clients.

(4) "Department" means the Department of Health.

(5) "Marriage and family therapist" means a person licensed under this chapter to practice marriage and family therapy.

(6) "Mental health counselor" means a person licensed under this chapter to practice mental health counseling.

(7) The "practice of clinical social work" is defined as the use of scientific and applied knowledge, theories, and methods for the purpose of describing, preventing, evaluating, and treating individual, couple, marital, family, or group behavior, based on the person-in-situation perspective of psychosocial development, normal and abnormal behavior, psychopathology, unconscious motivation, interpersonal relationships, environmental stress, differential assessment, differential planning, and data gathering. The purpose of such services is the prevention and treatment of undesired behavior and enhancement of mental health. The practice of clinical social work includes methods of a psychological nature used to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, and substance abuse. The practice of clinical social work includes, but is not limited to, psychotherapy, hypnotherapy, and sex therapy. The practice of clinical social work also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients, when using methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, or substance abuse. The practice of clinical social work may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions.

(a) Clinical social work may be rendered to individuals, including individuals affected by the termination of marriage, and to marriages, couples, families, groups, organizations, and communities.

(b) The use of specific methods, techniques, or modalities within the practice of clinical social work is restricted to clinical social workers appropriately trained in the use of such methods, techniques, or modalities.

(c) The terms "diagnose" and "treat," as used in this chapter, when considered in isolation or in conjunction with the rules of the board, may not be construed to permit the performance of any act which clinical social workers are not educated and trained to perform, including, but not limited to, admitting persons to hospitals for treatment of the foregoing conditions, treating persons in hospitals without medical supervision, prescribing medicinal drugs as defined in chapter 465, authorizing clinical laboratory procedures, or radiological procedures, or use of electroconvulsive therapy. In addition, this definition may not be construed to permit any person licensed, provisionally licensed, registered, or certified pursuant to this chapter to describe or label any test, report, or procedure as "psychological," except to relate specifically to the definition of practice authorized in this subsection.

(d) The definition of "clinical social work" contained in this subsection includes all services offered directly to the general public or through organizations, whether public or private, and applies whether payment is requested or received for services rendered.

(8) The term "practice of marriage and family therapy" means the use of scientific and applied marriage and family theories, methods, and procedures for the purpose of describing, evaluating, and modifying marital, family, and individual behavior, within the context of marital and family systems, including the context of marital formation and dissolution, and is based on marriage and family systems theory, marriage and family development, human development, normal and abnormal behavior, psychopathology, human sexuality, psychotherapeutic and marriage and family therapy theories and techniques. The practice of marriage and family therapy includes methods of a psychological nature used to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders or dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, and substance abuse. The practice of marriage and family therapy includes, but is not limited to, marriage and family therapy, psychotherapy, including behavioral family therapy, hypnotherapy, and sex therapy. The practice of marriage and family therapy also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients, when using methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), sexual dysfunction, behavioral disorders, alcoholism, or substance abuse. The practice of marriage and

family therapy may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions.

(a) Marriage and family therapy may be rendered to individuals, including individuals affected by termination of marriage, to couples, whether married or unmarried, to families, or to groups.

(b) The use of specific methods, techniques, or modalities within the practice of marriage and family therapy is restricted to marriage and family therapists appropriately trained in the use of such methods, techniques, or modalities.

(c) The terms "diagnose" and "treat," as used in this chapter, when considered in isolation or in conjunction with the rules of the board, may not be construed to permit the performance of any act that marriage and family therapists are not educated and trained to perform, including, but not limited to, admitting persons to hospitals for treatment of the foregoing conditions, treating persons in hospitals without medical supervision, prescribing medicinal drugs as defined in chapter 465, authorizing clinical laboratory procedures or radiological procedures or the use of electroconvulsive therapy. In addition, this definition may not be construed to permit any person licensed, provisionally licensed, registered, or certified pursuant to this chapter to describe or label any test, report, or procedure as "psychological," except to relate specifically to the definition of practice authorized in this subsection.

(d) The definition of "marriage and family therapy" contained in this subsection includes all services offered directly to the general public or through organizations, whether public or private, and applies whether payment is requested or received for services rendered.

(9) The term "practice of mental health counseling" means the use of scientific and applied behavioral science theories, methods, and techniques for the purpose of describing, preventing, and treating undesired behavior and enhancing mental health and human development and is based on the person-in-situation perspectives derived from research and theory in personality, family, group, and organizational dynamics and development, career planning, cultural diversity, human growth and development, human sexuality, normal and abnormal behavior, psychopathology, psychotherapy, and rehabilitation. The practice of mental health counseling includes methods of a psychological nature used to evaluate, assess, diagnose, and treat emotional and mental dysfunctions or disorders, whether cognitive, affective, or behavioral, interpersonal relationships, sexual dysfunction, alcoholism, and substance abuse. The practice of mental health counseling includes, but is not limited to, psychotherapy, hypnotherapy, and sex therapy. The practice of mental health counseling also includes counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to

clients, when using methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions (whether cognitive, affective, or behavioral), behavioral disorders, sexual dysfunction, alcoholism, or substance abuse. The practice of mental health counseling may also include clinical research into more effective psychotherapeutic modalities for the treatment and prevention of such conditions.

(a) Mental health counseling may be rendered to individuals, including individuals affected by the termination of marriage, and to couples, families, groups, organizations, and communities.

(b) The use of specific methods, techniques, or modalities within the practice of mental health counseling is restricted to mental health counselors appropriately trained in the use of such methods, techniques, or modalities.

(c) The terms "diagnose" and "treat," as used in this chapter, when considered in isolation or in conjunction with any provision of the rules of the board, may not be construed to permit the performance of any act that mental health counselors are not educated and trained to perform, including, but not limited to, admitting persons to hospitals for treatment of the foregoing conditions, treating persons in hospitals without medical supervision, prescribing medicinal drugs as defined in chapter 465, authorizing clinical laboratory procedures or radiological procedures, or the use of electroconvulsive therapy. In addition, this definition may not be construed to permit any person licensed, provisionally licensed, registered, or certified pursuant to this chapter to describe or label any test, report, or procedure as "psychological," except to relate specifically to the definition of practice authorized in this subsection.

(d) The definition of "mental health counseling" contained in this subsection includes all services offered directly to the general public or through organizations, whether public or private, and applies whether payment is requested or received for services rendered.

(10) "Provisional clinical social worker licensee" means a person provisionally licensed under this chapter to provide clinical social work services under supervision.

(11) "Provisional marriage and family therapist licensee" means a person provisionally licensed under this chapter to provide marriage and family therapy services under supervision.

(12) "Provisional mental health counselor licensee" means a person provisionally licensed under this chapter to provide mental health counseling services under supervision.

(13) "Psychotherapist" means a clinical social worker, marriage and family therapist, or mental health counselor licensed pursuant to this chapter.

(14) "Registered clinical social worker intern" means a person registered under this chapter who is completing the postgraduate clinical social work experience requirement specified in s. 491.005(1)(c).

(15) "Registered marriage and family therapist intern" means a person registered under this chapter who is completing the post-master's clinical experience requirement specified in s. 491.005(3)(c).

(16) "Registered mental health counselor intern" means a person registered under this chapter who is completing the post-master's clinical experience requirement specified in s. 491.005(4)(c).

(17) "Social worker" means a person who has a bachelor's, master's, or doctoral degree in social work.

History.—ss. 15, 19, ch. 87-252; s. 10, ch. 89-70; ss. 5, 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 192, ch. 94-218; s. 9, ch. 97-198; s. 201, ch. 97-264; s. 2, ch. 2008-154; s. 103, ch. 2018-24.

491.004 **Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.**—

(1) There is created within the department the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling composed of nine members appointed by the Governor and confirmed by the Senate.

(2)(a) Six members of the board shall be persons licensed under this chapter as follows:

1. Two members shall be licensed practicing clinical social workers.

2. Two members shall be licensed practicing marriage and family therapists.

3. Two members shall be licensed practicing mental health counselors.

(b) Three members shall be citizens of the state who are not and have never been licensed in a mental health-related profession and who are in no way connected with the practice of any such profession.

(3) No later than January 1, 1988, the Governor shall appoint nine members of the board as follows:

(a) Three members for terms of 2 years each.

(b) Three members for terms of 3 years each.

(c) Three members for terms of 4 years each.

(4) As the terms of the initial members expire, the Governor shall appoint successors for terms of 4 years; and those members shall serve until their successors are appointed.

(5) The board shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement and enforce the provisions of this chapter.

(6) All applicable provisions of chapter 456 relating to activities of regulatory boards shall apply to the board.

(7) The board shall maintain its official headquarters in the City of Tallahassee.

History.—ss. 15, 19, ch. 87-252; ss. 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 193, ch. 94-218; s. 152, ch. 98-166; s. 163, ch. 98-200; s. 212, ch. 2000-160.

491.0045 **Intern registration; requirements.**—

(1) An individual who has not satisfied the postgraduate or post-master's level experience requirements, as specified in s. 491.005(1)(c), (3)(c), or (4)(c), must register as an intern in the profession for which he or she is seeking licensure before commencing the post-master's experience requirement or an individual who intends to satisfy part of the required graduate-level practicum, internship, or field experience, outside the academic arena for any profession, and must register as an intern in the profession for which he or she is seeking licensure before commencing the practicum, internship, or field experience.

(2) The department shall register as a clinical social worker intern, marriage and family therapist intern, or mental health counselor intern each applicant who the board certifies has:

(a) Completed the application form and remitted a nonrefundable application fee not to exceed $200, as set by board rule;

(b)1. Completed the education requirements as specified in s. 491.005(1)(c), (3)(c), or (4)(c) for the profession for which he or she is applying for licensure, if needed; and

2. Submitted an acceptable supervision plan, as determined by the board, for meeting the practicum, internship, or field work required for licensure that was not satisfied in his or her graduate program.

(c) Identified a qualified supervisor.

(3) An individual registered under this section must remain under supervision while practicing under registered intern status.

(4) An individual who fails to comply with this section may not be granted a license under this chapter, and any time spent by the individual completing the experience requirement as specified in s. 491.005(1)(c), (3)(c), or (4)(c) before registering as an intern does not count toward completion of the requirement.

(5) An intern registration is valid for 5 years.

(6) A registration issued on or before March 31, 2017, expires March 31, 2022, and may not be renewed or reissued. Any registration issued after March 31, 2017, expires 60 months after the date it is issued. The board may make a one-time exception to the requirements of this subsection in emergency or hardship cases, as defined by board rule, if the candidate has passed the theory and practice examination described in s. 491.005(1)(d), (3)(d), and (4)(d).

(7) An individual who has held a provisional license issued by the board may not apply for an intern registration in the same profession.

History.—s. 10, ch. 97-198; s. 202, ch. 97-264; s. 165, ch. 99-397; s. 1, ch. 2016-80; s. 48, ch. 2016-241; s. 43, ch. 2020-133.

491.0046 Provisional license; requirements.—

(1) An individual applying for licensure by examination who has satisfied the clinical experience requirements of s. 491.005 or an individual applying for licensure by endorsement pursuant to s. 491.006 intending to provide clinical social work, marriage and family therapy, or mental health counseling services in Florida while satisfying coursework or examination requirements for licensure must be provisionally licensed in the profession for which he or she is seeking licensure prior to beginning practice.

(2) The department shall issue a provisional clinical social worker license, provisional marriage and family therapist license, or provisional mental health counselor license to each applicant who the board certifies has:

(a) Completed the application form and remitted a nonrefundable application fee not to exceed $100, as set by board rule; and

(b) Earned a graduate degree in social work, a graduate degree with a major emphasis in marriage and family therapy or a closely related field, or a graduate degree in a major related to the practice of mental health counseling; and

(c) Met the following minimum coursework requirements:

1. For clinical social work, a minimum of 15 semester hours or 22 quarter hours of the coursework required by s. 491.005(1)(b)2.b.

2. For marriage and family therapy, 10 of the courses required by s. 491.005(3)(b), as determined by the board, and at least 6 semester hours or 9 quarter hours of the course credits must have been completed in the area of marriage and family systems, theories, or techniques.

3. For mental health counseling, a minimum of seven of the courses required under s. 491.005(4)(b)1.a.-c.

(3) A provisional licensee must work under the supervision of a licensed mental health professional, as defined by the board, until the provisional licensee is in receipt of a license or a letter from the department stating that he or she is licensed as a clinical social worker, marriage and family therapist, or mental health counselor.

(4) A provisional license expires 24 months after the date it is issued and may not be renewed or reissued.

History.—s. 11, ch. 97-198; s. 203, ch. 97-264; s. 166, ch. 99-397; s. 31, ch. 2017-3; s. 48, ch. 2020-133.

491.005 Licensure by examination.—

(1) CLINICAL SOCIAL WORK.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual per applicant cost to the department for purchase of the examination from the American Association of State Social Worker's Boards or a similar national organization, the department shall issue a license as a clinical social worker to an applicant who the board certifies:

(a) Has submitted an application and paid the appropriate fee.

(b)1. Has received a doctoral degree in social work from a graduate school of social work which at the time the applicant graduated was accredited by an accrediting agency recognized by the United States Department of Education or has received a master's degree in social work from a graduate school of social work which at the time the applicant graduated:

a. Was accredited by the Council on Social Work Education;

b. Was accredited by the Canadian Association of Schools of Social Work; or

c. Has been determined to have been a program equivalent to programs approved by the Council on Social Work Education by the Foreign Equivalency Determination Service of the Council

on Social Work Education. An applicant who graduated from a program at a university or college outside of the United States or Canada must present documentation of the equivalency determination from the council in order to qualify.

2. The applicant's graduate program must have emphasized direct clinical patient or client health care services, including, but not limited to, coursework in clinical social work, psychiatric social work, medical social work, social casework, psychotherapy, or group therapy. The applicant's graduate program must have included all of the following coursework:

a. A supervised field placement which was part of the applicant's advanced concentration in direct practice, during which the applicant provided clinical services directly to clients.

b. Completion of 24 semester hours or 32 quarter hours in theory of human behavior and practice methods as courses in clinically oriented services, including a minimum of one course in psychopathology, and no more than one course in research, taken in a school of social work accredited or approved pursuant to subparagraph 1.

3. If the course title which appears on the applicant's transcript does not clearly identify the content of the coursework, the applicant shall be required to provide additional documentation, including, but not limited to, a syllabus or catalog description published for the course.

(c) Has had at least 2 years of clinical social work experience, which took place subsequent to completion of a graduate degree in social work at an institution meeting the accreditation requirements of this section, under the supervision of a licensed clinical social worker or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If the applicant's graduate program was not a program which emphasized direct clinical patient or client health care services as described in subparagraph (b)2., the supervised experience requirement must take place after the applicant has completed a minimum of 15 semester hours or 22 quarter hours of the coursework required. A doctoral internship may be applied toward the clinical social work experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) Has passed a theory and practice examination provided by the department for this purpose.

(e) Has demonstrated, in a manner designated by rule of the board, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

(2) CLINICAL SOCIAL WORK.—

(a) Notwithstanding the provisions of paragraph (1)(b), coursework which was taken at a baccalaureate level shall not be considered toward completion of education requirements for licensure unless an official of the graduate program certifies in writing on the graduate school's stationery that a specific course, which students enrolled in the same graduate program were ordinarily required to complete at the graduate level, was waived or exempted based on completion of a similar course at the baccalaureate level. If this condition is met, the board shall apply the baccalaureate course named toward the education requirements.

(b) An applicant from a master's or doctoral program in social work which did not emphasize direct patient or client services may complete the clinical curriculum content requirement by returning to a graduate program accredited by the Council on Social Work Education or the Canadian Association of Schools of Social Work, or to a clinical social work graduate program with comparable standards, in order to complete the education requirements for examination. However, a maximum of 6 semester or 9 quarter hours of the clinical curriculum content requirement may be completed by credit awarded for independent study coursework as defined by board rule.

(3) MARRIAGE AND FAMILY THERAPY.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual cost of the purchase of the examination from the Association of Marital and Family Therapy Regulatory Board, or similar national organization, the department shall issue a license as a marriage and family therapist to an applicant who the board certifies:

(a) Has submitted an application and paid the appropriate fee.

(b) Has a minimum of a master's degree with major emphasis in marriage and family therapy or a closely related field from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education or from a Florida university program accredited by the Council for Accreditation of Counseling and Related Educational Programs and graduate courses approved by the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. If the course title that appears on the applicant's transcript does not clearly identify the content of the coursework, the applicant shall provide additional documentation, including, but not limited to, a syllabus or catalog description published for the course. The required master's degree must have been received in an institution of higher education that, at the time the applicant graduated, was fully accredited by a regional accrediting body recognized by the Commission on Recognition of Postsecondary Accreditation or publicly recognized as a member in good standing with the Association of Universities and Colleges of Canada, or an institution of higher education located

outside the United States and Canada which, at the time the applicant was enrolled and at the time the applicant graduated, maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by a regional accrediting body recognized by the Commission on Recognition of Postsecondary Accreditation. Such foreign education and training must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as professional marriage and family therapists or psychotherapists. The applicant has the burden of establishing that the requirements of this provision have been met, and the board shall require documentation, such as an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country. An applicant with a master's degree from a program that did not emphasize marriage and family therapy may complete the coursework requirement in a training institution fully accredited by the Commission on Accreditation for Marriage and Family Therapy Education recognized by the United States Department of Education.

(c) Has had at least 2 years of clinical experience during which 50 percent of the applicant's clients were receiving marriage and family therapy services, which must be at the post-master's level under the supervision of a licensed marriage and family therapist with at least 5 years of experience, or the equivalent, who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If a graduate has a master's degree with a major emphasis in marriage and family therapy or a closely related field which did not include all of the coursework required by paragraph (b), credit for the post-master's level clinical experience may not commence until the applicant has completed a minimum of 10 of the courses required by paragraph (b), as determined by the board, and at least 6 semester hours or 9 quarter hours of the course credits must have been completed in the area of marriage and family systems, theories, or techniques. Within the 2 years of required experience, the applicant shall provide direct individual, group, or family therapy and counseling to cases including those involving unmarried dyads, married couples, separating and divorcing couples, and family groups that include children. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) Has passed a theory and practice examination provided by the department.

(e) Has demonstrated, in a manner designated by board rule, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

For the purposes of dual licensure, the department shall license as a marriage and family therapist any person who meets the requirements of s. 491.0057. Fees for dual licensure may not exceed those stated in this subsection.

(4) MENTAL HEALTH COUNSELING.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual per applicant cost of purchase of the examination from the National Board for Certified Counselors or its successor organization, the department shall issue a license as a mental health counselor to an applicant who the board certifies:

(a) Has submitted an application and paid the appropriate fee.

(b)1. Has a minimum of an earned master's degree from a mental health counseling program accredited by the Council for the Accreditation of Counseling and Related Educational Programs which consists of at least 60 semester hours or 80 quarter hours of clinical and didactic instruction, including a course in human sexuality and a course in substance abuse. If the master's degree is earned from a program related to the practice of mental health counseling which is not accredited by the Council for the Accreditation of Counseling and Related Educational Programs, then the coursework and practicum, internship, or fieldwork must consist of at least 60 semester hours or 80 quarter hours and meet all of the following requirements:

a. Thirty-three semester hours or 44 quarter hours of graduate coursework, which must include a minimum of 3 semester hours or 4 quarter hours of graduate-level coursework in each of the following 11 content areas: counseling theories and practice; human growth and development; diagnosis and treatment of psychopathology; human sexuality; group theories and practice; individual evaluation and assessment; career and lifestyle assessment; research and program evaluation; social and cultural foundations; substance abuse; and legal, ethical, and professional standards issues in the practice of mental health counseling. Courses in research, thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.

b. A minimum of 3 semester hours or 4 quarter hours of graduate-level coursework addressing diagnostic processes, including differential diagnosis and the use of the current diagnostic tools, such as the current edition of the American Psychiatric Association's Diagnostic and Statistical

Manual of Mental Disorders. The graduate program must have emphasized the common core curricular experience.

c. The equivalent, as determined by the board, of at least 700 hours of university-sponsored supervised clinical practicum, internship, or field experience that includes at least 280 hours of direct client services, as required in the accrediting standards of the Council for Accreditation of Counseling and Related Educational Programs for mental health counseling programs. This experience may not be used to satisfy the post-master's clinical experience requirement.

2. Has provided additional documentation if a course title that appears on the applicant's transcript does not clearly identify the content of the coursework. The documentation must include, but is not limited to, a syllabus or catalog description published for the course.

Education and training in mental health counseling must have been received in an institution of higher education that, at the time the applicant graduated, was fully accredited by a regional accrediting body recognized by the Council for Higher Education Accreditation or its successor organization or publicly recognized as a member in good standing with the Association of Universities and Colleges of Canada, or an institution of higher education located outside the United States and Canada which, at the time the applicant was enrolled and at the time the applicant graduated, maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by a regional accrediting body recognized by the Council for Higher Education Accreditation or its successor organization. Such foreign education and training must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as mental health counselors. The applicant has the burden of establishing that the requirements of this provision have been met, and the board shall require documentation, such as an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country. Beginning July 1, 2025, an applicant must have a master's degree from a program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs which consists of at least 60 semester hours or 80 quarter hours to apply for licensure under this paragraph.

(c) Has had at least 2 years of clinical experience in mental health counseling, which must be at the post-master's level under the supervision of a licensed mental health counselor or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If a graduate has a master's degree with a major related to the practice of mental health counseling which did not include all the coursework required under

sub-subparagraphs (b)1.a. and b., credit for the post-master's level clinical experience may not commence until the applicant has completed a minimum of seven of the courses required under sub-subparagraphs (b)1.a. and b., as determined by the board, one of which must be a course in psychopathology or abnormal psychology. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) Has passed a theory and practice examination provided by the department for this purpose.

(e) Has demonstrated, in a manner designated by board rule, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

(5) RULES.—The board may adopt rules necessary to implement any education or experience requirement of this section for licensure as a clinical social worker, marriage and family therapist, or mental health counselor.

History.—ss. 15, 19, ch. 87-252; s. 37, ch. 88-205; s. 29, ch. 88-392; ss. 6, 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 11, ch. 93-260; s. 31, ch. 94-310; s. 10, ch. 95-279; ss. 12, 13, ch. 97-198; ss. 204, 205, ch. 97-264; ss. 167, 168, ch. 99-397; s. 2, ch. 2016-80; s. 44, ch. 2020-133.

491.0057 **Dual licensure as a marriage and family therapist.**—The department shall license as a marriage and family therapist any person who demonstrates to the board that he or she:

(1) Holds a valid, active license as a psychologist under chapter 490 or as a clinical social worker or mental health counselor under this chapter, or is licensed under s. 464.012 as an advanced practice registered nurse who has been determined by the Board of Nursing as a specialist in psychiatric mental health.

(2) Has held a valid, active license for at least 3 years.

(3) Has passed the examination provided by the department for marriage and family therapy.

History.—s. 14, ch. 97-198; s. 206, ch. 97-264; s. 69, ch. 2018-106.

491.006 **Licensure or certification by endorsement.**—

(1) The department shall license or grant a certificate to a person in a profession regulated by this chapter who, upon applying to the department and remitting the appropriate fee, demonstrates to the board that he or she:

(a) Has demonstrated, in a manner designated by rule of the board, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

(b)1. Holds an active valid license to practice and has actively practiced the licensed profession in another state for 3 of the last 5 years immediately preceding licensure;

2. Has passed a substantially equivalent licensing examination in another state or has passed the licensure examination in this state in the profession for which the applicant seeks licensure; and

3. Holds a license in good standing, is not under investigation for an act that would constitute a violation of this chapter, and has not been found to have committed any act that would constitute a violation of this chapter.

The fees paid by any applicant for certification as a master social worker under this section are nonrefundable.

(2) The department shall not issue a license or certificate by endorsement to any applicant who is under investigation in this or another jurisdiction for an act which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of s. 491.009 shall apply.

History.—ss. 15, 19, ch. 87-252; ss. 7, 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 21, ch. 95-145; s. 12, ch. 95-279; s. 509, ch. 97-103; s. 169, ch. 99-397; s. 32, ch. 2000-242; s. 45, ch. 2020-133.

491.0065 **Requirement for instruction on HIV and AIDS.**—The board shall require, as a condition of granting a license under this chapter, that an applicant making initial application for licensure complete an education course acceptable to the board on human immunodeficiency virus and acquired immune deficiency syndrome. An applicant who has not taken a course at the time of licensure shall, upon submission of an affidavit showing good cause, be allowed 6 months to complete this requirement.

History.—s. 13, ch. 95-279.

491.007 **Renewal of license, registration, or certificate.**—

(1) The board or department shall prescribe by rule a method for the biennial renewal of licenses or certificates at a fee set by rule, not to exceed $250.

(2) Each applicant for renewal shall present satisfactory evidence that, in the period since the license or certificate was issued, the applicant has completed continuing education requirements

set by rule of the board or department. Not more than 25 classroom hours of continuing education per year shall be required. A certified master social worker is exempt from the continuing education requirements for the first renewal of the certificate.

History.—ss. 15, 19, ch. 87-252; ss. 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 288, ch. 94-119; s. 15, ch. 97-198; s. 207, ch. 97-264; s. 9, ch. 98-130; s. 46, ch. 2020-133.

491.008 Inactive status; reactivation of licenses; fees.—

(1) Inactive status is the licensure status that results when a licensee has applied to be placed on inactive status and has paid a $50 fee to the department.

(a) An inactive license may be renewed biennially for $50 per biennium.

(b) An inactive license may be reactivated by submitting an application to the department, completing the continuing education requirements, complying with any background investigation required, complying with other requirements prescribed by the board, and paying a $50 reactivation fee plus the current biennial renewal fee at the time of reactivation.

(2) The board may adopt rules relating to inactive licenses and the reactivation of licenses.

History.—ss. 15, 19, ch. 87-252; ss. 8, 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 289, ch. 94-119.

491.0085 Continuing education and laws and rules courses; approval of providers, programs, and courses; proof of completion.—

(1) Continuing education providers, programs, and courses and laws and rules courses and their providers and programs shall be approved by the department or the board.

(2) The department or the board has the authority to set a fee not to exceed $200 for each applicant who applies for or renews provider status. Such fees shall be deposited into the Medical Quality Assurance Trust Fund.

(3) Proof of completion of the required number of hours of continuing education and completion of the laws and rules course shall be submitted to the department or the board in the manner and time specified by rule and on forms provided by the department or the board.

(4) The department or the board shall adopt rules and guidelines to administer and enforce the provisions of this section.

History.—ss. 15, 19, ch. 87-252; ss. 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 14, ch. 95-279; s. 170, ch. 99-397.

491.009 Discipline.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(a) Attempting to obtain, obtaining, or renewing a license, registration, or certificate under this chapter by bribery or fraudulent misrepresentation or through an error of the board or the department.

(b) Having a license, registration, or certificate to practice a comparable profession revoked, suspended, or otherwise acted against, including the denial of certification or licensure by another state, territory, or country.

(c) Being convicted or found guilty of, regardless of adjudication, or having entered a plea of nolo contendere to, a crime in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession. However, in the case of a plea of nolo contendere, the board shall allow the person who is the subject of the disciplinary proceeding to present evidence in mitigation relevant to the underlying charges and circumstances surrounding the plea.

(d) False, deceptive, or misleading advertising or obtaining a fee or other thing of value on the representation that beneficial results from any treatment will be guaranteed.

(e) Advertising, practicing, or attempting to practice under a name other than one's own.

(f) Maintaining a professional association with any person who the applicant, licensee, registered intern, or certificateholder knows, or has reason to believe, is in violation of this chapter or of a rule of the department or the board.

(g) Knowingly aiding, assisting, procuring, or advising any nonlicensed, nonregistered, or noncertified person to hold himself or herself out as licensed, registered, or certified under this chapter.

(h) Failing to perform any statutory or legal obligation placed upon a person licensed, registered, or certified under this chapter.

(i) Willfully making or filing a false report or record; failing to file a report or record required by state or federal law; willfully impeding or obstructing the filing of a report or record; or inducing another person to make or file a false report or record or to impede or obstruct the filing of a report or record. Such report or record includes only a report or record which requires the signature of a person licensed, registered, or certified under this chapter.

(j) Paying a kickback, rebate, bonus, or other remuneration for receiving a patient or client, or receiving a kickback, rebate, bonus, or other remuneration for referring a patient or client to another provider of mental health care services or to a provider of health care services or goods; referring a patient or client to oneself for services on a fee-paid basis when those services are already being paid for by some other public or private entity; or entering into a reciprocal referral agreement.

(k) Committing any act upon a patient or client which would constitute sexual battery or which would constitute sexual misconduct as defined pursuant to s. 491.0111.

(l) Making misleading, deceptive, untrue, or fraudulent representations in the practice of any profession licensed, registered, or certified under this chapter.

(m) Soliciting patients or clients personally, or through an agent, through the use of fraud, intimidation, undue influence, or a form of overreaching or vexatious conduct.

(n) Failing to make available to a patient or client, upon written request, copies of tests, reports, or documents in the possession or under the control of the licensee, registered intern, or certificateholder which have been prepared for and paid for by the patient or client.

(o) Failing to respond within 30 days to a written communication from the department or the board concerning any investigation by the department or the board, or failing to make available any relevant records with respect to any investigation about the licensee's, registered intern's, or certificateholder's conduct or background.

(p) Being unable to practice the profession for which he or she is licensed, registered, or certified under this chapter with reasonable skill or competence as a result of any mental or physical condition or by reason of illness; drunkenness; or excessive use of drugs, narcotics, chemicals, or any other substance. In enforcing this paragraph, upon a finding by the State Surgeon General, the State Surgeon General's designee, or the board that probable cause exists to believe that the licensee, registered intern, or certificateholder is unable to practice the profession because of the reasons stated in this paragraph, the department shall have the authority to compel a licensee, registered intern, or certificateholder to submit to a mental or physical examination by psychologists, physicians, or other licensees under this chapter, designated by the department or board. If the licensee, registered intern, or certificateholder refuses to comply with such order, the department's order directing the examination may be enforced by filing a petition for enforcement in the circuit court in the circuit in which the licensee, registered intern, or certificateholder resides or does business. The licensee, registered intern, or certificateholder against whom the petition is filed shall not be named or identified by initials in any public court

records or documents, and the proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011. A licensee, registered intern, or certificateholder affected under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that he or she can resume the competent practice for which he or she is licensed, registered, or certified with reasonable skill and safety to patients.

(q) Performing any treatment or prescribing any therapy which, by the prevailing standards of the mental health professions in the community, would constitute experimentation on human subjects, without first obtaining full, informed, and written consent.

(r) Failing to meet the minimum standards of performance in professional activities when measured against generally prevailing peer performance, including the undertaking of activities for which the licensee, registered intern, or certificateholder is not qualified by training or experience.

(s) Delegating professional responsibilities to a person whom the licensee, registered intern, or certificateholder knows or has reason to know is not qualified by training or experience to perform such responsibilities.

(t) Violating a rule relating to the regulation of the profession or a lawful order of the department or the board previously entered in a disciplinary hearing.

(u) Failure of the licensee, registered intern, or certificateholder to maintain in confidence a communication made by a patient or client in the context of such services, except as provided in s. 491.0147.

(v) Making public statements which are derived from test data, client contacts, or behavioral research and which identify or damage research subjects or clients.

(w) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(2) The board or, in the case of certified master social workers, the department may enter an order denying licensure or imposing any of the penalties authorized in s. 456.072(2) against any applicant for licensure or any licensee who violates subsection (1) or s. 456.072(1).

History.—ss. 15, 19, ch. 87-252; ss. 9, 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 229, ch. 96-410; s. 1136, ch. 97-103; s. 16, ch. 97-198; s. 208, ch. 97-264; s. 154, ch. 98-166; s. 214, ch. 2000-160; s. 53, ch. 2001-277; s. 28, ch. 2005-240; s. 103, ch. 2008-6; s. 9, ch. 2019-134; s. 123, ch. 2020-2; s. 47, ch. 2020-133.

491.0111 Sexual misconduct.—Sexual misconduct by any person licensed or certified under this chapter, in the practice of her or his profession, is prohibited. Sexual misconduct shall be defined by rule.

History.—ss. 15, 19, ch. 87-252; ss. 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 510, ch. 97-103.

491.0112 Sexual misconduct by a psychotherapist; penalties.—

(1) Any psychotherapist who commits sexual misconduct with a client, or former client when the professional relationship was terminated primarily for the purpose of engaging in sexual contact, commits a felony of the third degree, punishable as provided in s. 775.082 or s. 775.083; however, a second or subsequent offense is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(2) Any psychotherapist who violates subsection (1) by means of therapeutic deception commits a felony of the second degree punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(3) The giving of consent by the client to any such act shall not be a defense to these offenses.

(4) For the purposes of this section:

(a) The term "psychotherapist" means any person licensed pursuant to chapter 458, chapter 459, part I of chapter 464, chapter 490, or chapter 491, or any other person who provides or purports to provide treatment, diagnosis, assessment, evaluation, or counseling of mental or emotional illness, symptom, or condition.

(b) "Therapeutic deception" means a representation to the client that sexual contact by the psychotherapist is consistent with or part of the treatment of the client.

(c) "Sexual misconduct" means the oral, anal, or vaginal penetration of another by, or contact with, the sexual organ of another or the anal or vaginal penetration of another by any object.

(d) "Client" means a person to whom the services of a psychotherapist are provided.

History.—s. 1, ch. 90-70; s. 13, ch. 91-201; s. 4, ch. 91-429; s. 137, ch. 2000-318.

491.012 Violations; penalty; injunction.—

(1) It is unlawful and a violation of this chapter for any person to:

(a) Use the following titles or any combination thereof, unless she or he holds a valid, active license as a clinical social worker issued pursuant to this chapter:

1. "Licensed clinical social worker."

2. "Clinical social worker."

3. "Licensed social worker."

4. "Psychiatric social worker."

5. "Psychosocial worker."

(b) Use the following titles or any combination thereof, unless she or he holds a valid, active license as a marriage and family therapist issued pursuant to this chapter:

1. "Licensed marriage and family therapist."

2. "Marriage and family therapist."

3. "Marriage counselor."

4. "Marriage consultant."

5. "Family therapist."

6. "Family counselor."

7. "Family consultant."

(c) Use the following titles or any combination thereof, unless she or he holds a valid, active license as a mental health counselor issued pursuant to this chapter:

1. "Licensed mental health counselor."

2. "Mental health counselor."

3. "Mental health therapist."

4. "Mental health consultant."

(d) Use the terms psychotherapist, sex therapist, or juvenile sexual offender therapist unless such person is licensed pursuant to this chapter or chapter 490, or is licensed under s. 464.012 as an advanced practice registered nurse who has been determined by the Board of Nursing as a specialist in psychiatric mental health and the use of such terms is within the scope of her or his practice based on education, training, and licensure.

(e) Present as her or his own the clinical social work, marriage and family therapy, or mental health counseling license of another.

(f) Give false or forged evidence to the board or a member thereof for the purpose of obtaining a license.

(g) Use or attempt to use a license issued pursuant to this chapter which has been revoked or is under suspension.

(h) Knowingly conceal information relative to violations of this chapter.

(i) Practice clinical social work in this state for compensation, unless the person holds a valid, active license to practice clinical social work issued pursuant to this chapter or is an intern registered pursuant to s. 491.0045.

(j) Practice marriage and family therapy in this state for compensation, unless the person holds a valid, active license to practice marriage and family therapy issued pursuant to this chapter or is an intern registered pursuant to s. 491.0045.

(k) Practice mental health counseling in this state for compensation, unless the person holds a valid, active license to practice mental health counseling issued pursuant to this chapter or is an intern registered pursuant to s. 491.0045.

(l) Use the following titles or any combination thereof, unless he or she holds a valid registration as an intern issued pursuant to this chapter:

1. "Registered clinical social worker intern."

2. "Registered marriage and family therapist intern."

3. "Registered mental health counselor intern."

(m) Use the following titles or any combination thereof, unless he or she holds a valid provisional license issued pursuant to this chapter:

1. "Provisional clinical social worker licensee."

2. "Provisional marriage and family therapist licensee."

3. "Provisional mental health counselor licensee."

(n) Practice juvenile sexual offender therapy in this state, as the practice is defined in s. 491.0144, for compensation, unless the person holds an active license issued under this chapter and meets the requirements to practice juvenile sexual offender therapy. An unlicensed person may be employed by a program operated by or under contract with the Department of Juvenile Justice or the Department of Children and Families if the program employs a professional who is

licensed under chapter 458, chapter 459, s. 490.0145, or s. 491.0144 who manages or supervises the treatment services.

(2) It is unlawful and a violation of this chapter for any person to describe her or his services using the following terms or any derivative thereof, unless such person holds a valid, active license under this chapter or chapter 490, or is licensed under s. 464.012 as an advanced practice registered nurse who has been determined by the Board of Nursing as a specialist in psychiatric mental health and the use of such terms is within the scope of her or his practice based on education, training, and licensure:

(a) "Psychotherapy."

(b) "Sex therapy."

(c) "Sex counseling."

(d) "Clinical social work."

(e) "Psychiatric social work."

(f) "Marriage and family therapy."

(g) "Marriage and family counseling."

(h) "Marriage counseling."

(i) "Family counseling."

(j) "Mental health counseling."

(3) Any person who violates any provision of subsection (1) or subsection (2) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(4) The department may institute appropriate judicial proceedings to enjoin violation of this section.

History.—ss. 15, 19, ch. 87-252; s. 30, ch. 88-392; ss. 11, 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 118, ch. 92-149; s. 511, ch. 97-103; s. 17, ch. 97-198; s. 209, ch. 97-264; s. 4, ch. 98-158; s. 127, ch. 2001-277511, ch. 97-103; s. 17, ch. 97-198; s. 209, ch. 97-264; s. 4, ch. 98-158; s. 127, ch. 2001-277; s. 274, ch. 2014-19; s. 70, ch. 2018-106; s. 87, ch. 2019-3.

491.014 Exemptions.—

(1) No provision of this chapter shall be construed to limit the practice of physicians licensed pursuant to chapter 458 or chapter 459, or psychologists licensed pursuant to chapter 490, so long as they do not unlawfully hold themselves out to the public as possessing a license, provisional license, registration, or certificate issued pursuant to this chapter or use a professional title protected by this chapter.

(2) No provision of this chapter shall be construed to limit the practice of nursing, school psychology, or psychology, or to prevent qualified members of other professions from doing work of a nature consistent with their training and licensure, so long as they do not hold themselves out to the public as possessing a license, provisional license, registration, or certificate issued pursuant to this chapter or use a title protected by this chapter.

(3) No provision of this chapter shall be construed to limit the performance of activities of a rabbi, priest, minister, or member of the clergy of any religious denomination or sect, or use of the terms "Christian counselor" or "Christian clinical counselor" when the activities are within the scope of the performance of his or her regular or specialized ministerial duties and no compensation is received by him or her, or when such activities are performed, with or without compensation, by a person for or under the auspices or sponsorship, individually or in conjunction with others, of an established and legally cognizable church, denomination, or sect, and when the person rendering service remains accountable to the established authority thereof.

(4) No person shall be required to be licensed, provisionally licensed, registered, or certified under this chapter who:

(a) Is a salaried employee of a government agency; a developmental disability facility or program; a mental health, alcohol, or drug abuse facility operating under chapter 393, chapter 394, or chapter 397; the statewide child care resource and referral network operating under s. 1002.92; a child-placing or child-caring agency licensed pursuant to chapter 409; a domestic violence center certified pursuant to chapter 39; an accredited academic institution; or a research institution, if such employee is performing duties for which he or she was trained and hired solely within the confines of such agency, facility, or institution, so long as the employee is not held out to the public as a clinical social worker, mental health counselor, or marriage and family therapist.

(b) Is a salaried employee of a private, nonprofit organization providing counseling services to children, youth, and families, if such services are provided for no charge, if such employee is performing duties for which he or she was trained and hired, so long as the employee is not held out to the public as a clinical social worker, mental health counselor, or marriage and family therapist.

(c) Is a student providing services regulated under this chapter who is pursuing a course of study which leads to a degree in a profession regulated by this chapter, is providing services in a training setting, provided such services and associated activities constitute part of a supervised course of study, and is designated by the title "student intern."

(d) Is not a resident of this state but offers services in this state, provided:

1. Such services are performed for no more than 15 days in any calendar year; and

2. Such nonresident is licensed or certified to practice the services provided by a state or territory of the United States or by a foreign country or province.

(5) No provision of this chapter shall be construed to limit the practice of any individual who solely engages in behavior analysis so long as he or she does not hold himself or herself out to the public as possessing a license issued pursuant to this chapter or use a title protected by this chapter.

(6) Nothing in subsections (2)-(4) shall exempt any person from the provisions of s. 491.012(1)(a)-(c), (l), and (m).

(7) Except as stipulated by the board, the exemptions contained in this section do not apply to any person licensed under this chapter whose license has been suspended or revoked by the board or another jurisdiction.

(8) Nothing in this section shall be construed to exempt a person from meeting the minimum standards of performance in professional activities when measured against generally prevailing peer performance, including the undertaking of activities for which the person is not qualified by training or experience.

History.—ss. 15, 19, ch. 87-252; ss. 12, 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 120, ch. 92-149; s. 34, ch. 93-39; s. 15, ch. 95-279; s. 512, ch. 97-103; s. 18, ch. 97-198; s. 210, ch. 97-264; s. 157, ch. 98-403; s. 171, ch. 99-397; s. 128, ch. 2001-277; s. 63, ch. 2006-227; s. 25, ch. 2010-210; s. 27, ch. 2013-252.

491.0141 Practice of hypnosis.—A person licensed under this chapter who is qualified as determined by the board may practice hypnosis as defined in s. 485.003(1). The provisions of this chapter may not be interpreted to limit or affect the right of any person qualified pursuant to chapter 485 to practice hypnosis pursuant to that chapter or to practice hypnosis for nontherapeutic purposes, so long as such person does not hold herself or himself out to the public as possessing a license issued pursuant to this chapter or use a title protected by this chapter.

History.—ss. 15, 19, ch. 87-252; ss. 19, 20, ch. 90-263; s. 4, ch. 91-429; ss. 121, 127, ch. 92-149; s. 2, ch. 95-279; s. 513, ch. 97-103; s. 215, ch. 2000-160.

491.0143 **Practice of sex therapy.**—Only a person licensed by this chapter who meets the qualifications set by the board may hold herself or himself out as a sex therapist. The board shall define these qualifications by rule. In establishing these qualifications, the board may refer to the sexual disorder and sexual dysfunction sections of the most current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association or other relevant publications.

History.—ss. 15, 19, ch. 87-252; ss. 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 514, ch. 97-103.

491.0144 **The practice of juvenile sexual offender therapy.**—Only a person licensed by this chapter who meets the qualifications set by the board may hold himself or herself out as a juvenile sexual offender therapist, except as provided in s. 490.0145. These qualifications shall be determined by the board. The board shall require training and coursework in the specific areas of juvenile sexual offender behaviors, treatments, and related issues. In establishing these qualifications, the board may refer to the sexual disorder and dysfunction sections of the most current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, Association for the Treatment of Sexual Abusers Practitioner's Handbook, or other relevant publications.

History.—s. 5, ch. 98-158.

491.0145 **Certified master social worker.**—The department may certify an applicant for a designation as a certified master social worker upon the following conditions:

(1) The applicant completes an application to be provided by the department and pays a nonrefundable fee not to exceed $250 to be established by rule of the department. The completed application must be received by the department at least 60 days before the date of the examination in order for the applicant to qualify to take the scheduled exam.

(2) The applicant submits proof satisfactory to the department that the applicant has received a doctoral degree in social work, or a master's degree with a major emphasis or specialty in clinical practice or administration, including, but not limited to, agency administration and supervision, program planning and evaluation, staff development, research, community organization, community services, social planning, and human service advocacy. Doctoral degrees must have been received from a graduate school of social work which at the time the applicant was enrolled and graduated was accredited by an accrediting agency approved by the United States Department of Education. Master's degrees must have been received from a graduate school of social work

which at the time the applicant was enrolled and graduated was accredited by the Council on Social Work Education or the Canadian Association of Schools of Social Work or by one that meets comparable standards.

(3) The applicant has had at least 3 years' experience, as defined by rule, including, but not limited to, clinical services or administrative activities as defined in subsection (2), 2 years of which must be at the post-master's level under the supervision of a person who meets the education and experience requirements for certification as a certified master social worker, as defined by rule, or licensure as a clinical social worker under this chapter. A doctoral internship may be applied toward the supervision requirement.

(4) Any person who holds a master's degree in social work from institutions outside the United States may apply to the department for certification if the academic training in social work has been evaluated as equivalent to a degree from a school accredited by the Council on Social Work Education. Any such person shall submit a copy of the academic training from the Foreign Equivalency Determination Service of the Council on Social Work Education.

(5) The applicant has passed an examination required by the department for this purpose. The nonrefundable fee for such examination may not exceed $250 as set by department rule.

(6) Nothing in this chapter shall be construed to authorize a certified master social worker to provide clinical social work services.

History.—ss. 15, 19, ch. 87-252; ss. 14, 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 10, ch. 98-130; s. 33, ch. 2000-242.

491.0147 Confidentiality and privileged communications.—Any communication between any person licensed or certified under this chapter and her or his patient or client is confidential.

(1) This privilege may be waived under the following conditions:

(a) When the person licensed or certified under this chapter is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by the patient or client, in which case the waiver shall be limited to that action.

(b) When the patient or client agrees to the waiver, in writing, or, when more than one person in a family is receiving therapy, when each family member agrees to the waiver, in writing.

(c) When a patient or client has communicated to the person licensed or certified under this chapter a specific threat to cause serious bodily injury or death to an identified or readily available person, and the person licensed or certified under this chapter makes a clinical judgment that the

patient or client has the apparent intent and ability to imminently or immediately carry out such threat, and the person licensed or certified under this chapter communicates the information to the potential victim. A disclosure of confidential communications by a person licensed or certified under this chapter when communicating a threat pursuant to this subsection may not be the basis of any legal action or criminal or civil liability against such person.

(2) This privilege must be waived, and the person licensed or certified under this chapter shall disclose patient or client communications to the extent necessary to communicate the threat to a law enforcement agency, if a patient or client has communicated to such person a specific threat to cause serious bodily injury or death to an identified or readily available person, and the person licensed or certified under this chapter makes a clinical judgment that the patient or client has the apparent intent and ability to imminently or immediately carry out such threat. A law enforcement agency that receives notification of a specific threat under this subsection must take appropriate action to prevent the risk of harm, including, but not limited to, notifying the intended victim of such threat or initiating a risk protection order. A disclosure of confidential communications by a person licensed or certified under this chapter when communicating a threat pursuant to this subsection may not be the basis of any legal action or criminal or civil liability against such person.

History.—ss. 15, 19, ch. 87-252; ss. 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 515, ch. 97-103; s. 1, ch. 2009-103; s. 6, ch. 2019-134.

491.0148 Records.—Each psychotherapist who provides services as defined in this chapter shall maintain records. The board may adopt rules defining the minimum requirements for records and reports, including content, length of time records shall be maintained, and transfer of either the records or a report of such records to a subsequent treating practitioner or other individual with written consent of the client or clients.

History.—ss. 13, 20, ch. 90-263; s. 4, ch. 91-429.

491.0149 Display of license; use of professional title on promotional materials.—

(1)(a) A person licensed under this chapter as a clinical social worker, marriage and family therapist, or mental health counselor, or certified as a master social worker shall conspicuously display the valid license issued by the department or a true copy thereof at each location at which the licensee practices his or her profession.

(b)1. A licensed clinical social worker shall include the words "licensed clinical social worker" or the letters "LCSW" on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the licensee.

2. A licensed marriage and family therapist shall include the words "licensed marriage and family therapist" or the letters "LMFT" on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the licensee.

3. A licensed mental health counselor shall include the words "licensed mental health counselor" or the letters "LMHC" on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the licensee.

(2)(a) A person registered under this chapter as a clinical social worker intern, marriage and family therapist intern, or mental health counselor intern shall conspicuously display the valid registration issued by the department or a true copy thereof at each location at which the registered intern is completing the experience requirements.

(b) A registered clinical social worker intern shall include the words "registered clinical social worker intern," a registered marriage and family therapist intern shall include the words "registered marriage and family therapist intern," and a registered mental health counselor intern shall include the words "registered mental health counselor intern" on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the registered intern.

(3)(a) A person provisionally licensed under this chapter as a provisional clinical social worker licensee, provisional marriage and family therapist licensee, or provisional mental health counselor licensee shall conspicuously display the valid provisional license issued by the department or a true copy thereof at each location at which the provisional licensee is providing services.

(b) A provisional clinical social worker licensee shall include the words "provisional clinical social worker licensee," a provisional marriage and family therapist licensee shall include the words "provisional marriage and family therapist licensee," and a provisional mental health counselor licensee shall include the words "provisional mental health counselor licensee" on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the provisional licensee.

History.—ss. 15, 20, ch. 90-263; s. 4, ch. 91-429; s. 516, ch. 97-103; s. 19, ch. 97-198; s. 211, ch. 97-264.

491.015 Duties of the department as to certified master social workers.—

(1) All functions reserved to boards under chapter 456 shall be exercised by the department with respect to the regulation of certified master social workers and in a manner consistent with the exercise of its regulatory functions.

(2) The department shall adopt rules to implement and enforce provisions relating to certified master social workers.

History.—ss. 15, 19, ch. 87-252; ss. 16, 19, 20, ch. 90-263; s. 4, ch. 91-429; s. 155, ch. 98-166; s. 216, ch. 2000-160.

491.016 Social work; use of title.—

(1) A social worker is not authorized to conduct clinical social work without obtaining and possessing a license or certification issued pursuant to this chapter.

(2) It shall be a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, for a person, for or without compensation, to hold himself or herself out to the public as a social worker either directly or through a governmental or private organization, entity, or agency unless that person:

(a) Possesses at least a bachelor's or master's degree in social work from a social work program accredited by or from an institution that is an active candidate for accreditation as a social work program by the Council on Social Work Education; or

(b) Completes, at a university or college outside the United States or Canada, a social work program determined by the Foreign Equivalency Determination Service of the Council on Social Work Education to be equivalent to a bachelor's or master's degree in social work.

(3) This section does not apply to:

(a) A person who, prior to July 1, 2008, used the title "social worker" in his or her employment.

(b) Employees providing social work services under administrative supervision in long-term care facilities licensed by the Agency for Health Care Administration.

(4) The department shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement and enforce this section.

History.—s. 3, ch. 2008-154.

Florida Statute Title XLVII Chapter 916.17

Title XLVII	Chapter 916	View Entire Chapter
CRIMINAL PROCEDURE AND CORRECTIONS	MENTALLY ILL AND INTELLECTUALLY DISABLED DEFENDANTS	

916.17 Conditional release.—

(1) Except for an inmate currently serving a prison sentence, the committing court may order a conditional release of any defendant in lieu of an involuntary commitment to a facility pursuant to s. 916.13 or s. 916.15 based upon an approved plan for providing appropriate outpatient care and treatment. Upon a recommendation that outpatient treatment of the defendant is appropriate, a written plan for outpatient treatment, including recommendations from qualified professionals, must be filed with the court, with copies to all parties. Such a plan may also be submitted by the defendant and filed with the court with copies to all parties. The plan shall include:

(a) Special provisions for residential care or adequate supervision of the defendant.

(b) Provisions for outpatient mental health services.

(c) If appropriate, recommendations for auxiliary services such as vocational training, educational services, or special medical care.

In its order of conditional release, the court shall specify the conditions of release based upon the release plan and shall direct the appropriate agencies or persons to submit periodic reports to the court regarding the defendant's compliance with the conditions of the release and progress in treatment, with copies to all parties.

(2) Upon the filing of an affidavit or statement under oath by any person that the defendant has failed to comply with the conditions of release, that the defendant's condition has deteriorated to the point that inpatient care is required, or that the release conditions should be modified, the court shall hold a hearing within 7 days after receipt of the affidavit or statement under oath. After the hearing, the court may modify the release conditions. The court may also order that the defendant be returned to the department if it is found, after the appointment and report of experts, that the person meets the criteria for involuntary commitment under s. 916.13 or s. 916.15.

(3) If at any time it is determined after a hearing that the defendant who has been conditionally released under subsection (1) no longer requires court-supervised followup care, the court shall terminate its jurisdiction in the cause and discharge the defendant.

History.—s. 1, ch. 80-75; s. 37, ch. 85-167; s. 1534, ch. 97-102; s. 21, ch. 98-92; s. 16, ch. 2006-195.

Florida Statute Title XLVII Chapter 951.032

Title XLVII CRIMINAL PROCEDURE AND CORRECTIONS	Chapter 951 COUNTY AND MUNICIPAL PRISONERS	View Entire Chapter

951.032 Financial responsibility for medical expenses.—

(1) A county detention facility or municipal detention facility incurring expenses for providing medical care, treatment, hospitalization, or transportation may seek reimbursement for the expenses incurred in the following order:

(a) From the prisoner or person receiving medical care, treatment, hospitalization, or transportation by deducting the cost from the prisoner's cash account on deposit with the detention facility. If the prisoner's cash account does not contain sufficient funds to cover medical care, treatment, hospitalization, or transportation, then the detention facility may place a lien against the prisoner's cash account or other personal property, to provide payment in the event sufficient funds become available at a later time. Any existing lien may be carried over to future incarceration of the same prisoner as long as the future incarceration takes place within the county originating the lien and the future incarceration takes place within 3 years of the date the lien was placed against the prisoner's account or other personal property.

(b) From an insurance company, health care corporation, or other source if the prisoner or person is covered by an insurance policy or subscribes to a health care corporation or other source for those expenses.

(2) A prisoner who receives medical care, treatment, hospitalization, or transportation shall cooperate with the county detention facility or municipal detention facility in seeking reimbursement under paragraphs (1)(a) and (b) for expenses incurred by the facility for the prisoner. A prisoner who willfully refuses to cooperate with the reimbursement efforts of the detention facility may have a lien placed against the prisoner's cash account or other personal property and may not receive gain-time as provided by s. 951.21.

History.—s. 2, ch. 83-189; s. 45, ch. 95-283.

Florida Statute Title XLVII Chapter 951.231

Title XLVII CRIMINAL PROCEDURE AND CORRECTIONS	Chapter 951 COUNTY AND MUNICIPAL PRISONERS	View Entire Chapter

951.231 County residential probation program.–

(1) Any prisoner who has been sentenced under s. 921.18 to serve a sentence in a county residential probation center as described in s. 951.23 shall:

(a) Reside at the center at all times other than during employment hours and reasonable travel time to and from his or her place of employment, except that supervisory personnel at a county residential probation center may extend the limits of confinement to include, but not be limited to, probation, community control, or other appropriate supervisory techniques.

(b) Seek and obtain employment on an 8-hours-a-day basis and retain employment throughout the period of time he or she is housed at the center.

(c) Participate in and complete the program required by s. 958.045, if required by the supervisor of the center.

(d) Participate in the education program provided at the center, if required by the supervisor of the center.

(e) Participate in the drug treatment program provided at the center, if required by the supervisor of the center.

(2) The center participating in the county residential probation program must provide or contract to provide for the programs established under subsection (1) as well as provide or contract to provide for necessary health care for the period of time the prisoner is housed at the center.

(3) A local government having an existing Department of Corrections probation and restitution center within its boundaries with current available capacity may contract with the Department of Corrections to house prisoners sentenced in accordance with s. 921.18.

(4) A local government having an existing Department of Corrections probation and restitution center within its boundaries without current available capacity, or a local government not having an existing Department of Corrections probation and restitution center within its boundaries, may provide facilities either through construction, purchase, or lease of new facilities or purchase, renovation, or lease of existing facilities.

(5) Local governments participating in this program may apply to the Department of Corrections for funding. The department shall allocate the funding for this program to the extent authorized in the General Appropriations Act.

History.—s. 79, ch. 88-122; s. 1701, ch. 97-102; s. 48, ch. 2010-117.

Florida Statutes Title V Chapter 30 Sheriffs

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CHAPTER 30

SHERIFFS

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30.01 Bond of sheriffs; small counties.—In each county of the state having a population of 150,000 or less according to the last state census, the sheriff shall give bond as required by the board of county commissioners of the county, to be filed with the clerk of the circuit court and be conditioned upon the faithful discharge of the duties of his or her office. When a sheriff is appointed to fill a vacancy, a bond may not be a prerequisite to succession in office; however, if the county commission requires a bond for the office of sheriff, the commission shall allow a period of 10 days after the effective date of the appointment in which the bond may be provided.

History.—ss. 1, 4, ch. 3724, 1887; RS 1237; GS 1666; RGS 2871; CGL 4568; s. 1, ch. 17754, 1937; s. 1, ch. 20719, 1941; ss. 10, 12, 35, ch. 69-106; s. 171, ch. 95-147; s. 14, ch. 95-312; s. 10, ch. 98-34.

30.02 Bond of sheriffs; large counties.—In each county in the state having a population in excess of 150,000 according to the last state census, the sheriff shall give bond as required by the board of county commissioners, to be filed with the clerk of the circuit court and be conditioned upon the faithful discharge of the duties of his or her office. When a sheriff is appointed to fill a vacancy, a bond may not be a prerequisite to succession in office; however, if the county commission requires a bond for the office of sheriff, the commission shall allow a period of 10 days after the effective date of the appointment in which the bond may be provided.

History.—ss. 1, 4, ch. 3724, 1887; RS 1237; GS 1666; RGS 2871; CGL 4568; s. 1, ch. 17754, 1937; ss. 10, 12, 35, ch. 69-106; s. 172, ch. 95-147; s. 15, ch. 95-312; s. 11, ch. 98-34.

30.03 Obligation of sureties.—Each surety upon such bond may bind himself or herself for a specified sum, but the aggregate amount for which the sureties may bind themselves shall not be less than the penalty of the bond.

History.—s. 9, ch. 3724, 1887; RS 1238; GS 1667; RGS 2872; CGL 4569; s. 2, ch. 17754, 1937; s. 1, ch. 20719, 1941; s. 173, ch. 95-147.

30.04 Justification of sureties.—Each surety upon such bond shall make an affidavit that he or she is a resident of the county for which the officer is to be commissioned, and that the surety has sufficient visible property therein, unencumbered and not exempt from sale under legal process, to make good his or her bond.

History.—s. 10, ch. 3724, 1887; RS 1239; GS 1668; RGS 2873; CGL 4570; s. 3, ch. 17754, 1937; s. 1, ch. 20719, 1941; s. 174, ch. 95-147.

30.05 Surety companies.—The provisions of ss. 30.01-30.04, as to number of sureties, affidavits of residence and justification of same shall not apply to solvent surety companies authorized to do business and execute bonds in this state.

History.—s. 4, ch. 3724, 1887; RS 1237; GS 1666; RGS 2871; CGL 4568; s. 4, ch. 17754, 1937; s. 1, ch. 20719, 1941.

30.06 Liability of sureties.—The sureties, if any, are liable for all fines and amercements imposed upon the principal, or sheriff.

History.—s. 4, ch. 987, 1859; RS 1240; GS 1669; RGS 2874; CGL 4571; s. 1, ch. 20719, 1941; s. 12, ch. 98-34.

30.07 Deputy sheriffs.—Sheriffs may appoint deputies to act under them who shall have the same power as the sheriff appointing them, and for the neglect and default of whom in the execution of their office the sheriff shall be responsible.

History.—s. 4, ch. 1659, 1868; RS 1247; GS 1675; RGS 2881; CGL 4578.

30.071 Applicability and scope of act.—

(1) This act applies to all deputy sheriffs, with the following exceptions:

(a) Deputy sheriffs in a county that, by special act of the Legislature, local charter, ordinance, or otherwise, has established rights and procedures for deputy sheriffs which are equivalent to or greater than those prescribed by this act.

(b) Deputy sheriffs in a county that, by special act of the Legislature, local charter, ordinance, or otherwise, has established a civil or career service system which grants collective bargaining rights for deputy sheriffs, including, but not limited to, deputy sheriffs in the following counties: Broward, Miami-Dade, Duval, Escambia, and Volusia.

(c) Special deputy sheriffs appointed under s. 30.09(4).

(d) Members of a sheriff's posse or reserve unit.

(e) Part-time deputy sheriffs.

(2) This act does not grant to deputy sheriffs the right of collective bargaining.

(3) This act does not change the alter ego relationship which exists between a deputy sheriff and the appointing sheriff.

History.—s. 2, ch. 94-143; s. 10, ch. 2008-4.

30.072 Definitions.—As used in this act, the term:

(1) "Actual, continuous service" means the time during which a deputy sheriff performs the duties and responsibilities of the position to which she or he is appointed.

(2) "Deputy sheriff" means a law enforcement officer appointed by the sheriff and certified under chapter 943. The term does not include a person who performs managerial, confidential, or policymaking duties. Managerial, confidential, and policymaking appointees who are not covered by this act include the undersheriff, chief deputy, director, legal advisor, sheriff's personal secretary or administrative assistant, or members of the sheriff's personal staff who report to or work under the direct supervision of the sheriff or who assist the sheriff in the formulation of general or special orders or in the preparation of the fiscal year budget, or appointees whose duties primarily involve the management or operation of the sheriff's office or a department or subdivision of that office.

(3) "Probation" means a period of actual, continuous service following initial employment or following a promotion from a regular appointment.

(4) "Regular appointment" means the employment status of a deputy sheriff who has satisfactorily completed probation.

(5) "Sheriff" means the constitutional officer elected in accordance with this chapter.

History.—s. 3, ch. 94-143; s. 1325, ch. 95-147.

30.073 Appointment; probation; regular appointment.—

(1) A sheriff has exclusive power to appoint a deputy sheriff. However, a person may not be appointed as a deputy sheriff unless the person meets all qualifications set out in the Florida Statutes.

(2)(a) A person's appointment as a deputy sheriff is not a regular appointment until the person has satisfactorily completed 12 consecutive months of probation.

(b) A deputy sheriff's promotion to a higher rank within the agency is not a regular appointment to that rank until the deputy sheriff has satisfactorily completed 6 consecutive months of probation.

(c) If a deputy sheriff is unable to perform the duties and responsibilities of the position to which he or she is appointed or promoted due to a nonservice-connected disability or other

justifiable cause, the period of probation may be extended by the amount of time the deputy sheriff is unable to perform his or her duties.

(3) At any time, the sheriff may terminate, with or without cause, the appointment or promotion of a deputy sheriff who has not completed probation.

(a) An appointment is terminated upon the receipt by the deputy sheriff of written notice, signed by the sheriff, advising the deputy sheriff of his or her termination from appointment.

(b) A promotion is terminated upon the receipt by the deputy sheriff of a written notice, signed by the sheriff, advising the deputy sheriff of his or her return to his or her previous regular appointment.

(4) A deputy sheriff who satisfactorily completes probation is considered regularly appointed to his or her position and is entitled to all the rights and privileges set forth in this act.

(5) A deputy sheriff covered by ss. 30.071-30.079, other than the undersheriff or chief deputy, who is regularly appointed to his or her position may not be terminated for lawful off-duty political activity or for a discriminatory reason.

History.—s. 4, ch. 94-143; s. 1326, ch. 95-147; s. 1, ch. 95-155.

30.074 Regular appointee status.—When a deputy sheriff to whom the provisions of this act apply has served for a period of 1 calendar year, such deputy sheriff shall have attained regular deputy status in the office of the sheriff. Any deputy who is required to serve a probationary period attendant to a promotion shall retain regular status in the office of the sheriff, but may be returned to his or her prior rank during such probationary period without the right of appeal.

History.—s. 5, ch. 94-143; s. 1327, ch. 95-147.

30.075 Review boards.—

(1) Each sheriff shall establish a review board to review, pursuant to appeals taken under ss. 30.071-30.079, terminations taken by the sheriff against regularly appointed deputy sheriffs for lawful off-duty political activity or for discriminatory reasons.

(2) Each member of a review board shall be selected on the basis of fairness, objectivity, and impartiality. The board shall have no investigative powers and shall function in the capacity of a fact finder in an effort to arrive at a fair and equitable recommendation in all matters brought before it. A member shall not be involved in the issue under consideration. Membership on the

board is voluntary and without remuneration. Members may not discuss matters to be heard before the board until the board convenes.

(3) A review board may receive verbal or written testimony concerning any matter considered relevant by the board and may receive any records, including, but not limited to, performance evaluations and disciplinary files.

(4)(a) The review board of an agency having 150 or more deputy sheriffs shall be comprised of:

1. Two members selected by the sheriff from among the certified law enforcement officers within the sheriff's jurisdiction.

2. Two members selected by the deputy sheriff who is appealing the termination action from among the certified law enforcement officers within the sheriff's jurisdiction.

3. One member selected by the other members of the board and acting as the chairperson of the board.

4. If an impartial local chairperson cannot be agreed upon within 10 working days after the appeal is submitted, then the parties shall jointly request the American Arbitration Association to furnish a panel of seven names from which each party shall have the option, within 5 days of receipt, of striking three names in alternating fashion. The seventh or remaining name shall be the chairperson. The parties shall jointly notify the arbitrator of his or her selection. Either party may object to all names on the list, provided the objection is made prior to the commencement of the striking process. If this occurs, the objecting party may request the American Arbitration Association to furnish another list of arbitrators. No more than two lists may be requested. The costs of the arbitrator shall be shared by both parties.

(b) The review board of an agency having fewer than 150 deputy sheriffs shall be comprised of:

1. One member selected by the sheriff from among the certified law enforcement officers within the sheriff's jurisdiction.

2. One member selected by the deputy sheriff who is appealing the termination from among the certified law enforcement officers within the sheriff's jurisdiction.

3. One member selected by the other members of the board and acting as the chairperson of the board.

(5) The chairperson of a review board shall:

(a) Conduct each meeting using parliamentary rules of order.

(b) Request that the deputy sheriff who is appealing provide the names of his or her witnesses, if any.

(c) Schedule and provide written notice of each meeting to the Internal Affairs Bureau, witnesses, board members, and deputies.

(d) Provide copies of all charges to the board members.

(6) The scope of the review board is limited to terminations.

History.—s. 6, ch. 94-143; s. 1328, ch. 95-147; s. 2, ch. 95-155.

30.076 Appeal.—

(1) The sheriff may not terminate a regularly appointed deputy sheriff for exercising lawful off-duty political rights.

(2) The review board shall be utilized to make the determination as to whether or not the termination of a deputy sheriff was politically or discriminatorily motivated.

(3)(a) A deputy sheriff must make a request for a hearing in writing to the deputy sheriff's immediate supervisor within 10 working days after the deputy sheriff receives notice of termination for off-duty political activity. The request must contain a brief statement of the matters to be considered by the review board and the names of the two law enforcement officers selected to serve on the board.

(b) The immediate supervisor shall forward the request for hearing to the sheriff and the appropriate division commander without delay. The review board shall be empaneled and a hearing date scheduled within 10 working days of receipt. The rules of evidence applicable to administrative hearings under chapter 120 apply to the hearing.

(c) The sheriff has the burden of proving the appropriateness of the termination by the preponderance of evidence. The sheriff or the sheriff's appointed representative must present evidence in support of the termination.

(d) The deputy sheriff has the right to be present, to present his or her case, to explain or defend his or her position, and to cross-examine each witness or complainant.

(e) The deputy sheriff has the right to be represented during the hearing by counsel or other representative of choice.

(f) The deputy sheriff shall not discuss the matter before the review board except through its chairperson.

(g) The sheriff may offer rebuttal evidence, and the review board may hear argument from both parties in support of the evidence presented.

(h) The chairperson of the review board shall, through the appropriate chain of command, give written notice to each witness of the date, time, and place of the hearing.

(i) The review board shall confine its deliberation to the evidence presented. The board shall have 10 working days within which to make its findings. The findings of the board are binding on the parties. If the board finds that action on appeal is justified, it may recommend an alternative action.

(j) A decision of the review board must be made by a majority vote of its members.

(k) Each complaint shall receive a separate finding and recommendation by a majority of the review board. Each finding shall take into consideration the seriousness of the complaint, any extenuating circumstances, and the tenure and past conduct record of the deputy sheriff. The board shall submit to the sheriff its written findings of fact and recommendations within 10 working days after the hearing.

(l) The sheriff shall notify the deputy sheriff of the final recommendations of the review board and the reasons therefor.

(m) If the sheriff's action on appeal is not sustained, the deputy sheriff shall be reinstated without prejudice or penalty.

(n) All proceedings of the review board shall be recorded and retained by the Internal Affairs Bureau. Rest periods shall be duly noted and there shall be no unrecorded questions or statements by a party or witness. Recordings shall be properly marked and identified before filing.

History.—s. 7, ch. 94-143; s. 1329, ch. 95-147; s. 3, ch. 95-155.

30.077 Conduct of hearing.—A review board shall determine the truth while maintaining an atmosphere of fundamental fairness.

History.—s. 8, ch. 94-143.

30.078 Continuation of appointment after a change in sheriff.—When a newly elected or appointed sheriff assumes office, the incoming sheriff may not terminate the employment of any deputy sheriff covered by ss. 30.071-30.079 for lawful off-duty political activity or for a

discriminatory reason. The incoming sheriff may replace deputy sheriffs assigned to managerial, confidential, or policymaking positions or part-time deputy sheriffs.

History.—s. 9, ch. 94-143; s. 4, ch. 95-155.

30.079 Effects of act; no property interest or expectancy in office; sheriff's authority.—The provisions of this act shall not be construed to provide deputy sheriffs with a property interest or expectancy of continued appointment as a deputy sheriff, nor shall these provisions serve as a limitation of the sheriff's authority as a constitutional officer to determine unilaterally the purpose of the office or department, to such standards of service to be offered to the public, and to exercise control and discretion over the organization and operations of the sheriff's office or department.

History.—s. 10, ch. 94-143.

30.09 Qualification of deputies; special deputies.—

(1) BOND, SURETIES, PERFORMANCE OF SERVICES.—

(a) Each deputy sheriff who is appointed shall give bond as required by the board of county commissioners. The amount of the bond and the bond must be approved by the board of county commissioners. The bond must be filed with the clerk of the circuit court and be conditioned upon the faithful performance of the duties of his or her office. A deputy sheriff may not perform any services as deputy until he or she subscribes to the oath prescribed for sheriffs. Sureties are liable for all fines and amercements imposed upon their principal.

(b) The board of county commissioners of any county may accept a blanket surety bond issued by a solvent surety company authorized to do business in this state, conditioned upon the faithful performance of the duties of the deputy sheriffs appointed by a sheriff, in a sum to be fixed by the board of county commissioners. If such a blanket surety bond is accepted, individual surety bonds for each deputy sheriff are not necessary. The cost of the blanket bond must be paid by the appropriate sheriff's department. Sureties are liable for all fines and amercements imposed upon their principals under the provisions of the blanket bond.

(2) SURETY COMPANIES.—The requisite of two sureties and justification of same does not apply when surety is by a solvent surety company authorized to do business in this state.

(3) LIABILITY OF SHERIFF.—The giving of such bond by a deputy does not relieve the sheriff of the liability for the acts of his or her deputies.

(4) EXCEPTIONS.—This section does not apply to the appointment of special deputy sheriffs appointed by the sheriff:

(a) To attend elections on election days.

(b) To perform undercover investigative work.

(c) For specific guard or police duties in connection with public sporting or entertainment events, not to exceed 30 days; or for watch or guard duties, when serving in such capacity at specified locations or areas only.

(d) For special and temporary duties, without power of arrest, in connection with guarding or transporting prisoners.

(e) To aid in preserving law and order, or to give necessary assistance in the event of any threatened or actual hurricane, fire, flood, or other natural disaster, or in the event of any major tragedy such as an act of local terrorism or a national terrorism alert, an airplane crash, a train or automobile wreck, or a similar accident.

(f) To raise the power of the county, by calling bystanders or others, to assist in quelling a riot or any breach of the peace, when ordered by the sheriff or an authorized general deputy.

(g) To serve as a parking enforcement specialist pursuant to s. 316.640(2).

The appointment of a special deputy sheriff in any such circumstance, except with respect to paragraph (g), may be made with full powers of arrest when the sheriff considers such appointment reasonable and necessary in the execution of the duties of his or her office. Except under circumstances described in paragraphs (a), (e), (f), and (g), the appointees must possess at least the minimum requirements established for law enforcement officers by the Criminal Justice Standards and Training Commission. The appointment of any such special deputy sheriff must be recorded in a register maintained for such purpose in the sheriff's office, showing the terms and circumstances of such appointment.

(5) REMOVAL FOR VIOLATION.—A violation of this section subjects the offender to removal by the Governor.

History.—ss. 1, 2, 3, 4, 6, ch. 6478, 1913; RGS 2883; CGL 4580; s. 2, ch. 22790, 1945; s. 1, ch. 57-93; s. 1, ch. 72-307; s. 1, ch. 75-100; s. 1, ch. 79-246; s. 14, ch. 79-400; s. 3, ch. 83-167; s. 5, ch. 87-224; s. 175, ch. 95-147; s. 13, ch. 98-34; s. 1, ch. 2002-193.

30.10 Place of office.—The place of office of every sheriff shall be at the county seat of the county.

History.—s. 3, Feb. 12, 1834; RS 1248; GS 1676; RGS 2884; CGL 4581.

30.12 Power to appoint sheriff.—If any sheriff in the state fails to attend, in person or by deputy, the circuit court or county court of the county, from sickness, death, or other cause, the judge attending the court may appoint an interim sheriff, who shall assume all the responsibilities, perform all the duties, and receive the same compensation as if he or she had been duly appointed sheriff for only the term of nonattendance and no longer.

History.—s. 1, ch. 1394, 1863; RS 1243; GS 1672; RGS 2877; CGL 4574; s. 3, ch. 22790, 1945; s. 4, ch. 73-334; s. 177, ch. 95-147; s. 4, ch. 2013-25.

30.14 Succession of office.—

(1) Upon the expiration of the term of office, the sheriff shall deliver to his or her successor in office, taking a receipt for the same, the following:

(a) All such writs and processes as shall remain in his or her hands unexecuted; and

(b) All persons who are held in confinement by legal process, with the warrants, indictments, or causes of such confinement.

(2)(a) Upon the death of any sheriff, the executors, administrators, or other representatives shall deliver by hand, taking a receipt for the same, all papers and documents which relate to official duties and which were in the possession of and belonging to such decedent as sheriff.

(b) If the successor as sheriff should not be qualified in due time to serve or execute the process of the court, the chief deputy of such deceased sheriff shall be appointed by an order from the judge of the circuit court to fulfill the responsibilities and requirements of subsection (1) until such time as a successor is qualified.

(3) The succeeding sheriff, or the chief deputy pursuant to paragraph (2)(b), shall sell and carry into effect any levy made by a predecessor in office in like manner as the former sheriff could have done had he or she continued therein, and shall make titles to the purchaser for all the property sold under execution or other process and not conveyed by any predecessor.

(4) In any case in which an incumbent sheriff neglects or refuses to turn over such process in the manner aforesaid, such person shall be liable to make such satisfaction by damage and costs to the party aggrieved as he or she shall sustain by reason of such neglect or refusal.

History.—s. 16, Nov. 23, 1828; RS 1254; GS 1682; RGS 2890; CGL 4587; s. 7, ch. 22858, 1945; s. 1, ch. 87-288; s. 178, ch. 95-147.

30.15 Powers, duties, and obligations.—

(1) Sheriffs, in their respective counties, in person or by deputy, shall:

(a) Execute all process of the Supreme Court, circuit courts, county courts, and boards of county commissioners of this state, to be executed in their counties.

(b) Execute such other writs, processes, warrants, and other papers directed to them, as may come to their hands to be executed in their counties.

(c) Attend all sessions of the circuit court and county court held in their counties.

(d) Execute all orders of the boards of county commissioners of their counties, for which services they shall receive such compensation, out of the county treasury, as said boards may deem proper.

(e) Be conservators of the peace in their counties.

(f) Suppress tumults, riots, and unlawful assemblies in their counties with force and strong hand when necessary.

(g) Apprehend, without warrant, any person disturbing the peace, and carry that person before the proper judicial officer, that further proceedings may be had against him or her according to law.

(h) Have authority to raise the power of the county and command any person to assist them, when necessary, in the execution of the duties of their office; and, whoever, not being physically incompetent, refuses or neglects to render such assistance, shall be punished by imprisonment in jail not exceeding 1 year, or by fine not exceeding $500.

(i) Be, ex officio, timber agents for their counties.

(j) Perform such other duties as may be imposed upon them by law.

(k) Assist district school boards and charter school governing boards in complying with s. 1006.12. A sheriff must, at a minimum, provide access to a Coach Aaron Feis Guardian Program to aid in the prevention or abatement of active assailant incidents on school premises, as required under this paragraph. Persons certified as school guardians pursuant to this paragraph have no

authority to act in any law enforcement capacity except to the extent necessary to prevent or abate an active assailant incident.

1.a. If a local school board has voted by a majority to implement a guardian program, the sheriff in that county shall establish a guardian program to provide training, pursuant to subparagraph 2., to school district or charter school employees, either directly or through a contract with another sheriff's office that has established a guardian program.

b. A charter school governing board in a school district that has not voted, or has declined, to implement a guardian program may request the sheriff in the county to establish a guardian program for the purpose of training the charter school employees. If the county sheriff denies the request, the charter school governing board may contract with a sheriff that has established a guardian program to provide such training. The charter school governing board must notify the superintendent and the sheriff in the charter school's county of the contract prior to its execution.

c. The sheriff conducting the training pursuant to subparagraph 2. will be reimbursed for screening-related and training-related costs and for providing a one-time stipend of $500 to each school guardian who participates in the school guardian program.

2. A sheriff who establishes a program shall consult with the Department of Law Enforcement on programmatic guiding principles, practices, and resources, and shall certify as school guardians, without the power of arrest, school employees, as specified in s. 1006.12(3), who:

a. Hold a valid license issued under s. 790.06.

b. Complete a 144-hour training program, consisting of 12 hours of certified nationally recognized diversity training and 132 total hours of comprehensive firearm safety and proficiency training conducted by Criminal Justice Standards and Training Commission-certified instructors, which must include:

(I) Eighty hours of firearms instruction based on the Criminal Justice Standards and Training Commission's Law Enforcement Academy training model, which must include at least 10 percent but no more than 20 percent more rounds fired than associated with academy training. Program participants must achieve an 85 percent pass rate on the firearms training.

(II) Sixteen hours of instruction in precision pistol.

(III) Eight hours of discretionary shooting instruction using state-of-the-art simulator exercises.

(IV) Eight hours of instruction in active shooter or assailant scenarios.

(V) Eight hours of instruction in defensive tactics.

(VI) Twelve hours of instruction in legal issues.

c. Pass a psychological evaluation administered by a psychologist licensed under chapter 490 and designated by the Department of Law Enforcement and submit the results of the evaluation to the sheriff's office. The Department of Law Enforcement is authorized to provide the sheriff's office with mental health and substance abuse data for compliance with this paragraph.

d. Submit to and pass an initial drug test and subsequent random drug tests in accordance with the requirements of s. 112.0455 and the sheriff's office.

e. Successfully complete ongoing training, weapon inspection, and firearm qualification on at least an annual basis.

The sheriff who conducts the guardian training shall issue a school guardian certificate to individuals who meet the requirements of this section to the satisfaction of the sheriff, and shall maintain documentation of weapon and equipment inspections, as well as the training, certification, inspection, and qualification records of each school guardian certified by the sheriff. An individual who is certified under this paragraph may serve as a school guardian under s. 1006.12(3) only if he or she is appointed by the applicable school district superintendent or charter school principal.

(2) Sheriffs, in their respective counties, in person or by deputy, shall, at the will of the board of county commissioners, attend, in person or by deputy, all meetings of the boards of county commissioners of their counties, for which services they shall receive such compensation, out of the county treasury, as said boards may deem proper.

(3) Every sheriff shall incorporate an antiracial or other antidiscriminatory profiling policy into the sheriff's policies and practices, utilizing the Florida Police Chiefs Association Model Policy as a guide. Antiprofiling policies shall include the elements of definitions, traffic stop procedures, community education and awareness efforts, and policies for the handling of complaints from the public.

(4)(a) In accordance with each county's obligation under s. 14, Art. V of the State Constitution and s. 29.008 to fund security for trial court facilities, the sheriff of each county shall coordinate with the board of county commissioners of that county and the chief judge of the circuit in which that county is located on the development of a comprehensive plan for the provision of security for trial court facilities. Each sheriff shall retain authority over the implementation and provision of law enforcement services associated with the plan. The chief judge of the circuit shall retain decisionmaking authority to ensure the protection of due process rights, including, but not limited

to, the scheduling and conduct of trials and other judicial proceedings as part of his or her responsibility for the administrative supervision of trial courts under s. 43.26.

(b) Sheriffs and their deputies, employees, and contractors are officers of the court when providing security for trial court facilities under this subsection.

History.—s. 14, ch. 4, 1845; ss. 1, 4, ch. 157, 1848; s. 9, ch. 1626, 1868; ss. 1, 2, ch. 1659, 1868; RS 650, 651, 653, 1241, 1242, 2583; GS 991, 992, 994, 1670, 1671, 3503; RGS 1804, 1805, 1807, 2875, 2876, 5388; CGL 2856, 2857, 2859, 4572, 4573, 7527; s. 4, ch. 22790, 1945; s. 4, ch. 73-334; s. 1, ch. 91-95; s. 179, ch. 95-147; s. 2, ch. 2001-264; s. 5, ch. 2013-25; s. 5, ch. 2018-3; s. 9, ch. 2019-3; s. 1, ch. 2019-22; s. 1, ch. 2020-100.

Note.—Former ss. 144.01-144.03, 30.16.

30.20 False return.—For every false return, the sheriff shall forfeit and pay $500, one moiety thereof to the party aggrieved, and the other moiety to him or her who will sue for the same, to be recovered with costs by action of debt; and the said sheriff shall be further liable to an action of the party aggrieved.

History.—s. 2, ch. 997, 1859; RS 1251; GS 1679; RGS 2887; CGL 4584; s. 181, ch. 95-147.

30.21 Failure to pay over money.—If any sheriff fails to collect or pay over fines, fees, costs, or other moneys adjudged to the state which he or she has been by proper process directed to collect, the sheriff forfeits his or her commissions and also is liable for a fine of $50, to be recovered by motion before the circuit court, after 10 days' notice, and the sheriff's sureties, if any, are also liable for the amount of such moneys upon his or her bond as sheriff.

History.—s. 9, ch. 217, 1849; RS 1252; GS 1680; RGS 2888; CGL 4585; s. 182, ch. 95-147; s. 14, ch. 98-34.

30.22 When sheriff may accept service.—Sheriffs, when sued in their official capacity, may accept service, and when so sued with others may serve their codefendants and receive the fees allowed by law, except no fees shall be allowed for acceptance of service.

History.—s. 1, ch. 4411, 1895; GS 1674; RGS 2879; CGL 4576; s. 6, ch. 22790, 1945.

30.231 Sheriffs' fees for service of summons, subpoenas, and executions.—

(1) The sheriffs of all counties of the state in civil cases shall charge fixed, nonrefundable fees for service of process, according to the following schedule:

(a) All summons or writs except executions: $40 for each summons or writ to be served.

(b) All writs except executions requiring a levy or seizure of property: $50 in addition to the $40 fee as stated in paragraph (a).

(c) Witness subpoenas: $40 for each witness to be served.

(d) Executions:

1. Forty dollars for processing each writ of execution, regardless of the number of persons involved.

2. Fifty dollars for each levy.

a. A levy is considered made when any property or any portion of the property listed or unlisted in the instructions for levy is seized, or upon demand of the sheriff the writ is satisfied by the defendant in lieu of seizure. Seizure requires that the sheriff take actual possession, if practicable, or, alternatively, constructive possession of the property by order of the court.

b. When the instructions are for levy upon real property, a levy fee is required for each parcel described in the instructions.

c. When the instructions are for levy based upon personal property, one fee is allowed, unless the property is seized at different locations, conditional upon all of the items being advertised collectively and the sale being held at a single location. However, if the property seized cannot be sold at one location during the same sale as advertised, but requires separate sales at different locations, the sheriff may then impose a levy fee for the property and sale at each location.

3. Forty dollars for advertisement of sale under process.

4. Forty dollars for each sale under process.

5. Forty dollars for each deed, bill of sale, or satisfaction of judgment.

(2) For levying on property and for the seizure of persons, the sheriff shall be allowed anticipated expenses necessary for the execution of the process directing such levy or seizure and for the safekeeping of property and persons in the custody of the sheriff. A reasonable cost deposit to cover said fees and expenses in connection with the requested services shall be deposited in advance, by the party requesting the service, with the officer requested to perform the service.

(3) The party requesting service of process must furnish to the sheriff the original process, a certified copy of the process, or an electronic copy of the process, which was signed and certified by the clerk of court, and sufficient copies to be served on the parties receiving the service of process. The party requesting service of process shall provide the sheriff with the best known

address where the person may be served. Failure to perfect service at the address provided does not excuse the sheriff from his or her duty to exercise due diligence in locating the person to be served.

(4) All fees collected under paragraphs (1)(a), (b), (c), and (d) shall be nonrefundable and shall be earned when each original request or service of process is made.

(5) All fees collected under the provisions of this section shall be paid monthly into the fine and forfeiture fund of the county.

(6) Fees under this section chargeable to the state or its agencies shall be those fees that were effective under this section on June 30, 2009.

History.—ss. 1, 2, ch. 63-41; s. 2, ch. 72-92; s. 4, ch. 79-396; s. 1, ch. 82-118; s. 1, ch. 83-255; s. 1, ch. 87-405; s. 1, ch. 94-170; s. 1330, ch. 95-147; s. 6, ch. 2000-258; s. 1, ch. 2009-215; s. 1, ch. 2011-159; s. 1, ch. 2014-207.

30.24 Transportation and return of prisoners.—

(1) The sheriff of any county of the state, when required to go beyond the limits of this state to bring back a prisoner charged with any offense or who has been convicted of any crime in this state and has escaped, shall receive the actual and necessary expense on account of returning the prisoner to the state. Travel under this subsection is exempt from the provisions of s. 112.061.

(2)(a) The sheriff of each county of the state is authorized to contract with private transport companies for the transportation of prisoners both within and beyond the limits of this state. Each prisoner shall be delivered to the transport company by a sheriff or other proper law enforcement official for transportation and then delivered by the same transport company to the proper sheriff or other law enforcement official upon arriving at the point of destination.

(b) Any company transporting a prisoner pursuant to this section shall be considered an independent contractor and shall be solely liable for the prisoner while the prisoner is in the custody of the company. Any transport company contracting with a sheriff for the transportation of prisoners as provided for in this section shall be insured and shall provide no less than $100,000 in liability insurance with respect to the transporting of the prisoners.

(c) Personnel employed by any transport company for the transportation of prisoners as provided for in this section are specifically exempted from:

1. Any requirements of being appointed as deputy sheriffs.

2. Providing bond.

3. Meeting requirements and training as provided by the Criminal Justice Standards and Training Commission for law enforcement and correctional officers.

History.—s. 1, ch. 5407, 1905; ss. 2, 5, ch. 7886, 1919; RGS 2893; s. 2, ch. 10091, 1925; CGL 4591; s. 2, ch. 20943, 1941; s. 1, ch. 77-154; s. 1, ch. 81-176; s. 4, ch. 83-167; s. 183, ch. 95-147.

30.27 Constructive mileage not to be charged.—No sheriff or coroner shall charge constructive mileage. The mileage charged for must be actually traveled by the nearest and most direct route by the public highway.

History.—s. 2, ch. 3106, 1879; RS 1256; GS 1684; RGS 2894; CGL 4592; s. 4, ch. 73-334.

30.29 Sheriffs may furnish vital war industries guard service against sabotage.—

(1) The sheriffs of the respective counties of the state be and they are hereby authorized and empowered to furnish adequate guard service to vital war industries if requested to so do by such industries; provided, such industries reimburse said sheriffs the actual cost of such guard service; that the furnishing of guard service by said sheriffs to vital war industries is and shall be an official act of the various sheriffs and said guards shall be deemed to be in the employ of the various sheriffs as an instrumentality of the state.

(2) Such guards shall be regular or special deputy sheriffs, residents of the state, citizens of the United States, and bonded, with no prior criminal record, and shall be always under the control of the respective sheriffs who employ said guards. All orders to said guards shall emanate from the respective sheriffs; provided, however, that industry shall have the right to supervise said guards and make recommendations in connection with the guarding of its property to said sheriffs.

(3) The term "industry," as used in this section, shall be construed to include any person, firm, or corporation engaged, directly or indirectly, in the manufacture or furnishing of any materials, equipment, commodities, or services which contribute to the prosecution of the war effort.

(4) The said guards employed by the various sheriffs hereunder shall be acceptable to the particular industry involved at all times and shall receive such pay as is agreeable to the sheriff, industry, and the guard to be employed.

(5) All guards heretofore employed by sheriffs and used in connection with the guarding of industry, shall be deemed to have been employed according to the terms and conditions of this section and the employment by the various sheriffs in this connection is hereby ratified, confirmed, and held to be employment in their official capacities as an instrumentality of the state.

(6) The powers given to the various sheriffs of the various counties of this state herein shall not be deemed to be limiting the powers of the sheriffs already existing but shall be deemed to be cumulative.

History.—ss. 1, 2, 3, 4, 5, 7, ch. 21798, 1943.

30.2905 Program to contract for employment of off-duty deputies for security services.—

(1) A sheriff may operate or administer a program to contract for the employment of sheriff's deputies, during off-duty hours, for public or private security services.

(2)(a) Any such public or private employer of a deputy sheriff shall be responsible for the acts or omissions of the deputy sheriff while performing services for that employer while off duty, including workers' compensation benefits.

(b) However, for the workers' compensation purposes of this section:

1. A deputy sheriff so employed who sustains an injury while enforcing the criminal, traffic, or penal laws of this state shall be regarded as working on duty.

2. The term "enforcing the criminal, traffic, or penal laws of this state" shall be interpreted to include, but is not limited to, providing security, patrol, or traffic direction for a private or public employer.

3. A sheriff may include the sheriff's proportionate costs of workers' compensation premiums for the off-duty deputy sheriffs providing such services.

(3) Deputy sheriffs employed during off-duty hours pursuant to the provisions of this section are exempt from the licensure requirements of chapter 493 for persons who watch or guard, patrol services, or private investigators.

History.—s. 5, ch. 91-174; s. 184, ch. 95-147; s. 1, ch. 2010-175.

30.291 Closing of public facilities upon threat of violence.—

(1) The sheriff of any county of the state is hereby authorized to temporarily close any public beach, park, or other public recreation facility within the sheriff's jurisdiction when in his or her discretion conditions exist which present a clear and present or probable threat of violence, danger, or disorder, or at any time a disorderly situation exists which in the sheriff's opinion warrants such action.

(2) The power of the sheriff in exercising the authority conferred herein shall be full, complete and plenary.

(3) Any public recreation facility closed pursuant to the provisions of this section shall be reopened by the sheriff when the conditions upon which such closing was predicated have abated.

History.—ss. 1, 2, ch. 59-377; s. 185, ch. 95-147.

30.30 Writs, process; duties and liabilities in levying.—

(1) Whenever any writ, issuing out of any court of this state, shall be delivered to a sheriff, commanding the sheriff to levy upon property specifically described therein, it shall be his or her duty to levy upon such property. If no property is specifically described in the writ, he or she shall levy upon:

(a) Any property in the possession of the defendant which is described in instructions for levy; and

(b) Upon any property assessed against the defendant on the current tax rolls of the county or registered in his or her name under any law of the United States or of the state, upon the request of the plaintiff or the plaintiff's attorney listing such property in an instructions for levy. The instructions for levy shall state the balance due on such writ.

(2) No sheriff shall be liable in damages to anyone whomsoever for making a wrongful levy whenever the same has been made as required under subsection (1).

(3) If the sheriff, in attempting to execute any writ describing specific property, shall find it in the possession of anyone, other than the defendant, who is claiming the ownership or the right to the possession thereof, the sheriff, in his or her discretion, may require the plaintiff suing out the writ to furnish a bond, payable to such sheriff, in a sum not exceeding the reasonable value of the described property, as fixed by such sheriff, with sureties satisfactory to him or her conditioned to hold the sheriff harmless against liability for any loss or damage that might be sustained by anyone whomsoever by reason of his or her levying upon such described property, and indemnifying him or her for any expense (including reasonable attorney's fees) incurred by reason of any such claim.

(4) If the sheriff, in attempting to execute any writ not describing specific property, shall be requested to levy upon any property other than that described in subsection (1), he or she may require the plaintiff suing out the writ to furnish a bond upon the terms and conditions prescribed in subsection (3).

(5) Whenever a party suing out any writ shall demand that the sheriff levy upon specific property and anyone, other than the defendant, shall claim the ownership or right of possession thereof, the sheriff, at his or her option, may file a petition in the court out of which the writ issued and procure a rule to issue to the plaintiff and to the party so claiming the property or the right to possession thereof, to show cause why the levy should or should not be made; provided, that if the issue shall involve the titles or boundaries of real estate, the petition shall be filed in the circuit court. The judge of such court, after due notice to all parties in interest, shall determine whether or not such property is subject to levy under the writ. Any party aggrieved by such ruling, including the sheriff, may appeal therefrom, as from a final decree in a chancery cause, and may have a supersedeas upon such terms and conditions as the judge shall fix. In the event the property is ultimately held to be subject to the writ, the plaintiff's writ shall have priority over any writs levied subsequent to the date upon which the plaintiff's writ was delivered to the sheriff.

(6) No sheriff shall be liable for making any levy pursuant to the specific order of a court of competent jurisdiction.

History.—ss. 1, 2, 3, 4, 5, 6, ch. 22019, 1943; s. 3, ch. 77-234; s. 27, ch. 81-259; s. 2, ch. 82-118; s. 186, ch. 95-147.

30.46 Sheriffs; motor vehicles color combination; badges; simulation prohibited; penalties.—

(1) The color combination of forest green and white is adopted as the official color for use on the motor vehicles and motorcycles used by the various sheriffs of Florida and their deputies.

(2) For purposes of uniformity and in aid of the recognition of their official identity by the public, a badge in the shape of a five-pointed star with a replica of the great seal of Florida with the map of Florida superimposed thereon inscribed in the center is designated as the official badge to be worn by the sheriffs and deputy sheriffs of all counties of the state.

(3) It shall be unlawful for any person other than the sheriffs of Florida and their deputies, to color or cause to be colored any motor vehicle or motorcycle the same or similar color combination prescribed herein; provided, however, that any municipal police department or other law enforcement agency or any private person or concern using the same or similar color combination as of the date of this act shall be permitted to continue to use such colors until such time as new colors are adopted by such agencies, or private person or concern.

(4) It shall be unlawful for any person other than sheriffs and deputy sheriffs to wear an official sheriff's badge as prescribed herein, or to wear a badge or insignia of such similarity to the official sheriff's badge as to be indistinguishable therefrom at a distance of 20 feet; provided, nothing therein shall be construed to prevent members of any military, fraternal, or similar organization or any other law enforcement officer from wearing any insignia officially adopted or worn prior to the effective date of this section.

(5) Violation of any of the provisions of this act shall be a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

History.—ss. 1, 2, 3, 4, 5, ch. 57-3; s. 13, ch. 71-136.

30.48 Salaries.—Each sheriff shall receive for the performance of official duties as sheriff an annual salary, which shall be payable monthly, twice per month, or biweekly; provided, that compensation for service in office for a part of a calendar month shall be paid in the proportion that the days served bear to the number of days in that month.

History.—s. 2, ch. 57-368; s. 1, ch. 59-216; s. 16, ch. 77-104; s. 1, ch. 88-212; s. 187, ch. 95-147.

30.49 Budgets.—

(1) Pursuant to s. 129.03(2), each sheriff shall annually prepare and submit to the board of county commissioners a proposed budget for carrying out the powers, duties, and operations of the office for the next fiscal year. The fiscal year of the sheriff commences on October 1 and ends September 30 of each year.

(2)(a) The proposed budget must show the estimated amounts of all proposed expenditures for operating and equipping the sheriff's office and jail, excluding the cost of construction, repair, or capital improvement of county buildings during the fiscal year. The expenditures must be categorized at the appropriate fund level in accordance with the following functional categories:

1. General law enforcement.

2. Corrections and detention alternative facilities.

3. Court services, excluding service of process.

(b) The sheriff shall submit a sworn certificate along with the proposed budget stating that the proposed expenditures are reasonable and necessary for the proper and efficient operation of the office for the next fiscal year.

(c) Within the appropriate fund and functional category, expenditures must be itemized in accordance with the uniform accounting system prescribed by the Department of Financial Services, as follows:

1. Personnel services.

2. Operating expenses.

3. Capital outlay.

4. Debt service.

5. Grants and aids.

6. Other uses.

(d) The sheriff shall submit to the board of county commissioners for consideration and inclusion in the county budget, as deemed appropriate by the county, requests for construction, repair, or capital improvement of county buildings operated or occupied by the sheriff.

(3) The sheriff shall furnish to the board of county commissioners or the budget commission, if there is a budget commission in the county, all relevant and pertinent information concerning expenditures made in previous fiscal years and proposed expenditures which the board or commission deems necessary, including expenditures at the subobject code level in accordance with the uniform accounting system prescribed by the Department of Financial Services. The board or commission may not amend, modify, increase, or reduce any expenditure at the subobject code level. The board or commission may not require confidential information concerning details of investigations which is exempt from s. 119.07(1).

(4) The board of county commissioners or the budget commission, as appropriate, may require the sheriff to correct mathematical, mechanical, factual, and clerical errors and errors as to form in the proposed budget. At the hearings held pursuant to s. 200.065, the board or commission may amend, modify, increase, or reduce any or all items of expenditure in the proposed budget, as certified by the sheriff pursuant to paragraphs (2)(a)-(c), and shall approve such budget, as amended, modified, increased, or reduced. The board or commission must give written notice of its action to the sheriff and specify in such notice the specific items amended, modified, increased, or reduced. The budget must include the salaries and expenses of the sheriff's office, cost of operation of the county jail, purchase, maintenance and operation of equipment, including patrol cars, radio systems, transporting prisoners, court duties, and all other salaries, expenses, equipment, and investigation expenditures of the entire sheriff's office for the previous year.

(a) The sheriff, within 30 days after receiving written notice of such action by the board or commission, in person or in his or her office, may file an appeal by petition to the Administration Commission. The petition must set forth the budget proposed by the sheriff, in the form and manner prescribed by the Executive Office of the Governor and approved by the Administration Commission, and the budget as approved by the board of county commissioners or the budget commission and shall contain the reasons or grounds for the appeal. Such petition shall be filed with the Executive Office of the Governor, and a copy served upon the board or commission from the decision of which appeal is taken by delivering the same to the chair or president thereof or to the clerk of the circuit court.

(b) The board or commission shall have 5 days following delivery of a copy of such petition to file a reply with the Executive Office of the Governor, and shall deliver a copy of such reply to the sheriff.

(5) Upon receipt of the petition, the Executive Office of the Governor shall provide for a budget hearing at which the matters presented in the petition and the reply shall be considered. A report of the findings and recommendations of the Executive Office of the Governor thereon shall be promptly submitted to the Administration Commission, which, within 30 days, shall either approve the action of the board or commission as to each separate item, or approve the budget as proposed by the sheriff as to each separate item, or amend or modify the budget as to each separate item within the limits of the proposed board of expenditures and the expenditures as approved by the board of county commissioners or the budget commission, as the case may be. The budget as approved, amended, or modified by the Administration Commission shall be final.

(6) The board of county commissioners and the budget commission, if there is a budget commission within the county, shall include in the county budget the items of proposed expenditures as set forth in the budget required by this section to be submitted, after the budget has been reviewed and approved as provided herein; and the board or commission, as the case may be, shall include the reserve for contingencies provided herein for each budget of the sheriff in the reserve for contingencies in the budget of the appropriate county fund.

(7) The reserve for contingencies in the budget of a sheriff shall be governed by the same provisions governing the amount and use of the reserve for contingencies appropriated in the county budget, except that the reserve for contingency in the budget of the sheriff shall be appropriated upon written request of the sheriff.

(8) The items placed in the budget of the board of county commissioners pursuant to this law shall be subject to the same provisions of law as the county annual budget; except that no

amendments may be made to the appropriations for the sheriff's office except as requested by the sheriff.

(9) The proposed expenditures in the budget shall be submitted to the board of county commissioners or budget commission, if there is a budget commission within the county, by June 1 each year; and the budget shall be included by the board or commission, as the case may be, in the budget of either the general fund or the fine and forfeiture fund, or in part of each.

(10) If in the judgment of the sheriff an emergency should arise by reason of which the sheriff would be unable to perform his or her duties without the expenditure of larger amounts than those provided in the budget, he or she may apply to the board of county commissioners for the appropriation of additional amounts. If the board of county commissioners approves the sheriff's request, no further action is required on either party. If the board of county commissioners disapproves a portion or all of the sheriff's request, the sheriff may apply to the Administration Commission for the appropriation of additional amounts. The sheriff shall at the same time deliver a copy of the application to the Administration Commission, the board of county commissioners, and the budget commission, if there is a budget commission within the county. The Administration Commission may require a budget hearing on the application, after due notice to the sheriff and to the boards, and may grant or deny an increase or increases in the appropriations for the sheriff's offices. If any increase is granted, the board of county commissioners, and the budget commission, if there is a budget commission in the county, shall amend accordingly the budget of the appropriate county fund or funds. Such budget shall be brought into balance, if possible, by application of excess receipts in such county fund or funds. If such excess receipts are not available in sufficient amount, the county fund budget or budgets shall be brought into balance by adding an item of "Vouchers unpaid" in the appropriate amount to the receipts side of the budget, and provision for paying such vouchers shall be made in the budget of the county fund for the next fiscal year.

(11) Notwithstanding any provision of law to the contrary, a sheriff may include a clothing and maintenance allowance for plainclothes deputies within his or her budget.

History.—s. 3, ch. 57-368; ss. 3, 4, ch. 59-216; ss. 12, 28, 35, ch. 69-106; s. 7, ch. 71-355; s. 7, ch. 73-349; s. 1, ch. 74-103; s. 17, ch. 77-104; s. 85, ch. 79-190; s. 28, ch. 81-259; s. 1, ch. 82-33; s. 12, ch. 82-154; s. 1, ch. 83-204; s. 35, ch. 84-254; s. 9, ch. 90-360; s. 188, ch. 95-147; s. 1, ch. 95-169; s. 12, ch. 96-406; s. 22, ch. 97-96; s. 2, ch. 2002-193; s. 91, ch. 2003-261; s. 2, ch. 2011-144.

30.50 Payment of salaries and expenses.—

(1) The sheriff shall requisition and the board of county commissioners shall pay him or her, at the first meeting in October of each year, and each month thereafter, one-twelfth of the total amount budgeted for the office; provided, that at the first meeting in January of each year, the board shall, at the request of the sheriff, pay one-sixth of the total appropriated, and one-twelfth each month thereafter, which payments shall be not more than the total appropriation. Provided further that any part of the amount budgeted for equipment shall be paid at any time during the year upon the request of the sheriff.

(2) The sheriff shall deposit the county warrant or warrants in his or her official bank account as provided in s. 30.51(3) and draw his or her own checks thereon in payment of the salaries of the sheriff and his or her deputies, clerks, and employees and the expenses of office. All salaries paid shall be supported by payrolls, and all expenses paid shall be supported by approved bills; provided, that the sheriff may draw a check to himself or herself for the expense of an investigation, and may note on the voucher only the information that he or she may consider proper to divulge.

(3) The sheriff may set up a revolving fund for payment in cash of small items. The revolving fund shall be reimbursed from time to time by payment of the vouchers representing the cash payments.

(4) The sheriff shall keep necessary budget accounts and records, and shall charge all paid bills and payrolls to the proper budget accounts. The reserve for contingencies, or any part thereof, may be transferred to any of the budget appropriations, in the discretion of the sheriff. With the approval of the board of county commissioners, or of the budget commission if there is a budget commission in the county, the budget may be amended as provided for county budgets in s. 129.06(2).

(5) All expenses incurred in the fiscal year for which the budget is made shall be vouchered and charged to the budget for that year, and to carry out this purpose the books may be held open for 30 days after the end of the year.

(6) All unexpended balances at the end of each fiscal year shall be refunded to the board of county commissioners, and deposited to the county fund or funds from which payment was originally made.

History.—s. 4, ch. 57-368; s. 189, ch. 95-147.

30.501 Bailiffs' meals and lodging.—The sheriff may provide meals and lodging to bailiffs appointed by the sheriff who, by order of any court, provide security to sequestered juries.

History.—s. 2, ch. 88-212.

30.51 Fees and commissions.—

(1) No bills shall be rendered to the county for any services, nor shall any fees, commissions, or other remuneration for official services as sheriff be paid by the board of county commissioners of any county to the sheriff of the county except as provided by this section. All fees, commissions and other remuneration provided by law for services other than criminal shall be charged by the said sheriff to other authorities and parties doing business with their offices, and shall be paid over to the county as provided in this section.

(2) The fees authorized, or a deposit sufficient to cover them, shall be collected in advance from the party who requests the service; provided, that services may be performed for any governmental agency or unit without advance payment, and the officer shall bill and collect the fees earned from such agency after the service is performed or when the amount due is determined.

(3) Deposits for fees shall be placed in a depository trust account. The officer who receives the deposit shall keep an account with the depositor, and shall withdraw monthly from the deposits the fees earned and shall remit them to the county fund or funds as provided by this section.

(4) Fees or commissions commingled when received with other official collections may be deposited with such other collections in the trust account or accounts and distributed to the county fund or funds at the time that the other collections, with which they were received, are distributed.

(5) All fees, commissions, or other funds collected by the sheriff for services rendered or performed by his or her office shall be remitted monthly to the county.

(6) No sheriff shall render to another county a bill for service of process in any criminal matter.

History.—s. 5, ch. 57-368; s. 1, ch. 59-365; s. 8, ch. 69-82; s. 190, ch. 95-147; s. 26, ch. 2001-266.

30.52 Handling of public funds.—The sheriff shall keep public funds in his or her custody, either in his or her office in an amount not in excess of the burglary, theft, and robbery insurance provided, the cost of which is hereby authorized as an expense of the office, or in a depository in an amount not in excess of the security provided pursuant to s. 658.60 and the regulations of the Department of Financial Services. The title of the depository accounts shall include the word "sheriff" and the name of the county, and withdrawals from the accounts shall be made by checks

signed by the duly qualified and acting sheriff of the county, or his or her designated deputy or agent.

History.—s. 6, ch. 57-368; ss. 12, 35, ch. 69-106; s. 147, ch. 80-260; s. 191, ch. 95-147; s. 92, ch. 2003-261.

30.53 Independence of constitutional officials.—The independence of the sheriffs shall be preserved concerning the purchase of supplies and equipment, selection of personnel, and the hiring, firing, and setting of salaries of such personnel; provided that nothing herein contained shall restrict the establishment or operation of any civil service system or civil service board created pursuant to s. 14, Art. III, of the Constitution of Florida, provided, further that nothing contained in ss. 30.48-30.53 shall be construed to alter, modify or change in any manner any civil service system or board, state or local, now in existence or hereafter established.

History.—s. 7, ch. 57-368; s. 36, ch. 69-216.

30.555 Liability insurance.—The sheriff may obtain insurance to cover liability for damages arising out of claims for false arrests, false imprisonment, false or improper service of process, or other claims arising out of the performance of his or her duties or the duties of his or her deputies or employees and may pay the premiums for such insurance from funds appropriated for the necessary and regular expenses of office without specific appropriation or specification of expenses with respect thereto.

History.—s. 1, ch. 88-103; s. 192, ch. 95-147.

30.56 Release of traffic violator on recognizance or bond; penalty for failure to appear.—In all cases of arrest for traffic violations, by a sheriff or a deputy sheriff, the person arrested may in the discretion of such officer be released upon his or her own recognizance or upon bond provided said officer shall obtain from such person arrested a recognizance or, if deemed necessary, a cash bond or other sufficient security conditioned for his or her appearance before the proper tribunal of such county to answer the charge for which he or she has been arrested. Any person who is so arrested and released on his or her own recognizance by an officer and given a written summons to appear before the proper tribunal of such county to answer the charge for which arrested and who shall fail to appear or respond to such summons shall, in addition to the traffic violation charge, be guilty of a noncriminal traffic infraction subject to the penalty provided in s. 318.18(2).

History.—s. 1, ch. 59-97; s. 14, ch. 71-136; s. 1, ch. 72-244; s. 2, ch. 87-288; s. 193, ch. 95-147.

Note.—Former s. 146.08.

[1]**30.60 Establishment of neighborhood crime watch programs.**—A county sheriff or municipal police department may establish neighborhood crime watch programs within the county or

municipality. The participants of a neighborhood crime watch program shall include, but need not be limited to, residents of the county or municipality and owners of businesses located within the county or municipality.

History.—s. 1, ch. 2004-18.

[1]**Note.**—Also published at s. 166.0485.

Appendix C
Community Mental Health Act of 1963

282 PUBLIC LAW 88-164-OCT. 31, 1963 [7
7 STAT.

Public Law 88-164

October 3 1 , 1963
[S. 1576]

AN ACT

To provide assistance in combating mental retardation through grants for construction of research centers and grants for facilities for the mentally retarded and assistance in improving mental health through grants for construction of community mental health centers, and for other purposes.

Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

Be it enacted hy the Seriate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963".

TITLE I—CONSTRUCTION OF RESEARCH CENTERS AND FACILITIES FOR THE MENTALLY RETARDED

SHORT TITLE

SEC. 100. This title may be cited as the "Mental Retardation Facilities Construction Act".

PART A—GRANTS FOR CONSTRUCTION or CENTERS FOR RESEARCH ON MENTAL RETARDATION AND RELATED ASPECTS OF HUMAN DEVELOPMENT

70 Stat. 717; Ante, p . 164.

SEC. 101. Title V I I of the Public Health Service Act is amended by adding at the end thereof the following new part:

42 u s e 292-

292i.

"PART D—CENTERS FOR RESEARCH ON MENTAL RETARDATION AND

RELATED ASPECTS OF H U M A N DEVELOPMENT

a A U T H O R I Z A T I O N OF APPROPRIATIONS

"SEC. 761. There are authorized to be appropriated $6,000,000 for the fiscal year ending June 30, 1964, $8,000,000 for the fiscal yea

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ending June 30, 1965, and $6,000,000 each for the fiscal year ending June 30, 1966, and the fiscal year ending June 30, 1967, for project grants to assist in meeting the costs of construction of facilities for research, or research and related purposes, relating to human development, whether biological, medical, social, or behavioral, which may assist in finding the causes, and means of prevention, of .mental retardation, or in finding means of ameliorating the ejffects of mental retardation. Sums so appropriated shall remain available until expended for payments with respect to projects or which applications have been filed under this part before July 1, 1967, and approved by the Surgeon General thereunder before July 1,1968.

((A P P L I C A T I O N S

"SEC. 762. (a) Applications for grants under this part with respect to any facility may be approved by the Surgeon General only if—

"(1) the applicant is a public or nonprofit institution which the Surgeon General determines is competent to engage in the type of research for which the facility is to be constructed; and

(2) the application contains or is supported by reasonable assurances that (A) for not less than twenty years after completion of construction, the facility will be used for the research

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or research and related purposes, for which it was constructed; (B) sufficient funds will be available for meeting the non-Federal

share of the cost of constructing the facility; (C) sufficient fund
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will be available, when the construction is completed, for effective

use of the facility for the research, or research and related pur-

poses, for which it was constructed; and (D) all laborers and

mechanics employed by contractors or subcontractors in the per-

formance of work on construction of the center will be paid

wages at rates not less than those prevailing on similar con-

struction in the locality as determined by the Secretary of Labor

in accordance with the Davis-Bacon Act, as amended (40 U.S.C.

276a–276a-540 U.S.C.

276a–276a-540 U.S.C.

276a–276a-540 U.S.C.

276a–276a-540 U.S.C.

276a–276a-540 U.S.C.

276a–276a-540 U.S.C.

276a–276a-5); and the Secretary of Labor shall have, with 49stat. ion.

respect to the labor standards specified in this clause (D) the

authority and functions set forth in Eeorganization Plan

Numbered 14 of 1950 (15 F.E. 3176; 5 U.S.C. 133z-155 U.S.C. 133z-155 U.S.C. 133z-155 U.S.C. 133z-155 U.S.C. 133z-15), and 64 stat. i267.

section 2 of the Act of June 13, 1934, as amended (40 U.S.C.

276c). 63 Stat. 108.

" (b) In acting on applications for grants, the Surgeon General shall take into consideration the relative effectiveness of the proposed facilities in expanding the Nation's capacity for research and related purposes in the field of mental retardation and related aspects of human development, and such other factors as he, after consultation with the national advisory council or councils concerned with the field or fields of research involved, may by regulation prescribe in order to assure that the facilities constructed with such grants, severally and together, will best serve the purpose of advancing scientific knowledge pertaining to mental retardation and related aspects of human development.

" A M O U N T o r GRANTS ; PAYMENTS

"SEC. 763. (a) The total of the grants with respect to any project for the construction of a facility under this part may not exceed 75 per centum of the necessary cost of construction of the center as determined by the Surgeon General.

" (b) Payments of grants under this part shall be made in advance or by way of reimbursement, in such installments consistent with construction progress, and on such conditions as the Surgeon General may determine.

"(c) No grant may be made after January 1, 1964, under any provision of this Act other than this part, for any of the four fiscal

years in the period beginning July 1, 1963, and ending June 30, 1967, for construction of any facility described in this part, unless the Surgeon General determines that funds are not available under this part to make a grant for the construction of such facility.

"RECAPTURE OF PAYMENTS

"SEC. 764. If, within twenty years after completion of any construction for which funds have been paid under this part—

"(1) the applicant or other owner of the facility shall cease to be a public or nonprofit institution, or

"(2) the facility shall cease to be used for the research purposes, or research and related purposes, for which it was constructed, unless the Surgeon General determines, in accordance with regulations, that there is good cause for releasing the applicant or other owner from the obligation to do so,

the L^ited States shall be entitled to recover from the applicant or other owner of the facility the amount bearing the same ratio to the then value (as determined by agreement of the parties or by action brought in the United States district court for the district in which such facility is situated) of the facility, as the amount of the Federal participation bore to the cost of construction of such facility.

((NONINTERFERENCE WITH ADMINISTRATION OF INSTITUTIONS

"SEC. 765. Excej)t as otherwise specifically provided in this part, nothing contained in this part shall be construed as authorizing any department, agency, officer, or employee of the United States to exercise any direction, supervision, or control over, or impose any requirement or condition with respect to, the research or related purposes conducted by, and the personnel or administration of, any institution.

uDEFINITIONS

"SEC. 766. As used in this part—

"(1) the terms 'construction' and 'cost of construction' include (A) the construction of new buildings and the expansion, remodeling, and alteration of existing buildings, including architects' fees, but not including the cost of acquisition of land or off-site improvements, and (B) equipping new buildings and existing buildings, whether or not expanded, remodeled, or altered;

"(2) the term 'nonprofit institution' means an institution owned and operated by one or more corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual."

PART B — P R O J E C T GRANTS FOR CONSTRUCTION OF UNIVERSITY-

AFFILIATED FACILITIES FOR THE MENTALLY RETARDED

AUTHORIZATION OF APPROPRIATIONS

SEC. 121. For the purpose of assisting in the construction of clinical facilities providing, as nearly as practicable, a full range of inpatient and outpatient services for the mentally retarded and facilities which will aid in demonstrating provision of specialized services for the diagnosis and treatment, education, training, or care of the mentally retarded or in the clinical training of physicians and other specialized personnel needed for research, diagnosis and treatment, education, training, or care of the mentally retarded, there are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1964, $7,500,000 for the fiscal year ending June 30, 1965, and $10,000,000 each for the fiscal year ending J u n e 30,1966, and the fiscal year ending June 30, 1967. The sums so appropriated shall be used for project grants for construction of public and other nonprofit facilities for the mentally retarded which are associated with a college or university.

APPLICATIONS

SEC. 122. Applications for grants under this part with respect to any facility may be approved by the Secretary only if the application contains or is supported by reasonable assurances that—

(1) the facility will be associated, to the extent prescribed in regulations of the Secretary, with a college or university hospital (including affiliated hospitals), or with such other part of a college or university as the Secretary may find appropriate in the light of the purposes of this p a r t ;

(2) the plans and specifications are in accord with regulations prescribed by the Secretary under section 133 (3) ;

(3) title to the site for the project is or will be vested in one or more of the agencies or institutions filing the application or in a public or other nonprofit agency or institution which is to operate the facility;

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(4) adequate financial support will be available for construction of the project and for its maintenance and operation when completed; and

(5) all laborers and mechanics employed by contractors or subcontractors in the performance of work on construction of the project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as

amended (40 U.S.C. 276a–276a-540 U.S.C. 276a–276a-540 U.S.C. 276a–276a-540 U.S.C. 276a–276a-540 U.S.C. 276a–276a-540 U.S.C. 276a–276a-540 U.S.C. 276a–276a-5); and the Secretary of Labor
49 stat. 1011.

shall have with respect to the labor standards specified in this

paragraph the authority and functions set forth in Reorganiza-

tion Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z-155 U.S.C. 133z-155 U.S.C. 133z-155 U.S.C. 133z-155 U.S.C. 133z-15) 64 stat. 1257.

and section 2 of the Act of June 13, 1934, as amended (40 U.S.C.

276c). 63 Stat. 108.

A M O U N T OF G R A N T S ; PAYMENTS

SEC. 123. (a) The total of the grants with respect to any project for the construction of a facility under this part may not exceed 75 per centum of the necessary cost of construction thereof as determined by the Secretary.

(b) Payments of grants under this part shall be made in advance or by way of reimbursement, in such installments consistent with construction progress, and on such conditions as the Secretary may determine.

RECOVERY

SEC. 124. If any facility with respect to which funds have been paid under this part shall, at any time within twenty years after the completion of construction—

(1) be sold or transferred to any person, agency, or organization which is not qualified to file an application under this part, or

(2) cease to be a public or other nonprofit facility for the mentally retarded, unless the Secretary determines, in accord-

ance with regulations, that there is good cause for releasing the applicant or other owner from the obligation to continue such facility as a public or other nonprofit facility for the mentally retarded,

the United States shall be entitled to recover from either the transferor or the transferee (or, in the case of a facility which has ceased to be a public or other nonprofit facility for the mentally retarded, from the ow^ners thereof) an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the facility is situated) of so much of the facility as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction of such project or projects.

NONDUPLICATION OF GRANTS

SEC. 125. No grant may be made after January 1, 1964, under any provision of the Public Health Service Act, for any of the four fiscal years in the period beginning July 1, 1963, and ending June 30, 1967, for construction of any facility for the mentally retarded described in this part, unless the Secretary determines that funds are not available under this part to make a grant for the construction of such facility.

^^ stat. 682.
42 use 201 note.

PART C — G R A N T S FOR CONSTRUCTION OF FACILITIES FOR THE MENTALLY RETARDED

AUTHORIZATION OF APPROPRIATIONS

SEC. 131. There are authorized to be appropriated, for grants for construction of public and other nonprofit facilities for the mentally retarded, $10,000,000 for the fiscal year ending June 30, 1965, $12,500,000 for the fiscal year ending June 30, 1966, $15,000,000 for the fiscal year ending June 30, 1967, and $30,000,000 for the fiscal year ending June 30,1968.

ALLOTMENTS TO STATES

SEC. 132. (a) For each fiscal year, the Secretary shall, in accordance with regulations, make allotments from the sums appropriated under section 131 to the several States on the basis of (1) the population, (2) the extent of the need for facilities for the mentally retarded, and (3) the financial need of the respective States; except that no such allotment to any State, other than the Virgin Islands, American Samoa, and Guam, for any fiscal year may be less than $100,000. Sums so allotted to a State for a fiscal year for con-

struction and remaining unobligated at the end of such year shall remain available to such State for such purpose for the next fiscal year (and for such year only), in addition to the sums allotted, to such State for such next fiscal year.

(b) In accordance with regulations of the Secretary, any State may file with him a request that a specified portion of its allotment under this part be added to the allotment of another State under this part for the purpose of meeting a portion of the Federal share of the cost of a project for the construction of a facility for the mentally retarded in such other State. If it is found by the Secretary that construction of the facility with respect to which the request is made would meet needs of the State making the request and that use of the specified portion of such State's allotment, as requested by it, would assist in carrying out the purposes of this part, such portion of such State's allotment shall be added to the allotment of the other State under this part, to be used for the purpose referred to above.

(c) Upon the request of any State that a specified portion of its allotment under this part be added to the allotment of such State under title I I , and upon (1) the simultaneous certification to the Secretary by the State agency designated as provided in the State plan approved under this part to the effect that it has afforded a reasonable opportunity to make applications for the portion so specified and there have been no approvable applications for such por-

tion, or (2) a showing satisfactory to the Secretary that the need for the community mental health centers in such State is substantially greater than for the facilities for the mentally retarded, the Secretary shall, subject to such limitations as he may by regulations prescribe, promptly adjust the allotments of such State in accordance with such request and shall notify such State agency and the State agency designated under the State plan approved under title I I , and thereafter the allotments as so adjusted shall be deemed the State's allotments for purposes of this part and title I I .

REGULATIONS

SEC. 133. Within six months after enactment of this Act, the Secretary shall, after consultation with the Federal Hosj)ital Council (established by section 633 of the Public Health Service Act and eo st^at. io48. hereinafter in this part referred to as the "Council"), by general 42 u s e 291k. regulations applicable uniformly to all the States, prescribe—

(1) the kinds of services needed to provide adequate services for mentally retarded persons residing in a State;

(2) the general manner in which the State agencj (designated as provided in the State plan approved under this part) shall determine the priority of projects based on the relative need of different areas, giving special consideration to facilities which

will provide comprehensive services for a particular community or communities;

(3) general standards of construction and equipment for facilities of different classes and in different types or location; and

(4) that the State plan shall provide for adequate facilities for the mentally retarded for persons residing in the State, and shall provide for adequate facilities for the mentally retarded to furnish needed services for persons unable to pay therefor. Such regulations may require that before approval of an application for a facility or addition to a facility is recommended by a State agency, assurance shall be received by the State from the applicant that there will be made available in such facility or addition a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

STATE PLANS

SEC. 134. (a) After such regulations have been issued, any State desiring to take advantage of this part shall submit a State plan for carrying out its purposes. Such State plan must—

(1) designate a single State agency as the sole agency for the administration of the plan, or designate such agency as the sole agency for supervising the administration of the plan;

(2) contain satisfactory evidence that the State agency designated in accordance with paragraph (1) hereof will have authority to carry out such plan in conformity with this part;

(3) provide for the designation of a State advisory council which shall include representatives of State agencies concerned with planning, operation, or utilization of facilities for the mentally retarded and of nongovernment organizations or groups concerned with education, employment, rehabilitation, welfare, and health, and including representatives of consumers of the services provided by such facilities;

(4) set forth a program for construction of facilities for the mentally retarded (A) which is based on a statewide inventory of existing facilities and survey of need; (B) which conforms with the regulations prescribed under section 133(1); and (C) which meets the requirements for furnishing needed services to persons unable to pay therefor, included in regulations prescribed under section 133(4);

(5) set forth the relative need, determined in accordance with the regulations prescribed under section 133(2), for the several projects included in such programs, and provide for the construction, insofar as financial resources available therefor and for

maintenance and operation make possible, in the order of such relative need;

(6) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(7) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of facilities which receive Federal aid under this part;

(8) provide for affording to every applicant for a construction project an opportunity for hearing before the State agency;

(9) provide that the State agency will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports; and

(10) provide that the State agency will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) The Secretary shall approve any State plan and any modification thereof which complies with the provisions of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

APPROVAL OF PROJECTS

SEC. 135. (a) For each project for construction pursuant to a State plan approved under this part, there shall be submitted to the Secretary through the State agency an application by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more such agencies join in the construction of the project, the application may be filed by one or more of such agencies. Such application shall set forth—

(1) a description of the site for such project;

(2) plans and specifications therefor in accordance with the regulations prescribed by the Secretary under section 133(3);

(3) reasonable assurance that title to such site is or will be vested in one or more of the agencies filing the application or in a public or other nonprofit agency which is to operate the facility;

(4) reasonable assurance that adequate financial support will be available for the construction of the project and for its maintenance and operation when completed;

(5) reasonable assurance that all laborers and mechanics em-

ployed by contractors or subcontractors in the performance of

work on construction of the project will be paid wages at rates

not less than those prevailing on similar construction in the

locality as determined by the Secretary of Labor in accordance

with the Davis-Bacon Act, as amended (40 U.S.C. 276a–40 U.S.C. 276a–40 U.S.C. 276a–40 U.S.C. 276a–40 U.S.C. 276a–

49 Stat. 1011. 276a-5); and the Secretary of Labor shall have with respect to

the labor standards specified in this paragraph the authority and

functions set forth in Reorganization Plan Numbered 14 of 1950

64 Stat. 1267. (15 F.R. 3176; 5 U.S.C. 133z-155 U.S.C. 133z-155 U.S.C. 133z-155 U.S.C. 133z-155 U.S.C. 133z-15) and section 2 of the Act of

63 Stat. 108. j^j^g -^3^ ^93^^ ^g ajnended (40 U.S.C. 276c) ; and

(6) a certification by the State agency of the Federal share for

the project.

The Secretary shall approve such application if sufficient funds to

pay the Federal share of the cost of construction of such project

are available from the allotment to the State, and if the Secretary

finds (A) that the application contains such reasonable assurance

as to title, financial support, and payment of prevailing rates of

wages and overtime pay; (B) that the plans and specifications are

in accord with the regulations prescribed pursuant to section 133;

(C) that the application is in conformity with the State plan

approved under section 134 and contains an assurance that in the

operation of the facility there will be compliance with the applicable requirements of the State plan and of the regulations prescribed under section 133(4) for furnishing needed facilities for persons unable to pay therefor, and with State standards for operation and maintenance; and (D) that the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State in accordance with the regulations prescribed pursuant to section 133(2). No application shall be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing.

(b) Amendment of any approved application shall be subject to approval in the same manner as an original application.

WITHHOLDING OF PAYMENTS

SEC. 136. Whenever. the Secretary after reasonable notice and opportunity for hearing to the State agency designated as provided in section 134(a) (1), finds—

(1) that the State agency is not complying substantially with the provisions required by section 134 to be included in its State plan or with regulations under this part;

(2) that any assurance required to be given in an application filed under section 135 is not being or cannot be carried out;

(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 135; or

(4) that adequate State funds are not being provided annually for the direct administration of the State plan,

the Secretary may forthwith notify the State agency that—

(5) no further payments will be made to the State from allotments under this part; or

(6) no further payments will be made from allotments under this part for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph (1), (2), (3), or (4) of this section,

as the Secretary may determine to be appropriate under the circumstances; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments from such allotments may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurance or plans and specifications or to provide adequate State funds, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

NONDUPLICATION OF GRANTS

SEC. 137. No grant may be made after January 1, 1964, under any provision of the Public Health Service Act, for any of the four fiscal ^s stat. 682. years in the period beginning July 1, 1964, and ending June 30, 1968, "^^ ^°^ "°''-

for construction of any facility for the mentally retarded described

in this part, unless the Secretary determines that funds are not avail-

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able under this part to make a grant for the construction of such

facility.

TITLE II—CONSTEUCTION OF COMMUNITY MENTAL HEALTH CENTEES

SHORT TITLE

Citation of ""'.

SEC. 200. This title may be cited as the "Community Mental Health Centers Act".

AUTHORIZATION OF APPROPRIATIONS

SEC. 201. There are authorized to be appropriated, for grants for construction of public and other nonprofit community mental health centers, $35,000,000 for the fiscal year ending June 30, 1965, $50,000,000 for the fiscal year ending June 30, 1966, and $65,000,000 for the fiscal year ending June 30,1967.

ALLOTMENTS TO STATES

SEC. 202. (a) For each fiscal year, the Secretary shall, in accordance with regulations, make allotments from the sums appropriated under section 201 to the several States on the basis of (1) the population, (2) the extent of the need for community mental health centers, and (3) the financial need of the respective States; except that no such allotment to any State, other than the Virgin Islands, American Samoa, and Guam, for any fiscal year may be less than $100,000. Sums so allotted to a State for a fiscal year and remaining unobligated at the end of such year shall remain available to such State for such purpose for the next fiscal year (and for such year only), in addition to the sums allotted for such State for such next fiscal year.

(b) In accordance with regulations of the Secretary, any State may file with him a request that a specified portion of its allotment under this title be added to the allotment of another State under this title for the purpose of meeting a portion of the Federal share of the cost of a project for the construction of a community mental health center in such other State. If it is found by the Secretary that construction of the center with respect to which the request is made would meet needs of the State making the request and that use of the specified portion of such State's allotment, as requested by it, would assist in carrying out the purpose^ of this title, such portion of such State's allotment shall be added to the allotment of the other State under this title to be used for the purpose referred to above.

(c) Upon the request of any State that a specified portion of its

allotment under this title be added to the allotment of such State under part C of title I and upon (1) the simultaneous certification to the Secretary by the State agency designated as provided in the State plan approved under this title to the effect that it has afforded a reasonable opportunity to make applications for the portion so specified and there have been no approvable applications for such portion or (2) a showing satisfactory to the Secretary that the need for facilities for the mentally retarded in such State is substantially greater than for community mental health centers, the Secretary shall, subject to such limitations as he may by regulation prescribe, promptly adjust the allotments of such State in accordance with such request and shall notify such State agency and the State agency designated under the State plan approved under part C of title I , and thereafter the allotments as so adjusted shall be deemed the State's allotments for purposes of this title and part C of title I.

REGULATIONS

SEC. 203. Within six months after enactment of this Act, the Secretary shall, after consultation with the Federal Hospital Council (established by section 633 of the Public Health Service Act) eo stat. io48. and the National Advisory Mental Health Council (established by 42 use 291k.

section 217 of the Public Health Service Act), by general regula- 64 stat. 446.
tions applicable uniformly to all the States, prescribe— 42 use 218.

(1) the kinds of community mental health services needed to provide adequate mental health services for persons residing m a State;

(2) the general manner in which the State agency (designated as provided in the State plan approved under this title) shall determine the priority of projects based on the relative need of different areas, giving special consideration to projects on the basis of the extent to which the centers to be constructed there- by will, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, provide comprehensive mental health services (as determined by the Secretary in accordance with regulations) for mentally ill persons in a particular community or com- munities or which will be part of or closely associated with a general hospital;

(3) general standards of construction and equipment for centers of different classes and in different types of location; and

(4) that the State plan shall provide for adequate community mental health centers for people residing in the State, and shall provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor.

Such regulations may require that before approval of an application for a center or addition to a center is recommended by a State agency, assurance shall be received by the State from the applicant that there will be made available in such center or addition a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

STATE PLANS

SEC. 204. (a) After such regulations have been issued, any State desiring to take advantage of this title shall submit a State plan for carrying out its purposes. Such State plan must—

(1) designate a single State agency as the sole agency for the administration of the plan, or designate such agency as the sole agency for supervising the administration of the plan;

(2) contain satisfactory evidence that the State agency designated in accordance with paragraph (1) hereof will have authority to carry out such plan m conformity with this title;

(3) provide for the designation of a State advisory council which shall include representatives of nongovernment organizations or groups, and of State agencies, concerned with planning, operation, or utilization of comm'inity mental health centers or other mental health facilities, including representatives of consumers of the services provided by such centers and facilities

who are familiar with the need for such services, to consult with the State agency in carrying out such plan;

(4) set forth a program for construction of community mental health centers (A) which is based on a statewide inventory of

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existing facilities and survey of need; (B) which conforms with the regulations prescribed by the Secretary under section 203(1); and (C) which meets the requirements for furnishing needed services to persons unable to pay therefor, included in regulations prescribed under section 203(4);

(5) set forth the relative need, determined in accordance with the regulations prescribed under section 203(2), for the several projects included in such programs, and provide for the construction, insofar as financial resources available therefor and for maintenance and operation make possible, in the order of such relative need;

(6) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to

be necessary for the proper and efficient operation of the plan;

(7) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of centers which receive Federal aid under this title;

(8) provide for affording to every applicant for a construction project an opportunity for hearing before the State agency;

(9) provide that the State agency will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports; and

(10) provide that the State agency will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) The Secretary shall approve any State plan and any modification thereof which complies with the provisions of subsection (a) . The Secretary shall not finally disapprove a- State plan except after reasonable notice and opportunity for a hearing to the State.

APPROVAL OF P R O J E C T S

SEC. 205. (a) For each project for construction pursuant to a State plan approved under this title, there shall be submitted to the Secre-

tary through the State agency an application by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more such agencies join in the construction of the project, the application may be filed by one or more of such agencies. Such application shall set forth—

(1) a description of the site for such project;

(2) plans and specifications therefor in accordance with the regulations prescribed by the Secretary under section 203(3);

(3) reasonable assurance that title to such site is or will be vested in one or more of the agencies filing the application or in a public or other nonprofit agency which is to operate the community mental health center;

(4) reasonable assurance that adequate financial support will be available for the construction of the project and for its maintenance and operation when completed;

(5) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on construction of the project will be paid wages at rates not less than those prevailing on similar construction in the

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locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—40 U.S.C. 276a—40 U.S.C. 276a—40 U.S.C. 276a—40 U.S.C. 276a—

276a-5); and the Secretary of Labor shall have with respect to 49 stat. 1011.

the labor standards specified in this paragraph the authority and

functions set forth in Reorganization Plan Numbered 14 of 1950

(15 F.R. 3176; 5 U.S.C. 133z-155 U.S.C. 133z-155 U.S.C. 133z-155 U.S.C. 133z-155 U.S.C. 133z-15) and section 2 of the Act of 64 stat. 1257.

June 13,1934, as amended (40 U.S.C. 276c); and 63 stat. los.

(6) a certification by the State agency of the Federal share for the project.

The Secretary shall approve such application if sufficient funds to pay the Federal share of the cost of construction of such project are available from the allotment to the State, and if the Secretary finds (A) that the application contains such reasonable assurance as to title, financial support, and payment of prevailing rates of wages and overtime pay; (B) that the plans and specifications are in accord with the regulations prescribed pursuant to section 203; (C) that the application is in conformity with the State plan approved under section 204 and contains an assurance that in the operation of the center there will be compliance with the applicable requirements of the State plan and of the regulations prescribed under section 203(4) for furnishing needed services for persons unable to pay therefor, and with State standards for operation and maintenance; (D) that the services to be provided by the center, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, will be part of a program providing, principally for persons residing in a particular community or communities in or near which such center is to be situated,

at least those essential elements of comprehensive mental health services for mentally ill persons which are prescribed by the Secretary in accordance with regulations; and (E) that the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State in accordance with the regulations prescribed pursuant to section 203 (2). No application shall be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing,

(b) AmCTifdment of any approved application shall be subject to approval in the same manner as an original application.

WITHHOLDING OF PAYMENTS

SEC. 206. Whenever the Secretary, after reasonable notice and opportunity for hearing to the State agency designated as provided in section 204 (a) (1) , finds—

(1) that the State agency is not complying substantially with the provisions required by section 204 to be included in its State plan, or with regulations under this title;

(2) that any assurance required to be given in an application filed under section 205 is not being or cannot be carried out;

(3) that there is a substantial failure to carry out plans and sp>ecifications approved by the Secretary under section 205; or

(4) that adequate State funds are not being provided annually for the direct administration of the State plan,

the Secretary may forthwith notify the State agency that—

(6) no further paj^ments will be made to the State from allotments under this title; or

(6) no further payments will be made from allotments under this title for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph (1), (2), (3), or (4) of this section,

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as the Secretary may determine to be appropriate under the circumstances; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments from such allotments may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurance or plans and specifications or to provide adequate State funds, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

NONDUPLICATION OF GRANTS

SEC. 207. No grant may be made after January 1, 1964, under auy provisiou of the Public Health Service Act, for any of the

58 Stat. 682.

note ^^^ ^^^ three fiscal years in the period beginning Jul;^ 1, 1964, and ending June 30, 1967, for construction of any facility described in this title, unless the Secretary determines that funds are not available under this title to make a grant for the construction of such facility.

TITLE III—TRAINING OF TEACHERS OF MENTALLY RETARDED AND OTHER HANDICAPPED CHILDREN

TRAINING OF TEACHERS OF HANDICAPPED CHILDREN

SEC. 301. (a) (1) The second sentence of the first section of the Act

72 Stat. 1777. of September 6, 1958 (Public Law 85-926), is amended by striking

20 use 611. Q^^ "Such grants" and inserting in lieu thereof "Grants under this section" and by striking out "fellowships" and inserting in lieu thereof "fellowships or traineeships".

(2) Such section is further amended by inserting before the second sentence thereof, the following new sentence: "He is also authorized to make grants to public or other nonprofit institutions of higher learning to assist them in providing professional or advanced training for personnel engaged or preparing to engage in employment as teachers of handicapped children, as supervisors of such teachers, or as speech correctionists or other specialists providing special services for education of such children, or engaged or preparing to engage in research in fields related to education of such children."

(3) The first sentence of such section is amended by striking out

"mentally retarded children" and inserting in lieu thereof "mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired children who by reason thereof require special education (hereinafter in this Act referred to as 'handicapped children')".

20 use 612. Section 2 of such Act is amended by striking out "mentally retarded children" and inserting in lieu thereof "handicapped children".

^''p^^^- (4) The second sentence of section 3 of such Act is repealed. Sec-

20 use 617! tio^ ' ^f s^^'^ ^^^ is amended to read as follows:

"SEC. 7. There are authorized to be appropriated for carrying out this Act $11,500,000 for the fiscal year ending June 30,-1964; $14,500,000 for the fiscal year ending June 30, 1965; and $19,500,000 for the fiscal year ending June 30,1966."

(5) The amendments made by this subsection shall apply in the case of fiscal years beginning after June 30, 1963, except that deaf children shall not be included as "handicapped children" for purposes of such amendments for the fiscal year ending June 30,1964.

(b) Effective for fiscal years beginning after J u n e 30, 1964, the first section of such Act is amended by adding at the end thereof the following new sentence: "The Commissioner is also authorized to

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make grants to public or other nonprofit institutions of higher learning to assist them in establishing and maintaining scholarships, with

such stipends as may be determined by the Commissioner, for training personnel preparing to engage in employment as teachers of the deaf."

(c) (1) The first sentence of subsection (a) of section 6 of the Act of September 22, 1961 (Public Law 87-276, 20 U.S.C. 676) is amended by inserting immediately before the period at the end thereof the following: ", and $1,500,000 for the fiscal year Miding June 30,1964".

75 stat. 576.

(2) Subsection (b) of such section 6 is amended by striking out "1963" and inserting in lieu thereof "1964".

RESEARCH AND DEMONSTRATION P R O J E C T S I N EDUCATION OF HANDICAPPED CHILDREN

S E C 302. (a) There is authorized to be appropriated for the fiscal year ending June 30, 1964, and each of the next two fiscal years, the sum of $2,000,000 to enable the Commissioner of Education to make grants to States, State or local educational agencies, public and non-profit private institutions of higher learning, and other public or nonprofit private educational or research agencies and organizations for research or demonstration projects relating to education for mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired children who by reason thereof require special educa-

tion (hereinafter in this section referred to as "handicapped children") . Such grants shall be made in installments, in advance or by way of reimbursement, and on such conditions as the Commissioner of Education may determine.

(b) The Commissioner of Education is authorized to appoint such special or technical advisory committees as he may deem necessary to advise him on matters of general policy relating to particular fields of education of handicapped children or relating to special services necessary thereto or special problems involved therein.

(c) The Commissioner of Education shall also from time to time appoint panels of experts who are competent to evaluate various types of research or demonstration projects under this section, and shall secure the advice and recommendations of such a panel before making any such grant in the field in which such experts are competent.

(d) Members of any committee or panel appointed under this section who are not regular full-time employees of the United States shall, while serving on the business of such committee or panel, be entitled to receive compensation at rates fixed by the Secretary of Health, Education, and Welfare, but not exceeding $75 per day, including travel time; and, while so serving away from their homes or regular place of business, they may be allowed travel expenses, including per diem in lieu of suDsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b-25 U.S.C. 73b-25 U.S.C. 73b-25 U.S.C. 73b-25 U.S.C. 73b-2) for eo stat. sos.

persons in the Government service employed intermittently.

(e) The Commissioner of Education is authorized to delegate any of his functions under this section, except the promulgation of regulations, to any officer or employee of the Office of Education.

TITLE IV—GENERAL

DEFINITIONS

SEC. 401. For purposes of this Act—

(a) The term "State" includes Puerto Rico, Guam, American Samoa, the Virgin Islands, and the District of Columbia.

(b) The term "facility for the mentally retarded" means a facility specially designed for the diagnosis, treatment, education, training, or custodial care of the mentally retarded, including facilities for training specialists and sheltered workshops for the- mentally retarded, out only if such workshops are part of facilities which provide or will provide comprehensive services for the mentally retarded.

(c) The term "community mental health center" means a facility providing services for the prevention or diagnosis of mental illness, or care and treatment of mentally ill patients, or rehabilitation of such persons, which services are provided principally for persons residing in a particular community or communities in or near which

the facility is situated.

(d) The terms "nonprofit facility for the mentally retarded", "nonprofit community mental health center", and "nonprofit private institution of higher learning" mean, respectively, a facility for the mentally retarded, a community mental health center, and an institution of higher learning which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual; and the term "nonprofit private agency or organization" means an agency or organization which is such a corporation or association or which is owned and operated by one or more of such corporations or associations.

(e) The term "construction" includes construction of new buildings, expansion, remodeling, and alteration of existin;^ buildings, and initial equipment of any such buildings (including medical transportation facilities); including architect's fees, but excluding the cost of off-site improvements and the cost of the acquisition of land.

(f) The term "cost of construction" means the amount found by the Secretary to be necessary for the construction of a project.

(g) The term "title", when used with reference to a site for a project, means a fee simple, or such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Secretary finds sufficient to assure for a period of not less than fifty years undistui^bed use and possession for

the purposes of construction and operation of the project.

(h) The term "Federal share" with respect to any project means—

(1) if the State plan under which application for such project is filed contains, as of the date of approval of the project application, standards approved by the Secretary pursuant to section 402 the amount determined in accordance with such standards by the State agency designated under such plan; or

(2) if the State plan does not contain such standards, the amount (not less than 331/^ per centum and not more than either 66% per centum or the State's Federal percentage, whichever is the lower) established by such State agency for all projects in the State: Provided^ That prior to the approval of the first such project in the State during any fiscal year such State agency shall give to the Secretary written notification of the Federal share established under this paragraph for such projects in such State to be approved by the Secretary during such fiscal year, and the Federal share for such projects in such State approved during such fiscal year shall not be changed after such approval.

(i) The Federal percentage for any State shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of

the United States, except that the Federal percentage for Puerto Eico, Guam, American Samoa, and the Virgin Islands shall be 66% per centum.

(j) (1) The Federal percentages shall be promulgated by the Secretary between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the United States for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgation; except that the Secretary shall promulgate such percentages as soon as possible after the enactment of this Act, which promulgation shall be conclusive for the fiscal year ending June 30, 1965.

(2) The term "United States" means (but only for purposes of this subsection and subsection (i)) the fifty States and the District of Columbia.

(k) The term "Secretary" means the Secretary of Health, Education, and Welfare.

STATE STANDARDS FOR VARIABLE FEDERAL SHARE

SEC. 402. The State plan approved under part C of title I or title I I may include standards for determination of the Federal share of the cost of projects approved in the State under such part

or title, as the case may be. Such standards shall provide equitably (and, to the extent practicable, on the basis of objective criteria) for variations between projects or classes of projects on the basis of the economic status of areas and other relevant factors. No such standards shall provide for a Federal share of more than 66% per centum or less than 331/^ per centum of the cost of construction of any project. The Secretary shall approve any such standards and any modifications thereof which comply with the provisions of this section.

PAYMENTS FOR CONSTRUCTION

S E C 403. (a) Upon certification to the Secretary by the State agency, designated as provided in section 134 in the case of a facility for the mentally retarded, or section 204 in the case of a community mental health center, based upon inspection by it, that work has been performed upon a project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment is due to the applicant, such installment shall be paid to the State, from the applicable allotment of such State, except that (1) if the State is not authorized by law to make payments to the applicant, the payment shall be made directly to the applicant, (2) if the Secretary, after investigation or otherwise, has reason to believe that any act (or failure to act) has occurred requiring action

pursuant to section 136 or section 206, as the case may be, payment may, after he has given the State agency so designated notice of opportunity for hearing pursuant to such section, be withheld, in whole or in part, pending corrective action or action based on such hearing, and (3) the total of payments under this subsection with respect to such project may not exceed an amount equal to the Federal share of the cost of construction of such project.

(b) I n case an amendment to an approved application is approved as provided in section 135 or 205 or the estimated cost of a project is revised upward, any additional payment with respect thereto may be made from the applicable allotment of the State for the fiscal year in which such amendment or revision is approved.

JUDICIAL REVIEW

SEC. 404. If the Secretary refuses to approve any application for a project submitted under section 135 or 205, the State agency through which such application was submitted, or if any State is dissatisfied with his action under section 134(b) or 204(b) or section 136 or 206, such State, may appeal to the United States court of appeals for the circuit in which such State is located, by filing a petition

with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

72 Stat. 941.

62 Stat. 928.

RECOVERY

SEC. 405. If any facility or center with respect to which funds have been paid under section 403 shall, at any time within twenty years after the completion of construction—

(1) be sold or transferred to any person, agency, or organization (A) which is not qualified to file an application under section 135 or 205, or (B) which is not approved as a transferee by the State agency designated pursuant to section 134 (in the case of a facility for the mentally retarded) or section 204 (in case of a community mental health center), or its successor; or

(2) cease to be a public or other nonprofit facility for the mentally retarded or community mental health center, as the case may be^ unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the applicant or other owner from the obligation to continue such facility as a public or other nonprofit facility for the mentally retarded or such center as a community mental health center,

the United States shall be entitled to recover from either the transferor or the transferee (or, in the case of a facility or center which has ceased to be public or other nonprofit facility for the mentally

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retarded or community mental health center, from the owners

thereof) an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the center is situated) of so much of such facility or center as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction of such project or projects. Such right of recovery shall not constitute a lien upon such facility or center prior to judgment.

STATE CONTROL OF OPERATIONS

SEC. 406. Except as otherwise specifically provided, nothing in this Act shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility for the mentally retarded or community mental health center with respect to which any funds have been or may be expended under this Act.

CONFORMING AMENDMENT

SEC. 407. (a) The first sentence of section 633(b) of the Public Health Service Act is amended by striking out "eight" and inserting in lieu thereof "twelve". The second sentence thereof is amended to read: "Six of the twelve appointed members shall be persons who

60 Stat. 1048.
42 u s e 291k.

are outstanding in fields pertaining to medical facility and health activities, and three of these six shall be authorities in matters relating to the operation of hospitals or other medical facilities, one of them shall be an authority in matters relating to the mentally retarded and one of them shall be an authority in matters relating to mental health, and the other six members shall be appointed to represent the consumers of services provided by such facilities and shall be persons familiar with the need for such services in urban or rural areas."

(b) The terms of office of the additional members of the Federal Hospital Council authorized by the amendment made by subsection (a) who first take office after enactment of this Act shall expire, as designated by the Secretary at the time of appointment, one at the end of the first year, one at the end of the second year, one at the end of the third year, and one at the end of the fourth year after the date of appointment.

.\pproved October 31, 1963, 10:Cf7 a.m.

Public Law 88-165

AN ACT

November 4, 1963

^^' ^"^"^^

To amend the Act redefining the units and establishing the standards of electrical and photometric measurements to provide that the candela shall be the unit of luminous intensity.

Be it enacted hy the Senate and House of Representatives of the United States of America in Congress assembled^ That the Act entitled "An Act to redefine the units and establish the standards of electrical and photometric measurements" (Act of July 21, 1950; 64 Stat. 370) is amended by deleting the word "candle" wherever it appears and inserting in lieu thereof the word "candela".

is use 223.

Approved November 4, 1963.

Mentally Ill Offender Treatment and Crime Reduction Act of 2004

[108th Congress Public Law 414]
[From the U.S. Government Printing Office]

[DOCID: f:publ414.108]

[[Page 118 STAT. 2327]]

Public Law 108-414
108th Congress

An Act

To foster local collaborations which will ensure that resources are effectively and efficiently used within the criminal and juvenile justice systems. <<NOTE: Oct. 30, 2004 - [S. 1194]>>

Be it enacted by the Senate and House of Representatives of the United States of America in <<NOTE: Mentally Ill Offender Treatment and Crime Reduction Act of 2004.>> Congress assembled,

SECTION 1. <<NOTE: 42 USC 3711 note.>> SHORT TITLE.

This Act may be cited as the ``Mentally Ill Offender Treatment and Crime Reduction Act of 2004''.

SEC. 2. <<NOTE: 42 USC 3797aa note.>> FINDINGS.

Congress finds the following:

(1) According to the Bureau of Justice Statistics, over 16 percent of adults incarcerated in United States jails and prisons have a mental illness.

(2) According to the Office of Juvenile Justice and Delinquency Prevention, approximately 20 percent of youth in the juvenile justice system have serious mental health problems, and

a significant number have co-occurring mental health and substance abuse disorders.

(3) According to the National Alliance for the Mentally Ill, up to 40 percent of adults who suffer from a serious mental illness will come into contact with the American criminal justice system at some point in their lives.

(4) According to the Office of Juvenile Justice and Delinquency Prevention, over 150,000 juveniles who come into contact with the juvenile justice system each year meet the diagnostic criteria for at least 1 mental or emotional disorder.

(5) A significant proportion of adults with a serious mental illness who are involved with the criminal justice system are homeless or at imminent risk of homelessness, and many of these individuals are arrested and jailed for minor, nonviolent offenses.

(6) The majority of individuals with a mental illness or emotional disorder who are involved in the criminal or juvenile justice systems are responsive to medical and psychological interventions that integrate treatment, rehabilitation, and support services.

(7) Collaborative programs between mental health, substance abuse, and criminal or juvenile justice systems that ensure the provision of services for those with mental illness or co-occurring mental illness and substance abuse disorders can reduce the number of such individuals in adult and juvenile corrections facilities, while providing improved public safety.

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SEC. 3. <<NOTE: 42 USC 3797aa note.>> PURPOSE.

The purpose of this Act is to increase public safety by facilitating collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems. Such collaboration is needed to--

(1) protect public safety by intervening with adult and juvenile offenders with mental illness or co-occurring mental illness and substance abuse disorders;

(2) provide courts, including existing and new mental health courts, with appropriate mental health and substance abuse treatment options;

(3) maximize the use of alternatives to prosecution through graduated sanctions in appropriate cases involving nonviolent offenders with mental illness;

(4) promote adequate training for criminal justice system personnel about mental illness and substance abuse disorders and the appropriate responses to people with such illnesses;

(5) promote adequate training for mental health and substance abuse treatment personnel about criminal offenders with mental illness or co-occurring substance abuse disorders and the appropriate response to such offenders in the criminal justice system;

(6) promote communication among adult or juvenile justice personnel, mental health and co-occurring mental illness and substance abuse disorders treatment personnel, nonviolent offenders with mental illness or co-occurring mental illness and substance abuse disorders, and support services such as housing, job placement, community, faith-based, and crime victims organizations; and

(7) promote communication, collaboration, and intergovernmental partnerships among municipal, county, and State elected officials with respect to mentally ill offenders.

SEC. 4. DEPARTMENT OF JUSTICE MENTAL HEALTH AND CRIMINAL JUSTICE

COLLABORATION PROGRAM.

(a) In General.--Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.) is amended by adding at the end the following:

``PART HH--ADULT AND JUVENILE COLLABORATION PROGRAM GRANTS

``SEC. 2991. <<NOTE: 42 USC 3797aa.>> ADULT AND JUVENILE COLLABORATION PROGRAMS.

``(a) Definitions.--In this section, the following definitions shall apply:

``(1) Applicant.--The term `applicant' means States, units of local government, Indian tribes, and tribal organizations that apply for a grant under this section.

``(2) Collaboration program.--The term `collaboration program' means a program to promote public safety by ensuring access to adequate mental health and other treatment services for mentally ill adults or juveniles that is overseen cooperatively by--

``(A) a criminal or juvenile justice agency or a mental health court; and

``(B) a mental health agency.

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``(3) Criminal or juvenile justice agency.--The term `criminal or juvenile justice agency' means an agency of a State or local government or its contracted agency that is responsible for detection, arrest, enforcement, prosecution, defense, adjudication, incarceration, probation, or parole relating to the violation of the criminal laws of that State or local government.

``(4) Diversion and alternative prosecution and sentencing.--

``(A) In general.--The terms `diversion' and `alternative prosecution and sentencing' mean the appropriate use of effective mental health treatment alternatives to juvenile justice or criminal justice system institutional placements for preliminarily qualified offenders.

``(B) Appropriate use.--In this paragraph, the term `appropriate use' includes the discretion of the judge or supervising authority, the leveraging of graduated sanctions to encourage compliance with treatment, and law enforcement diversion, including crisis intervention teams.

``(C) Graduated sanctions.--In this paragraph, the term `graduated sanctions' means an accountability-based graduated series of sanctions (including incentives, treatments, and services) applicable to mentally ill offenders within both the juvenile and adult justice system to hold individuals accountable for their actions and to protect communities by providing appropriate sanctions for inducing law-abiding behavior and preventing subsequent involvement in the criminal justice system.

``(5) Mental health agency.--The term `mental health agency' means an agency of a State or local government or its contracted agency that is responsible for mental health services or co-occurring mental health and substance abuse services.

``(6) Mental health court.--The term `mental health court'

means a judicial program that meets the requirements of part V
of this title.
``(7) Mental illness.--The term `mental illness' means a
diagnosable mental, behavioral, or emotional disorder--
``(A) of sufficient duration to meet diagnostic
criteria within the most recent edition of the
Diagnostic and Statistical Manual of Mental Disorders
published by the American Psychiatric Association; and
``(B)(i) that, in the case of an adult, has resulted
in functional impairment that substantially interferes
with or limits 1 or more major life activities; or
``(ii) that, in the case of a juvenile, has resulted
in functional impairment that substantially interferes
with or limits the juvenile's role or functioning in
family, school, or community activities.
``(8) Nonviolent offense.--The term `nonviolent offense'
means an offense that does not have as an element the use,
attempted use, or threatened use of physical force against the
person or property of another or is not a felony that by its
nature involves a substantial risk that physical force against
the person or property of another may be used in the course of
committing the offense.

[[Page 118 STAT. 2330]]

``(9) Preliminarily qualified offender.--The term
`preliminarily qualified offender' means an adult or juvenile
accused of a nonviolent offense who--
``(A)(i) previously or currently has been diagnosed
by a qualified mental health professional as having a
mental illness or co-occurring mental illness and
substance abuse disorders; or
``(ii) manifests obvious signs of mental illness or
co-occurring mental illness and substance abuse
disorders during arrest or confinement or before any
court; and
``(B) has faced, is facing, or could face criminal
charges for a misdemeanor or nonviolent offense and is
deemed eligible by a diversion process, designated
pretrial screening process, or by a magistrate or judge,
on the ground that the commission of the offense is the
product of the person's mental illness.
``(10) Secretary.--The term `Secretary' means the Secretary
of Health and Human Services.
``(11) Unit of local government.--The term `unit of local
government' means any city, county, township, town, borough,
parish, village, or other general purpose political subdivision
of a State, including a State court, local court, or a
governmental agency located within a city, county, township,
town, borough, parish, or village.

``(b) Planning and Implementation Grants.--
``(1) In general.--The Attorney General, in consultation
with the Secretary, may award nonrenewable grants to eligible
applicants to prepare a comprehensive plan for and implement an
adult or juvenile collaboration program, which targets
preliminarily qualified offenders in order to promote public
safety and public health.
``(2) Purposes.--Grants awarded under this section shall be
used to create or expand--
``(A) mental health courts or other court-based
programs for preliminarily qualified offenders;
``(B) programs that offer specialized training to

the officers and employees of a criminal or juvenile justice agency and mental health personnel serving those with co-occurring mental illness and substance abuse problems in procedures for identifying the symptoms of preliminarily qualified offenders in order to respond appropriately to individuals with such illnesses;

``(C) programs that support cooperative efforts by criminal and juvenile justice agencies and mental health agencies to promote public safety by offering mental health treatment services and, where appropriate, substance abuse treatment services for--

``(i) preliminarily qualified offenders with mental illness or co-occurring mental illness and substance abuse disorders; or

``(ii) adult offenders with mental illness during periods of incarceration, while under the supervision of a criminal justice agency, or following release from correctional facilities; and

``(D) programs that support intergovernmental cooperation between State and local governments with respect to the mentally ill offender.

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``(3) Applications.--

``(A) In general.--To receive a planning grant or an implementation grant, the joint applicants shall prepare and submit a single application to the Attorney General at such time, in such manner, and containing such information as the Attorney General and the Secretary shall reasonably require. An application under part V of this title may be made in conjunction with an application under this section.

``(B) Combined <<NOTE: Procedures.>> planning and implementation grant application.--The Attorney General and the Secretary shall develop a procedure under which applicants may apply at the same time and in a single application for a planning grant and an implementation grant, with receipt of the implementation grant conditioned on successful completion of the activities funded by the planning grant.

``(4) Planning grants.--

``(A) Application.--The joint applicants may apply to the Attorney General for a nonrenewable planning grant to develop a collaboration program.

``(B) Contents.--The Attorney General and the Secretary may not approve a planning grant unless the application for the grant includes or provides, at a minimum, for a budget and a budget justification, a description of the outcome measures that will be used to measure the effectiveness of the program in promoting public safety and public health, the activities proposed (including the provision of substance abuse treatment services, where appropriate) and a schedule for completion of such activities, and the personnel necessary to complete such activities.

``(C) Period of grant.--A planning grant shall be effective for a period of 1 year, beginning on the first day of the month in which the planning grant is made. Applicants may not receive more than 1 such planning grant.

``(D) Amount.--The amount of a planning grant may

not exceed $75,000, except that the Attorney General may, for good cause, approve a grant in a higher amount.
``(E) Collaboration set aside.--Up to 5 percent of all planning funds shall be used to foster collaboration between State and local governments in furtherance of the purposes set forth in the Mentally Ill Offender Treatment and Crime Reduction Act of 2004.
``(5) Implementation grants.--
``(A) Application.--Joint applicants that have prepared a planning grant application may apply to the Attorney General for approval of a nonrenewable implementation grant to develop a collaboration program.
``(B) Collaboration.--To receive an implementation grant, the joint applicants shall--
``(i) document that at least 1 criminal or juvenile justice agency (which can include a mental health court) and 1 mental health agency will participate in the administration of the collaboration program;
``(ii) describe the responsibilities of each participating agency, including how each agency will use

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grant resources to provide supervision of offenders and jointly ensure that the provision of mental health treatment services and substance abuse services for individuals with co-occurring mental health and substance abuse disorders are coordinated, which may range from consultation or collaboration to integration in a single setting or treatment model;
``(iii) in the case of an application from a unit of local government, document that a State mental health authority has provided comment and review; and
``(iv) involve, to the extent practicable, in developing the grant application--
``(I) preliminarily qualified offenders;
``(II) the families and advocates of such individuals under subclause (I); and
``(III) advocates for victims of crime.
``(C) Content.--To be eligible for an implementation grant, joint applicants shall comply with the following:
``(i) Definition of target population.--Applicants for an implementation grant shall--
``(I) describe the population with mental illness or co-occurring mental illness and substance abuse disorders that is targeted for the collaboration program; and
``(II) develop guidelines that can be used by personnel of an adult or juvenile justice agency to identify preliminarily qualified offenders.
``(ii) Services.--Applicants for an implementation grant shall--
``(I) ensure that preliminarily qualified offenders who are to receive

treatment services under the collaboration program will first receive individualized, validated, needs-based assessments to determine, plan, and coordinate the most appropriate services for such individuals;

``(II) specify plans for making mental health, or mental health and substance abuse, treatment services available and accessible to preliminarily qualified offenders at the time of their release from the criminal justice system, including outside of normal business hours;

``(III) ensure that there are substance abuse personnel available to respond appropriately to the treatment needs of preliminarily qualified offenders;

``(IV) determine eligibility for Federal benefits;

``(V) ensure that preliminarily qualified offenders served by the collaboration program will have adequate supervision and access to effective and appropriate community-based mental health services, including, in the case of individuals with co-occurring mental health and substance abuse disorders, coordinated services, which may range from consultation or collaboration to integration in a single setting treatment model;

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``(VI) make available, to the extent practicable, other support services that will ensure the preliminarily qualified offender's successful reintegration into the community (such as housing, education, job placement, mentoring, and health care and benefits, as well as the services of faith-based and community organizations for mentally ill individuals served by the collaboration program); and

``(VII) include strategies, to the extent practicable, to address developmental and learning disabilities and problems arising from a documented history of physical or sexual abuse.

``(D) Housing and job placement.--Recipients of an implementation grant may use grant funds to assist mentally ill offenders compliant with the program in seeking housing or employment assistance.

``(E) Policies and procedures.--Applicants for an implementation grant shall strive to ensure prompt access to defense counsel by criminal defendants with mental illness who are facing charges that would trigger a constitutional right to counsel.

``(F) Financial.--Applicants for an implementation grant shall--

``(i) explain the applicant's inability to fund the collaboration program adequately without Federal assistance;
``(ii) specify how the Federal support provided will be used to supplement, and not supplant, State, local, Indian tribe, or tribal organization sources of funding that would otherwise be available, including billing third-party resources for services already covered under programs (such as Medicaid, Medicare, and the State Children's Insurance Program); and
``(iii) outline plans for obtaining necessary support and continuing the proposed collaboration program following the conclusion of Federal support.
``(G) Outcomes.--Applicants for an implementation grant shall--
``(i) identify methodology and outcome measures, as required by the Attorney General and the Secretary, to be used in evaluating the effectiveness of the collaboration program;
``(ii) ensure mechanisms are in place to capture data, consistent with the methodology and outcome measures under clause (i); and
``(iii) submit specific agreements from affected agencies to provide the data needed by the Attorney General and the Secretary to accomplish the evaluation under clause (i).
``(H) State plans.--Applicants for an implementation grant shall describe how the adult or juvenile collaboration program relates to existing State criminal or juvenile justice and mental health plans and programs.
``(I) Use of funds.--Applicants that receive an implementation grant may use funds for 1 or more of the following purposes:

[[Page 118 STAT. 2334]]

``(i) Mental health courts and diversion/alternative prosecution and sentencing programs.--Funds may be used to create or expand existing mental health courts that meet program requirements established by the Attorney General under part V of this title, other court-based programs, or diversion and alternative prosecution and sentencing programs (including crisis intervention teams and treatment accountability services for communities) that meet requirements established by the Attorney General and the Secretary.
``(ii) Training.--Funds may be used to create or expand programs, such as crisis intervention training, which offer specialized training to--
``(I) criminal justice system personnel to identify and respond appropriately to the unique needs of preliminarily qualified offenders; or
``(II) mental health system personnel to respond appropriately to the treatment needs of preliminarily qualified offenders.
``(iii) Service delivery.--Funds may be used

to create or expand programs that promote public safety by providing the services described in subparagraph (C)(ii) to preliminarily qualified offenders.

``(iv) In-jail and transitional services.--Funds may be used to promote and provide mental health treatment and transitional services for those incarcerated or for transitional re-entry programs for those released from any penal or correctional institution.

``(J) Geographic distribution of grants.--The Attorney General, in consultation with the Secretary, shall ensure that planning and implementation grants are equitably distributed among the geographical regions of the United States and between urban and rural populations.

``(c) Priority.--The Attorney General, in awarding funds under this section, shall give priority to applications that--

``(1) demonstrate the strongest commitment to ensuring that such funds are used to promote both public health and public safety;

``(2) demonstrate the active participation of each co-applicant in the administration of the collaboration program;

``(3) document, in the case of an application for a grant to be used in whole or in part to fund treatment services for adults or juveniles during periods of incarceration or detention, that treatment programs will be available to provide transition and re-entry services for such individuals; and

``(4) have the support of both the Attorney General and the Secretary.

``(d) Matching Requirements.--

``(1) Federal share.--The Federal share of the cost of a collaboration program carried out by a State, unit of local government, Indian tribe, or tribal organization under this section shall not exceed--

``(A) 80 percent of the total cost of the program during the first 2 years of the grant;

``(B) 60 percent of the total cost of the program in year 3; and

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``(C) 25 percent of the total cost of the program in years 4 and 5.

``(2) Non-federal share.--The non-Federal share of payments made under this section may be made in cash or in-kind fairly evaluated, including planned equipment or services.

``(e) Federal Use of Funds.--The Attorney General, in consultation with the Secretary, in administering grants under this section, may use up to 3 percent of funds appropriated to--

``(1) research the use of alternatives to prosecution through pretrial diversion in appropriate cases involving individuals with mental illness;

``(2) offer specialized training to personnel of criminal and juvenile justice agencies in appropriate diversion techniques;

``(3) provide technical assistance to local governments, mental health courts, and diversion programs, including technical assistance relating to program evaluation;

``(4) help localities build public understanding and support

for community reintegration of individuals with mental illness;
``(5) develop a uniform program evaluation process; and
``(6) conduct a national evaluation of the collaboration program that will include an assessment of its cost-effectiveness.

``(f) Interagency <<NOTE: Establishment.>> Task Force.--
``(1) In general.--The Attorney General and the Secretary shall establish an interagency task force with the Secretaries of Housing and Urban Development, Labor, Education, and Veterans Affairs and the Commissioner of Social Security, or their designees.
``(2) Responsibilities.--The task force established under paragraph (1) shall--
``(A) identify policies within their departments that hinder or facilitate local collaborative initiatives for preliminarily qualified offenders; and
``(B) <<NOTE: Reports. Deadline.>> submit, not later than 2 years after the date of enactment of this section, a report to Congress containing recommendations for improved interdepartmental collaboration regarding the provision of services to preliminarily qualified offenders.

``(g) Minimum Allocation.--Unless all eligible applications submitted by any State or unit of local government within such State for a planning or implementation grant under this section have been funded, such State, together with grantees within the State (other than Indian tribes), shall be allocated in each fiscal year under this section not less than 0.75 percent of the total amount appropriated in the fiscal year for planning or implementation grants pursuant to this section.
``(h) Authorization of Appropriations.--There are authorized to be appropriated to the Department of Justice to carry out this section--
``(1) $50,000,000 for fiscal year 2005; and
``(2) such sums as may be necessary for fiscal years 2006 through 2009.''.

(b) List of ``Best Practices''.--The Attorney General, in consultation with the Secretary of Health and Human Services, shall

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develop a list of ``best practices'' for appropriate diversion from incarceration of adult and juvenile offenders.

Approved October 30, 2004.

LEGISLATIVE HISTORY--S. 1194:

HOUSE REPORTS: No. 108-732 (Comm. on the Judiciary).
CONGRESSIONAL RECORD:
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<all>

Disability Rights Florida v. Jones

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

DISABILITY RIGHTS FLORIDA, INC.,
On behalf of its Clients and Constituents,

Plaintiff,

vs. Case No. 3:18-cv-179-J-25JRK

JULIE JONES, Secretary, Florida Department of Corrections in her Official Capacity and FLORIDA DEPARTMENT OF CORRECTIONS, an Agency of the State of Florida,

Defendants.
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SETTLEMENT AGREEMENT

I. INTRODUCTION

A. This Settlement Agreement ("Agreement") comes before the Court on the Complaint filed by Plaintiff, Disability Rights Florida, Inc., on January 30, 2018 (DE 1), on behalf of its clients and constituents seeking declaratory and injunctive relief on behalf of inmates within the Florida Department of Corrections (FDC) who are currently clients and constituents of Disability Rights Florida and who are mentally ill and confined in a FDC inpatient mental health unit or who may be transferred to a FDC inpatient mental health unit. Plaintiff, Disability Rights Florida, (DRF), is an organization charged by federal law to protect the rights of individuals with mental illness in Florida. Defendants are Julie Jones, in her official capacity as Secretary of the Florida Department of Corrections, and the Florida Department of Corrections (collectively "Defendants" or "FDC"). The Defendants and the Plaintiff shall be referred to in this Agreement collectively as the "Parties."

B. Jurisdiction and Venue: This action is brought by Disability Rights Florida, Inc., on behalf of its clients and constituents, pursuant to 42 U.S.C. § 1983, the Americans with Disabilities Act ("ADA"), codified at 42 U.S.C. § 12132 et seq., and the Federal Rehabilitation Act ("FRA"), codified at 29 U.S.C. § 794. Accordingly, this Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331, and may grant declaratory and injunctive relief pursuant to 28 U.S.C. §§ 2201-2202. This Court has personal jurisdiction over the Defendants. Venue lies in this judicial district pursuant to 28 U.S.C. § 1391 because a substantial part of the events or omissions giving rise to this claim occurred in this district – over 70% of the FDC inpatient mental health beds are located in this district, and the largest number of inpatient health beds are located in this division. For purposes of this Agreement, or any action to enforce this Agreement, Defendants consent to the Court's jurisdiction over this Agreement or such action and over Defendants, and consent to venue in this judicial district.

C. In the Complaint, Plaintiff alleges Defendants, by their actions and inactions, have deliberately and chronically denied mental health care to individuals with mental illness who were and are confined in inpatient mental health units operated and managed by Defendants. Plaintiff alleges that many of these patients are confined in segregated, isolated and harsh conditions which exacerbate their illnesses. As a result of their segregation and isolation, Plaintiff claims that these patients are denied the benefits of many of the Defendants' programs, services and activities.

D. On February 20-23, 2017, the FDC allowed Plaintiff's expert team access to Union CI and Lake CI to view and tour the physical plant, including the housing areas, treatment space, staff office space, recreation areas, indoor recreation space, dayroom, medication and administration areas. Plaintiff's experts were also permitted to observe daily operations, group treatment, individual treatment, treatment team meetings, medication passes, meal time and disciplinary or classification meetings. The experts were permitted to interview FDC management staff and health services staff and 4-5 patients per inpatient level of care at each facility.

E. The Defendants state that prior to and since the initiation of this litigation, the FDC commenced significant initiatives to improve recruiting and retention of qualified security staff and enhance the delivery of mental health services. This process has been ongoing prior to and throughout the course of this litigation. To date, the FDC's initiatives include, but are not limited to, the following: Creation of a Central Office Mental Health Ombudsman and Mental Health Ombudsman four at (4) inpatient units; Creation of a Behavior Risk Management Team (BRMT) comprising one (1) psychologist, a part-time psychiatrist and a part-time psychiatric nurse; development and implementation of two (2) Quality Assurance instruments (MHIMI – Mental Health Inpatient Monitoring Instrument and STAMI – Structured Therapeutic Activities Monitoring Instrument) to monitor mental health services in inpatient units; policy revisions; targeted training for security staff; site visits conducted by OHS leadership.

F. Beginning in January 2017, the Parties engaged in multiple mediation sessions with the Honorable Harvey E. Schlesinger, U.S. District Judge, to see if they could come to an amicable, mutually agreeable resolution of this matter prior to filing a Complaint. To immediately address the significant and urgent conditions state-wide, to avoid costly and protracted litigation, and to settle the disputes in this action fully and finally, the Parties have voluntarily agreed, subject to the terms and conditions of this Agreement, to resolve all claims and issues in this action by entering into and requesting the Court's approval of this Agreement. The Parties agree that the representations made in this Agreement are in compliance with 18 U.S.C. § 3626, fair, reasonable, and adequate to protect the interests of all Parties. The Parties further believe that this Agreement will benefit mentally ill patients who are housed in a FDC inpatient mental health unit.

G. The terms of this Agreement shall be applicable to and binding upon the Defendants in their official capacities, and their officers, agents, employees, assigns, and successors for the duration of the time specified herein. This Agreement applies to all of the FDC's existing inpatient mental health units and any new facilities that will provide inpatient mental health care during the life of this Agreement. The FDC agrees that the services and treatment required by this Agreement are necessary to satisfy patient treatment needs and the FDC further agrees, in the event it engages

a third party to perform any act needed to comply with the terms of the Agreement, it will contractually obligate such third party to satisfy the terms of the Agreement.

H. The Agreement becomes effective at the time of adoption by the Court. The Parties will file this Agreement with the Court and ask that the Court adopt the terms of the Agreement as an order of the Court and retain jurisdiction to enforce its provisions as specified in Section XIV of this Agreement. Adoption of the Agreement by the Court is a condition precedent to the Agreement's enforcement.

II. DEFINITIONS

A. Department: means the Florida Department of Corrections (FDC).

B. Confidentiality Agreement: means the agreement entered into by the parties allowing access to and protecting the confidentiality of any protected health information of current or former mentally ill patients housed in an inpatient unit within the FDC. The Confidentiality Agreement will be submitted to the Court no later than March 15, 2018.

C. Core Mental Health Services: means individual and group therapy, case management, therapeutic community and medication management. These services must be provided by a mental health care professional who is qualified in accordance with applicable Florida statutes and regulations.

D. Corrections Mental Health Treatment Facility (CMHTF): means any extended treatment or hospitalization-level unit that the assistant secretary for health services specifically designates by Rule 33-404.201, F.A.C., to provide acute mental health care and that may include involuntary treatment and therapeutic intervention, in contrast to less intensive levels of care such as out-patient mental health care, infirmary mental health care, transitional mental health care, or crisis stabilization care.

E. Crisis Stabilization Care (CSU): means a level of care that is less restrictive and intensive than care provided in a corrections mental health treatment facility that includes a broad range of evaluation and treatment services provided within a highly structured residential setting. It is intended for patients who are experiencing debilitating symptoms of acute mental impairment and who cannot be adequately evaluated and treated in a transitional care unit or in infirmary mental health care. Such treatment is also more intensive than in transitional care units as it is devoted principally toward rapid stabilization of acute symptoms and conditions.

F. Policy: means Procedure Manuals (PM) and Health Services Bulletins (HSB) that provide requirements and guidelines for the provision of inmate health care which is a component of the Department's comprehensive health care delivery system. HSBs do not take the place of or override Department of Corrections' rules or PMs. HSBs provide additional guidance as a supplement to sound clinical judgment for the delivery of health services within each institution.

G. Individualized Services Plan (ISP): means a dynamic, written description of an patient's current mental health problems, goals, and services that is developed and implemented by a multi-disciplinary services team and the patient.

H. **Multi-Disciplinary Services Team (MDST):** means the staff representing different professions, disciplines, or service areas, which comprise a team that provides assessment, care, and treatment to the patient, and develops, implements, reviews, and revises an "Individualized Service Plan," as needed.

I. **Self-Harm Observations Status (SHOS):** means to a clinical status ordered by the attending clinician that provides for safe housing and close monitoring of patients who are determined to be suicidal or at risk for serious self-injurious behavior, by mental health staff, or in the absence of mental health staff, by medical staff.

J. **Serious Self-Injurious Behavior:** means an patient's deliberate self-harm behavior that has or could have caused serious bodily harm as assessed by mental health staff, or in the absence of mental health staff, by medical staff, as evidenced by the need for medical care.

K. **Structured Out of Cell Treatment and Services (SOCTS):** means weekly scheduled individualized treatment services, psychoeducational groups and therapeutic activities to ameliorate disabling symptoms of mental illness and improve behavioral functioning as identified in the ISPs.

L. **Psychoeducational Group and Therapeutic Activity:** means a treatment service designed to improve resiliency in behavioral functioning and self-directed recovery as identified in the ISP.

M. **Transitional Mental Health Care (TCU):** means a level of care that is more intensive than outpatient and infirmary care but less intensive than crisis stabilization care, characterized by the provision of mental health treatment in the context of a structured residential setting. Transitional mental health care is indicated for a person with chronic or residual symptomology who does not require crisis stabilization care or placement in a corrections mental health treatment facility but whose impairment in functioning nevertheless renders him or her incapable of adaptive functioning within the incarceration environment.

N. **Unstructured Out of Cell Time:** means out of cell activities monitored by security staff without involvement of mental health staff. Examples include outdoor recreation, dayroom, visitation, telephone calls, showers, etc.

III. IMPLEMENTATION TIMELINE

The Parties agree that systemic reform will require a significant modification to the current delivery of mental health services, and that such reform will require a multi-year approach. Further, the Parties acknowledge that all funds required to meet the requirements of this Agreement must be appropriated by the Florida Legislature, and that this Agreement does not bind the Legislature to any specific appropriations.

A. Upon the effective date of this Agreement, the FDC will:

1. Within ninety (90) calendar days of the effective date of this Agreement, patients on the Lake inpatient mental health units shall receive individualized assessment for use of restraints.

2. The Parties agree the FDC will discontinue the use of the TCU at UCI for inpatient mental health care by the execution date of this Agreement. The FDC may, however, resume use of these dorms if adequate modifications are made to the facility to provide sufficient treatment space.

3. One year after the effective date of the Agreement:

   a. Implement the Oversight requirements of paragraph IV. G. and continue those provisions for the duration of this Agreement;
   b. Complete relevant policy and procedure review and initiate rule making process;
   c. Complete modification to training materials and train staff as required in Section IV.

4. Two years after the effective date of the Agreement:

   a. Continue training of inpatient mental health and security staff as needed or as they are assigned to the inpatient mental health units;
   b. Complete construction of open court or yard area for those inpatient mental health units without current access to an open court or yard.

B. Whenever the FDC has agreed to adopt new procedures, HSBs, policies, or rules in this Agreement, unless otherwise specified, the time frame for submission of such proposed procedures, HSBs, policies, or rules to Plaintiff shall not exceed six (6) months from the approval date.

C. Whenever a specific time frame for the achievement of a particular goal is not specified herein, the time frame shall be a "reasonable time" as interpreted initially by the CMA monitoring team.

IV. RELIEF

A. Individualized Treatment

The FDC shall provide individualized treatment for patients assigned to inpatient mental health units as follows:

1. **Creation and Revision of ISPs:** Individualized treatment requires the creation of an ISP. The FDC will:

   a. Provide treatment plans individualized to the patients' needs. Treatment goals will match the documented problems identified for each patient.

b. Ensure ISPs include measurable goals. The process to achieve the goals will include, as clinically appropriate, group therapy, individual psychotherapy, medication management and transition planning.

c. Ensure ISPs are updated in accordance with policy to reflect changes in patient's treatment progress.

d. MDST meetings will be scheduled to address initial placement on the unit, refusal of treatment for more than five days, receipt of a DR, refusing to maintain hygiene for more than seven days, significant changes in mental status and/or behavioral functioning, "significant events" as referenced in policy and transfer to a different level of care.

e. The patient will be invited to attend the MDST meeting. If the patient is not able to attend or refuses, an incidental note will be entered in the mental health record, identifying the reason for non-attendance and encouragement that was provided.

f. For each patient being discussed at the MDST meeting, each staff member on the patient's ISP will provide input. The patient should be asked how treatment is progressing from his or her perspective, and to participate in the development of a collaborative plan of care.

g. The supervising psychologist or Psychological Services Director, in consultation with the inpatient unit's OIC and the treating mental health clinician, will have the authority to modify property, activity, and privileges available in the level system based on the individual treatment needs of the patient. If such modifications will be ongoing, the MDST must review and approve them and will be documented in the patient's mental health records.

h. The MDST team will review the treatment plan in its entirety with the patient, and will give the patient an opportunity to read and review the treatment plan before signing. The patient shall be provided a copy of the plan, unless the patient is on SHOS, and the attending clinician documents the specific clinical justification for withholding it.

i. Patients who have been in the CSU for sixty (60) days or longer, or the TCU for one (1) year or longer will be reviewed by a regional mental health consultant to determine whether additional services or a higher level of care is clinically indicated. The consultation and determination regarding care will be documented via an incidental note in the patient's mental health record and reported to the FDC Chief of Mental Health Services, or his or her designee, for review.

2. **Provision of Treatment and Services:** To provide treatment and services, the FDC will:

   a. Provide mental health treatment and services that uses evidence-based practices and measures for treatment progress to guide continued or modified treatment.

   b. Ensure all patients in the inpatient units are offered a minimum of ten hours per week of SOCTS tied to the patient's ISP. Unstructured recreation time shall not be counted toward the minimum required hours of SOCTS.

   c. Patients on the units shall receive unstructured out-of-cell time in accordance with an individual determination assessing their required level of restraint and freedom of movement. In no case shall any patient be offered less than ten hours of unstructured out-of-cell time per week unless there is an individualized determination by the MDST and the clinical justification is documented in the inpatient mental health record. Five hours of the unstructured out-of-cell time shall be exercise outdoors.

   d. The minimum number of hours required for SOCTS and unstructured out of cell time shall be offered to all patients regardless of their privilege level.

   e. Tailor SOCTS to the individual needs of the patient.

   f. Offer individual psychotherapy, group therapy, and clinical encounters with psychiatric and psychology clinicians in treatment rooms that provide for an appropriate level of confidentiality.

   g. Offer therapeutic community group in a location with all participants able to share their issues with each other and the clinicians. The goals of therapeutic community are to identify concerns and develop verbal problem solving skills.

   h. Provide appropriately credentialed clinical staff.

3. **Serious Self-Injurious Behavior ("SIB") Treatment:** The FDC will provide the following treatment for SIB:

   a. Provide appropriate assessment for the causes of serious SIB.

   b. Require clinicians to create treatment plans as warranted by the SIB assessments to include the antecedent, triggers and consequences of each incident of SIB.

   c. Modify treatment plans over time as needed.

   d. Train staff to assess, create, implement and modify treatment plans.

e. A psychologist will be assigned to each inpatient unit to create, implement and modify treatment plans collaboratively with other members of the MDST and the patient.

f. Create a systematized program to provide appropriate interventions, including, but not limited to, cognitive behavioral therapy and dialectical behavioral therapy, for inpatient patients identified as at risk for serious self-injurious behavior.

4. **Self-Harm Assessments and SHOS Supervision:** In order to better identify and remediate cases of self-harm, the FDC will:

a. Train staff on policies regarding attending clinicians' orders for required supervision, and checks for patients on SHOS, including ordering continuous observation as warranted.

b. Train staff on FDC suicide and self-injury prevention policy in accordance with PM 404.001.

c. Provide certified IMR cells in accordance with procedure PM 404.002.

5. **Treatment Refusers:** For patients who resist treatment, including refusal of prescribed psychotropic medication(s), documented as a problem on their ISPs, the FDC will:

a. Train security staff in motivational interviewing.

b. Require mental health staff to document engagement with patients identified as treatment refusers and attempting to address those reasons in the ISP.

c. Within 24 hours from an patient's refusal to attend a scheduled clinical encounter, the patient will be visited by the patient's case manager or other clinician member of the patient's MDST, who will counsel with the patient so that he or she will attend or participate in future clinical appointments. This will also be documented via an incidental note in the mental health record.

d. If an patient refuses to come out of his/her cell for any SOCTS for more than one week, efforts will be made to bring the patient out of his/her cell to conduct a wellbeing check and mental status exam. These efforts and the result of the wellbeing check and mental status exam will be documented in the patient's mental health record. The MDST will meet to consider changing the patient's ISP.

e. If a patient fails to attend an average of at least 50% of the scheduled structured therapeutic activities over a 30-day period, then the MDST will meet to consider changing the patient's ISP.

f. Clinical staff will consult with the appropriate clinical regional staff for treatment resistant or difficult cases. Patients in the TCU with resistance to treatment issues documented on their ISP will be reviewed quarterly by regional mental health staff, and this consultation will be documented with an incidental note in the inpatient record.

g. Patients in the CSU with resistance to treatment issues documented on their ISP will be reviewed every thirty days by regional mental health staff, and this consultation will be documented with an incidental note in the inpatient record. If the condition has not improved within a reasonable period of time further consultation is clinically indicated, then regional staff will continue consulting up their chain of command for additional options, and such consultations shall be documented with an incidental note in the inpatient record.

6. **Discharge Planning:** The FDC will:

a. Transfer to a different level of inpatient care or discharge from inpatient care is accomplished by consensus of the MDST. Clinical rationale for transfer or discharge must be clearly documented in the patient's records. When a patient is discharged from inpatient care, a Discharge Summary for Inpatient Mental Health Care will be completed and will include an outpatient aftercare plan to ensure the patient will be able to function adequately in the setting to which he/she is discharged.

b. Provide clinical justification for discharge from inpatient units to a special housing setting. The MDST will meet to determine whether there is a clinical justification that, with outpatient level mental health care, the patient's mental status and level of functioning will enable satisfactory adjustment to the special housing to which the patient will be assigned. The clinical justification for discharge from inpatient to a special housing setting will be clearly documented in the patient's records, an aftercare plan will be completed prior to discharge from the inpatient unit, and the patient will have gone at least seven (7) days since the end of the last episode of psychiatric seclusion, psychiatric restraints, or self-harm observation status. Patients will not be discharged from an inpatient unit to an outpatient level of care if there has been an incident of psychiatric seclusion, psychiatric restraints or SHOS within the past seven (7) days.

7. **Psychotropic Medication Practices:** The FDC will:

a. Ensure patients are seeing their psychiatric practitioner in the intervals required in the FDC's policies.

b. Ensure practitioner notes are completed in a timely manner and contain all of the required clinical information.

c. Ensure the psychotropic medication ordered is appropriate for the patient's symptoms and diagnosis.

d. Ensure drug exception request dispositions are considered and documented in accordance with FDC policy, including HSB 15.05.19.

e. Ensure psychotropic medication is properly and timely administered to patients.

f. Ensure that the treating mental health clinician is informed when an patient refuses any psychotropic medication.

g. Ensure there are no lapses in the availability of prescribed psychotropic medications for patients on the inpatient mental health units.

h. Ensure Medication Administration Records (MARs) are completed in accordance with FDC Policy.

B. Excessive Isolation and Restraints:

1. Excessive Isolation:

The FDC will:

a. Complete individualized risk assessments to determine the level of restrictions on movement.

b. Incorporate results of the Risk Assessment Team ("RAT") as specified in Rule 33-404.108, F.A.C, or as amended, to assess patients to determine appropriateness for multi bed-celling to allow for additional interaction with others.

2. Excessive Use of Restraints:

The FDC will:

a. Conduct an individualized risk assessment, to include a validated violence risk assessment instrument to assess which patients need to be in correctional restraints.

b. Correctional restraints will not be utilized for any out of cell activities unless an individualized determination is made in accordance with the process outlined in Rule 33-404.108, F.A.C, or as amended.

c. Security will not be present in the room during treatment activities unless there is an individualized determination of risk by the treating mental health clinician warranting security presence during the activity.

d. Implement a policy that when patients are admitted to an inpatient mental health unit, prior confinement or close management status shall be suspended; for patients admitted to the CSU, a risk assessment shall be completed within 3 working days; for patients admitted to TCU or CMHTF the initial risk assessment shall be completed within 7 working days; and after the initial risk assessment restrictions on housing, program participation and clinical activities shall be determined by the MDST and shall be documented in the patient's inpatient mental health record.

e. Implement a policy that, after the initial risk assessment upon admission to the inpatient mental health unit, security restraints shall not be applied to patients when they are out of their cells by default because of their suspended close management status.

f. Patients not requiring security restraints based on their risk assessment shall have recreation in an open court or yard instead of the secured individual recreation areas. For those inpatient mental health units without current access to an open court or yard, the FDC will construct an open court or yard area for all inpatient mental health units and provide wellness equipment in accordance with statutory authority.

C. **Disciplinary Reports in the Inpatient Units**

1. The FDC will:

a. Require staff to comply with policy pertinent to inpatient mental health treatment and services.

b. Prior to issuing a DR, require staff to consult with either the supervising psychologist or the unit psychiatrist. The consultation will be documented via an incidental note made in the mental health record.

c. If a DR is issued, ensure the supervising psychologist or the unit psychiatrist, documents on the DC6-1008 that the patient's mental condition either did or did not contribute to the alleged offense. If the supervising psychologist or the unit psychiatrist determines that the patient's mental condition did contribute to the offense, then s/he will make recommendations for alternate disposition or treatment interventions in lieu of a sanction.

d. Ensure that mental health staff attempts to resolve lower level offenses on the Inpatient Unit through behavioral techniques. These efforts will be documented in the patient's mental health record. The Parties agree the goal is to deal with those behaviors through the MDST rather than through the disciplinary process.

D. **Medical Records**

1. The FDC will:

   a. Train staff regarding the elements of an organized and complete medical record.

   b. Monitor medical records on the inpatient mental health units to ensure the records are organized, complete, and up to date and have all of the documentation necessary to support the provision of adequate treatment and care to patients.

E. **Coordination Between Medical and Mental Health Providers**

1. The FDC will:

   a. Order labs on DC4-714B clinician order sheet.

   b. Ensure that mental health encounter sheets are completed.

   c. Ensure that mental health encounters are forwarded to data entry for appropriate entry in OBIS and laboratory system. All entries will have an appropriate clinician staff ID.

   d. Once lab results are received, they will be separated by ordering clinicians and forwarded to Mental Health Providers for review.

   e. Ensure that, 48 hours from the time labs are received, the results will be entered into OBIS and data entry will generate a lab tracking log to forward to the ordering clinicians. Upon request, medical records staff can also generate a report from laboratory record system listing all mental health labs ordered and results by clinician.

   f. Ensure that, on weekends, the on-call psychiatrist will be contacted about any abnormal lab results. Further, lab reports will be put in provider's mailboxes on the unit for review of abnormal lab results. That review will occur by the next business day.

   g. Ensure that all prescribing staff will have OBIS and laboratory record system accounts with passwords. The staff will receive training on both systems, both initially and periodically as needed.

   h. Require clinicians to follow the guidelines outlined in Appendix 1 to HSB 15.05.19 regarding baseline laboratory tests and timeframes for follow up laboratory tests.

   i. Ensure each inpatient unit has unit clerks responsible for monitoring the entry of lab requests and the return of the lab results. The clerks will maintain a log for lab

requests that includes the lab order date, the draw date, and the date that results were received.

j. Provide at least two computers on each Inpatient Unit so that providers will be able to access both the OBIS and the laboratory record systems.

k. Incorporate primary care into MDST meetings to develop effective communication and include documentation in the records of communications between medical and mental health staff.

l. Ensure there will be a MDST note indicating medical and mental health providers have consulted regarding coordination of care for any patients attending a chronic care clinic.

F. **Training**

1. The FDC will oversee that the following training is provided on an annual basis, as follows:

a. Mental health clinical staff will receive training on the development, implementation, and revision of ISPs.

b. All clinical and nursing staff, classification, and security staff working in the mental health inpatient unit will receive training regarding the purpose, required attendees and substance of an appropriate MDST meeting. The training will include a discussion about both routine MDST meetings for patients as well as events triggering the need for an MDST meeting for an patient.

c. Clinical and security staff will receive training on the prevention, management, and treatment of patients at risk to engage in self injurious behavior.

d. Clinical staff will receive training on appropriate organization and timely completion of medical records.

e. Psychologist, psychiatrist, and security staff will receive training on the proper procedure, documentation and considerations in determinations regarding whether to discipline a patient for behavior on the mental health inpatient units.

f. Clinical and security staff will receive training on the identification and assessment of suicide risk, suicide prevention, SHOS procedures and required supervision of patients on SHOS.

g. Clinical and security staff routinely assigned to the inpatient mental health units will receive training on how to conduct individualized assessments for use of restraints, the application of restraints on the inpatient mental health units, and the use of ETOs.

h. Security staff routinely assigned to an inpatient mental health unit will receive CIT training, and at least eight hours of specialized training pertinent to the inpatient mental health units.

C. Oversight

1. The FDC will:

   a. Maintain central office and regional ombudspersons.

   b. Maintain BRMT and reviews.

V. MONITORING TEAM

A. Monitoring Team Selection

1. Monitoring of the implementation of this Agreement shall include the processes and authority of the Correctional Medical Authority (CMA), as provided in Section 945.601, et. seq., Florida Statutes. The CMA shall select a Monitoring Team to monitor implementation of this Agreement. The CMA shall provide the names and CVs of each team member to the Parties for review and comment prior to hiring.

2. The CMA will draft a monitoring tool based on the content of the Agreement. The Parties will jointly review and comment on the monitoring instrument to be used by the CMA monitoring team to measure compliance with this Agreement. The CMA will be the final decisionmaker with regard to the monitoring instrument.

3. The Parties shall file the CMA-approved monitoring instrument with the Court no later than March 15, 2018.

4. Neither Party, nor any employee or agent of either Party, shall have any supervisory authority over the CMA monitoring team's activities, reports, findings, or recommendations.

5. Should the Parties agree that the CMA monitoring team or individual CMA team members are not fulfilling their duties in accordance with this Agreement, the Parties may amend this Agreement to immediately remove and replace the CMA monitoring team with an agreed upon monitor.

B. Monitoring Team Qualifications

The Monitoring Team shall be hired as independent contractors of the CMA. The Team shall, at a minimum, consist of a psychiatrist, a psychologist, a psychiatric nurse practitioner, a registered nurse, and at least two licensed clinical social workers or licensed mental health clinicians. The CMA monitoring team shall have appropriate experience and education or training related to the subject areas covered in this Agreement. Each member

of the CMA monitoring team should have significant experience working on an inpatient mental health unit either in the community, a jail, or a state or federal prison.

C. **Monitor Access**

1. The CMA monitoring team shall have full and complete access to the FDC's inpatient units, all unit records, patient medical and mental health records, staff, and patients.

2. FDC will direct all employees and agents to cooperate fully with the CMA monitoring team. All information obtained by the team shall be maintained in a confidential manner.

D. **Monitoring Team Ex Parte Communications**

The CMA monitoring team, through the CMA executive director, shall be permitted to initiate and receive ex parte communications with all Parties.

E. **Monitoring Team Distribution of FDC Documents, Reports, and Assessments**

The FDC will continue its contract monitoring, BRMT assessments and any other routine monitoring or assessments of the inpatient mental health units. Any assessments, reports or monitoring shall be provided to the CMA monitoring team within seven days of completion. Within seven days of receipt by the team, the team shall distribute the assessments, reports or routine monitoring documents to DRF. Additionally, any documents the CMA monitoring team requests and receives from the FDC to determine compliance will be copied and sent to DRF within seven days of receipt.

F. **Limitations on the Monitoring Team**

1. The Parties agree that the monitoring team shall be limited as follows:

   a. If the CMA is required to contract for additional staff, the Parties' experts shall not be eligible to be retained to provide monitoring of this Agreement.

   b. The CMA shall monitor this Agreement separate and apart from its statutorily mandated survey requirements.

   c. Reports issued by the CMA monitoring team shall not be admissible against the FDC in any proceeding other than a proceeding related to the enforcement of this Agreement or the filing of a new case in accordance with the circumstances outlined in Section VIII(H) below.

G. **Technical Assistance by the Monitoring Team**

The CMA monitoring team shall provide the FDC with technical assistance as requested by the FDC. Technical assistance should be reasonable and should not interfere with the team's ability to assess compliance.

VI. COMPLIANCE ASSESSMENTS

A. Compliance Assessments

1. The CMA monitoring team shall evaluate the level of compliance for each relevant provision of the Agreement using a monitoring instrument reviewed by the Parties.

2. The CMA's monitoring team shall evaluate the level of compliance for each relevant provision in the Agreement based on a multi-day site visit to each inpatient mental health unit that includes, but is not limited to, the monitoring team:

   a. Receiving demographic information for the inpatient mental health unit, a unit roster, the unit restraint logs and any other information the monitoring team deems necessary prior to the site visit;
   b. Interviewing a representative sample consisting of a minimum of 10% of the patients on the inpatient mental health unit ;
   c. Reviewing records for the randomly selected patients on site;
   d. Review disciplinary action taken against patients on the inpatient mental health unit on site;
   e. Interviewing mental health and correctional staff on site;
   f. Observe SOCTS;
   g. Observe rounds and medication administration;
   h. Observe an MDST meeting;
   i. Observe recreation.

3. The CMA monitoring team shall conduct a compliance assessment for each inpatient unit as outlined in the implementation schedule below, and shall develop a report for each inpatient facility.

4. Each CMA monitoring team report shall describe the steps taken by each member of the CMA monitoring team to analyze conditions and assess compliance, including documents reviewed and individuals interviewed, and the factual basis for each of team's findings.

5. For any deficiency found by the CMA monitoring team, the team shall determine whether insufficient clinical, nursing or security staffing levels may have caused or contributed to such deficiency.

6. Any deficiencies found by the CMA monitoring team to be life-threatening or otherwise serious shall be immediately reported to the Secretary of the Department of Corrections as provided in Section 945.6031(3) and to the Parties.

7. The FDC will achieve seventy (70) percent compliance at each institution for each of the items in the agreed upon monitoring tool for the first compliance monitoring period.

8. Substantial compliance shall be reached when the FDC obtains eighty (80) percent compliance at each institution for each of the items in the agreed upon monitoring tool for the second compliance monitoring period.

9. The Parties shall have the right to observe the assessments.

B. **Implementation**

This Agreement shall be implemented as follows:

1. The CMA Monitoring Team shall conduct two rounds of monitoring with each inpatient unit being assessed at least once during each monitoring period as outlined below.

2. The first monitoring period shall begin December 2018 and be completed no later than October 2019.

3. The second monitoring period and the final reports shall be completed no later than October 2020.

4. The CMA monitoring team shall provide reports to the Parties no later than 30 days after completion of each assessment.

5. If more than one visit per monitoring period is necessary for an inpatient unit, the CMA monitoring team shall inform the Parties of the reason(s) for the follow up visit(s).

C. **Monitoring Team's Reports**

1. The CMA monitoring team shall provide to the Parties reports evaluating the extent to which the FDC has complied with each substantive provision of the Agreement. The Parties shall have seven days to provide a written response to the findings. The written response will be submitted to the CMA and the other Party.

2. The CMA monitoring team shall consider the Parties' responses and make appropriate changes, if any, and issue the final report within seven days of receiving the Parties' response(s), if any. These reports shall be written with due regard for the privacy interests of individual patients and staff, and the interest of Defendants in protecting against disclosure of information not permitted by this Agreement.

VII. DOCUMENTS TO BE PRODUCED TO DRF

During the duration of this Agreement, the FDC will provide to DRF the following documents on a quarterly basis:

A. Contract Monitoring Reports for institutions with inpatient units;
B. BRMT Reports and STAMIs for inpatient units;
C. Name and location of death for any patient who died while assigned to an inpatient unit;

D. All DC-4-781J Psychiatric Restraint Log, regarding use of psychiatric restraints on the inpatient units;
E. Inpatient unit schedules of activities; and
F. A roster of patients assigned to each inpatient unit from the first of each month that includes, at a minimum, admission date and S-grade.

VIII. DISPUTE RESOLUTION AND ENFORCEMENT

A. If Plaintiff believes the FDC is not in substantial compliance with any provision of this Agreement, Plaintiff shall provide the FDC, in writing, specific reasons why they believe that the FDC is not in substantial compliance with such provision or provisions, referencing the specific provision or provisions. Plaintiff may not allege that FDC is not in substantial compliance based on minor or isolated delays in compliance. Substantial compliance, as provided for in this Agreement, shall be achieved if:

1. The FDC performs its essential, material components of this Agreement, even in the absence of strict compliance with the exact terms, or

2. Any delays in compliance with the Agreement are minor and/or isolated.

B. To the extent Plaintiff relies on observations or opinions of the CMA to support an allegation that the FDC is not in substantial compliance, Plaintiff shall make a reference to the written reports of the monitoring team and to portions thereof which support Plaintiff's belief. To the extent Plaintiff relies upon documents provided by the FDC to support an allegation that the FDC is not in substantial compliance, Plaintiff shall make reference to the specific performance measures which support Plaintiff's belief.

C. The FDC shall have the opportunity to consult their designated expert, if any, with respect to Plaintiff's allegations that the FDC is not in substantial compliance with such provision or provisions. The FDC shall provide Plaintiff with a written response to the notification within thirty (30) days of its receipt. The FDC's response shall contain a description of the steps it took to investigate the issues addressed in the Plaintiff's notice, the results of the investigation, and, where the FDC proposes corrective action, a specific plan and corrective action for addressing the described issues. If no corrective action is proposed by reason of legal considerations or for other reasons, the FDC's response shall specifically state those reasons and any statutes, regulations, expert opinion, or technical bases upon which they are relying in reaching such conclusion.

D. Plaintiff agrees to advise the FDC of its acceptance or rejection of the FDC's response within ten (10) days of its receipt. The Parties shall meet to discuss and attempt to resolve any disputes addressed in the written submissions. The FDC and Plaintiff shall meet within twenty (20) days of Plaintiff's rejection of the FDC's response, unless a later meeting is agreed by both sides. The CMA monitoring team will participate in these meetings to offer evaluations of the disputed conditions and recommendations for resolution. The Parties may engage a Mediator to assist with resolution of the dispute.

E. If the FDC and Plaintiff are not successful in their efforts to resolve their dispute, Plaintiff may seek relief from the Court to effect substantial compliance with the provisions of the Agreement alleged to have been breached. All remaining provisions of the Agreement will remain in full force and effect.

F. In the case that the CMA Monitoring Team identifies a situation that is life-threatening or otherwise serious and contemplated by this Agreement, DRF may, after 72 hours notice to the Defendants, omit the notice and cure requirements herein and seek relief from the Court.

G. In the case that DRF identifies a non-systemic situation that is life-threatening or otherwise serious and contemplated by this Agreement, DRF may, after 72 hours notice to the Defendants, omit the notice and cure requirements herein and seek relief from the Court.

H. The Parties recognize that the Agreement includes plans for activities extending beyond the current fiscal year. The FDC will exercise reasonable efforts to secure the legislative appropriations necessary to meet the terms of the Agreement. The inability to perform any act required under the Agreement due to non-appropriation of funds, so long as those funds are necessary to implement or support the Agreement, shall not be a basis for holding the Secretary in contempt so long as the FDC exercised reasonable efforts to secure the appropriation at issue. If the inability to perform is the result of non-appropriation of funds, DRF may file a motion to enforce the Agreement with respect to those issues which it contends amount to a breach of the Agreement, or file a new lawsuit with respect to those issues which it contends amount to systemic violations of federal law and the official capacity agency head of the FDC will not raise the defense of collateral estoppel or res judicata in an action for prospective declaratory and injunctive relief.

I. The Parties acknowledge that failure to obtain necessary funding does not preclude the Court from entering any order to achieve compliance with this Agreement that comports with the applicable provisions of the Prison Litigation Reform Act, 18 U.S.C. section 3626 and with other applicable law, provided that the FDC reserves the right to assert that the lack of funding should be taken into account in any remedial order.

J. If Plaintiff contends that the FDC has not complied with an order entered under the preceding paragraphs, they may, after reasonable notice and a meeting with the FDC, move for further relief from the Court to obtain compliance with the Court's prior order. The Court may apply equitable principles and may use any appropriate equitable or remedial power available to it.

IX. PLAINTIFF'S ACCESS TO CLIENTS AND CONSTITUENTS

Nothing in this Agreement shall be construed to limit Plaintiff's federally-mandated access to its clients and constituents at any of the inpatient mental health units.

X. PLAINTIFF'S ATTORNEYS' FEES AND COSTS

A. Fees and Costs: The FDC agrees that Plaintiff is entitled to payment of reasonable fees and costs up to adoption of the Agreement by the Court in an amount to be determined by the Parties. If the Parties cannot reach resolution, the issue will be resolved through mediation. If the Parties cannot reach resolution through mediation, then the Court will determine reasonable fees and costs.

B. Timing:

1. The FDC agrees it will pay the Plaintiff its reasonable fees and costs accrued through the date of adoption of this Agreement. Within 30 days of adoption of the Agreement by the Court, Plaintiff will submit its fees and costs to the FDC. FDC will respond to Plaintiff's fees and costs request within 60 days of receipt. The Parties will have 30 days from receipt of the FDC's response to resolve the fees and costs before submitting a motion to the Court for resolution of fees and costs.

2. In the event enforcement proceedings are initiated, Plaintiff may seek additional fees and costs for successful enforcement activities during the duration of the Order.

XI. MODIFICATION

A. The Parties recognize the change of some conditions or practices may reduce the necessity of change to other conditions or practices. Therefore, it may be appropriate that the Agreement be modified from time to time. After no less than six (6) months of operation under the Agreement, FDC may ask Plaintiff to review a proposed modification, amendment, or alteration of any of the rights or obligations in any portion of this Agreement.

B. If Plaintiff agrees with the proposed modification, the Parties will seek Court approval of the modification, amendment, or alteration.

C. If Plaintiff disagrees with the proposed modification, the Parties will meet and confer as to whether they can reach agreement. If the Parties cannot agree within thirty (30) days, the Parties will seek the assistance of a mediator to resolve the dispute.

D. If mediation is not successful, then appropriate relief may be sought from the Court in the form of a motion for modification.

XII. PLRA

Pursuant to 18 U.S.C. § 3626(a)(1)(A), the Parties have submitted this Agreement to the Court seeking a finding that the relief agreed to by Plaintiff and the FDC and required by this Agreement is narrowly drawn, extends no further than necessary to correct the alleged violation of the patients' constitutional rights, and is the least intrusive means necessary to correct the violation. The Parties agree that the Court must consider any adverse impact on public safety or the operation of a

criminal justice system. The Parties stipulate that no provision of this Agreement has an adverse impact on public safety or the operation of the criminal justice system. Additionally, the FDC agrees it will not move to terminate the Agreement pursuant to 18 USC 3626(b) any sooner than than the termination of the jurisdiction of the Court pursuant to Section XIII(C)(2).

XIII. COURT APPROVAL AND JURISDICTION

A. **Scope:** The Parties hereby memorialize the terms of their agreement in this Agreement. This Agreement constitutes the entire agreement of the parties and, except for any Protective Order entered by the Court, supersedes all prior agreements, representations, negotiations and undertakings in this litigation not set forth or incorporated herein.

B. **Court Adoption:** The Agreement is not effective absent adoption by the Court as an order of the Court.

C. **Jurisdiction:**

1. The Court shall be the sole forum for the enforcement of this Agreement.

2. The terms of this Agreement and the jurisdiction of the Court shall commence upon the date of the Court's adoption of this Agreement as an order of the Court and shall extend from the date of adoption until December 31, 2020 or 60 days after the receipt of the final monitoring report, whichever is sooner.

3. The jurisdiction of the Court shall terminate on December 31, 2020 or 60 days after the receipt of the final monitoring report, whichever is sooner, unless Plaintiff files a motion to extend jurisdiction based on the argument that prospective relief remains necessary to correct a current and ongoing violation of the Federal rights.

4. Nothing in this Agreement shall limit the Parties' rights to challenge or appeal any finding as to whether the FDC is not in substantial compliance, i.e., in substantial non-compliance, or consequent order entered by the Court.

IN WITNESS WHEREOF, the Parties to this Settlement Agreement have executed the same through the signatories below:

For Plaintiff:

Maryellen McDonald
Executive Director, Disability Rights Florida

Dated:

12/22/2017

For Defendants:

Julie L. Jones
Secretary, Florida Department of Corrections

Dated:

12/22/17

Lake v. Cameron

No. 18809.

Argued January 19, 1966.

Decided May 19, 1966. As Amended September 19, 1966.

Mr. Hyman Smollar, Washington, D.C. (appointed by this court), with whom Mr. Lawrence S. Schaffner, Washington, D.C., was on the brief, for appellant.

Mr. John A. Terry, Asst. U.S. Atty., with whom Messrs. David G. Bress, U.S. Atty., and Frank Q. Nebeker, Asst. U.S. Atty., were on the brief, for appellee. Mr. Oscar Altshuler, Asst. U.S. Atty., also entered an appearance for appellee.

Before BAZELON, Chief Judge, EDGERTON, Senior Circuit Judge, and FAHY, DANAHER, BURGER, WRIGHT, McGOWAN, TAMM and LEVENTHAL, Circuit Judges, sitting *en banc*.

Sitting by authority of 28 U.S.C. § 46, as amended Nov. 13, 1963.

On Rehearing en banc

BAZELON, Chief Judge:

Appellant is confined in Saint Elizabeths Hospital as an insane person and appeals from denial of release in habeas corpus. On September 29, 1962, when she was sixty years old, a policeman found her wandering about and took her to the D.C. General Hospital. On October 11, 1962, she filed in the District Court a petition for a writ of habeas corpus. The court transferred her to St. Elizabeths Hospital for observation in connection with pending commitment proceedings, allowed her to amend her petition by naming the Superintendent of Saint Elizabeths as defendant, and on November 2, 1962, dismissed her petition without holding a hearing or requiring a return.

D.C. Code § 21-326 (1961), 33 Stat. 316.

After she filed her appeal from denial of habeas corpus, she was adjudged "of unsound mind" and committed to Saint Elizabeths. At the commitment hearing two psychiatrists testified that she was mentally ill and one of them that she was suffering from a "chronic brain syndrome" associated with aging and "demonstrated very frequently difficulty with her memory * * *. Occasionally, she was unable to tell me where she was or what the date was." Both psychiatrists testified to the effect that she could not care for herself adequately. She did not take a timely appeal from the commitment order. We heard her appeal from the summary dismissal of her

petition for habeas corpus and remanded the case to the District Court with directions to require a return and hold a hearing.

Lake v. Cameron, 118 U.S.App.D.C. 25, 331 F.2d 771 (1964). This court treated the petition as attacking appellant's post-commitment confinement in St. Elizabeths. The District Court on remand and the parties properly proceeded on this basis since the detention from which appellant sought release continues.

At the hearing on remand, the sole psychiatric witness testified that appellant was suffering from a senile brain disease, "chronic brain syndrome, with arteriosclerosis with reaction." The psychiatrist said she was not dangerous to others and would not intentionally harm herself, but was prone to "wandering away and being out exposed at night or any time that she is out." This witness also related that on one occasion she wandered away from the Hospital, was missing for about thirty-two hours, and was brought back after midnight by a police officer who found her wandering in the streets. She had suffered a minor injury which she attributed to being chased by boys. She thought she had been away only a few hours and could not tell where she had been. The psychiatrist also testified that she was "confused and agitated" when first admitted to the Hospital but became "comfortable" after "treatment and medication."

At both the commitment hearing and the habeas corpus hearing on remand, appellant testified that she felt able to be at liberty. At the habeas corpus hearing her husband, who had recently reappeared after a long absence, and her sister said they were eager for her release and would try to provide a home for her. The District Court found that she "is suffering from a mental illness with the diagnosis of chronic brain syndrome associated with cerebral arteriosclerosis"; that she "is in need of care and supervision, and that there is no member of the family able to give the petitioner the necessary care and supervision; and that the family is without sufficient funds to employ a competent person to do so"; that she "is a danger to herself in that she has a tendency to wander about the streets, and is not competent to care for herself." The District Court again denied relief in habeas corpus, but noted appellant's right "to make further application in the event that the patient is in a position to show that there would be some facilities available for her provision." The court thus recognized that she might be entitled to release from Saint Elizabeths if other facilities were available, but required her to carry the burden of showing their availability.

Appellant contends in written and oral argument that remand to the District Court is required for a consideration of suitable alternatives to confinement in Saint Elizabeths Hospital in light of the new District of Columbia Hospitalization of the Mentally Ill Act, which came into effect after the hearing in the District Court. Indeed, her counsel appointed by this court, who had interviewed appellant, made clear in answer to a question from the bench on oral argument that although appellant's formal pro se pleading requests outright release, her real complaint is total confinement in a mental institution; that she would rather be in another institution or hospital, if available, or at home, even though under some form of restraint.

D.C. Code §§ 21-501 to 21-591 (Supp. V, 1966).

Habeas corpus challenges not only the fact of confinement but also the place of confinement. And the court is required to "dispose of the matter as law and justice require." 28

U.S.C. § 2243. The court is not restricted to the alternative of returning appellant to Saint Elizabeths or unconditionally releasing her.

See Bolden v. Clemmer, 111 U.S.App.D.C. 392, 298 F.2d 306 (1961); Benton v. Reid, 98 U.S.App.D.C. 27, 231 F.2d 780 (1956); Miller v. Overholser, 92 U.S.App. D.C. 110, 206 F.2d 415 (1953).

We are not called upon to consider what action we would have taken in the absence of the new Act, because we think the interest of justice and furtherance of the congressional objective require the application to the pending proceeding of the principles adopted in that Act. It provides that if the court or jury finds that a "person is mentally ill and, because of that illness, is likely to injure himself or other persons if allowed to remain at liberty, the court may order his hospitalization for an indeterminate period, or order any other alternative course of treatment which the court believes will be in the best interests of the person or of the public." D.C. Code § 21-545(b) (Supp. V, 1966). This confirms the view of the Department of Health, Education and Welfare that "the entire spectrum of services should be made available, including outpatient treatment, foster care, halfway houses, day hospitals, nursing homes, etc." The alternative course of treatment or care should be fashioned as the interests of the person and of the public require in the particular case. Deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection.

S.Rep. No. 925, 88th Cong., 2d Sess., 31 (1964). The Committee said: "The original bill did not provide for court order of any course of treatment besides indeterminate hospitalization. This provision was included to cover those cases where such treatment as placement in halfway houses or outpatient care may be indicated." S.Rep. No. 925 at 19.
Compare California Welfare and Institutions Code § 5568, which grants broad discretion in selecting treatment alternatives:

If * * * the court finds a person to be mentally disordered and bordering on mental illness but not dangerously mentally ill, the court may commit him to the care and custody of the counselor in mental health and may allow him to remain in his home subject to the visitation of a counselor in mental health and subject to return to the court for further proceedings whenever such action appears necessary or desirable; or the court may commit him to be placed in a suitable home, sanitarium or rest haven home, subject to the supervision of the counselor in mental health and the further order of the court.

The District of Columbia Department of Public Health, in its COMPREHENSIVE MENTAL HEALTH SERVICES IN THE DISTRICT OF COLUMBIA, 82, says of the 1964 Act:

"This certainly provides the necessary flexibility to commit a patient to less than 24-hour care; for example, to an outpatient program, a Halfway House, etc. It also makes it possible for the court to send a senile patient to a nonpsychiatric chronic disease facility at St. Elizabeths or elsewhere. In short, the machinery of the court can be used to obtain compulsory attendance at any variant of treatment, provided * * * [the standards of the Act apply]."

See Guttmacher Weihofen, PSYCHIATRY AND THE LAW 311-12 (1952); Brenner, *Denial of Due Process and Civil Rights Under Sections 73 and 73a of the Mental Hygiene Law to Aged Seniles without Major Mental Impairment,* 34 N.Y.ST.B.J. 19, 20 (1962).

The court's duty to explore alternatives in such a case as this is related also to the obligation of the state to bear the burden of exploration of possible alternatives an indigent cannot bear. This appellant, as appears from the record, would not be confined in Saint Elizabeths if her family were able to care for her or pay for the care she needs. Though she cannot be given such care as only the wealthy can afford, an earnest effort should be made to review and exhaust available resources of the community in order to provide care reasonably suited to her needs.

"Economic dependency should not be a reason for sending physically ill and socially dependent oldsters to state mental hospitals. Financial arrangements should be made to give them physical, nursing, and domiciliary care in their own communities." Statement of the National Association of State Mental Health Program Directors before the Joint Subcommittee on Long-Term Care of the Special Senate Committee on Aging, 88th Cong., 2d Sess., pt. 3 at 287. The inquiry into alternatives will not only reveal the facilities available but will uncover the need for those that are not available.

At the habeas corpus hearing, the psychiatrist testified that appellant did not need "constant medical supervision," but only "attention"; that the psychiatrist would have no objection if appellant "were in a nursing home, or a place where there would be supervision." At the commitment hearing one psychiatrist testified that "Mrs. Lake needs care, whether it be in the hospital or out of the hospital," and did not specify what, if any, *psychiatric* care she needs. The second psychiatrist testified that she "needs close watching. She could wander off. She could get hurt and she certainly needs someone to see that her body is adequately cared for * * *. [She] needs care and kindness * * *." It does not appear from this testimony that appellant's illness required the complete deprivation of liberty that results from commitment to Saint Elizabeths as a person of "unsound mind."

Dr. Dale C. Cameron, Superintendent of Saint Elizabeths Hospital, has said that "only 50% of the patients * * * hospitalized required hospitalization in a mental institution" and "for many older patients, the primary need was found to be for physical rather than psychiatric care." Hearings Before the Subcommittee on St. Elizabeths Hospital of the House Committee on Education and Labor, 88th Cong., 1st Sess. 23-4 (1963). At the hearing before the Joint Subcommittee on Long-Term Care of the Special Senate Committee on Aging, *supra* note 8, the National Association of State Mental Health Program Directors commented on the elderly who

"are forgetful, mildly confused, and need various degrees of nursing care or domiciliary care which should be provided in approved nursing homes or private care homes. They should not be required to live in state mental hospitals in 60 to 100 bed wards with gang bathrooms, and loss of all individuality and personal dignity, even though this type of `human warehousing' is cheaper than care in nursing homes.

"Any infirm person, but especially the aged infirm, should be kept as near to home as possible, where family, friends and familiar surroundings offer the best possible link with his usual life."

See also GAP COMMITTEE ON AGING, PSYCHIATRY AND THE AGED, AN INTRODUCTORY APPROACH 544 (1965).

Appellant may not be required to carry the burden of showing the availability of alternatives. Proceedings involving the care and treatment of the mentally ill are not strictly adversary proceedings. Moreover, appellant plainly does not know and lacks the means to ascertain what alternatives, if any, are available, but the government knows or has the means of knowing and should therefore assist the court in acquiring such information.

See Dooling v. Overholser, 100 U.S.App. D.C. 247, 250, 243 F.2d 825, 828 (1957); DeMarcos v. Overholser, 78 U.S.App.D.C. 131, 137 F.2d 698, cert. denied, 320 U.S. 785, 64 S.Ct. 157, 88 L.Ed. 472 (1943); Overholser v. Treibly, 79 U.S.App.D.C. 389, 392, 147 F.2d 705, 708, cert. denied, 326 U.S. 730, 66 S.Ct. 38, 90 L.Ed. 434 (1945). The commitment judge in the present case rightly said: "This is not strictly an adversary proceeding and, as a consequence, there is no argument made to the jury * * *. [This proceeding] makes absolutely certain that no one will be `railroaded' * * *."

We remand the case to the District Court for an inquiry into "other alternative courses of treatment." The court may consider, *e.g.*, whether the appellant and the public would be sufficiently protected if she were required to carry an identification card on her person so that the police or others could take her home if she should wander, or whether she should be required to accept public health nursing care, community mental health and day care services, foster care, home health aide services, or whether available welfare payments might finance adequate private care. Every effort should be made to find a course of treatment which appellant might be willing to accept.

"Care may range from as little as help for a few hours once a week with heavy chores to full bed care. Supervision may range from as little as an informal call by a neighbor once a day to the complete supervision of a mental hospital." THE NATIONAL COUNCIL ON AGING, GUARDIANSHIP AND PROTECTIVE SERVICES FOR OLDER PEOPLE 2 (1963).

See U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, FOSTER FAMILY CARE FOR THE AGED (1965).

See U.S. PRESIDENT'S COUNCIL ON AGING, FEDERAL PAYMENTS TO OLDER PERSONS IN NEED OF PROTECTION (1965).

"Care and services should be provided in such a way as to be most satisfying to the person concerned. This will usually, although not necessarily, imply keeping the person in his own home if possible; otherwise arranging for his care in surroundings which take into consideration not only his physical and mental health but also his usual and preferred mode of life." THE NATIONAL COUNCIL ON THE AGING, *supra* note 11, at 5.

In making this inquiry, the District Court may seek aid from various sources, for example the D.C. Department of Public Health, the D.C. Department of Public Welfare, the Metropolitan Police Department, the D.C. Department of Vocational Rehabilitation, the D.C. Association for Mental Health, the various family service agencies, social workers from the patient's neighborhood, and neighbors who might be able to provide supervision. The court can also require the aid of the Commission on Mental Health, which was established "in recognition of the fact that the assistance of unbiased experts was essential to assist courts in dealing with insanity cases." The Commission's aid is available in habeas corpus proceedings as well as

commitment proceedings. The Commission, like the court, may obtain the aid of appropriate groups and individuals.

See HEALTH AND WELFARE COUNCIL OF THE NATIONAL CAPITAL AREA, WHERE TO TURN FOR HEALTH, WELFARE AND RECREATION SERVICES (1965); D.C. DEPARTMENT OF PUBLIC HEALTH, COMPREHENSIVE MENTAL HEALTH SERVICES IN THE DISTRICT OF COLUMBIA 47-69 (1965).

DeMarcos v. Overholser, 78 U.S.App. D.C. 131, 132, 137 F.2d 698, 699, cert. denied, 320 U.S. 785, 64 S.Ct. 157 (1943).

DeMarcos v. Overholser, *supra* note 16; Overholser v. Boddie, 87 U.S.App. D.C. 186, 189, 184 F.2d 240, 243, 21 A.L.R.2d 999 (1950).

In the initial statutory proceedings, the Commission is required to "hear testimony of any person whose testimony may be relevant and * * * receive all relevant evidence which may be offered." D.C. Code § 21-542 (Supp. V, 1966). Before the statutory commitment proceedings in the District Court, the Commission is required to report to the court its "findings of fact, conclusions of law, and recommendations." D.C. Code § 21-544 (Supp. V, 1966). This contemplates that the Commission will report the alternatives it has considered and the reasons for its recommendation. If the Commission's inquiry is inadequate, the court may require that it be supplemented. The court may subpoena witnesses to appear before the Commission. DeMarcos v. Overholser, *supra* note 16.

We express no opinion on questions that would arise if on remand the court should find no available alternative to confinement in Saint Elizabeths.

Such questions might be whether so complete a deprivation of appellant's liberty basically because of her poverty could be reconciled with due process of law and the equal protection of the laws.

We respectfully reject the suggestion that our opinion may be read as amounting to a revival of all commitments that had already become final. This case has its special features within which the opinion is confined. This appears from the factual setting of the opinion. The District Court recognized the problem in suggesting that if this patient could show that there were other facilities available for her provision she could apply again to the court. Our decision does no more than require the exploration respecting other facilities to be made by the government for the indigent appellant in the circumstances of this case.

Habeas corpus proceedings always have been available to test the validity of a deprivation of liberty — see, *e.g.*, Stewart v. Overholser, 87 U.S.App. D.C. 402, 186 F.2d 339 (1950); and where there has occurred, as here, a change in the applicable statutory law pending the appeal, remand for consideration by the trial court under the intervening statute is appropriate if not required. To require in a habeas corpus proceeding that the court consider an intervening statute applicable to the situation is not to require a new commitment proceeding, nor does it open one already concluded.

Remanded for further proceedings in accordance with this opinion.

J. SKELLY WRIGHT, Circuit Judge (concurring):

I concur in the court's opinion, but wish to make clear my position that, while the District of Columbia may be able to make some provision for Mrs. Lake's safety under our statute, the permissible alternatives, on the record before us, do not include full-time involuntary confinement. The record shows only that Mrs. Lake is somewhat senile; that she has a poor memory, has wandered on a few occasions, and is unable to care for herself at all times. This evidence makes out a need for custodial care of some sort, but I cannot accept the proposition that this showing automatically entitles the Government to compel Mrs. Lake to accept its help at the price of her freedom.

BURGER, Circuit Judge, with whom DANAHER and TAMM, Circuit Judges, join (dissenting).

We disagree with remanding the case to require the District Court to carry out an investigation of alternatives for which Appellant has never indicated any desire. The only issue before us is the legality of Mrs. Lake's confinement in Saint Elizabeths Hospital and the only relief she herself has requested is immediate unconditional release. The majority does not intimate that Appellant's present confinement as a patient at Saint Elizabeths Hospital is illegal, or that there is anything wrong with it except that she does not like it and wishes to get out of any confinement. Nevertheless, this Court now orders the District Court to perform functions normally reserved to social agencies by commanding search for a judicially approved course of treatment or custodial care for this mentally ill person who is plainly unable to care for herself. Neither this Court nor the District Court is equipped to carry out the broad geriatric inquiry proposed or to resolve the social and economic issues involved. This is particularly illustrated in the first alternative the majority commands the District Court to explore:

The question of alternative treatment was never raised until this court requested counsel to discuss it in their briefs and arguments on rehearing *en banc*.

Undisputed medical testimony was that Appellant "surely could not take care of herself in the community; * * * she needs supervision."

whether the appellant and the public would be sufficiently protected if she were required to carry an identification card on her person so that the police or others could take her home if she should wander * * *.

The list of subjects to explore concludes with an admonition that "every effort should be made to find a course of treatment which appellant might be willing to accept."

Although proceedings for commitment of mentally ill persons are not strictly adversary, a United States court in our legal system is not set up to initiate inquiries and direct studies of social welfare facilities or other social problems. This Court exists to decide questions put before it by parties to litigation on the basis of issues raised by them in pleadings and facts adduced by those parties. D.C. CODE § 21-545 (Supp. 1966) does not transmute the United States District Court for the District of Columbia into an administrative agency for proceedings involving the

mentally ill. This statute provides only that "the court may order [a mentally ill person's] * * * hospitalization for an indeterminate period, or order any other alternative course of treatment which *the court believes* will be in the best interests of the person or of the public." (Emphasis added.) All this section does, or was intended to do, is authorize the court to order alternative courses of treatment, provided the evidence presented to it leads it to believe that some alternative is preferable to confinement in Saint Elizabeths Hospital. This appellant seeks only her release, not a transfer. We cannot find anything in this statute which even vaguely hints at a requirement that the court conduct broad inquiries into possible treatment facilities. In the absence of such language, we must interpret the statute as not enlarging the role of the court beyond its normal judicial function of deciding issues presented by the parties on the basis of such facts as the parties present.

Even if the statute were read to require the District Court or the Mental Health Commission to investigate alternatives during the commitment proceedings, clearly a petitioner in a habeas corpus proceeding bears the initial burden of establishing the illegality of the present confinement. If, in order to accomplish this end, it is relevant to show that there are preferable alternatives to confinement in Saint Elizabeths, then the burden is on the petitioner to show the existence of these alternatives. Yet, from the filing of Mrs. Lake's petition to the present moment, no one including the majority of this Court has demonstrated any alternative "course of treatment."

What the majority has done here is first rewrite Mrs. Lake's petition for her, to demand something which she has never requested, then it has proceeded to remand, ordering the District Court to consider this new "petition" written by this court. Mrs. Lake and her successive lawyers have never asked for exploration of alternatives; she requested total release. The majority orders the District Court to make "every effort * * * to find a course of treatment which appellant might be willing to accept" yet at the same time the majority flouts the petitioner's wishes. What she wants this Court to do is to decide the legality of her commitment; however, the majority explicitly reserves that question pending the results of the study of District of Columbia social welfare facilities which it has ordered the Trial Court to undertake. We believe that this court should decide the issues raised by Appellant, not the issues it feels the Appellant should have raised. The Court's failure to decide the issues raised leaves her confined in St. Elizabeths Hospital while the District Court conducts a study largely unrelated to the question of the legality of that confinement, and for which a court is not equipped.

To show that Appellant really does object to the *place* of her confinement, the majority is forced to rely on the response of her appointed counsel to a question from the bench at oral argument. Counsel said that Appellant's major objection was that she was confined in a mental institution, and he intimated that possibly she might not be so unhappy with confinement in some other institution. This indicates that a large part of what troubles both Appellant and the majority is the fact that she is being confined in a *mental* institution and not some type of home for the aged which would provide essentially the same care but would not have attached to it the "onus" of being associated with a mental institution.

If Appellant were to receive precisely the same care she is presently receiving in the geriatrics ward of St. Elizabeths at an institution elsewhere with a name like Columbia Rest Haven, it does

not appear that there would be much disagreement over the propriety of her confinement. However, a person's freedom is no less arrested, nor is the effect on him significantly different, if he is confined in a rest home with a euphemistic name rather than at St. Elizabeths Hospital. The cases the majority cites to support the proposition that habeas corpus is available to challenge the place of custody all involved the quite different situation of challenges based on the nature rather than simply the name of the place of custody. Any conceivable relevance of those cases to the contentions made in the present case is eliminated by the fact that no one denies that Appellant is mentally ill.

We can all agree in principle that a series of graded institutions with various kinds of homes for the aged and infirm would be a happier solution to the problem than confining harmless senile ladies in St. Elizabeths Hospital with approximately 8000 patients, maintained at a great public expense. But it would be a piece of unmitigated folly to turn this appellant loose on the streets with or without an identity tag; and I am sure for my part that no District Judge will order such a solution. This city is hardly a safe place for able-bodied men, to say nothing of an infirm, senile, and disoriented woman to wander about with no protection except an identity tag advising police where to take her. The record shows that in her past wanderings she has been molested, and should she be allowed to wander again all of her problems might well be rendered moot either by natural causes or violence.

McGOWAN, Circuit Judge (dissenting):

I dissent for the reason that, with all respect, I am unable to understand just what the majority's concept of finality is in civil commitment proceedings for the mentally ill.

As for the instant case, appellant sought only her outright release on habeas corpus. Represented by counsel, she endeavored to show by evidence that her condition did not require further custody of any kind, and that, in any event, her husband and other relatives could furnish such care and supervision as might be required. The District Court found the facts to be otherwise on both of these approaches, and no one suggests that those findings are erroneous. That ordinarily would end the matter, subject always to the right of appellant to seek hereafter a different disposition of her person, either on habeas corpus or under the specific provisions of the new law referred to hereinafter.

Appellant's original commitment in mental health proceedings was under a statute which, effective September 15, 1964, was replaced by a new one, which is now codified as 21 D.C. Code §§ 501-591 (Supp. V, 1966). The majority opinion may perhaps mean that all those originally committed under the old law may, by means of habeas corpus, have a new original commitment hearing under the terms of the new statute. This would presumably be for the purpose of giving everyone a chance to have the committing tribunal consider "any other alternative course of treatment which the court believes will be in the best interests of the person or of the public." 21 D.C. Code § 545. Under this approach, all commitment proceedings which became final before the new statute are now open for a *de novo* inquiry, with the party seeking the commitment cast in the usual role of moving party. But, if the majority opinion be regarded

as accomplishing this much, it is by no means clear that the replay on habeas corpus is limited only to those finally committed before the new law became effective.

Just how much of a change in substance there is between the new law and the old in this respect is problematical. The corresponding language of the latter, 21 D.C. Code § 315 (1961 ed.), is as follows:

If the judge be satisfied that the alleged insane person is insane, or if a jury shall so find, the judge may commit the insane person *as he in his discretion shall find to be for the best interests of the public and of the insane person*. (Emphasis added.)

I am by no means persuaded that Congress, by the enactment of the new statute, intended either of these consequences. The new law, indeed, contains its own provisions for periodic review of commitments made either under it or the old law, 21 D.C. Code §§ 546, 589; and those provisions are hardly to be identified with what is prescribed on the remand which the court orders. And it may well come as a surprise to Congress to know that the new mental hospitalization act is fully retrospective in operation to the point of reopening all commitments which had become final earlier. It may have thought, contrarily, that such complete retroactivity was not necessary in view of the traditional availability of habeas corpus under which any person under commitment, aided by counsel either retained or provided, may come into court and show that the particular relief sought is justified. In any event, it seems likely that it was this kind of habeas corpus which Congress expressly preserved in the new law, 21 D.C. Code § 549, for the benefit of all persons originally committed under either the new or the old law.

Judges DANAHER, BURGER, and TAMM have authorized me to say that they concur in this opinion.

Appendix D

Psychology in the Public Forum

Public and Private Responsibility for Mental Health Services

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ABSTRACT: Relative to public services, private sector corporate mental health care has significantly increased since the late 1960s. The many tensions encountered in assigning public and private responsibility for mental health services give rise to significant value-laden questions for psychologists. These questions go to the heart of community mental health, deinstitutionalization, mental health policy development and evaluation, and many other areas in which psychologists are playing major roles. The public–private issue should be understood historically, from the twin vantage points of developments in general medicine and in mental health. Among the many public interest and public policy matters psychologists and others concerned with mental health should address are the emergence of corporate chains; the nature, cost, and quality of private sector services; the compatibility of profit motivation and the motivation to provide care; and patient selection issues (e.g., cream-skimming). Public and private cooperation and planning are certainly in order if the public interest is to be served in addressing the nation's mental health problems.

In an important 1986 book, *The Cycles of American History,* noted historian Arthur M. Schlesinger, Jr., demonstrated that the political life of the nation entails a cyclical ebb and flow in which the national mood and priorities shift between public purpose and private interest. Schlesinger described this public–private cycle as follows:

> Each phase breeds its distinctive contradictions. Public action, in its effort to better our condition, piles up a lot of change. . . . Finally the rush of innovation begins to choke the body politic, which demands time for digestion. . . . Nature insists on a respite.
>
> So public action, passion, idealism and reform recede. Public problems are turned over to the invisible hand of the market. . . . The pursuit of private interest is seen as the means of social salvation. These are times of "privatization" (barbarous but useful word), of materialism, hedonism and the overriding quest for personal gratification.
>
> And they are times of preparation. Epochs of private interest breed contradictions too. Such periods are characterized by an-ostriches of dissatisfaction, criticism, ferment, protest. . . . Problems neglected become acute, thereafter to become unmanageable and demand remedy. . . . The vacation from public responsibility replenishes the national energies and recharges the national batteries. (pp. 28–29)

Each cycle takes about 30 years, and Schlesinger argued that the currently prevailing private interest phase is scheduled to burn out as we approach the 1990s. The nation may be ready for a burst of public purpose innovation like the ones that occurred in 1901 under Theodore Roosevelt, 1933 under Franklin Roosevelt, and 1961 under John Kennedy. "The 1990s," said Schlesinger, "should be the turn in the generational succession for the young men and women who came of political age in the Kennedy years" (p. 47). Levine and Levine's (1970) historical analysis of human services is remarkably complementary to Schlesinger's analysis.

Schlesinger's provocative analysis and hypothesis raise important questions for psychologists and those concerned with mental health. Having only recently seen and appreciated the tremendous growth of corporate mental health care since the late 1960s, are we in for a backlash and a return to public-sector provision of services? Or is the rise of the private sector—which in general medicine Starr (1982) has called reprivatizing the public household—so significant a development that its momentum cannot easily be stopped? In either event, what is the fate of community mental health and deinstitutionalization? What will be the preferred mode of service delivery for the 1990s and beyond? Will there be inevitable conflicts among the public, voluntary, and private sectors? Which public mental health policies are truly in the public interest? These and related issues have been identified and debated in the literature (e.g., Checker, 1986; Eisenberg, 1984; Gaylin, 1985; Levenson, 1982, 1983; Rafferty, 1984; Relman, 1980; Schlesinger & Dorwart, 1984; Shadish, 1984).

The public–private issue should be viewed from two historical vantage points: that of general developments in American medicine and that of the specific developments within mental health.

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General Medical Developments

Arnold Relman (1980), past editor of the prestigious *New England Journal of Medicine*, identified what he called the new medical-industrial complex, "an unprecedented phenomenon with broad and potentially troubling implications for the future of our medical care system" (p. 963). Starr (1982) described this rise of corporate medicine as the social transformation of American medicine. He argued that "this transformation—so extraordinary in view of medicine's past, yet so similar to changes in other industries—has been in the making, ironically enough since the passage of Medicare and Medicaid" (p. 428). Moreover, reprivatization through the rise of corporate control of medical care in America has entailed "a general movement throughout the health care industry toward higher levels of integrated control" (p. 419).

Starr identified five dimensions of this general movement characterizing recent medical history:

1. *Change in type of ownership and control*: The shift from nonprofit and governmental organizations to for-profit companies in health care.

2. *Horizontal integration*: the decline of freestanding institutions and the rise of multi-institutional systems, and the consequent shift in the locus of control from community boards to regional and national health care corporations.

3. *Diversification and corporate restructuring*: the shift from single-unit organizations operating in one market to "polycorporate" and conglomerate enterprises, often organized under holding companies sometimes with both nonprofit and for-profit subsidiaries involved in a variety of different health care markets.

4. *Vertical integration*: the shift from single-level-of-care organizations, such as acute-care hospitals, to organizations that embrace the various phases and levels of care, such as HMOs.

5. *Industry concentration*: the increasing concentration of ownership and control of health services in regional markets and the nation as a whole. (p. 429)

These structural changes are coming to characterize mental health service delivery as well.

Mental Health Developments

Consistent with Schlesinger's (1986) general historical thesis, political-economic and institutional cycles have been observed in the history of mental health in America (Dokecki & Mashburn, 1984). Before 1830, mental health care was mostly a private or local matter, provided in mostly noninstitutional or community settings. By 1830, a consensus began to emerge that care of mentally ill individuals was a public matter, and Americans built the first public asylums. From that time until the modern era, these state institutions dominated the mental health system. For their first 25 years, the asylums were apparently very successful; however, thereafter until the middle of the 20th century, they were little more than human warehouses. After World War II, the federal government entered the public institutional arena, and during the last several decades, the quality of public institutions has been upgraded and the institutional population has been reduced, with a concomitant increase in community programs. This apparent movement toward deinstitutionalization has been intertwined with the emergence of the private sector. We seem to be cycling and spiraling through time: We started with private and noninstitutional policies, and we now seem to be evolving toward reprivatization and deinstitutionalization.

But what of this claim that there is a deinstitutionalization movement? Charles Kiesler (1982) has maintained that

> Our national *de jure* policy is the development of outpatient care and deinstitutionalization. The policy of developing outpatient care, at least, has been quite successfully implemented. . . . There has been a twelvefold increase in outpatient services over the course of 20 years. The centerpiece of this effort has been the community mental health center system. . . . Deinstitutionalization has been more controversial, although many feel it has been clinically successful. . . . However, our national *de facto* policy in mental health is hospitalization. NIMH reports that over 70% of mental health money is spent on hospitalization. (p. 1323)

Thus, hospitalization (what many would continue to call institutionalization) is the de facto mental health policy in the United States. In that regard, Kiesler and Sibulkin (1983) observed that "general hospitals are now the most likely place to be hospitalized for mental disorders" (p. 610) and that "more inpatient episodes for mental disorders occur in general hospitals without psychiatric units than any other site . . . and this population of patients is rapidly growing" (Kiesler & Sibulkin, 1984, p. 48). Moreover, most general hospitals are in the private sector, with a recent dramatic increase in those owned by for-profit, multiple-facility organizations (Checker, 1986; Gaylin, 1985; Levenson, 1982, 1983).

Although the nation has implemented a policy of developing outpatient services, hospitalization (or institutionalization) still seems to be our de facto mental health policy. The private sector, for its part, seems to be heavily implicated in both the development of outpatient services and in the seeming de facto hospitalization or institutionalization policy. In particular, the major for-profit health corporations have experienced the most recent growth.

Growth of the Chains

The absolute number of private psychiatric hospitals has not grown significantly during the last four decades. There were 187 in 1940 and about 189 in 1979 (Kimmel, 1983). However, the control of these hospitals within the private sector has changed. The type of proprietary ownership has changed from ownership of single facilities to multihospital systems or chains. According to the National Association of Private Psychiatric Hospitals' 1982 data (Levenson, 1983), there are 148 freestanding psychiatric hospitals. Of these, 43% are in investor-owned chains,

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14% are voluntary, not-for-profit, and 22% are independent for-profit. Two years earlier, only 25% were owned by chains. Twelve years previously, none were owned by chains. Moreover, only four corporations own 81% of the chain-owned hospitals and 53% of all the private for-profit psychiatric hospitals (Levenson, 1983). In the last 30 years the ratio of private to public beds has also changed because of the reduction in the number of public beds by more than two thirds.

The acquisition rate of the chains is impressive by itself, but when compared to nonprofit hospitals it is even more startling. A 1983 survey of multihospital psychiatric hospitals by *Modern Healthcare* (Punch, 1983) indicated that the chains increased the number of units they owned by 36% over their 1981 holdings and their beds by 37% over 1981. The nonprofit hospitals (secular and religious) showed no change. Relative to all psychiatric hospitals, the chains increased the proportion of beds by 34%. The chains showed a 257% increase in the number of beds managed (i.e., not owned) and a 100% increase in the number of units owned for this same one-year period (Punch, 1983). Moreover, chains generally manage a hospital only when they are in the process of buying the hospital (Kuntz, 1981).

In addition to the increasing acquisition of beds and units by the chains, the fiscal growth of the market has also been phenomenal. A 1983 investment report on the inpatient psychiatric market estimated that the 2.5 billion dollar revenues of the private psychiatric hospitals will rise to 6 billion dollars by 1987 (Rucker, 1983). This prediction appears to be in accord with the estimation of Richard Dodson, the president of National Medical Enterprise's psychiatric sector (NME is the third largest psychiatric chain). He reported that his group's revenues have tripled during the last five years and operating profits have quadrupled. Furthermore, he estimated that the overall industry revenues are increasing at a 20% rate each year and should have reached $4 billion by 1985 (Punch, 1983).

These data are clear. Inpatient psychiatric care is going to be increasingly provided by for-profit private psychiatric hospitals owned by large corporations. Is this a positive trend? Will this mean that the cost of quality care will decrease as some claim, or does this trend pose a thorny problem for those concerned with the public interest? There are a number of potential problems that may arise due to the nature of the ownership of these hospitals. In the next section, we discuss some of the issues raised in this context.

The Implications of Private Sector Services

Opponents of for-profit care indicate that their perception of the values implied by for-profit ownership is one of the bases of their opposition. For example, when the leading psychiatric hospital chain, Hospital Corporation of American (HCA) entered into negotiations to purchase Harvard's McLean Hospital, one involved physician dubbed the process like Harvard meeting Godzilla (Culliton, 1984). Other affiliated physicians also opposed the sale to HCA. So strong was their opposition that the Harvard advisory committee, which had been leaning toward acceptance of the HCA offer, recommended against acceptance of the offer. Their report stated that the previous performance and the specific terms of the HCA proposal were not the basis for the majority of the opposition. The committee stated that the ethics of many of the faculty and staff "hold that the operations of hospitals, and particularly teaching hospitals, should not be influenced by the motivation for profit" (Culliton, 1984, p. 910). The report also stated that some individuals saw the sale as a violation of public trust but that the "rationale behind this belief was complex and not clearly articulated by the Committee" (Culliton, 1984, p. 910).

In contrast, Vanderbilt University and the Hospital Corporation of America have constructed an 88-bed child and adolescent hospital. "Vanderbilt will be solely responsible for research and education, and will be a co-equal partner with HCA in all other policy decisions," according to university medical center officials (Brookheim, 1984, p. 1). Vanderbilt views the hospital as not only filling a community need but also strengthening the department of psychiatry.

Profit Motivation

The effects of operating the hospital as a profit-making venture can have both positive and negative aspects. Supporters argue that the increased competition created by the chains results not only in improved care but also in reduced prices for the consumer. They further argue that physicians control most of the expenditures (e.g., ordering tests and supplies, admitting and discharging patients). Thus, when physicians are owners (investors), they have excellent incentives to keep costs down (Levenson, 1983). Detractors argue that for-profit hospital boards cannot avoid allowing the need to show a profit to influence their decisions concerning other important values. The inference is that the quality of care will suffer and that access to or availability of services will be negatively affected. There is also a question of whether the multihospital corporations, with their highly diversified holdings, can provide an appropriate environment for the small psychiatric hospital (Levenson, 1983).

As noted earlier, one of the more vocal critics of the effects of profit motivation in health care is Arnold Relman. Although he has admitted that there are no adequate studies comparing quality of care or costs between the private and public sectors, he has presented a number of concerns (Relman, 1980). He has noted that the "expected" free market system characterized by supply and demand balances is not present in the health care field. Consumers are not knowledgeable, nor are they interested so much in price comparisons as in immediate help. When one considers that 90% of the population is covered by some form of health insurance and that 70% of all expenditures for personal health care are determined by physicians, the possibilities for abuse in the system are heightened. Relman has further argued that most people have come to consider health care as a basic right. As

such, there is public support for research and treatment. Relman has found problems in private corporations' "expropriating" these publicly funded discoveries and then selling them back to the public. Finally, concerns about access, quality, and equity must be addressed. Relman concluded that there must be regulation of private industry lest there be exploitation. At all times, the patient and society must come before the interests of the stockholders (Relman, 1980).

Schlesinger and Dorwart (1984) pointed out that there are no adequate studies that have determined if one type of ownership is more efficient than another. The major reason for this is that there are no published cost studies that also control for type of client and type and quality of services. Although there are many studies that are counts of beds, the field is generally ignorant of actual treatment on a large scale. There will not be much progress on this issue until good program evaluation techniques are developed that measure the quality of services. Cost data alone yield contradictory findings because of the different ways costs are considered in different surveys.

Patient Selection

Patient selection, economies of scale, pricing and markup, and use of ancillary services are four managerial strategies available to all hospitals for use in improving their long-term profitability, viability, and growth (Pattison & Katz, 1983). Within the area of patient selection, the phenomenon of "cream skimming" by the private hospitals is of concern. It is argued that for-profit hospitals "can and do profit by concentrating on providing the most profitable services to the best-paying patients, thereby skimming the cream off the market for acute hospital care and leaving the remainder to nonprofit hospitals" (Steinwald & Neuhauser, 1970, p. 817). This skimming is typically accomplished by using one of four strategies: (a) eliminating low-frequency and unprofitable (but apparently necessary) services, (b) recruiting medical staff who have only "desirable" practices and patients, (c) locating in affluent areas where there are fewer or no indigent, uninsured, or Medicaid patients, and (d) denying all but emergency services to indigent patients (Pattison & Katz, 1983; Relman, 1980). Relman also suggested that for-profit hospitals functionally skim when they have no teaching responsibilities. Such residency and other medical education programs are expensive and require services that although necessary for training purposes are not economical (Relman, 1980).

The institution of the Medicare prospective payment plan based on diagnosis-related groups (DRGs) may also promote the practice of skimming. With prospective payment systems (PPS), hospitals are paid a set rate for services provided to patients regardless of the actual costs incurred. Thus, private hospitals may choose to admit only the patients that they feel will not require long-term or specialized services that would incur additional nonreimbursable costs to the hospital (Widem, Pincus, Goldman, & Jencks, 1984).

There is strong evidence that proprietary ownership is related to selection based on ability to pay. Data analyzed by Schlesinger and Dorwart (1984) indicate that free care was provided more often in public and nonprofit facilities than private ones. Although one third of the patients in public facilities were not charged, less than 1% of the services in private facilities were free. Because of the limitations of the data, it was difficult to draw any conclusions about the relationship between ownership and the proportion of patients who were costly to treat.

In summary, the rapid and predicted market dominance of the private for-profit chains has enveloped the mental health delivery system in a major controversy. Proponents of the private sector believe that the rise of for-profit chains will result in improved patient care at reduced prices. In contrast, the detractors hold not only that quality will suffer but also that accessibility and availability of services will be reduced. Furthermore, they argue that the profit motive will override other important values.

The policy implications of the growth of chains are manifold. Will we develop a more formal two-tier service system, in which those who are poor and those who are expensive to treat receive care only in public facilities and those who have insurance and are wealthy receive care in private facilities? Will the quality of care be better in private facilities? Will the cost of care increase or decrease and how will quality be affected? If states no longer provide services but contract to private providers, how will quality be assured? As a small number of corporations control an increasing percentage of beds, will they be able to exert undue influence on regulatory agencies?

Ambivalence and unacknowledged value conflicts are the stage on which the drama of mental health public policy development occurs. But a system of mental health care need not involve conflict between the public, voluntary, and private sectors. It is unlikely, however, that such a system will develop without planning and cooperation between the various sectors.

REFERENCES

Beckham, J. (1984, Fall). Construction under way on new $11 million psychiatric hospital. *Medicine*, p. 1.

Christian, A. C. (1986). Research needs in investor-owned psychiatric facilities. *Hospital and Community Psychiatry, 37,* 1049–1051.

Culliton, B. J. (1984). University hospitals for sale. *Science, 223,* 909–911.

[illegible], P. K., & [illegible], J. D. (1984). *Beyond the asylum: The history of mental handicap policy in Tennessee, 1796–1984.* Nashville: Tennessee Department of Mental Health and Mental Retardation.

Eisenberg, L. (1984). The case against for-profit hospitals. *Hospital and Community Psychiatry, 35,* 1009–1013.

[illegible], S. (1985). The coming of the corporation and the marketing of psychiatry. *Hospital and Community Psychiatry, 36,* 134–139.

Kiesler, C. A. (1982). Public and professional myths about mental hospitalization: An empirical reassessment of policy-related beliefs. *American Psychologist, 37,* 1323–1339.

Kiesler, C. A., & Sibulkin, A. E. (1983). Proportion of inpatient days for mental disorders: 1969–1978. *Hospital and Community Psychiatry, 34,* 606–611.

Kiesler, C. A., & Sibulkin, A. E. (1984). Episodic rate of mental hospitalization: Stable or increasing? *American Journal of Psychiatry, 141,* 44–48.

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Study Protocol: A randomized controlled trial of suicide risk reduction in the year following jail release (the SPIRIT Trial)

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ABSTRACT

Purpose: This article describes the protocol for a randomized effectiveness and cost-effectiveness trial of Stanley and Brown's Safety Planning Intervention (SPI) during pretrial jail detention to reduce post-release suicide events (suicide attempts, suicide behaviors, and suicide-related hospitalizations).
Background: With 10 million admissions per year and short stays (often days), U.S. jails touch many individuals at risk for suicide, providing an important opportunity for suicide prevention that is currently being missed. This study ($N = 800$) is the first randomized evaluation of an intervention to reduce suicide risk in the vulnerable year after jail release. Given that roughly 10% of all suicides in the U.S. with known circumstances occur in the context of a criminal legal stressor, reducing suicide risk in the year after arrest and jail detention could have a noticeable impact on national suicide rates.
Design: Pretrial jail detainees at risk for suicide were randomized to SPI during jail detention plus post-release phone follow-up or to enhanced Standard Care. Outcomes assessed through 12 months post-release include suicide events, suicide attempts, weeks of active suicide ideation, severity of suicide ideation, time to first event, psychiatric symptoms, functioning, and cost-effectiveness. Methods accommodate short jail stays and maximize trial safety and follow-up in a large sample with severe suicide risk, access to lethal means including substances and firearms, high rates of psychiatric illness, and unstable circumstances.
Conclusion: Adequate funding was important to create the infrastructure needed to run this large trial cleanly. We encourage funders to provide adequate resources to ensure clean, well-run trials.

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1. Introduction

There were more than 10 million admissions to U.S. jails in 2017 [1]. Jailed individuals have high rates of past-year mental health (56%) and substance use (66%) disorders [2], and a disproportionate risk for suicide. Roughly half (40–50%) of incarcerated individuals report suicide ideation or behavior at some point in their lives, and 13–20% report having attempted suicide [3–5]. Arrest and jail detention often occur in the wake of other stressors that further exacerbate suicide risk. The epidemic of suicide during jail detention has been recognized. Less attention has been paid to the high suicide risk and mortality following jail release [6–9], as individuals re-enter their communities, are faced with financial, legal, and social stressors, and have increased access to lethal means (e.g., drugs, firearms, vehicles). Given that roughly 10% of all suicides in the U.S. with known circumstances occur following a recent criminal legal stressor [10] (often arrest and jail detention), reducing suicide risk in the year after jail detention could have a noticeable impact on national suicide rates.

Most (95%) people who are arrested are booked into jail [11,12]. Unlike prison, where individuals have been sentenced and often stay years, pretrial jail detainees are not yet sentenced. Most are released within days [13]. Therefore, brief interventions are required. Fortunately, previous studies support the effectiveness of brief interventions for reducing suicidality among other high-risk (e.g., emergency department, inpatient) populations. Stanley and Brown's Safety Planning Intervention (SPI; initially a single session intervention which now often includes telephone follow up), is a brief, adjunctive suicide risk reduction intervention developed for suicidal patients presenting to urgent care settings. SPI plus phone follow-up increases treatment utilization and reduces subsequent suicide attempts among at-risk individuals in emergency rooms [14,15]. However, there is no previous large-scale randomized controlled trial (RCT) of this intervention (or any other) for reducing suicidality in the year following jail release.

This protocol paper describes an RCT to evaluate the effectiveness and cost-effectiveness of SPI plus phone follow-up, relative to enhanced standard care (SC), to reduce suicide events (attempts, suicide behaviors, suicide-related hospitalizations, and suicide deaths) among 800 male and female releasing pretrial jail detainees in 2 states. This study represents the first randomized evaluation of a suicide prevention intervention in the vulnerable year after jail release. Novel aspects of the trial include recruitment and training of embedded community counselors to bridge between jail and community mental health services, safety procedures for post-release telephone intervention sessions and outcome assessments, limited exclusion criteria (i.e., many participants are psychotic, manic, and/or using drugs and alcohol), use of both self-report and medical records from area hospitals to identify suicide attempts and hospitalizations, managing post-randomization ineligibility, and overall trial management in an extremely high-risk population. We describe the bioinformatics and workflow processes used to manage this large, complex trial in the context of high risk and multiple layers of regulation, including two interfacing custom-programmed REDCap databases for study counselor case notes, research assistant clinical interviews, and efficient reporting of the more than 1000 expected adverse events to date.

2. Method

The SPIRIT (Suicide Prevention Intervention for at-Risk Individuals in Transition) RCT compares the Safety Planning Intervention (SPI) plus enhanced standard care (SC) to enhanced SC alone among 800 (male and female) pretrial jail detainees who are at risk for suicide events (i.e., they endorse suicidal ideation with some intent to act or a suicide attempt in the past month). SPI consists of an in-person safety planning meeting during jail detention, and 4 post-release phone calls over 6 months post-release. Study assessments occur at baseline, and 1, 4, 8, and 12 months post-release. Outcomes include:

1. Number of suicide events (a composite of attempts, behaviors, suicide-related hospitalizations, and suicide deaths) in the year following jail release (primary).
2. Number of suicide attempts, weeks of active suicidal ideation, severity of suicide ideation, time to first suicide event, psychiatric symptoms, and functioning (secondary).
3. Hypothesized mechanisms of SPI's effect on suicide events: (a) treatment utilization, (b) suicide-related problem-solving, and (c) sense of belongingness.
4. Cost, cost-offsets, and cost-effectiveness (which drive adoption and sustainability in re-entry settings [16–18]).

The trial is funded by the National Institute of Mental Health (NIMH), the National Institute of Justice (NIJ), and the Office of Behavioral and Social Science Research (OBSSR). It is approved by Michigan State University's Institutional Review Board and regulatory bodies overseeing jail research in our participating jails, and NIMH's Data Safety and Monitoring Board. The trial is registered at clinicaltrials.gov (NCT02750172).

2.1. Potential population-level impact

Most individuals in the U.S. who die by suicide are not in mental health treatment at the time of their suicide [10,19]. Recent suicide prevention agendas explain that to prevent suicide on a population level, it is necessary to find individuals at risk wherever they are, and one of those places is in the justice system [20]. Our query of the National Violent Death Reporting System (NVDRS) general population data indicates that roughly 10% of all suicides with known circumstances occur in the context of a recent criminal legal stressor (typically arrest and jail detention) [10]. Therefore, if the effects of brief suicide prevention interventions found in other at-risk populations (relative risks of 0.38–0.63 [21–25] for attempts and 0.09 for suicide deaths [26]) hold for recently released jail detainees, implementation of this intervention could result in a noticeable reduction in U.S. suicide rates.

Because the goal of the study is to contribute to population-level suicide prevention efforts as quickly as possible, the study was designed with intervention scalability and future implementation in mind. For example, the study includes cost-effectiveness analyses to inform national decision-making about adoption of SPI in jails. Follow-up phone calls like SPI's are already known to be cost-effective in other health care settings [27]. Our research team includes collaborators from the jails and affiliated community mental health centers to provide input about the outcomes we should assess to be most persuasive to correctional behavioral health policy-makers (in this case, cost-effectiveness, service linkage, and re-arrest) to ensure that the trial has utility [28]. In addition, the study addresses known service linkage challenges between correctional and community mental health services nationally that are a priority for both systems [4,17,29–32]; better communication and cooperation between justice and community agencies has also been identified as a priority for suicide prevention [33]. SPI fits known needs of the jail and affiliated community treatment systems in which it will be provided; namely, it is a brief, flexible, low-cost intervention that can be delivered by a broad range of clinicians in a crisis-oriented setting. The trial takes place in the community and uses the community providers who would eventually deliver the intervention in routine practice, and has minimal exclusion criteria for patient participants. Thus, this trial has been designed to be as relevant to informing real-world decisions about adoption as possible.

2.2. Preliminary studies

2.2.1. Relevant findings from our suicide prevention research

We conducted an online query of suicide data from the National Violent Death Reporting System (NVDRS) [10]. This system includes data from 32 states. In 2016 (the most recent year available), there

were 22,517 suicides with known circumstances (92% of a total of 24,396 suicides) in the 32 NVDRS reporting states. Of the suicides with known circumstances, 8.5% occurred in the context of a recent criminal legal problem and 3.3% in the context of another kind of legal problem. Over the most recent 10 years of data (2007–2016), these numbers ranged from 8.2% - 9.6% (mean of 9.0%) and from 3.0% to 4.2% (mean of 3.9%) respectively. Since it is not clear how much these groups overlap, we estimate that as many as 10% of suicides with known causes occur in the context of a recent criminal or legal stressor.

Safety planning generally and SPI specifically is already the expected standard of care in non-jail settings [34–36]. A single session of SPI produced greater decreases in suicidal ideation at the 3 month outcome assessment among suicidal ED patients relative to treatment as usual (TAU), with a large between-group effect size (d = 0.88) [37]. Studies which added structured phone follow-up intervention included (1) SAFE VET, a large demonstration project evaluating implementation of SPI in 5 Veteran's Affairs (VA) emergency departments (EDs) [38], (2) a cohort comparison study of SPI in 8 VA EDs, 4 in which eligible patients received the intervention and 4 matched VA EDs in which patients received TAU, and (3) a cohort study of 96 veterans who visited the ED for a suicide-related concern twice over 12 months and were discharged. These studies suggest that SPI reduces suicide attempts, increase subsequent outpatient mental health and substance use treatment utilization [38]. Survey data from these studies suggests that participants use the written safety plan created in the first session and view it as helpful. SAFE VET participants rated the most helpful components of the SPI phone follow-up calls were having someone check on them regularly (75%) and feeling cared for (58%); hence, a sense of belonging [39] is a hypothesized mediator in the proposed study. As evidence of SPI's sustainability in EDs, a vast majority (90%) of ED staff indicated that SPI was acceptable and that it had become integrated into routine care [14].

2.2.2. Relevant findings from our criminal justice intervention research

In our previous work, re-entering individuals [40] and their providers [41] emphasized the importance of having at least some contact with the same provider before and after release. However, released individuals often face crises within days of release, sooner than is feasible to meet them for an in-person intervention session [40–44]. Our work has found that in-person contact during incarceration and phone contact with the same person after release (as we propose to do in the current study) is feasible [42]. Furthermore, participants found post-release phone sessions to be acceptable and meaningful: "calling proves that they care." [42,45] Although the phone numbers and locations of our target population often change, our research with recently incarcerated individuals (as well as with suicidal individuals in the community [24,25,46]) has shown that telephone intervention is feasible, acceptable, and powerful in building trust and reducing risk among these disenfranchised, often isolated, populations.

Prior to this RCT, we conducted a survey of employees (N = 61 providers, correctional officers, and administrators) in the jail in the more economically distressed of our two study locations (Genesee County Jail [GCJ] in Flint, MI). 70% of jail employee respondents expressed concern over the risk of suicide among people being released to the community. Only 4 (7%) thought the SPI was not feasible at GCJ, and only 2 (3%) thought that it would not be implemented, if found effective. Thus, jail employee perspectives support the importance, feasibility, and likely implementation of SPI.

2.3. Study sites

Recruitment takes place at the Rhode Island Department of Corrections (RIDOC) and GCJ jails. RIDOC jail has 15,000 commitments per year [47]; GCJ has about 13,000. The average daily censuses are 680 and 600, respectively. At each site, 13–14% of detainees are female. In RIDOC, 24% are African-American and 18% are Hispanic. In GCJ, 55% are African-American and 5% are Hispanic. Private areas are available for research procedures. **Generalizability**. Nationally, jails tend to serve metro areas or counties, covering areas similar in size to those served by the RIDOC and GCJ jails. Nationally, as in our study sites, most people passing through jails are charged with misdemeanor offenses, such as public drunkenness, trespassing, shoplifting, and public disturbances [48], tend to be young (with most in their 20s and 30s) and to have low SES [47,49,50]. Length of stay at our sites (median of 4 days) [51] is similar to reported national rates (65% weekly turnover rate) [53].

2.4. Interventions

2.4.1. Enhanced SC control condition

NIMH's Road Ahead report states that, "policy makers need to know if a new program works better than what is currently available, or if it is better than doing nothing at all" (p. 10). In some cases, the most important question for informing real-world practice is: "how much better is the new program than care-as-usual and at what cost?" (p.11) [52]. Because our goal was to design a study that would inform jail and community mental health policy decisions, we decided to employ an enhanced Standard Care (SC) control condition. Enhanced SC consists of treatment as usual plus monitoring and emergency referral, as is required to fulfill ethical obligations to trial participants. To determine the naturalistic effects and costs of adding SPI for at-risk pretrial jail detainees, participants in both conditions may receive other treatments available to them and we do not exclude participants receiving other treatment. We characterize treatment as usual for each condition as part of our service utilization assessment.

The current standard strategy for caring for suicidal jail detainees nationally is assessment and psychiatric stabilization while in jail with essentially no community follow-up [53–56]. Our study sites typically conduct screening (by an intake worker) and assessment of risk (by a social worker). Individuals considered to be at acute risk of suicide are placed on psychiatric observation in the jail, where they are stabilized to the extent possible during their jail detention (i.e., they may be high, manic, or floridly psychotic when detained and may only be in jail for a few days). If jail staff determine their imminent suicide risk to decrease while they are in jail, they leave observation, enter the general jail population, and then are released with no community follow-up. If an individual on observation is released on bail, the jail asks the person picking the detainee up to take him or her to the ED for evaluation; no further follow-up is provided. If an individual on observation goes to court, the jail provides a letter asking the court to have the person evaluated by a mental health professional before releasing him or her; no further follow-up is provided. Individuals identified by the jail as having a severe mental illness (i.e., schizophrenia, bipolar disorder) are provided with post-release appointments. The study provides post-release monitoring (via research assessments) and emergency referral for trial participants on the basis of suicidality, in keeping with ethical obligations to trial participants. This should be considered enhanced standard care compared to current jail practice.

2.4.2. SPI

Stanley and Brown's Safety Planning Intervention (SPI) [59] is a brief, adjunctive intervention designed to reduce subsequent suicidal behavior in high risk populations. SPI has been identified as a 'Best Practice' in the joint Suicide Prevention Resource Center-American Foundation for Suicide Prevention (SPRC-AFSP) Registry. The core element of SPI is the collaborative development of the Safety Plan, which is a prioritized written list – in the patient's own words – of coping strategies and supports that individuals can use during or preceding suicidal crises. To address challenges of continuity of care across vulnerable transitions (e.g., from ED to community treatment, from inpatient to outpatient treatment), SPI often includes telephone follow-up with the same treatment provider to conduct periodic risk

assessment and mood checks, review the Safety Plan, problem-solve obstacles to treatment, and assist with linkage to services. SPI incorporates evidence-based suicide prevention strategies, including facilitation of suicide-related safety skills, identification of social supports and emergency contacts, lethal means restriction, service linkage, and motivational enhancement to promote community treatment engagement [14,59]. The goal with SPI in jail settings is not to solve all of patients' challenges with a single brief intervention, but rather to intervene in targeted ways to reduce suicide risk and to improve linkage to mental health care and other needed services. Consistent with the need for rapid, flexible intervention for pretrial jail detainees, in this trial, SPI includes one in-person meeting in jail to create a safety plan and then 4–8 telephone meetings in the 6 months after release to review the safety plan and problem-solve barriers to use of safety behaviors after jail release.

2.4.2.1. Initial session during jail detention. In this trial, the initial session during jail detention takes place in person at the jail. It includes a comprehensive clinical suicide risk assessment and development of a Safety Plan, a prioritized list of coping strategies and sources of support that patients can use during or preceding suicidal crises. The Safety Plan uses a simple, easy-to-follow format meant to enhance individuals' sense of self-control over suicidal urges and thoughts. The in-jail session begins with a risk assessment, during which the clinician obtains an accurate account of the events that transpired before, during, and after participants' self-identified most recent suicidal crisis. This description may include the activating events as well as the patient's reactions to them. This discussion helps to facilitate the identification of warning signs to be included on the Safety Plan, as well as the identification of specific strategies or behaviors that may have been used to alleviate the crisis. The SPI hierarchically-arranged steps are: (1) Identification of warning signs; (2) Use of internal coping strategies including distraction; (3) Social contact with others who may offer support and distraction from the crisis, without discussing suicidal thoughts; (4) Contacting family members or friends who may help resolve a crisis and with whom suicidality can be discussed; (5) Professional contacts including crisis hotline number, nearest ED address, clinicians' contact; (6) Restriction of access to lethal means. Patients are instructed to first recognize when they are in or at risk for crisis (Step 1) and then to follow Steps 2 through 6 as outlined in the plan. If following the instructions outlined in Step 2 fails to decrease the level of suicide risk, then the next step is followed, and so forth. SPI conveys a very clear path to follow. Since cognitive resources are taxed during emergencies, a clear predetermined strategy is most effective to mitigate risk [60,61].

2.4.2.2. Post-release telephone sessions. The same clinician who met with the individual in jail contacts him or her 4 times by phone at key time points (within the first week, 1 month, 3 months, and 6 months) after jail release, providing the most frequent contact in the highest risk period just after release. For individuals in crisis, clinicians have the option of scheduling an additional 4 calls. Calls have an agenda: (1) mood check and suicide risk assessment; (2) review and revise the safety plan; and (3) review treatment options and problem-solve obstacles to treatment. Clinicians ask when the person's next mental health appointment is scheduled, assess motivational and structural barriers to attendance, and help address these barriers. Clinicians can help identify treatment and other resources and facilitate appointments for patients if needed. If patients are determined to be at acute risk, we take appropriate action to maintain their safety, which may include contacting existing providers, ED referral, or calling the police.

2.4.3. Hypothesized mechanisms of SPI and fit to target population

The suicide risk suicide risk reduction strategies utilized in SPI with phone follow-up (including self-monitoring of crisis warning signs, internal and external coping strategies, service linkage, identification of social supports and emergency contacts, continuity of care from jail) address critical potential mechanisms of suicide reduction in our target population: treatment utilization, problem-solving, and belongingness.

2.4.3.1. Treatment utilization. Mental health and substance use treatment utilization is strongly linked to suicide risk reduction [62–64]. SPI increases treatment utilization following suicide-related ED visits [14,15]. SPI helps problem-solve service linkage issues, which present challenges for re-entering individuals given difficulties with transportation, service availability, stigma, and trust of medical institutions. In fact, service linkage is recognized by jails as the primary, top-priority barrier to post-release health outcomes [4,29–32]. SPI also works to increase motivation for service engagement. Finally, continuity of at least one provider across the transition from jail to the community has been described as essential for post-release care [40,41,43,45]. SPI's blended in-person/phone approach delivered by community mental health center clinicians provides this continuity, responding to recommendations of the National Confidential Inquiry (NCI) into Suicide and Homicide [33] to reduce community-level suicide rates through better communication and cooperation between justice and community mental health agencies.

2.4.3.2. Suicide-related problem solving. There is a robust association between problem solving deficits, which are prevalent among incarcerated populations [5,65–67], and suicide risk in community [68–70] and incarcerated [5,65,71] populations. Stressful life events, also common in our target population [57,72–74], can also interfere with cognitive processes needed for deliberation, further priming poor and impulsive decision making [75–77]. SPI facilitates the use of safety-related coping skills (skills which reduce suicide risk [60,61]) for managing crises using a template for rehearsing safety behaviors. The written safety plan, developed when participants are in controlled setting with time to deliberate (i.e., jail), allows individuals the opportunity to make decisions now that support safety in future situations when their ability to generate and weigh options might be more limited (e.g., in the context of an acute life stressor, psychiatric symptom exacerbation, etc.) or when the environment is less controlled (i.e., less supervision, more access to lethal means). Thus, SPI helps at-risk individuals make and enact safety decisions now so that they do not need to generate, weigh, and execute options for the first time when faced with an acute crisis [75–77].

2.4.3.3. Belongingness. A sense of thwarted belongingness, defined as the belief that one does not have meaningful relationships with others or that others cannot relate to an individual's experience, is associated with increased suicide risk [39]. This construct of thwarted belongingness is especially relevant to criminal justice-involved populations because they are often socially marginalized. In fact, loneliness, interpersonal conflicts or stress, and having no one with whom to discuss bad news are strong predictors of suicide attempts and deaths in incarcerated samples [57,78–81]. SPI harnesses social supports and identifies contacts to reduce isolation in times of crisis, enhancing belongingness. Moreover, because recent detainees are often disenfranchised and marginalized [41], receiving outreach in the form of caring telephone calls may also serve to increase a sense of belongingness [42,43].

2.4.4. Clinicians

Because external validity is a primary concern of this study, we have hired the community clinicians who would eventually deliver this intervention in regular practice to moonlight as clinicians on this study. They are recruited from the community mental health agencies contracted to provide mental health services to individuals re-entering their respective communities from jail and prison (Genesee Health

System in MI and Providence Center in RI). Because these agencies' clinicians serve a large number of re-entering individuals, they are experienced in working with justice-involved clients and with common co-occurring problems, such as substance use and partner violence. In addition, these embedded clinicians can facilitate the linkage of participants to services at their respective community mental health agencies.

We hired and trained masters-level clinicians (to cover the two jails 7 days per week plus back-ups) from the two states to moonlight on this study. In-person initial training consists of reviewing the SPI rationale, materials, and strategies; audio-taped demonstrations; and live practice sessions with feedback. After the in-person training, counselors record two mock SPI sessions, which are certified for adherence and competence by Drs. Weinstock, Stanley, and Brown before counselors can begin seeing study participants. Counselors who do not meet expectations are given feedback and record additional practice sessions until they do.

In-jail treatment sessions are recorded using credit-card sized digital audio recorders that we are able to bring in and out of the jail. Recording of phone sessions uses a digital audio recorder connected to a telephone headset system and transmitter patch. Study clinicians upload the recordings to our secure research audio/video server from their (remote) computers. Study supervisors, consultants, and fidelity raters can then listen to study intervention sessions from their (local or remote) computers, and supervision takes place by phone. Using encrypted audio recorders and a secure file transfer server allows counselors in different states to upload sessions for review by supervisors across the country. Supervision includes weekly group supervision and case discussion by phone, and individual phone consultation on an as-needed basis. Fidelity ratings occur throughout the RCT, with retraining as necessary.

2.4.5. Treatment integrity

We use Stanley and Brown's existing SPI fidelity rating scale, the Safety Plan Intervention Rating Scale to rate fidelity of 10% of in-jail and post-release SPI audio recordings.

2.5. Participants

Unsentenced male and female pretrial jail detainees are eligible for the study if they are: (1) 18+ years of age; (2) at risk for suicide, operationalized as a past-month suicide attempt or a response of "yes" on item 4 or 5 on the initial 5 screening questions of the Columbia Suicide Severity Rating Scale (C-SSRS) [82,83], indicating the presence of at least some active suicide ideation with some intent to act in the past month (i.e., individuals at higher risk, such as those who report intent with specific plan and/or suicide attempt/s in the last month, are also included); and (3) speak and understand English well enough to understand questionnaires when they are read aloud. We exclude people who: (1) expect to be sentenced to prison (i.e., expect to go directly to prison, not home, from the jail), (2) cannot provide the name and contact information of at least two locator persons, and/or (3) do not have access to any telephone. In our previous jail studies, most people screened (92%) owned a phone and virtually all had access to a phone through owning one, a relative/friend, or an agency. Some individuals are intoxicated, high, manic, and/or flagrantly psychotic when arrested and brought to the jail. We do approach individuals who are on psychiatric observation at the jail (typically for suicidality or other safety concerns), who, in the opinion of the nurse on duty, are stable enough to be approached for research. Our limited exclusion criteria (i.e., many participants are psychotic, manic, and/or substance dependent) increase generalizability of results to the full range of jailed individuals at risk for suicide. However, we do not include individuals who are too impaired to provide informed consent (i.e., are unable to respond coherently to the screening and consent process). If someone reports being or appears to be intoxicated or high, we postpone screening and consent procedures.

2.6. Recruitment

Participants who are on mental health watch at the jails (often for suicide risk) or who volunteer to be screened for the study are called into individual meetings at the jail with study staff. After obtaining potential participants' consent for screening, research assistants (RAs) screen potential participants privately to determine eligibility. RAs explain all aspects of the study, including confidentiality and its limits, and address questions. If the participant agrees, s/he signs an informed consent form and complete the baseline assessment. We ask participants if they would like us to read consent forms aloud.

Recruitment began on May 11, 2016 and ended with the recruitment of the 800th eligible participant on November 13, 2018. Our goal was to enroll an average of 30 participants (who meet study criteria and consent to participate) per month for 27 months, resulting in a randomized sample size of 800 (500 in RI, 300 in MI). We reached this goal in 30 months. Given the 2333 commitments per month (28,000/year) at these two jails and high rates of suicidality among jailed individuals, potential participants are available; the rate-limiting factor was research staff person power. Given that many people are arrested on the weekend and released from court on Monday, we hired enough RAs and clinicians to recruit and intervene at the jails 7 days per week.

2.7. Randomization

Randomization to SPI or enhanced SC in a 1:1 ratio occurs in the jail after the baseline assessment; therefore, all baseline assessments are blind. Randomization is stratified by jail (i.e., GCJ or RIDOC), gender, and yes/no history of suicide attempts. We do not stratify by jail suicide watch status because entry and clearance from watch depend on jail staff availability, meaning that watch status is not a reliable indicator of suicidality. Interventionists meet with those assigned to the intervention condition within 24 h of randomization. Typically, we recruit participants in the morning to meet with the interventionist/s scheduled to come to the jail that afternoon or evening, including weekends (given that many people are arrested on Friday or Saturday and released Monday or Tuesday). Immediately after randomization, RAs also review the study outcome assessment schedule, means of contacting the research staff, and participants' contacts with all participants. A different RA, who is blind to intervention assignment, performs telephone outcome assessments. The study statistician, Dr. Jones, prepared the randomization schedule before the first participant was enrolled.

2.8. Retention, attrition, and power

2.8.1. Retention

Outcome assessments (at 1, 4, 8, and 12 months post-release) are typically conducted by phone. If a participant is reincarcerated or at a local residential treatment facility, RAs conduct the outcome assessment in person. Although we have conducted in-person outcome assessments for previous trials enrolling incarcerated women [84–86], this required RAs to travel to community locations to meet participants (it was easier for RAs to go to participants than to try to get participants to our research offices). As a way to increase efficiency in this large trial and to increase safety for RAs (often young and female) in this study which enrolls both male and female participants, we decided to conduct outcome assessments by phone, when possible (i.e., participant is not reincarcerated).

We employ several approaches that we have found helpful in achieving low attrition rates (0–20%) in our previous intervention studies with individuals re-entering the community after incarceration (including those who were homeless) [42,44,84–86]. These include study staff's strong relationships with participants and efforts to value and appreciate their study participation. RAs call and text (with

permission) participants, mail them letters, and maintain a list of 2 other people who always know where participants reside. We also request (optional) releases to get updated locator information from probation and parole offices and residential treatment facilities. If a participants call (or we reach them by phone) within the interview window (+/− 31 days from the interview due date), RAs conduct the interview right then if possible. Locator information is updated at each study contact. Telephone outcome assessment (removing the need for transportation) and study team flexibility in scheduling outcome assessments (i.e., on evenings or weekends) also facilitate participant retention. Participants are remunerated $60 for each outcome assessment.

2.8.2. Attrition estimates

Our target population is pretrial detainees who are returning to the community. We exclude individuals who expect to serve prison or jail time as part of a sentence. However, we expect 6–8% of the pretrial jail detainee participants we consent who do not expect to be sentenced to serve prison or jail time will be sentenced anyway. These individuals do not leave jail for the community before serving their sentences (i.e., they go directly to prison or longer-term jail accommodations, not home), meaning that they are not actually eligible for the study, which is a study of suicide prevention in the year after release from *pretrial* jail detention. Therefore, individuals who are sentenced to prison or jail time rather than being released back to the community are not followed, and have been included in our study attrition estimates. This is a standard approach taken in other re-entry studies (e.g., R01 AA021732; U01DA016191 [37]) that must consent participants when their sentencing or release status is still unknown. Sentencing occurs independent of study condition, so the exclusion of these individuals from analysis (no "at-risk" community months) is unlikely to influence internal validity. We follow all remaining participants who are released from jail to the community after the index incarceration through the 12-month post-release period regardless of reincarceration, continued participation in SPI or enhanced SC, or subsequent suicide attempts or hospitalizations. Of the 92–94% of participants who are released from jail to the community after the index incarceration, we estimate that post-release outcome assessment rates will be 82% at 1 month, 80% at 3 months, 75% at 8 months, and 70% at 12 months, with 85% of participants providing data for at least one post-release outcome assessment. Therefore, we expect that 78% (85% of the 92% who are released from jail) of the 800 enrolled participants will provide evaluable outcome assessment data. Count (e.g., suicide events) data from missed assessments are gathered at later assessments when they occur, and we collect medical record and death record data on all eligible (i.e., released) participants, providing additional sources of otherwise missed data.

2.8.3. Power

Our primary outcome (suicide events) is a composite of the number of suicide attempts (including suicide deaths), suicide behaviors (C-SSRS-defined aborted attempts, interrupted attempts, and preparatory behaviors), and suicide-related hospitalizations. Previous trials of brief suicide risk reduction interventions in other at-risk populations have described ratios rather than count outcomes, yielding relative risks of 0.38 [24,25], 0.48 [23], 0.56 [22], 0.56 [21], and 0.63 for suicide attempts (0.09 for suicide deaths [26]), 0.32 [88] and 0.50 [24,25] for suicide behaviors, and 0.55 [24,25] for hospitalization. This study is powered to detect an effect size at the lower end of the range of y/n effect sizes of successful similar studies: RR of 0.56 for any attempts, 0.50 for any behaviors, and 0.59 for any hospitalization. In reality, our power will be better because we are measuring number of events (i.e., count outcomes), not just yes/no event occurrence.

2.8.3.1. *Base rates.* The literature provides information about base rates of suicide deaths among general populations of jail detainees, but not suicide *events* among jail detainees with suicide ideation. Therefore, we estimated control condition event rates among suicidal jail detainees conservatively as half the rates observed in ED and inpatient studies [24,25,46].

2.8.3.2. *Clinical significance.* We express clinical significance using the area under the curve (AUC) statistic [49]. The AUC is flexible and has a direct and clinically relevant interpretation: the proportion of pairs sampling one person exposed to the active treatment and another to the control, where the member of the pair exposed to SPI has a more favorable outcome profile. Our expected main effects translate into an AUC of 0.58, indicating that there is a 58% chance that a randomly selected participant from the enhanced SC condition will have more suicide events than a randomly selected person from the SPI condition. This corresponds to a d = 0.28 [49], meaning that our study is powered to detect small effects. This is the median effect size for suicide attempts reported in the literature, and we have superadequate power to detect this effect (96.5%; see below).

2.8.3.3. *Estimation.* We estimated power using Monte Carlo methods and 1001 replications per condition. Assuming: (1) the outcome is a total count of three outcomes [suicide attempts (including deaths), suicide behavior, and suicide related hospitalization] analyzed with ordinal logistic regression, (2) outcomes are correlated at 0.50 and have base rates of 10%, 18% and 12% in the control group and 5.5%, 9% and 7% in the SPI group (where these percentages reflect cumulative annual incidence), and (3) a baseline sample of 800 released persons of whom 78% are expected to provide evaluable data; using a type-I error risk of 5%, we will have 96.5% power to detect hypothesized main effects. Power is good but the study is not over-powered given the sensitivity of power to estimated effect sizes; assuming the control condition rates are as estimated, the minimum differences we can detect with 80% power would be SPI condition rates about 6.5% risk of attempts, 10.2% risk of behaviors, and 8% risk of hospitalization. The detectable effect size for mediation effects range from 0.11 to 0.13 as the correlation of the intervention and the potential mediator ranges from 0.2 to 0.5. Thus, we have power to detect any mediation effect that is clinically significant.

2.8.4. Non-completers and non-responders

Given the unpredictable lives of our target group, flexibility is important in order to make the intervention accessible to them. Participants are not be discontinued from the intervention protocol for noncompliance because it has been our experience that recently incarcerated individuals can reengage with providers, even after a period of absenteeism. Participants who report significant suicide or homicidal risk, increased psychiatric symptoms or substance use are referred to appropriate additional care, but remain in the research protocol. All participants who are released from jail are invited to continue all outcome assessments, and research staff attempt to maintain regular contact with all participants to collect data at each assessment interval. Medical and death records covering the year after release are collected for all participants.

2.9. Data quality and participant safety

2.9.1. Data quality and informatics

The study uses a REDCap database, which is accessible via web, allowing research staff and community mental health counselors from both study sites to access it. To maintain study RA blinding, we built two linked REDCap databases using custom REDCap programming. One of the databases serves as a proxy electronic health record for study counselors. It includes caseloads, case notes, outreach attempts, and study status for each participant. It also includes a form for counselors to report adverse events. The other database serves as the participant tracking and interview database for study RAs. It includes a locator form, record of outreach attempts, field notes, interview measures,

participant remuneration tracking, medical and death records reviews, and adverse events. We built custom functionality so that the two databases can communicate updates to locator information, due dates, and adverse event information.

Because this is a large trial (N = 800) of a high-risk population (justice-involved individuals at risk for suicide), we invested in custom programming for adverse event reporting. When a counselor or a RA learns of an adverse event through an SPI session, interview, or medical chart review, s/he completes an initial adverse event report. RAs enter reports directly into the main study database, and counselor adverse events are automatically copied into the main study database. Completion of the initial report triggers an automatic email to our study safety monitor, who completes the official adverse event report in REDCap. The safety monitor then emails the Safety Officer for review and electronic signature, and if the adverse event is serious, also emails one of the principal investigators for review and electronic signature. The safety monitor electronically prints and files pdf copies of each signed adverse event report and then emails pdf copies of serious adverse events to NIMH within 72 h of the initial event report. The custom REDCap databases have allowed us to unify adverse event reports from counselors and RAs and then efficiently and smoothly execute completion of the adverse event narrative by the safety monitor, signature by a safety officer, signature by a principal investigator, and electronic submission to NIMH within 72 h for more than 1000 adverse events (e.g., hospitalizations, suicide attempts) to date.

We also have well-specified procedures to produce high data quality. RAs enter phone interviews directly into REDCap and transfer paper forms into REDCap. RA field folders for in-person interviews (i.e., in the jail or other controlled environments) include clear checklists including what to do before leaving the office, each assessment, checklists for adverse events, mandatory reports, randomization, and what to do upon return to the office, as well as a clearly laid out participant inclusion/exclusion certification form. Telephone outcome assessments have similar prompts electronically programmed into REDCap. Both in-person and phone interviews are audiorecorded in case checking is needed. Interviews have both clerical (e.g., checking for completion and accuracy of forms and checklists) and clinical (e.g., checking for correct scoring and documentation of interviewer-rated instruments) checks, which are documented in REDCap.

2.9.2. Participant safety

Following our experience with previous large suicide prevention studies [46,90], which employed a similar protocol, primary clinical coverage for the anticipated 3200 telephone outcome assessments is provided by mental health crisis counselors staffed at the Boys Town National Suicide Hotline. Boys Town created a dedicated telephone line through which assessment calls that surpass a specific threshold of risk will be transferred, following a "warm transfer" process between the RA and the mental health crisis counselor at Boys Town. The thresholds for "warm transfer" to Boys Town are programmed into REDCap, so that reminders pop up when a call is indicated. The RA clicks a button in REDCap that sends critical information (e.g., participant name, location, telephone contact information) via secure email to Boys Town, and then stays on the call for the warm transfer. Boys Town has a set of specified safety procedures to follow, including assessing risk, referring to care, and calling locators or emergency services, if needed. Boys Town reports participant dispositions and outcomes back to the study via secure email in an official Call Record, within 24 h of each contact. Study staff check this information for adverse events, complete a summary form in REDCap (e.g., duration of call, disposition), and file the Record on the secure file transfer server. Emergency referral in the jail is provided by the jail. These procedures are clearly described in the study consent form.

We have several procedures in place to maximize study staff proficiency with safety and regulatory procedures in this highly regulated trial (the study is overseen by the university IRB, the jail oversight committees, and the NIMH DSMB, and has regular independent site monitoring). All study regulatory documents are on the secure file transfer server, for simultaneous use by our two teams and co-investigators around the country. RA field folders have detailed checklists and information on emergency procedures. RAs extensively review and quiz each other on the study protocol and Manual of Operating procedures before beginning field work, and then shadow and are shadowed by other RAs before working alone. The principal investigators are also available to provide advice and support with difficult interviews, as can occur in a population with high rates of mania, psychosis, and substance use. We also have clear reporting lines and processes. Principal investigators and project coordinators meet weekly to coordinate study procedures between the two sites. One of the sites (Michigan State University) conducts telephone outcome assessments for both states (Michigan and Rhode Island). The other site (Brown University) collects and enters medical and death records and provides remuneration for participants in both states. This division of labor is efficient and makes it easier to maintain study blinding.

2.10. Assessments

Assessments take place at baseline, and at 1, 4, 8, and 12 months post-release. Baseline assessments (including informed consent, locator, and release of information paperwork) take place in person at the jail. RAs offer to read each study assessment aloud. Outcome assessments take place by telephone unless a participant is re-incarcerated or in another controlled setting without telephone access, in which case the outcome assessment take place in person.

2.10.1. Length of assessments

Given that in jail, participants may be in distress (having just been arrested, having just gone through substance withdrawal, potentially being in psychiatric distress) and that time with participants in jail is limited, we have tried to keep the baseline interview and consent procedures to as close to an hour as possible to increase the feasibility of research procedures. Given that we conduct outcome assessments by phone, we have also tried to keep them to close to an hour and to offer a large ($60) compensation for each outcome assessment interview to offset participant costs (i.e., using phone minutes to talk with us).

2.10.2. Training assessment personnel

Assessments are conducted by trained RAs, who are supervised by the PIs. Training procedures consist of: (a) review of relevant written materials, (b) didactic instruction, (c) practice interviews with review, feedback and reliability ratings, and (d) continued practice until certification. Following initial training, interviewers and senior staff meet regularly to review assessment tapes, address questions/issues, and monitor inter-rater reliability. Assessments are recorded using digital audiorecorders. RAs upload their recordings to our secure file transfer server for review and inter-rater reliability rating.

2.10.3. Measures

2.10.3.1. Primary outcome. Suicide Events is a composite score consisting of the total number of occurrences of any of the following in the year after jail release: (a) attempted suicide (includes suicide deaths), (b) suicide behaviors (preparatory acts, aborted or interrupted suicide attempts), as defined using the Columbia criteria [82,83], and (c) suicide-related hospitalizations. We use the Treatment History Interview (THI [91]) as well as hospital records to track the number of subsequent hospitalizations and reasons for these admissions. Following the recommendation of Oquendo et al. [92], our primary outcome measure (i.e., number of suicide events) is a broadly defined composite which reflects suicide behavior/risk.

Suicide event data are collected from all possible sources, including outcome assessments (C-SSRS, THI), (b) hospital chart reviews from relevant area hospitals, and (c) state/national registries. We collect the

Table 1
Study assessments.

Assessment	Type	Time (min)	Baseline	1, 4, 8, 12 month (outcome assessment)
Suicidal ideation and behavior				
Columbia Suicide Severity Rating Scale (C-SSRS)	Interview	20	X	X
L.I.F.E. suicidal ideation and behavior	Interview	10		X
Suicide deaths: record review (state/national death registry)	Objective	0		X
Hospitalizations: Treatment History Interview, record review	Objective	0		X
Psychiatric Symptoms: DSM-5 Cross-Cutting Measure	Self-Report	7	X	X
Functioning: SF-12 from RAND Medical Outcomes Study	Self-Report	3	X	X
Hypothesized Mechanisms				
Treatment utilization: Treatment History Interview	Interview	8	X	X
Belongingness: Interpersonal Needs Questionnaire-12	Self-Report	5	X	4,8,12 only
Suicide-related problem-solving: Safety behavior checklist	Self-Report	5	X	4,8,12 only
Diagnosis:				
Mini International Neuropsychiatric Interview (MINI)	Interview	15		1 mo only
LEC-PCL for PTSD	Interview	7		1 mo only

full hospital chart for the relevant time period and code a suicide attempt when either: (1) the hospital has a field indicating a suicide attempt and it is checked "yes," or (2) the nurse or physician narratives indicate that the participant has made a suicide attempt or said s/he made a suicide attempt. We code a suicide death from death records if the manner of death is listed as "suicide." Data from all sources are reviewed by research team members for congruence. All reports are classified using C-SSRS criteria. The C-SSRS is the recommended measure of suicidal ideation and behaviors in the NIH PhenX Toolkit as a core data element in all clinical trials for suicide prevention. Although it will not be included in our suicide event composite, we also track implementation of rescue procedures (e.g. calling EMS/police, breaking confidentiality to inform clinician of high suicide risk) during SPI phone calls or study assessments and compare conditions on this variable.

2.10.3.2. Secondary outcomes. Suicide Attempts. We separately assess and evaluate total number of subsequent attempts using the procedures described above. Weeks of active suicidal ideation during the assessment follow-up period are operationalized using the Longitudinal Interval Follow-Up Evaluation (LIFE [93]). At each assessment point, we ask participants to rate their level of suicidal ideation week by week since the last assessment on a 6-point psychiatric status rating scale. This LIFE method yields weekly scores and allows us to examine both the occurrence and chronicity of suicidal ideation over the assessment period. The LIFE calendar is also used to assess time to first suicide event. Severity of suicide ideation. We also assess severity of suicidal ideation using the Suicidal Intensity subscale from the C-SSRS. Psychiatric symptoms are assessed using NIH's DSM-5 Cross-Cutting Symptom Measure (DSM-5 CCSM) [94]. Overall functioning is measured using the SF-12 [95], a brief, widely used measure of physical and mental health functioning that also provides our secondary cost-effectiveness measure.

2.10.3.3. Hypothesized mechanisms of SPI effects. We define treatment utilization (primary) as the number of outpatient mental health and substance use visits attended in the community in the 3 months prior to baseline or since the last assessment, as indexed by the THI. Belongingness (exploratory) is assessed using the INQ-12 [96,97]. Suicide-related problem-solving (exploratory) is assessed using a standard checklist of suicide safety behaviors [98] which asks whether each was utilized during the most suicidal period since the last interview. The checklist includes two subscales to minimize assessment reactivity: the sum of the number of recommended (e.g., call a friend) and the sum of the number of not recommended (e.g., use drugs) responses to suicidal thoughts or urges.

2.10.3.4. Additional outcomes. Suicide deaths. Given the low incidence of suicide deaths, even in this high-risk sample, we do not expect to have sufficient numbers of suicide deaths (separate from the suicide event composite) for meaningful analyses. However, we track number of suicide deaths using all possible data sources, including hospital records and reviews of state and national death registries. Although our intervention does not target re-arrest directly, it is possible that by increasing service linkage, SPI could reduce rearrest; therefore, we assess number of re-arrests and will compare conditions on this variable. We also track days incarcerated in the year after the index release to weight participants by time in the community for other analyses.

2.10.3.5. Sample descriptors. Sample descriptors include baseline demographics. Study inclusion criteria are based on suicide risk rather than diagnosis, but we gather some basic diagnostic information (lifetime psychosis, mania/hypomania, and major depression) using MINI modules [99]. We chose the MINI to keep assessment interviews to 1 h; keeping participant burden minimal (and hence, study procedures feasible and enrollment and outcome assessment rates high) was our primary consideration. We also assess posttraumatic stress disorder (PTSD) diagnosis, using the Life Events Checklist and PTSD Checklist for DSM-5 (LEC-PCL) [100,101]. We administer the MINI modules and the LEC-PCL at 1 month post release because: (1) we are assessing lifetime diagnosis, and (2) giving these scales at the 1-month outcome assessment best balances the length of all assessments (Table 1).

2.10.3.6. Hospital and death records. Most of RI is covered by 2 large health systems. Genesee County, MI is covered by 3 systems. As in ED-SAFE (a 7-state, 8-site suicide prevention trial) [102], we obtain releases of information from participants at study intake to conduct chart reviews at all of the hospital systems in each region. As in ED-SAFE, RAs review charts following a structured protocol, utilizing discharge codes, discharge summaries, medications, laboratory results, operation records, nursing notes, physician progress notes and other notes or comments to determine whether a suicide event occurred. ED-SAFE data showed that this approach is feasible and that it enhanced detection of suicide events over and above telephone outcome assessment, uniquely identifying 43% of the 187 detected suicide-related events [103]. Thus, a combination of records review with phone assessment is a feasible and robust approach to detecting suicide-related events. We also search the National Death Index [104] for ICD-coded suicide deaths in our sample.

2.10.3.7. Cost-effectiveness measures. Our grant accounting captures the costs of the SPI providers. We also track treatment received as part of standard care for the SPI and enhanced SC conditions. Standard care

(including outpatient, inpatient, and ED mental health and suicide-related medical care visits) is tracked using the THI, and costs of standard care are estimated using costs for similar visits to SPI providers and charge data from state hospital and ED data systems adjusted to costs with facility-specific cost-to-charge ratios obtained from Federal cost reports. We include training costs but exclude other research costs that would not be incurred if SPI were standard care. The primary cost-effectiveness (CE) measure is the sum of suicide-related hospitalizations and medically treated and fatal suicide acts [105]. Our secondary CE measure is the SF-12, using Sengupta's HUI3 scoring [106] which measures functional status in quality-adjusted life years (QALYs). Costs (and savings) in future years are discounted to present value in the year of treatment initiation using the 3% discount rate recommended by the Panel on Cost-Effectiveness in Health and Medicine [107]. Costs and benefits are converted to same-year dollars.

2.11. Data analysis

Primary analyses will be intent-to-treat; we will examine dose-response effects in secondary analyses. Primary tests will be 2-sided with $p = .05$. Site differences will be modeled with fixed effects. Descriptive statistics will include effect sizes and measures of clinical significance (i.e., area under the curve [AUC] [89]; number needed to treat [NNT]) for all major comparisons. We will separate primary hypothesis (Aim 1) from remaining hypotheses (Aims 2–4). Standard post hoc procedures will be used to adjust for multiple comparisons when testing secondary hypotheses. There is no interim analysis. Analyses will adjust for baseline levels of dependent variables, gender, and y/n history of suicide attempts. Consistent with CONSORT [103] guidelines, we will prespecify covariates and will not adjust for imbalance observed post hoc.

2.11.1. Missing data

We collect medical record and death record data on all participants. Self-reported count (e.g., suicide events) and historical (e.g., weekly LIFE ratings) data from missed assessments are gathered at later outcome assessments. We will use multiple imputation to deal with missing data. We will compare treatment conditions on rates of missingness and time to missingness and will test whether baseline characteristics are associated with missingness. Finally, we will perform a sensitivity analysis in which we impute extreme values for missing data to determine the sensitivity of analysis results to missing data.

2.11.2. Outcomes

Primary. We will test the hypothesis that, relative to enhanced SC alone, SPI + enhanced SC will result in fewer suicide events over the 12 month outcome assessment period, using ordinal logistic regression with lifetime suicide attempts events at baseline as a covariate. The analysis framework will be multivariate ordinal dependent variable regression. We begin with ordinal models because our simulations suggest the count outcome will not likely exceed 3. We will explore using different models such as zero-inflated Poisson or zero-inflated negative binomial with an offset defined by the length of assessment period and time in the community (as opposed to incarcerated), and other reasonable approaches. Determination of the appropriate modeling will be determined using model selection (information) criteria and the determination will be made blind to the effect of the SPI intervention. Secondary. We will separately test the hypotheses that, relative to enhanced SC alone, SPI + enhanced SC will result in fewer suicide attempts, fewer weeks of active suicide ideation (per the LIFE calendar), lower severity of suicide ideation (C-SSRS scores), longer time to first suicide event, fewer psychiatric symptoms (DSM-5 CCSM scores), and better psychosocial functioning (SF-12 scores). For normally distributed variables (i.e., C-SSRS, DSM-5 CCSM, SF-12), analyses will use a generalized linear mixed model framework for multilevel data (e.g., SAS proc. mixed, HLM) with baseline scores as covariates. For count data (i.e., number of suicide attempts, weeks of active suicide ideation), analyses will use Poisson-class regression methods (e.g., negative binomial regression) and will include appropriate tests for zero-inflation and over-dispersion and offset defined by length of the outcome assessment period and time in the community. Time to suicide event will be analyzed using time-to-event models, beginning with semi-parametric Cox regression models assuming proportionality assumptions are met, otherwise discrete time or parametric continuous time survival models will be used. Model choice will be informed by information criteria and decisions made blind to intervention assignment. Exploratory. Although not part of formal hypotheses, we will also compare conditions on (1) rates of death by suicide, (2) number of re-arrests, and (3) number of emergency referrals generated as part of study safety procedures.

2.11.3. Mechanisms of intervention effects

We will separately test the hypotheses that, relative to enhanced SC alone, SPI + enhanced SC will result in more treatment utilization (number of outpatient mental health and substance use visits as assessed by the THI), more sense of belongingness (INQ-12 Belongingness Scale score), and better suicide-related problem solving (as assessed by the safety behavior checklist), our proposed primary and exploratory mechanisms, using Mplus, which can accommodate both standard and Poisson-class regression methods. We will then test the hypothesis that treatment utilization, suicide-related problem-solving skills, and belongingness (1) predict suicide events, and (2) mediate the effects of SPI on suicide events in a structural equation model framework to decompose total effects into direct and specific indirect effects. As recommended by MacKinnon et al. [109], the statistical significance of the indirect effect will be assessed using bias-corrected bootstrapped standard errors; 95% CI estimates will be provided.

2.11.4. Predictors/Personalization

We will explore gender, race/ethnicity, lifetime suicide attempts, lifetime highest C-SSRS SI intensity score, severe mental illness (schizophrenia, bipolar disorder), substance use severity, PTSD, major depressive disorder, and number of lifetime arrests as moderators. We expect that SPI is appropriate for a full range of at-risk jail detainees.

2.11.5. Cost-effectiveness analyses

We will use a comparative cost effectiveness (CE) analysis of SPI + enhanced SC relative to enhanced SC alone. The primary effectiveness measure is the sum of suicide-related hospitalizations and medically treated and fatal suicide acts, with a secondary measure of QALYs (see D2.12). Following widely accepted CEA guidelines [107,110], analyses will adopt a societal perspective, considering all economic costs regardless of source. If direct cost savings exceed the program costs, the program is said to offer net cost savings. We describe our statistical plan for determining mean change in and standard deviations of these measures above. The CE ratio equals $\Delta C/\Delta E$, where ΔC is the difference in costs between SPI + enhanced SC and enhanced SC alone and ΔE is the difference in the outcome measure. Using the Crystal Ball add-in to Excel, we will bootstrap 95% confidence intervals around the CER and calculate a cost-effectiveness acceptability curve [111]. Sensitivity analysis will examine CERs at 0%, 1% and 5% discount rates.

2.12. Administrative supplement: intersection between suicide outcomes and substance use

Given the overlap in risk profiles, the recognition that some overdoses may actually be undetected suicide attempts, and the high rates of substance use in our sample, we received an administrative supplement to address the intersection between suicide outcomes and substance use. We will evaluate substance use as a moderator of the effects of SPI on suicide events, and will examine SPI as a moderator of the

relationship between substance use and suicide behaviors. We will also evaluate whether SPI (relative to enhanced SC) reduces overall rates of overdose, and whether SPI has a differential effect on overdose versus non-overdose suicide attempts. We define overdose as taking too much of a substance and experiencing symptoms of overdose for that substance, and measure it by self-report, supplemented with medical records. We will conduct a mixed-methods analysis of narrative sections of the participant interviews (i.e., on the C-SSRS, LIFE, Serious Adverse Event report narratives) to describe the functional associations between substance use and suicidal thoughts and behaviors in our sample. Finally, we added questions about whether participants went to the ED after their most recent accidental overdose, whether they went to the ED after their most recent suicide-related overdose, reasons why they did or did not go to the ED in each case, and whether they disclosed suicidal intent to ED personnel.

3. Discussion

Pretrial jail detention is a marker for increased suicide risk: jail detainees are a high-risk, low-resource population with complex psychiatric, health, housing, and employment challenges [11,2], who are facing a major life stressor (i.e., arrest). Release to the community decreases supervision and increases access to lethal means. Lack of education, poverty, victimization, substance use, homelessness, isolation, and poor employment skills complicate care and increase morbidity and mortality [113–120]. Suicide intervention research for this population is lacking. In fact, there are no existing research-supported approaches to reduce suicide after jail release.

This registered trial, published following CONSORT guidelines, will be the first RCT evaluating the effectiveness of any suicide risk reduction intervention for individuals leaving pretrial jail detention, a large population that contributes significantly to U.S. suicide rates. The trial takes place in community settings and tests an intervention that is scalable given resources and constraints of these settings. It is powered to examine mediators and moderators of intervention effects to help target future suicide risk reduction interventions among jail detainees whether or not SPI yields anticipated main effects. The study will also provide the data on cost-adjusted outcomes that systems need to make informed decisions about adoption, speeding implementation. Thus, the study will provide knowledge about both mechanisms and system-level intervention effects, providing maximum public health impact. Given that there are no existing research-supported approaches, if shown effective, SPI has the potential to change clinical practice and measurably reduce U.S. suicide rates.

This trial provides an example of how to manage research with two highly regulated research populations: those at risk for suicide and those involved in the justice system. Novel aspects of the trial that maximize external validity include use of embedded community mental health counselors, limited exclusion criteria, and post-randomization ineligibility. Other novel aspects of the trial (such as custom programming of two interfacing REDCap databases, use of self-report and medical records from hospitals in two states, efficient management of adverse events reported from multiple sources, a shared secure file transfer server, recruiting 800 suicidal individuals in pretrial jail detention in 29 months, and managing up to 3200 phone outcome assessments, including numerous outreach attempts, with appropriate checking and coordination in place) are made possible by adequate funding. At maximum staffing, this project included 2 principal investigators, 15 co-investigators or consultants, 2 full-time project coordinators, 6–10 full-time RAs, 16 hourly study counselors, site monitoring, and creation and maintenance of the REDCap databases by our university bioinformatics team. Having adequate funding to hire a large and capable team greatly facilitated running this complex trial cleanly. In particular, the REDCap custom programming integrating a counselor tracking and case note system with RA tracking, interview, and medical records data, while maintaining blinding and bringing together study adverse event reporting, was money well spent. We are grateful to our funders for setting us up to succeed, and we encourage funders to provide adequate resources to ensure clean, well-run trials.

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References

[1] Statista, Number of arrests for all offenses in the United States from 1990 to 2017, https://www.statista.com/statistics/191261/number-of-arrests-for-all-offenses-in-the-us-since-1990/, (2019) Accessed 4-6-2019, 2019.
[2] D. James, L.E. Glaze, Mental Health Problems of Prison and Jail Inmates, Bureau of Justice Statistics Special Report (2006).
[3] L.M. Hayes, J.R. Rowan, National Study of Jail Suicides: Seven Years Later, National Center for Institutions and Alternatives, Mansfield, MA, 1988.
[4] D.R. Charles, K.M. Abram, G.M. McClelland, L.A. Teplin, Suicidal ideation and behavior among women in jail, J. Contemp. Crim. Justice 19 (2003) 65–81.
[5] M. Sarchiapone, N. Jovanović, A. Roy, A. Podlesek, V. Carli, M. Amore, M. Mancini, A. Marusic, Relations of psychological characteristics to suicide behavior: results from a large sample of male prisoners, Personal. Individ. Differ. 47 (4) (2009) 250–255.
[6] A. Kariminia, M.G. Law, T.G. Butler, et al., Suicide risk among recently released prisoners in New South Wales, Australia, Med. J. Aust. 187 (7) (2007) 387–390.
[7] D. Pratt, M. Piper, L. Appleby, R. Webb, J. Shaw, Suicide in recently released prisoners: a population-based cohort study, Lancet 368 (9530) (2006) 119–123.
[8] L.M. Stewart, C.J. Henderson, M.S. Hobbs, S.C. Ridout, M.W. Knuiman, Risk of death in prisoners after release from jail, Aust. N. Z. J. Public Health 28 (1) (2004) 32–36.
[9] J. Zlodre, S. Fazel, All-cause and external mortality in released prisoners: systematic review and meta-analysis, Am. J. Public Health 102 (12) (2012) e67–e75.
[10] Centers for Disease Control and Prevention, National Violent Death Reporting System (NVDRS) Query, https://wisqars.cdc.gov:8443/nvdrs/nvdrsDisplay.jsp, (2019) Accessed 12-16-2019, 2019.
[11] US Department of Justice, Criminal Justice Information Services Division, Crime in the United States 2012, www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2012/crime-in-the-u.s.-2012/persons-arrested/persons-arrested, (2014).
[12] W. Sabol, T.D. Minton, Jail Inmates at Midyear 2007, Report No. NCJ 221945, Washington, D.C. Bureau of Justice Statistics, 2008.
[13] T.D. Minton, Jail Inmates at Midyear 2010: Statistical Tables, in: Bureau of Justice Statistics, ed. U.S. Department of Justice, Washington, DC, 2011.
[14] B. Stanley, G.K. Brown, L.A. Brenner, H.C. Galfalvy, G.W. Currier, K.L. Knox, S.R. Chaudhury, A.L. Bush, K.L. Green, Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department, JAMA Psychiatr. 75 (9) (2018) 894–900.
[15] B. Stanley, G.K. Brown, G.W. Currier, C. Lyons, M. Chesin, K.L. Knox, Brief intervention and follow-up for suicidal patients with repeat ED visits enhances treatment engagement, Am. J. Public Health 105 (8) (2015) 1570–1572.
[16] F.S. Taxman, S. Belenko, Implementing Evidence-Based Practices in Community Corrections and Addiction Treatment, Springer, New York, 2011.
[17] N. Wolff, Community reintegration of prisoners with mental illness: a social investment perspective, Int. J. Law Psychiatry 28 (2005) 43–58.
[18] J. Johnson, Y.C. Schonbrun, M.E. Peabody, R.T. Shefner, K.M. Fernandes, R.K. Rosen, C. Zlotnick, Provider experiences with prison care and aftercare for women with co-occurring mental health and substance use disorder: Treatment, resource, and systems integration challenges, J. Behav. Health Serv. Res. 42 (4) (2015) 417–436.
[19] L.A. Walby, M.O. Myhre, A.T. Kildahl, Contact with mental health services prior to suicide: A systematic review and meta-analysis, Psychiatr. Serv. 69 (2018) 751–759.
[20] National Action Alliance for Suicide Prevention, Research Prioritization Task Force, A prioritized research agenda for suicide prevention: An action plan to save lives, www.suicide-research-agenda.org, (2014).
[21] G. Vaiva, F. Ducrocq, P. Meyer, D. Mathieu, A. Philippe, C. Libersa, M. Goudemand, Effect of telephone contact on further suicide attempts in patients discharged from an emergency department: randomised controlled study, BMJ 332 (2006) 1241.
[22] G. Carter, K. Clover, I.M. Whyte, H.A. Dawson, C.D. Este, Postcards from the EDge project: randomised controlled trial of an intervention using postcards to reduce

A National Study of Transitional Hospital Services in Mental Health

ABSTRACT

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Introduction

One result of the deinstitutionalization of patients from public mental hospitals in the 1970s was the movement of many patients with severe and persistent psychiatric disorders into general hospitals, effectively mainstreaming the mentally ill into the acute medical care system. [illegible]

The Problem of Continuity of Care

[illegible]

[illegible]

The Link between Continuity of Care and Clinical Outcome

[illegible]

Hypotheses

[illegible]

Methods

[illegible]

often (on a scale of never, sometimes, often) primary responsibility for ensuring that patients receive aftercare (e.g., psychotherapy, occupational, or case management services) rested with the hospital as compared with the patients themselves, private practitioners, and state and community agencies; second, whether their facility conducted team review of discharge plans; third, whether staff were exclusively assigned to patient follow-up; fourth, whether case-management services were provided; fifth, whether the average length of follow-up contact lasted 1 week, up to 1 month, up to 6 months, or more than 1 year; and sixth, which of six follow-up methods was the one most often used: (1) patient is given follow-up appointment, (2) patient is given staff help with referral, (3) patient is sent appointment reminder, (4) patient is telephoned by aftercare provider, (5) staff visits aftercare providers, and (6) staff visits patients' homes.

Independent Variables

Each hospital reported the legal form of ownership (public, private non-profit, private for-profit) under which it operated, as well the type of psychiatric unit (general or specialty) and whether the unit was a teaching facility for medical interns and psychiatric residents.

Hospital administrators reported the percentage of total psychiatric patient care revenues from private insurance, Medicare, Medicaid, state and county contracts, and direct payment by patients. Administrators also reported the proportion, by diagnostic category, of inpatients treated in the last year. The percentage of patients diagnosed with schizophrenia was used as an indicator of long-term chronic illness and thus identified the hospitals with a high proportion of these patients most likely to need specific help in making the transition from inpatient care to community-based care (see Table 1).

Statistical Analysis

Several variables were used initially in regression analyses to control for hospital and community characteristics. Generally, the availability of resources of many kinds (including staff and level of staff training) is greater for larger hospitals and for those in more urban areas. To control for these influences, we included a measure of the percentage of the hospital service area population that is urban (Department of Commerce Area Resource Files),[24] the average daily hospital psychiatric census, and the concentration

TABLE 1—Descriptive Statistics for Independent Variables

	No. of Hospitals	% of Sample
Categorical variables		
Type		
Specialty	349	38.1
General	566	61.9
Ownership		
Public	284	31.6
Private	625	68.4
Residency program		
No	716	78.8
Yes	192	20.0
		Mean ± SD
Continuous variables		
Percentage of patients diagnosed with schizophrenia	902	27.31 ± 19.76
Percentage of hospital revenues from Medicaid	888	18.84 ± 16.02
Percentage of hospital revenues from Medicare	886	23.86 ± 14.88
Percentage of hospital revenues from state and county	880	10.42 ± 23.92
Daily hospital psychiatric census	909	103.84 ± 209.60
Population density in hospital service area	915	75.76 ± 21.02

Note. Responses rates to individual questions vary somewhat.

TABLE 3—Transitional Care Services Provided by Psychiatric Hospitals and General Hospital Psychiatric Units (n = 915)

	Frequency, %		
	Psychiatric Hospital (n = 349)	General Hospital (n = 566)	Total (n = 915)
Hospital responsible for ensuring aftercare			
Never	12	11	15
Sometimes	37	38	38
Often	57	45	55
Length of follow-up			
Up to 1 week	32	56	46
Up to 1 month	27	27	27
Up to 6 months	18	10	13
Up to 1 year	23	8	14
Method of follow-up used most often			
Patient given appointment	43	66	58
Staff available to help with referral	19	19	19
Letter sent reminding of patient appointment	4	4	4
Phone follow-up with aftercare provider	15	8	11
Staff visit to aftercare provider	7	2	4
Staff visit to patient's residence	5	1	3
Team review of discharge plan			
No	3	11	7
Yes	97	90	93
Staff assigned exclusively to patient follow-up			
No	30	48	41
Yes	70	52	59
Case management provided			
No	65	79	74
Yes	35	21	26

Note. Response rates to individual questions vary somewhat.

Regression

Discussion

Conclusion

services for severely mentally ill persons, national health care reform proposals should either provide for reimbursement (in the manner of current Medicaid programs) or else explicitly mandate responsibility for such services to state mental health authorities. [illegible]

Acknowledgments

The authors are grateful for comments and statistical review given by Sherrie Epstein, William Fisher, and Mark Schlesinger.

References

[illegible]

Call for Abstracts for Injury Control Late-Breaker Session

The Injury Control and Emergency Health Services Section of the American Public Health Association will again feature a late-breaker session during the APHA annual meeting October 30 through November 3, 1994, in Washington, DC. The session will be held on Thursday, November 3, at 8:30 AM and will feature work completed within the last few months, after the deadline for consideration in the regular synopsis of the meeting.

Abstracts of 250 words or fewer will be accepted by the author until September 10, 1994. No special form is required. Please send or fax the abstract, title of paper, author's name, address, telephone, and fax number to Rick Waxweiler, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Hwy, NE, Mail Stop F41, Chamblee, GA 30341; tel (404) 488-4031; fax (404) 488-4338. All submitters will be notified of decision by fax by September 24.

Full text
Translate

Headnote

Effects of Different Telephone Intervention Styles with Suicidal Callers at Two Suicide Prevention Centers: An Empirical Investigation1

Headnote

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Headnote

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Headnote

To determine the relative effectiveness of telephone intervention styles with suicidal callers, researchers listened unobtrusively to 617 calls by suicidal persons at two suicide prevention centers and categorized all 66, 953 responses by the 110 volunteer helpers according to a reliable 20-category checklist. Outcome measures showed observer evaluations of decreased depressive mood from the beginning to the end in 14% of calls, decreased suicidal urgency ratings from the beginning to the end in 27% of calls, and reaching a contract in 68% of calls, of which 54% of contracts were upheld according to follow-up data. Within the context of relatively directive interventions, a greater proportion of "Rogerian" nondirective responses was related to significantly more decreases in depression. Reduction in urgency and reaching a contract were related to greater use of Rogerian response categories only with nonchronic callers.

Headnote

KEY WORDS: suicide prevention; crisis centers; volunteers; intervention styles; evaluation; chronic callers; telephone services.

Each day, thousands of suicidal callers throughout the world contact community-based suicide prevention and crisis intervention centers for help. Despite the proliferation of the centers and their general community acceptance, there has been little systematic research to understand the nature

of telephone interventions by volunteers and their effectiveness (Lester, 1993; 1994; Medoff, 1984). Most prior attempts to evaluate the effectiveness of suicide prevention centers have focused on the effect of the presence of a suicide prevention center in an area on the population suicide rate. The results have sometimes been positive (e.g., Bagley, 1968; Lester, 1991, 1993; Medoff, 1984; Miller Coombs, Leeper, & Barton, 1984), but often no significant effects were found (e.g., Ashford & Lawrence, 1976; Barraclough, Jennings, & Moss, 1977; Kreitman, 1976). Such evaluations have two important shortcomings: First, death by suicide is an infrequent event; so, small annual fluctuations in the number of deaths may greatly effect annual suicide rates. Second, these studies ignore the fact that suicide prevention centers claim to do much more than prevent deaths by suicide; they help troubled and depressed people in crisis and they may reduce the likelihood of a nonlethal suicide attempt. Moreover, prior outcome research has generally focused only upon the effects of telephone interventions while ignoring the specific nature of the process of intervention. This study differs from previous investigations in several ways: (a) It explores the proximal effects of telephone interventions by volunteers with individual suicidal callers rather than studying population suicide rates, and (b) it relates proximal effects to process variables describing the nature of the interventions. Furthermore, we assess the relationship between process and outcome measures for two important client populations which traditionally use telephone intervention services: chronic and acutely suicidal persons.

Previous Studies of the Effectiveness of Suicide Prevention Center Activities

Apart from investigations of changes in population suicide rates, the effectiveness of volunteer suicide prevention activities has been generally studied by two methods: evaluation of client satisfaction and observations of changes from the beginning to the end of calls. Client satisfaction studies have invariably had favorable results (e.g., Apsler & Hoopke, 1976; King, 1977; McKenna Nelson, Chatterson, Koperno, & Brown, 1975; Motto, 1971; Rogers & Rogers, 1978; Stein & Cotler, 1973; Stein & Lambert, 1984; Streiner & Adams, 1987; Tekavcic-Grad & Zavasnik, 1987; Wold, 1973). However, satisfaction with the call does not necessarily indicate client improvement. Also, because of the confidential nature of calls, response rates in the satisfactory studies are generally poor (ranging from 40-80%), leaving open the possibility of a bias toward successfully contacting more satisfied clients in follow-up.

A few researchers have attempted to evaluate changes during calls using independent observers and qualitative measures. These evaluations were all conducted in a context where tape-recording of calls was permitted. Knickerbocker (1973) concluded that there was a general improvement from the beginning to the end of calls in anxiety, depression, and self-exploration. Similarly, Echterling

and Hartsough (1983) observed significant improvements on three dimensions (affective, behavioral, and cognitive) during telephone interventions.

Based upon our review of outcome measures used in these prior studies, we concluded that it would be desirable to evaluate effectiveness in terms of reliable proximal measures obtained from behavioral data gathered by outside observers. However, for ethical and legal reasons, we did not have the possibility of tape-recording telephone conversations. In the context of this constraint we identified three easily obtainable observable outcome measures relevant to telephone interventions: changes in the suicidal urgency from the beginning to the end of the call, changes in depression, and follow-up information on upholding a contract and not attempting suicide. The measures of changes in urgency and making a contract with the caller are very important components in community telephone crisis interventions. Monitoring depressive mood has been used before to evaluate telephone interventions, but refers more to a psychotherapeutic rather than a crisis intervention model. However, since depression is germane to the psychiatric explanations of the suicidal crisis and the fact that it has been previously investigated with volunteer organizations, we felt this type of measure would complement the other two outcome measures.

The Process of Intervention

In addition to gathering outcome information, this study explores the relationship between the nature of the telephone interventions and the outcome variables. This allows for investigation of whether certain intervention styles seem more beneficial than others. This research was inspired by a debate within the Montreal suicide prevention center over the value of teaching a specific intervention method to volunteers. A literature review revealed that there were no comparative studies indicating what type of intervention style is most effective. The principal investigator in this study was a volunteer consultant with the center and he formulated the present investigation in order to help respond to the center's desire to learn more about the relationship between intervention styles and outcomes.

Most prior research used indirect measures of the accomplishment of tasks during the intervention rather than studying the actual intervention styles. One such task-oriented method consisted of simply checking if there is systematic collection and registration of information on callers (Kolker & Katz, 1971; Whittemore, 1970). Others simply studied the amount of time it took to actually reach a volunteer helper on the phone (McGee, Richard, & Bercun, 1972). Fowler and McGee (1973) studied if helpers included three "essential" tasks in their telephone intervention: securing the communication with the caller, assessing the caller's condition, and developing a plan of action. Walfish, Tulkin, Tapp, Slaikeu, and Russel (1976) developed a similar task-oriented system which

looks at explorations of callers' internal and external resources, exploration of callers' feelings about a contract or a plan of action, an assessment of the clinical nature of the situation, and an exploration of the "practicalities" of the plan of action.

All of the above studies have assumed that certain practices are "good" and others less desirable. However, none of the research tested whether or not certain practices were actually related to more positive outcomes. Similarly, several researchers who examined the process of telephone interventions borrowed their methodology from research on the process of professional psychotherapy (e.g., Garfield & Bergin, 1986; Goodman & Dooley, 1976; Greenberg & Pinsof, 1986; Hill & Corbett, 1993; Kiesler, 1973; Lambert, Christensen, & DeJulio, 1983). These evaluations focused upon measuring what they believed to be facilitative of a therapeutic relationships according to the "Rogerian" model as reflected in the use of a set of well-defined techniques (Rogers, 1951; Truax & Carkhuff, 1967). These techniques (but not necessarily the entire Rogerian therapeutic method) are relevant to lay telephone crisis interventions since they are taught to volunteers in many suicide prevention centers. All previous researchers assumed that certain techniques are better than others because they fit a certain theoretical model, but they never tested their assumptions by assessing the relationship between process variables and outcome (Hirsch, 1981; Lester, 1970) Knickerbocker and McGee (1973) found that professionals and volunteers had "a low level" of performance according to criteria established by Rogerian theory. However they found that the nonprofessionals "did better" than the professionals. Genthner (1974) had one confederate caller pretend to seek help from 10 different community hotlines. He found that facilitative techniques, according to the Carkhuff (1968) psychotherapy model were "inadequate." Nevertheless, France and Kalafat (1975) and Kalafat, Boroto, and France (1979) showed that training methods could increase the use of facilitative techniques by volunteers. Carothers and Inslee (1974) suggested that although levels of empathy may be low in telephone interventions, volunteer services have the advantage over professional therapy of being free of charge and available at all times.

Several studies have tried to use more operational clinical constructs borrowed from psychotherapy research. D'Augelli et al. (1978) used a system to categorize helper responses into broad categories: continuing responses, leading responses, and self-referent responses. They concluded that volunteers at a University help-line were "too directive." Crocker (1985) used simulated calls to evaluate verbal responses (open vs. closed questions, reflections, advice), amount of talking time, and levels of comprehension, acceptance, and problem solving. He was also critical of the level of performance of volunteers based upon his assumptions about what is best. Again, these studies were all based upon an a priori model of which qualities are best for all interventions, and the researchers all assumed that the desired qualities in crisis intervention are the same qualities

previously suggested for nonsuicidal therapy patients. Our study is different in that we focus specifically upon crisis interventions with suicidal callers and we explore the actual relationship between process variables and outcome rather than simply evaluating an a priori model of what is supposed to be best according to a model of psychotherapy. To do so, we had to generate new objective measures of the intervention process which were not limited to the Rogerian model and which could be evaluated in the context of lay telephone interventions, within the ethical constraint of not being able to tape-record calls.

Chronic and Acute Callers to Suicide Prevention Centers

Since the beginning of the voluntary suicide prevention movement, persons involved in telephone intervention have recognized two broad categories of callers: chronic and acute suicidal persons. This distinction between those who are experiencing a recent suicidal crisis and individuals who call a suicide prevention center repeatedly, often many times a week, in a state of "perpetual" crisis over periods of months or years is well documented in descriptions of clinical interventions. However, there has been no empirical outcome research to evaluate if certain intervention styles seem more or less appropriate for acute and chronic callers. In the early 1970s, Wold (1971) and Lester and Brockopp (1970) described a "subgrouping" of callers to the Los Angeles suicide prevention center which they identified as "chronic callers," who were just as likely to have a high suicidal risk as the "average" caller, but who called the center a large number of times over an extended period. Since then, several published articles and presentations at suicidology meetings have suggested how crisis center volunteers may best respond to the needs of chronic callers. McKenna et al. (1975) reported that a crisis center in Winnipeg had more chronically suicidal than acute callers and suggested the chronic callers often did not improve after telephone interventions. Desmond et al. (1985) suggested that on the basis of their clinical opinion, chronic suicidal clients may fit the diagnostic criteria of the borderline personality disorder. Thigpen and Jones (1977) reported that among five categories of suicidal clients, only the chronic crisis clients have no set client management plan and are handled on an individual basis. Other articles and presentations at meetings for practitioners discuss the challenge of helping chronic callers (Bonie, Raab, & Sheehan, 1986; Lewin et al., 1992; Rudestam, 1978; Sawyer & Jameton, 1979).

All of the above articles and presentations emphasize the clinical importance of distinguishing between chronic and acute callers to suicide prevention centers and often describe the frustration of telephone volunteers in helping chronic callers after a limited number of contacts. When we developed the protocol for this research study, staff and volunteers in the community agencies involved suggested that it would be important to look at differences in the effectiveness of

intervention styles for chronic and acute callers. This appears to be the first study to gather empirical data on which intervention styles may prove to be more effective with chronic and acute callers. At the time the present study was conducted, no special guidelines for handling calls from chronic callers differently were in place at either of the centers. We investigated possible differences in the relationship between process and outcome for chronic and acute callers because of the expressed needs of the suicide prevention centers to better understand how they may most effectively help these different types of callers.

METHOD

Participants

Participants were the volunteers at two primarily French-speaking Canadian suicide prevention centers, Suicide-Action Montreal and Carrefour Intervention Suicide, Sherbrooke, Quebec. Both centers are identified only as suicide prevention centers and thus serve almost exclusively suicidal clients, which was not always the case for the "crisis centers" or "hotlines" previously studied. The first center is located in a large metropolitan area and is open 24 hours a day, 7 days a week. Most of its services are delivered by volunteers, particularly the telephone service. Other services include school suicide prevention programs, follow-up with suicidal clients, postsuicide interventions with the bereaved, and training for professional and nonprofessional helpers. The telephone service represented 23,790 hours of volunteer time for the year 1990-1991, that is, 18,852 telephone interventions (an average of 52 calls per day).

The Sherbrooke center, on the other hand, is located in a smaller community but serves a larger rural area by accepting long distance calls. It is open only from Mondays to Saturdays, 8:00 a.m. to midnight. At other times, there is a recording system giving general information to callers. At Sherbrooke, the volunteers gave 3,936 hours to the telephone service for 1990-1991 and there were 2,587 telephone interventions (an average of 8 calls per day). The centers readily agreed to participate in this study since the research objectives were developed out of a need expressed by the centers to better understand the relationship between the nature of their activities and outcome variables. Center personnel were consulted in all steps of developing the research protocol. Furthermore, the principal investigator (Brian L. Mishara) was involved on a volunteer basis with the Montreal center for over 10 years and had conducted previous studies on stress and coping among telephone volunteers which were well appreciated (Mishara & Giroux, 1993).

After screening, volunteers receive at least 32 hours of training on the nature of suicidal crises and how to help on the telephone. Training includes role plays and is followed by on-line supervision until

they are deemed ready to "go it alone." However, unlike the practice in many American centers, no specific style of intervention is taught and there is no practical training in specific active listening skills. Still, some volunteers have a background in human services and have had training in active Rogerian techniques.

We contacted all current volunteers at the two centers who had completed their on-line supervision. Of those contacted, 145 (95%) gave their consent to be part of the study and 110 were finally observed. Not all the volunteers who agreed to participate were observed because of the intermittent schedule of volunteers on vacation or ill and the balanced time sample in this study. Volunteers were informed that someone may listen to some of their calls for research purposes (with the listening device described in the next section), but complete anonymity would be maintained. The sample of volunteers observed had almost identical characteristics to the total population of all volunteers of the two centers. They were mainly women (59%). Their mean age was 32 (SD=11), ranging from 17 to 70, and they were rather new to the field of telephone intervention (M=109 hours of posttraining practice, SD=94).

The clients were 263 suicidal callers to the prevention centers. It is interesting to note that the callers had demographic characteristics similar to the volunteer helpers: 59% were women and the age ranged from 13 to 72 (M=35, SD=12). These clients were often considered "chronic" (25%), that is, long-time frequent callers with recurring problems. At the moment of the call, they were often previously prescribed psychotropic drugs (52%) or were already followed up by a mental health professional (60%). More important, 71% of callers reported previous suicide attempts and their mean suicidal risk was evaluated at 4.4 on a 9-point evaluation scale (1 = minimal). From these data one may conclude that the overlap with the clients of mental health services is about 60%. However, the other services were not necessarily available to answer the specific problems presented day and night by these clients at the suicide prevention centers.

Apparatus

Listening to the telephone interventions was accomplished through a custom-made electronic device which allowed for unnoticed listening of the calls from a remote area and without any signal on the Prevention Centers' intervention lines.

Process Measure

The intervention techniques were identified by the "Helper's Response List," an instrument we designed which lists 20 possible techniques a practitioner could use in a telephone intervention with

a suicidal caller (Daigle & Mishara, 1995). This instrument was derived from pretests with a more exhaustive inventory of 36 well-known techniques used in many different psychotherapeutic approaches. These techniques can also be considered "verbal responses modes" (Hill, 1986) which are the most easily observable behaviors utilized by practitioners in the field. However, categorization schemas of traditional psychotherapy and coding methods for professional interventions do not necessarily apply to this naturalistic study of lay volunteer telephone crisis intervention. We therefore developed what seems to be the first instrument for classifying telephone interventions by lay volunteers. Apart from the specificity of our instrument for volunteer interventions, we had to develop a new instrument because existing instruments used to evaluate psychotherapy relied upon taped interviews which allowed for repeated verifications of coding and classification. Since we were not allowed to tape interviews because of ethical concerns, we had to develop a simplified coding schema which could be reliably coded while listening only once to a telephone conversation.

First, two independent observers conducted a pretest (1,822 ratings) with the exploratory 36-technique instrument. The analyses of their observations (decision matrices) indicated when more than one category could be applied to the same observed verbal mode. On the basis of the pretest, we simplified the instrument. The final instrument had only 20 categories (Table I) including the two new categories added to cover statements which had not previously been identified: Information/suggestion/advice (S) and Threat (S). These categories involved "Structuring activity" (Stephenson, Ayling, & Rutter, 1976, p. 114) and described what telephone practitioners usually do when trying to structure (S) a sometimes disorganized contact with the callers. For example, "Speak louder, I can't hear you" (Suggestion S) or "Please stop cursing me or I will have to hang up" (Threat S).

Outcome Measures

According to Shneidman (1986) the desired immediate effect of interventions with suicidal individuals is "reduction of perturbation" (p. 13). We included three different outcome measures based upon the availability of data and what was practically possible given the nature and limitations of our observation techniques, two of which may well indicate degree of perturbation in the suicidal callers:

Brasington Depression Scale. Knickerbocker (1973) used a simple 5point rating scale developed by Brasington to assess the degree of depressive mood in telephone conversations (1=none; 5 =extreme). Knickerbocker indicated that Brasington had reported that three of four raters were in total agreement for 58% of rated tape segments and that disagreement tended to be in the form of a

consistent over- or underrating by one of the observers. Knickerbocker (1973) reported interrater reliability of .69 using three independent observers. A similar five-level scale was used to evaluate depression during psychotherapy by Luborsky, Singer, Hartke, Crits-Christoph, & Cohen (1984) and they reported interrater reliability between two independent observers of .87. In our study, observers used this scale to assess the caller's level of depression at the beginning and the end of the call.

Suicide Urgency Scale. This consists of a rating conducted by the telephone volunteer at the beginning of each telephone intervention and at the end of the intervention using a 9-point scale developed by Morissette (1984) to identify the probability of a suicide attempt in the immediate future (within the next 2 days). These ratings range from 1 (minimal urgency) to 9 (committed suicide during the intervention). Morissette did not report any reliability data for this instrument; however these ratings are routinely conducted by all volunteers on each intervention at both centers and constitutes a means of assessing changes in suicidal urgency as evaluated by the telephone helpers themselves. Furthermore, volunteers all received extensive supervision and training on how to make ratings in a standardized manner.

Table I.

Contract with the Client. Telephone helpers at both centers are trained to make a contract with the caller that involves not attempting suicide and engaging in follow-up activities aimed at developing a long-term resolution of the suicidal crisis. Thus, one indication of the effectiveness of interventions may be the extent to which such contracts were made and whether or not the callers upheld the contract. At the Montreal center clients are asked to call back the center for follow-up on the contract and at the Sherbrooke center volunteers initiate calls to follow-up with callers. Several researchers have emphasized the importance of the rate of follow-up as an indication of effectiveness (e.g., Lester, 1970; Slaikeu, 1984). From the data obtained during the call and subsequent follow-up calls, we were able to identify if a contract was made during the call and if the caller upheld the contract in terms of not attempting suicide and in following through with other aspects of the contract. We categorized the contract results into broad categories: contract made and upheld, contract made but not upheld, no contract and caller hang-ups before completing the intervention.

Procedure

The five observers were graduate students either in psychology or social work and they initially received 3 hours of formal training on the research methodology. Extensive posttraining by listening

to actual calls and comparing results was continued until they had reached a sufficient level of interrater reliability (see the following section for reliability data).

The data collection was conducted at two different periods: in 1988 and 1990 at the Montreal suicide prevention center and in 1990 at the Sherbrooke center. Each observer listened to all interventions on the first line to ring during a 4-hour shift. Observers listened to as many different shifts as possible, taking into account the schedule and the necessity to include as many participating volunteers as possible but also to cover all the times of day and days of the week (i.e., 24 hours, 7 days a week at the Montreal center). The observations were made without notifying the volunteer. The ethics committees of the Psychology Department of the University of Quebec at Montreal, the University Ethics committee, and the Ethics committees of the centers approved of our listening to calls, but forbade recording calls. According to the Ethical Guidelines of the centers, confidentiality of calls is guaranteed to all callers, but the calls are not anonymous. The centers ask callers to identify themselves and keep information on callers for use in helping callers with follow-up. The centers have occasional confidential listening to calls by supervisors as part of their regular practice and the fact that others may confidentially listen to calls is not hidden from callers. All volunteers and researchers signed an agreement to maintain complete confidentiality and no research records were kept in which callers are identified. After the study was completed, the researchers provided educational activities for the centers to share the results and discuss the implications of the findings. They also offered workshops on the results for center staff and volunteers at provincial and national meetings.

The observer listened to all the calls within a chosen shift, rejecting only the rare calls that were wrong numbers, redirected to the administration of the center (e.g., a call to reach a staff member), or were not related to suicide. For every call, each response by the volunteer was immediately coded sequentially, using the Helper's Response List, into one of the 20 predefined categories. The statements by the suicidal callers, on the other hand, were not analyzed in this study of the process of intervention-this was practically impossible.

Our unit of analysis, the helper's "response," was "all practitioner communication that occurs between two client communications," as defined by Reid (1978, p. 322). In the telephone context, almost all practitioner communications were short and matched only one of our predefined categories. On the rare occasions where two types of techniques seemed to be used within the same unit of measurement, one could reliably be identified as dominating. The chosen category on the instrument could not be changed at a later time, considering the fast pace of the interventions, but also the impossibility to listen to calls again.

Interrater Reliability and Description of Telephone Interventions

Interrater reliability for the Helper's Response List and the description of telephone interventions were reported previously by Daigle and Mishara (1995) and Mishara and Daigle (1992). These previous articles reported on the frequency of occurrence of different intervention categories and described client and helper characteristics at the two centers. The Helper's Response List was shown to be a reliable instrument for rating the target verbal behaviors. Of the 617 calls observed in this study, 117 (19%) were coded by more than one observer to establish the interrater reliability. These 117 calls represented 11,195 ratings on which two independent observers reached a mean agreement of .86 (κ = .80). Of these calls, 45 (3,707 ratings) were coded by a third independent observer who reached a mean agreement of .79 (κ = .71). The disagreements occurred mainly within five less utilized categories representing only 1% of the total classification.

Interrater reliability between two independent observers on 117 calls using the Brasington Depression Scale was .81 and, of the 45 calls coded by a third independent observer, there was a mean agreement of .61. With this scale, the reliability corresponds to a correlation (Pearson's r) between the observers' ratings, which leaves open the possibility of one of them consistently over- or underestimating. Hollenbeck (1978) suggested that when one of two observers tends to over- or underestimate, they tend to do so in a consistent manner. Since our objective is to compare changes from the beginning to the end of the telephone intervention, such consistent tendencies for over- or underestimation would not affect the reliability of the scale for this purpose, even though interrater agreement would be lessened (Hollenbeck, 1978). We therefore conclude that the level of reliability on the Brasington Scale is acceptable for this type of research. For the 117 calls used to test the reliability of measures, the mean of the two and three raters was retained for analyses.

The suicidal urgency ratings could not be tested for reliability since they are conducted by the individual telephone helpers themselves. However, they have a certain level of face validity, at least as an indication of the volunteer's evaluation of changes from the beginning to the end of the intervention. Information on the completion of a contract and follow-up is based upon written records in the dossier of each caller. These data were unambiguous in the written records and were taken as recorded without interpretation and thus were not tested for reliability.

The 617 calls observed generated 66,953 ratings on the 20-category Helper's Response list. Table I shows the total number of responses for each category. Considering the fact that phone calls lasted from 1 to 110 minutes (M=15, SD=17) these totals could bias a cumulative description of the intervention styles because of the greater influence of the longer calls. Thus, the percentage of utilization of each category was computed separately for each of the 617 calls in order to give each

call the same weight. Table I shows the calculated percentages based on the mean utilization per call. Acceptance is, by far, the most utilized category (34%). Orientation/investigation and Information/suggestion/advice follow with 26 and 15% of the total utilization, respectively. Other response categories are used much less frequently.

RESULTS

Outcome Measures

The mean ratings for the three outcome measures are first presented for the chronic and nonchronic callers. Then, these three variables are related to the intervention styles of the helpers and more specifically to their level of use of Rogerian techniques.

The level of depressive mood as observed on the 5-point Brasington scale had a mean decrease from the beginning to the end of the call of .16 (SD=.45) which was significant $t(613) = 8.65$, $p < .001$, paired t test. Nevertheless, the level of depression decreased in only 85 of the 613 calls (14%) and remained the same for the majority of calls (85%) and only increased in 3 calls (1%). The level of depression decreased in 12% of the calls from chronic (repeated) callers and 17% of nonchronic callers, but this difference was not significant.

The mean decrease in the 9-point Suicide Urgency Scale from the beginning to the end of the call was .40 (SD=.78), which was significant, $t(507) = 11.74$, $p < .001$, paired t test. The urgency decreased from the beginning to the end in 138 calls (27%) and increased in only 2 calls (1%); the majority of calls did not indicate a decrease in the urgency rating. The level of urgency decreased significantly, $t(505) = 21$, $p < .05$, two-tailed, more frequently among nonchronic callers (mean decrease .51, SD=.85 in nonchronic callers compared to M=.35, SD=.73 in chronic callers), 24% of chronic callers had decreased urgency compared to 35% of nonchronic callers and this difference was significant ($X2(2) = 11.97$, $p < .01$).

A contract was made with the callers in 68% of the calls. Contracts were more frequently made with chronic callers (79%) compared to nonchronic callers (49%), $X2(1) = 62.86$, $p < .001$. The contracts included having a follow-up contact with the center (those who did not have a follow-up contact with the center were classified as not respecting the contract since no information was provided on other aspects of the contract). Using this conservative classification of respecting contracts, 54% of contracts were considered upheld as indicated in follow-up contacts, however the Sherbrooke center had a higher rate (72%) compared to the Montreal center (50%). This may be due to the fact that the Sherbrooke center systematically calls back each client whereas the Montreal center never calls

clients but waits for clients to call them. Because the Sherbrooke center calls back all clients, they were perhaps more able to determine if contracts were upheld or not. It is possible that callers who did not call back the Montreal center upheld other aspects of the contract in terms of, for example, getting help or contacting other agencies but failed to contact the center to confirm this. No contract was made in 17% of the cases and 14% of calls terminated prematurely by the caller hanging up. In 54% of the calls the contract was upheld and in 14% a contract was made but not upheld. Three of the callers (1%) attempted suicide after contact with the center.

Intervention Process Measures

The 617 response profiles of the calls were analyzed with the cluster analysis method in SPSS (Quick Cluster procedure), using the values of the 20 response categories. This kind of statistical analysis, through a long process of assignment and reassignment, is used to extract a few constellations or patterns out of more complex sets of data. Our analysis of the mean response rates for the 617 calls was able to extract two clusters of intervention styles. This means that these 617 profiles of response could be assigned to one or the other of the styles. The styles were significantly different on 9 response categories. On the basis of differences in response categories we labeled them "Rogerian Style" and "Directive Style" since the responses were generally consistent with previous descriptions of these styles of intervention. Although the fit was not always perfect between our results and the classical styles of face-to-face psychotherapy, these results were similar and thus considered relevant in this context of investigating another form of intervention: volunteer crisis intervention. The same cluster analysis was repeated without the 18% of calls observed at the Sherbrooke center and the analysis generated the same two styles, including the same 9 significant differences. We were concerned that there may be a bias in classification of calls due to the presence of very brief calls. Thus, we repeated the cluster analysis including only calls lasting more than 1 minute. This analysis generated basically the same results.

The cluster analysis classified 391 calls in the category we labeled "Rogerian." These calls had significantly higher mean utilization of three categories: Acceptance, Approval, and Incomplete thought. Although incomplete thought (e.g., "You felt . . .") is not necessarily a component of the classical Rogerian approach, this response occurred infrequently and the overall portrait of callers seemed consistent with Rogerian theory. Six categories were more often used in the Directive style. Orientation/Investigation, Information/Suggestion/Advice, Reflection, Information/Suggestion/Advice (S), Information about helper, Rejection. This style was characterized by significantly more directive responses, with the exception of the category of Reflection. Because of the presence of more directivity in responses, we labeled this a "Directive" style. Although analyses show that only these 9

categories (out of 20) can discriminate between the two intervention styles, these 9 categories represent 90% of all interventions observed.

Relationships Between Process and Outcome Measures

The two intervention styles we identified were then related to our three outcome measures. Table II shows differences in the effects of intervention for the two styles identified by the cluster analysis. Volunteer helpers using a more Rogerian style had significantly more decreases in depression and were more likely to make a contract with the caller before the end of the call.

We then proceeded to explore intervention styles and outcomes in relation to whether callers could be considered chronic or nonchronic (acute). All 617 calls were classified in three equal groups according to their low, moderate, or high degree of utilization of those response categories that are characteristic of the Rogerian style. When analyses of variance were conducted comparing the three levels of utilization of Rogerian categories and changes in depression with chronic and nonchronic callers, there were no interactions or effects for type of caller but only a main effect, $F(2) = 7.91$, $p < .001$. Post hoc analyses showed that the moderate and high levels of use resulted in significantly more reduction in depression from the beginning to the end of the calls (see Figure 1 and Table III).

Table II.

Analyses of variance for changes in urgency indicated a significant interaction between level of utilization of Rogerian categories and type of caller, $F(2) = 3.69$, $p < .05$. As shown in Figure 2, and indicated in post hoc analyses (Table III), there was no significant relationship between use of Rogerian categories and changes in urgency among chronic callers; however a high level of use of Rogerian categories was related to significantly greater reductions in urgency among nonchronic callers.

Comparison of the three levels of use of Rogerian categories and whether or not a contract was made showed significant overall differences between high levels of utilization of Rogerian categories and low and moderate levels, $F(2) = 7.32$, $p < .001$. These differences are illustrated in Figure 3 and show that the significant overall differences are not paralleled among the chronic callers, for whom there are no significant differences in reaching a contract in relation to utilization of Rogerian categories. However in nonchronic callers, greater utilization of Rogerian categories is significantly related to the likelihood of making a contract with the caller before the end of the call. These results are confirmed by chi-square analysis.

Supplementary Analyses

Although there was no empirical basis to predict a relationship between outcomes and certain caller and helper characteristics for which we had data available, we conducted a number of exploratory analyses to study possible relationships that may merit further investigations. We examined the helper characteristics of age, number of hours of experience in telephone intervention, and sex. We also explored the caller variables of age, sex, previous suicide attempt, indication of presence of mental illness, and current psychiatric follow-up. The only significant relationships we found were (a) a small ($r=-.13$) negative correlation between the age of the volunteer helper and improvements in depressive mood and decreases in urgency ($r=.11$); (b) a small but significant tendency for female callers to respect contracts more often than male callers; (c) a small but significant tendency for persons without a current psychiatric follow-up to respect contracts more often than those with current psychiatric follow-up. Since these differences, although statistically significant, accounted for only a small percentage of the variance and were not consistently related to the three outcome measures, these variables were not included in our main analyses.

DISCUSSION

Effects of the Telephone Interventions

The results of this study indicate that the telephone interventions with suicidal clients observed in two suicide prevention centers appear to help a significant number of callers, at least in terms of reducing the urgency of the crisis situation in about one fourth of the calls. Nevertheless, one must keep in mind that ratings of urgency were made by the helpers themselves and their expectancies could have biased this measure. However, the other measures were taken by "blind" independent researchers and were shown to be sufficiently reliable. Observations of changes in the level of depressive mood from the beginning to the end of the call showed a decrease in 14% of the calls and a majority of the callers had a continued contact with the center and upheld a contract or agreement involving seeking long-term resolution of their problems. Calls rarely had negative effects: In this study only 3 of the 617 calls were rated as increasing in depression from the beginning to the end, and only 2 had increased urgency ratings. Although all 617 callers were suicidal to some extent, with the majority having at least considered how they would end their lives, only 3 individuals were known to have attempted suicide following their contact with the center.

Although a majority of callers could be`considered to be on the road to resolving their problems by respecting contracts made with the volunteer helpers, the majority of telephone interventions were not rated as resulting in a decreased level of depression or urgency. This is understandable since

serious long-term problems that lead to contemplating suicide should take more than just one telephone contact to resolve. Furthermore, 60% of callers had previous contacts with mental health professionals, indicating the possible presence of serious psychiatric disorders. One may conclude that the telephone interventions were helpful, particularly by initiating a process of resolving the caller's problems, and that the telephone interventions observed in this study showed very little negative effects. It is possible that the low number of attempts following calls indicates that the telephone interventions avoided possible deterioration of crisis situations which may have resulted in a suicide attempt, but this preventive effect is impossible to confirm on the basis of available data.

The Process of Intervention and Its Relationship to Outcome Variables

The method developed in this study for classifying lay telephone interventions was proven to yield a reliable measure of intervention responses. Furthermore, evaluation of response patterns of telephone helpers shows that the classification of calls in terms of their directivity appears to be useful, even though our classification was not strictly the same used in traditional psychotherapy. No specific intervention styles are taught at these suicide prevention centers other than the methods for evaluating suicidal risk and urgency at the beginning and end of the call and developing a contract with the caller (which includes an agreement not to attempt suicide and to have further contact with the center). Under these circumstances in which styles of intervention were not taught, volunteers used their personal styles which varied in terms of the amount of directivity. However, because of the practice of always evaluating risk and urgency and developing a contract with callers, even the most Rogerian calls involved an important element of directive questioning, investigating, and directive suggesting that a contract be made.

Fig. 1.

Table III.

Fig. 2.

Fig. 3

Within this context, in which all calls involved directive questioning and suggestions to make a contract, the more the calls used Rogerian nondirective techniques, the more likely that there would be decreases in depression and the establishment of a contract. However, results varied depending upon whether or not the suicidal person was a chronic or repeated caller to the center. High levels of use of Rogerian techniques were more likely to result in a decrease in depression among both chronic and non chronic callers. However, a decrease in the urgency of calls was significantly related to higher levels of Rogerian techniques only among nonchronic callers. This may be due to the fact that chronic callers may have a more long-standing need for help and be less likely to obtain any resolution of their long-term difficulties in one telephone conversation.

Possible Implications

This study constitutes a preliminary attempt at using empirical data on telephone interventions to determine which techniques may be more effective. Since intervention styles were not specifically taught, they can be seen as characteristics which may be sought out during recruitment and selection of potential volunteers. It is also possible that the training of helpers should include more practice of certain techniques, for example, Rogerian active listening skills, and that the teaching of such techniques would lead to more effective telephone interventions. This information was provided to the centers and inspired a reevaluation of existing training practices for volunteers. However, this study should not be interpreted to advocate using only a Rogerian style without directive questioning to evaluate risk and urgency and to establish a contract with callers. Furthermore, helpers at suicide prevention centers are usually told to be very directive with callers who are at high risk; they are taught to say "Put down the gun" or "Throw away the pills and talk with me." In this context, Rogerian active listening skills are seen as a complement to existing techniques rather than a panacea.

Telephone interventions are different from face-to-face contacts and crisis interventions with suicidal persons are very different from short- or long-term therapy situations. Whenever a caller returns a call to the center they speak with whoever answers the phone; they do not establish a longterm relationship with one individual helper. Because of the specific nature of these calls, one may not be able to generalize from outcome research on psychotherapy to volunteer telephone interventions nor is it possible to use the same evaluation and classification methods in this community context. This study is a preliminary attempt at an empirical investigation of the nature of volunteer telephone interventions and an examination of their effectiveness. The results suggest that chronic or repeated callers may benefit from different types of intervention than nonchronic callers. This fact has been recognized by staff and volunteers at suicide prevention centers, who often experience frustration at

dealing with chronic callers. This aspect of the results proved very useful to the agencies when the findings from this study were presented and discussed with the organizations involved.

In this study the outcome measures were limited by the availability of data on callers. We relied upon measures of urgency which are systematically gathered by the telephone volunteers and we included an assessment of depressive mood by the experimenter at the beginning and end of the call. These techniques are rather primitive compared to the more sophisticated and more psychometrically sound methods which may be used in assessing psychotherapy outcomes. However, this was a study of community organizations in their natural context. In this specific context, with confidential calls and tape-recording prohibited, additional information for research purposes cannot be gathered, and available data are generally limited. Also, it is difficult to imagine how to compare these results to a control group with similar characteristics or in similar crisis situations. All callers are offered the best help available and there are ethical concerns in varying the nature of interventions for experimental purposes or including a nonintervention control group. Since the outcome is the possible death of the caller by suicide, extreme care must be taken to respect the rights of callers when conducting empirical research. Nevertheless, the development of better outcome measures is one of the most important challenges facing researchers interested in studying the effects of volunteer community telephone interventions and the relative effectiveness of different styles of intervention.

Clinical Insights

Evaluating a Recovery-Oriented Intensive Outpatient Program for Veterans at Risk for Suicide

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Abstract. *Background:* Suicide is the 10th leading cause of death in the United States and suicide risk is elevated among military veterans. Risk for suicide is inherently transdiagnostic, complex, and multifaceted, which means a comprehensive psychotherapeutic approach to risk mitigation is required. *Aims:* Our aims were to summarize findings from an evaluation of an interdisciplinary, recovery-oriented intensive outpatient program (IR-IOP) that includes evidence-based suicide prevention strategies for veterans with varying psychiatric diagnoses who are at risk for suicide. *Method:* Veterans completed the Patient Health Questionnaire-9 and the Beck Scale for Suicide Ideation prior to and following their participation in the IR-IOP. *Results:* A significant decrease in the severity of suicide ideation was found between pre- and posttreatment. *Limitations:* This program evaluation utilized archival data and, as such, there was not a control group and posttreatment follow-up data were not collected. *Conclusion:* Preliminary findings suggest an IR-IOP for veterans with heterogeneous psychiatric diagnoses utilizing a multifaceted psychotherapeutic approach to suicide prevention may be effective in reducing suicide ideation.

Keywords: suicide ideation, suicide prevention, evidence-based, interdisciplinary, transdiagnostic

Suicide is the 10th leading cause of death in the United States (Centers for Disease Control and Prevention, 2019), and risk for suicide is heightened among military veterans. Although the rate of suicide among users of the Veterans Health Administration has remained relatively stable since 2001, rates have increased in the veteran population overall (Office of Mental Health Suicide Prevention, 2019). As such, suicide has been identified as a top clinical priority within the Veterans Health Administration to help address this public health concern (US Department of Veterans Affairs, 2018). Effective mental health treatment for individuals at risk for suicide remains an important component of a comprehensive approach to suicide prevention (Zalsman et al., 2016). Given the heightened risk for suicide among veterans, developing and evaluating the effectiveness of mental health treatment programs aimed at reducing suicide ideation among veterans is critically important.

Given the lack of research supporting the efficacy of inpatient hospitalization as a primary suicide prevention strategy and markedly increased risk for suicide after discharge (e.g., Luxton, Trofimovich, & Clark, 2013), clinical suicide prevention efforts have largely been researched and implemented in outpatient mental health settings. A variety of outpatient practices have demonstrated effectiveness in reducing suicide risk, including suicide ideation and suicide attempts. A comprehensive review of clinical practice guidelines (Roush, Brown, et al., 2018; US Department of Veterans Affairs/Department of Defense, 2019) identified empirically supported practices for suicide prevention, including safety planning (i.e., a collaborative intervention that involves identifying resources and coping strategies for use in a potential a suicidal crisis; Stanley & Brown, 2008), safety counseling regarding lethal means (i.e., education on means safety and collaboratively developing a plan to increase safety by reducing access to lethal means; Bennett, Horn, & Roberts, 2014), and providing contact information for suicide prevention or crisis hotlines (Gould, Kalafat, Harris Munfakh, & Kleinman, 2007). Additionally, clinical standards for suicide risk assessment include utilizing "an evidence-based process to conduct a suicide risk assessment of individuals served who have screened positive for suicidal ideation" that "directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors" (The Joint Commission, 2018). Despite the empirical support for these suicide prevention practices, there remains a high degree of variability in the overall use of evidence-based suicide risk assessment and intervention practices (Roush, Brown, et al., 2018).

In addition to these practices, several outpatient psychotherapeutic approaches have demonstrated effectiveness in mitigating suicide risk, including dialectical behavior therapy (Linehan et al., 2006) and cognitive behavior therapy (Rudd et al., 2015). These interventions each address

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emotion regulation and cognitive flexibility, among other treatment targets, which have been implicated as mechanisms of action for suicide risk reduction among military personnel (Bryan & Rozek, 2018). Additionally, one program evaluation found decreased suicide ideation following completion of a 12-week intensive outpatient program (IOP) integrating dialectical behavior therapy with prolonged exposure therapy for veterans with posttraumatic stress disorder and borderline personality symptoms (Meyers et al., 2017). Although these treatments were found to reduce suicide ideation or suicide attempts, they heavily utilize individual psychotherapy over the course of 12 weekly or biweekly sessions for cognitive behavior therapy and up to 1 year for dialectical behavior therapy. Further, therapeutic effects may not always generalize broadly given the diagnostic exclusionary criteria that may be used both in research and clinical settings. A short-term, transdiagnostic approach to suicide prevention utilizing a group modality may have the potential to improve access to mental health services and reduce treatment costs; however, research examining the effectiveness of such a program is limited.

Effective psychotherapeutic approaches that aim to reduce suicide risk account for the fact that risk for suicide is inherently transdiagnostic, complex, and multifaceted. Research reveals elevated rates of suicide among those diagnosed with a wide range of mental health conditions (Chesney, Goodwin, & Fazel, 2014; LeardMann et al., 2013); however, contemporary theories of suicide have discarded the notion that any particular mental illness causes suicide in place of explanations that highlight the role of transdiagnostic psychological, interpersonal, and biological processes underlying the development of suicide risk (e.g., Joiner, 2005; Klonsky & May, 2015; Van Orden et al., 2010). As such, an interdisciplinary, recovery-oriented, transdiagnostic IOP that targets emotion regulation and cognitive flexibility, and includes empirically supported practices for suicide prevention might be ideally suited to mitigate risk and address both access and cost issues. Our primary aim was to describe preliminary clinical outcomes of such a program that was specifically developed as an alternative to hospitalization for at-risk veterans.

Method

Participants

The sample consisted of 34 veterans who completed the recovery-oriented intensive outpatient program (IR-IOP) in south Texas. Six veterans who did not complete the program and were excluded from data analysis. The IR-IOP is intended for veterans with acute and chronic mental health concerns who are at risk for psychiatric hospitalization or re-hospitalization, many of whom have a history of chronic suicide ideation and attempts. The majority of the sample identified as male (*n* = 19; 55.9%), followed by female (*n* = 15; 44.1%). The majority of the sample also identified as non-Hispanic (*n* = 23; 67.6%), followed by Hispanic (*n* = 11; 32.3%). The majority of the sample identified as White (*n* = 24; 44.1%), followed by Black (*n* = 15; 44.1%) and American Indian (*n* = 1; 2.9%). A review of the electronic medical record indicated 82.4% (*n* = 28) of participants were diagnosed with posttraumatic stress disorder, 17.6% (*n* = 6) of participants were diagnosed with bipolar disorder, 76.5% (*n* = 26) with major depressive disorder, 26.5% (*n* = 9) with generalized anxiety disorder, 8.8% (*n* = 3) with schizophrenia, and 5.9% (*n* = 2) with borderline personality disorder. Notably, 85.3% (*n* = 29) had more than one psychiatric diagnosis. Based on a comprehensive suicide risk assessment conducted by a licensed psychologist utilizing standardized suicide risk stratification guidelines for low, intermediate, and high acute and chronic risk (Wortzel et al., 2013), 47.1% (*n* = 16) of participants were rated as low acute risk for suicide and 52.9% (*n* = 18) as intermediate acute risk for suicide upon admission. Additionally, 5.9% (*n* = 2) of participants were rated as low chronic risk for suicide, 91.2% (*n* = 31) as intermediate chronic risk for suicide, and 2.9% (*n* = 1) as high chronic risk for suicide. Further, 17% (*n* = 6) of participants were flagged in the electronic medical record as "high risk for suicide," as determined by a prior administrative review of suicide risk that routinely follows a patient suicide attempt or preparatory behavior. Regarding suicide attempt history, 23.5% (*n* = 8) participants reported one previous suicide attempt, 32.4% (*n* = 11) reported two or more previous suicide attempts, and 44.1% (*n* = 15) denied any previous suicide attempts.

Measures

Beck Scale for Suicide Ideation (BSS)

The BSS (Beck & Steer, 1991) is a 21-item self-report questionnaire that assesses severity of suicide ideation, including desire for suicide, frequency of suicidal thoughts, specificity of planning, and degree of intent, over the past week. Participants rate each item on a 3-point ordinal response scale ranging from 0 to 2. The first 19 items are summed to calculate a total score, with higher scores indicating greater severity of suicide ideation. The BSS has demonstrated adequate convergent validity with a clinician-rated assessment of suicide ideation (Beck, Steer, &

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Ranieri, 1988) and excellent internal consistency in a psychiatric inpatient sample (Pinninti, Steer, Rissmiller, Nelson, & Beck, 2002). In the current evaluation, Cronbach's α was excellent for the BSS pre- (0.94) and postadministration results (0.92).

Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 (Kroenke et al., 2001) is a 9-item self-report questionnaire that assesses depressive symptoms over the past 2 weeks. Participants rate each item on a 4-point ordinal response scale ranging from 0 (*not at all*) to 3 (*nearly every day*). Item 9 of the PHQ-9 assesses frequency of death, or morbid, ideation and thoughts of self-harm. The PHQ-9 has demonstrated adequate test-retest reliability and convergent validity with structured clinical interviews for depression (Kroenke et al., 2001). Given the widespread use of the PHQ-9 at VA medical centers and scores on Item 9 of the PHQ-9 have been associated with increased risk for suicide among veterans (Louzon, Bossarte, McCarthy, & Katz, 2016), the PHQ-9 Item 9 was examined in addition to the BSS to increase convergent validity. In the current evaluation, Cronbach's α was good for the PHQ-9 pre- (0.88) and postadministration results (0.89).

Procedures

The local Institutional Review Board deemed the program evaluation to be exempt from review. The IR-IOP is a 10-day interdisciplinary, recovery-oriented program within a VA medical center that admits veterans with acute mental health concerns irrespective of psychiatric diagnosis. The IR-IOP draws from previous research to target emotion regulation and cognitive flexibility skills and includes evidence-based suicide risk assessment and management strategies. Inclusion criteria comprised mental health concerns resulting in significant functional impairment, stable housing, access to transportation, and ability to articulate goals for participation. Exclusion criteria were substance use disorder that necessitated a greater level of supervision and treatment, significant cognitive impairment that would limit the ability to interact in a group setting, and inability to engage in activities of daily living required for basic self-care and hygiene.

Enrollment Process

Veterans were referred to the IR-IOP by mental health providers across various settings (e.g., primary care, mental health inpatient unit, outpatient mental health) to provide an enhanced level of outpatient mental health care for veterans considered to be at elevated risk for suicide, mental health decompensation, or hospitalization. Veterans were provided an opportunity to attend 1 day of programming to confirm interest in the program prior to program enrollment. Veterans then completed a 3-hr intake approximately 1–7 days prior to enrollment in the IR-IOP, which included a 1-hr psychiatric evaluation and pretreatment administration of the BSS and PHQ-9 conducted by a psychiatrist or psychiatry resident. A comprehensive suicide risk evaluation was conducted by a psychologist, which comprised a standardized, evidence-based, suicide risk assessment of suicidal ideation, plan, intent, suicidal and self-harm behaviors, risk factors, and protective factors. Additionally, standardized suicide risk stratification guidelines (Wortzel et al., 2013) were used and an individualized suicide risk mitigation plan was developed collaboratively with the veteran. A safety planning intervention (i.e., collaborative education and identification of warning signs, coping strategies, support, and resources for use in a potential a suicidal crisis) and means safety counseling (i.e., education on means safety and collaboratively developing a plan to increase safety by reducing access to lethal means) was also provided to all veterans by a psychologist. Lastly, a registered nurse developed an individualized treatment plan with the veteran, which included the development of treatment goals, personal strengths, needs, and abilities, and a review of the treatment program handbook. The discharge process included a review of treatment progress and posttreatment administration of the BSS and PHQ-9 following participation in the 10-day program.

Intervention

The IR-IOP included skills-, education-, discussion-, and process-based group programming provided by psychologists, psychiatrists, clinical social workers, a registered nurse, a recreational therapist, a mental health chaplain, a peer support specialist, and trainees (e.g., psychology fellow). See Table 1 for a description of the enrollment process and treatment groups that comprise the IR-IOP for all veterans. Group programming occurred Monday through Friday, with five groups per day on Mondays through Thursdays, and three groups on Fridays. Each group was held for approximately 60 min, with the exception of the Wellness Wrap-Up group, which was held for approximately 30 min. Group facilitators adapted the content of group sessions to ensure relevance to each veteran's treatment plan and goals. All interdisciplinary team members attended a 30-min treatment team meeting to discuss each veteran's treatment progress Monday through Friday.

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Table 1. Overview of treatment groups

Treatment groups	Primary focus
Wellness	Psychoeducation and discussion of sleep, healthy living, and nutrition
Coping skills	Psychoeducation and discussion of healthy behavior change, practical solutions, and effective coping strategies with topics including anger, cognitive restructuring, distress tolerance, emotional regulation, depression, and grief
Process group	Discussion to promote adaptive perspectives and exploration of solutions to current challenges
Weathering the storm	Psychoeducation and discussion of crisis management, cognitive-behavioral approaches to coping with suicidal thoughts, and suicide prevention resources
ACT for recovery	Psychoeducation and discussion with the aim of living a life of purpose even in the presence of difficult thoughts and feelings with an emphasis on mindfulness
Living in recovery	Psychoeducation and discussion of mental health recovery
Building spiritual strength	Discussion to promote greater understanding about how faith can impact emotions, reduce anxiety and depression, and increase hope
Healthy relationships	Psychoeducation, discussion, and practice of relationship building skills to promote interpersonal effectiveness
Emotional regulation	Psychoeducation and practice of emotion regulation skills
Catch it, check it, change it	Psychoeducation and practice of cognitive restructuring skills
Self-esteem	Psychoeducation and discussion of strategies to improve self-esteem and identify strengths and abilities
Social skills	Psychoeducation and practice of social skills to promote interpersonal growth
Medication review	Psychoeducation and discussion about psychotropic medications in mental health recovery with a psychiatrist
Relaxation	Psychoeducation, discussion, and practice of relaxation skills
Leisure education	Psychoeducation and discussion of leisure and recreational topics
Problem solving	Psychoeducation and discussion of effective problem-solving strategies
Wellness wrap-up	Process and review topics presented throughout the day

Note. ACT = acceptance and commitment therapy.

Data Analytic Strategy and Preparation

Analyses were conducted using IBM SPSS (Version 24). We first examined descriptive statistics and the frequency of responses on the PHQ-9 and BSS suggestive of increased risk for suicide. A cutoff score of 1 was used to indicate the presence of suicide ideation on the PHQ-9 Item 9 and BSS, which is consistent with methods utilized in previous studies (e.g., Na et al., 2018). Paired samples *t* tests were conducted to evaluate possible change in suicide ideation and depression pre- and posttreatment scores. Only participants who completed the program (92.9%) and program evaluation measures (87.2%) were included in analyses.

Results

Descriptive statistics and correlations are presented in Table 2. For the pretreatment administration, 66.6% and 70.6% of participants were assessed as being positive for suicide ideation (i.e., non-zero level of suicide ideation) on the PHQ-9 and BSS, respectively. For the posttreatment administration, 32.4% and 41.2% of participants were assessed as being positive for suicide ideation on the PHQ-9 and BSS, respectively. Results indicated a significant difference in severity of suicide ideation reported by participants prior to beginning the program (M = 8.12, SD = 8.60) compared with following completion of the program (M = 4.06, SD = 5.84), $t(33) = 3.18$, $p = .003$, $d = .55$, as measured by the BSS. Similarly, results indicated a significant difference in frequency of death, or morbid, ideation and thoughts of self-harm reported by participants prior to beginning the program (M = 1.06, SD = 0.97) compared with following completion of the program (M = 0.47, SD = 0.79), $t(32) = 4.40$, $p < .001$, $d = .67$, as measured by the PHQ-9 Item 9. Using the Reliable Change Index (Jacobson & Truax, 1991), 38.2% of all participants (n = 13), 54.2% of participants who reported non-zero level suicide ideation, and 72.2% of participants who reported severity of suicide ideation above 5.84 as measured by the BSS evidenced reliable reduction (> 5.84 points) in suicide ideation. Of note, none of the participants were hospitalized during the IR-IOP program participation.

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Table 2. Descriptive statistics and correlations

	1	2	3	4	5	6	7	8	9
1. Gender	–								
2. Age	.24	–							
3. Groups attended	−.33	−.20	–						
4. BSS pre	.18	.10	−.15	–					
5. BSS post	−.21	−.16	−.22	.50**	–				
6. PHQ-9 pre	.32	−.19	−.09	.55**	.32	–			
7. PHQ-9 post	.15	−.14	−.12	.13	.48**	.47**	–		
8. PHQ-9 item 9 pre	.25	−.12	−.18	.57**	.27**	.82**	.38*	–	
9. PHQ-9 item 9 post	.31	−.20	−.33	.36*	.98***	.39**	.70**	.65**	–
M	–	46.19	42.15	8.12	4.08	11.29	11.41	1.06	2.47
SD	–	10.91	7.26	4.60	3.92	6.25	6.18	2.87	0.79
Min.	–	27	26	0	0	5	2	0	0
Max.	–	67	68	28	18	27	26	3	3

Note. BSS = Beck Scale for Suicide Ideation total score; PHQ-9 = Patient Health Questionnaire-9. Point-biserial correlations reported for gender.
*$p < .05$. **$p < .01$. ***$p < .001$.

Discussion

The current program evaluation sought to describe preliminary clinical outcomes of a 10-day IR-IOP focused on the reduction of suicide risk. The average number of groups attended for the sample was 42.15 with a retention rate of 92.9%. Preliminary clinical outcomes indicated a significant reduction in the severity of suicide ideation and frequency of death, or morbid, ideation and thoughts of self-harm between pre- and posttreatment scores with moderate effect sizes. Of note, the mean severity of suicide ideation as measured by the BSS during the pretreatment administration was 8.12, which is similar to other psychiatric inpatient (M = 8.24–8.42, SD = 8.24–9.49; Pinninti et al., 2002; Roush, Cukrowicz, Mitchell, Brown, & Seymour, et al., 2018) and outpatient (M = 2.28–3.20, SD = 4.80–5.52; Beck et al., 1988; Hawkins et al., 2014) samples. Specifically, a 50% decrease in the severity of suicide ideation was found over the course of the IR-IOP, which likely represents clinically meaningful change given previous research among psychiatric outpatients using the Scale for Suicide Ideation, an interview-rated version of the BSS, indicated a hazard ratio of 1.11 (95% CI = 1.07–1.15; Brown, Beck, Steer, & Grisham, 2000), suggesting risk for death by suicide increases by 11% for every point increase in Scale for Suicide Ideation scores.

Items contained in the BSS assess various aspects of suicide ideation, including one's wish to live, wish to die, desire to kill oneself, and more nuanced facets of suicide ideation (e.g., attitude toward ideation, deterrents to attempting suicide, specificity of planning). Small fluctuations in scores may represent clinically meaningful changes in the severity of suicide ideation. For instance, a two-point decrease on an item assessing desire to kill oneself may represent a transition from moderate to strong desire to kill oneself to no desire to kill oneself. Although four veterans reported a moderate to strong desire to kill oneself prior to participating in the IR-IOP, no veterans reported a moderate to strong desire to kill oneself following completion of the program. Similarly, there was an 80% increase in the number of veterans reporting no wish to die following completion of the program. Research has also demonstrated the importance of creating a life worth living to attenuate suicide risk (Kleiman & Beaver, 2013) and wish to live predicts the emergence of suicidal behavior among active-duty military personnel (Bryan, Rudd, Peterson, Young-McCaughan, & Wertenberger, 2016). As such, our findings indicated an 81% increase in the number of veterans who reported a moderate-to-strong wish to live, a 71% decrease in the number of veterans that reported a weak wish to live, and no veterans reported no wish to live following completion of the IR-IOP.

The decrease in the severity of suicide ideation following completion of the IR-IOP is consistent with the decrease in suicide ideation found in a previous study evaluating the effectiveness of a 12-week IOP for veterans with posttraumatic stress disorder and borderline personality symptoms (Meyers et al., 2017). These findings converge to suggest that IOPs may lead to clinically significant reductions in suicide ideation. Notably, the IR-IOP under scrutiny with this evaluation is a 2-week program, provides veterans with an interdisciplinary, recovery-oriented approach to care, and does not follow a single treatment protocol but, rather, integrates multiple evidence-based

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approaches in a manner flexible enough to target the needs of the particular set of veterans enrolled in the program at any given time.

Limitations

Although findings from this program evaluation revealed a reduction in suicide ideation after participation in the IR-IOP, there are important limitations that should be considered. This program evaluation was constrained by the relatively small sample size. Further, the lack of a control group (e.g., treatment as usual) or postdischarge follow-up data precluded any causal inferences and results were constrained given the utilization of archival data in this program evaluation. Future studies should consider examining longer-term effects of an IR-IOP with the inclusion of posttreatment follow-up assessments. Although assessments were conducted both prior to and following treatment as part of an IOP, the program evaluation relied on self-report data, which is subject to bias. Future research is also needed to uncover specific mechanisms of change in such a program (e.g., CBT skill development vs. a sense of group belongingness) and the ideal therapeutic dose (e.g., duration and frequency of group sessions). Taken together, the findings from this program evaluation provide preliminary support for an IR-IOP for veterans with heterogeneous psychiatric diagnoses utilizing a multifaceted psychotherapeutic approach to suicide prevention.

References

Beck, A. T., & Steer, R. A. (1991). Manual for the Beck scale for suicide ideation. San Antonio, TX: Psychological Corporation.

Beck, A. T., Steer, R. A., & Ranieri, W. F. (1988). Scale for suicide ideation: Psychometric properties of a self-report version. Journal of Clinical Psychology, 44, 499–505. https://doi.org/10.1002/1097-4679(198807)44:4<499::AID-JCLP2270440404>3.0.CO;2-6

Bernert, R. A., Hom, M. A., & Roberts, L. W. (2014). A review of multidisciplinary clinical practice guidelines in suicide prevention: Toward an emerging standard in suicide risk assessment and management, training and practice. Academic Psychiatry, 38, 585–592. https://doi.org/10.1007/s40596-014-0180-1

Brown, G. K., Beck, A. T., Steer, R. A., & Grisham, J. R. (2000). Risk factors for suicide in psychiatric outpatients: A 20-year prospective study. Journal of Consulting and Clinical Psychology, 68, 371. https://doi.org/10.1037/0022-006X.68.3.371

Bryan, C. J., & Rozek, D. C. (2018). Suicide prevention in the military: A mechanistic perspective. Current Opinion in Psychology, 22, 27–32. https://doi.org/10.1016/j.copsyc.2017.07.022

Bryan, C. J., Rudd, M. D., Peterson, A. L., Young-McCaughan, S., & Wertenberger, E. G. (2016). The ebb and flow of the wish to live and the wish to die among suicidal military personnel. Journal of Affective Disorders, 202, 58–66. https://doi.org/10.1016/j.jad.2016.05.049

Centers for Disease Control and Prevention. (2019). WISQARS leading causes of death. Retrieved from http://www.cdc.gov/injury/wisqars/leading_causes_death.html

Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. World Psychiatry, 13, 153–160. https://doi.org/10.1002/wps.20128

Gould, M. S., Kalafat, J., Harris Munfakh, J. L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes part 2: Suicidal callers. Suicide and Life-Threatening Behavior, 37, 338–352. https://doi.org/10.1521/suli.2007.37.3.338

Hawkins, K. A., Hames, J. L., Ribeiro, J. D., Silva, C., Joiner, T. E., & Cougle, J. R. (2014). An examination of the relationship between anger and suicide risk through the lens of the interpersonal theory of suicide. Journal of Psychiatric Research, 50, 59–65. https://doi.org/10.1016/j.jpsychires.2013.12.005

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. Journal of Consulting and Clinical Psychology, 59, 12. https://doi.org/10.1037/0022-006X.59.1.12

Joiner, T. E. (2005). Why people die by suicide. Cambridge, MA: Harvard University Press.

Kleiman, E. M., & Beaver, J. K. (2013). A meaningful life is worth living: Meaning in life as a suicide resiliency factor. Psychiatry Research, 210, 934–939. https://doi.org/10.1016/j.psychres.2013.08.002

Klonsky, E. D., & May, A. M. (2015). The three-step theory (3ST): A new theory of suicide rooted in the "ideation-to-action" framework. International Journal of Cognitive Therapy, 8, 114–129. https://doi.org/10.1521/ijct.2015.8.2.114

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. Journal of General Internal Medicine, 16, 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

LeardMann, C. A., Powell, T. M., Smith, T. C., Bell, M. R., Smith, B., Boyko, E. J., … Hoge, C. W. (2013). Risk factors associated with suicide in current and former US military personnel. JAMA, 310, 496–506. https://doi.org/10.1001/jama.2013.65164

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., … Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. Archives of General Psychiatry, 63, 757–766. https://doi.org/10.1001/archpsyc.63.7.757

Louzon, S. A., Bossarte, R., McCarthy, J. F., & Katz, I. R. (2016). Does suicidal ideation as measured by the PHQ-9 predict suicide among VA patients? Psychiatric Services, 67, 517–522. https://doi.org/10.1176/appi.ps.201500149

Luxton, D. D., Trofimovich, L., & Clark, L. L. (2013). Suicide risk among US Service members after psychiatric hospitalization, 2001–2011. Psychiatric Services, 64, 626–629. https://doi.org/10.1176/appi.ps.201200413

Meyers, L., Voller, E. K., McCallum, E. B., Thuras, P., Shallcross, S., Velasquez, T., & Meis, L. (2017). Treating veterans with PTSD and borderline personality symptoms in a 12-week intensive outpatient setting: Findings from a pilot program. Journal of Traumatic Stress, 30, 178–181. https://doi.org/10.1002/jts.22174

Na, P. J., Yaramala, S. R., Kim, J. A., Kim, H., Goes, F. S., Zandi, P. P., … Bobo, W. V. (2018). The PHQ-9 item 9 based screening for suicide risk: A validation study of the Patient Health Questionnaire (PHQ)-9 item 9 with the Columbia Suicide Severity Rating Scale (C-SSRS). Journal of Affective Disorders, 232, 34–40. https://doi.org/10.1016/j.jad.2018.02.045

Office of Mental Health and Suicide Prevention. (2018). National veteran suicide prevention annual report. Retrieved from https://www.mentalhealth.va.gov/docs/data-sheets/2018/2018_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf

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Research paper

An evaluation of suicide prevention hotline results in Taiwan: Caller profiles and the effect on emotional distress and suicide risk

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ABSTRACT

Background: Hotlines are among commonly available and recommended suicide prevention strategies in many countries, but only a few empirical studies have focused on people who used this service and the proximal outcomes of calls made to the hotlines. This study is designed to investigate the demographic characteristics of the Taiwan National Suicide Prevention Hotline (NSPH) callers and whether the NSPH service helps to alleviate the callers' emotional distress and suicide risk.

Methods: Descriptive statistics were used to describe the gender, age and county/city distribution of the 63,696 callers from 2009 to 2011. Three hundred telephone records of 100 acute suicidal callers, 100 suicidal callers, and 100 non-suicidal callers were then randomly selected for further investigation of the proximal changes in the callers' emotional disturbance and suicidality.

Results: Notwithstanding the suicide status of the callers, significant decreases in their emotional distress and suicidality could be detected during the course of the telephone session. Men, the elderly, and people living outside northern Taiwan, however, were less likely to call the NSPH. An unexpected yet significant finding is that people with an ongoing suicide attempt were less emotionally distressed than those with only suicidal thoughts.

Conclusions: The hotline is a useful suicide preventive and crisis intervention service. However, further creative and consistent work is needed to make the service more appealing to the hard-to-reach population.

1. Introduction

Suicide continues to be recognized as a major health concern in Taiwan. The suicide rate has risen from 6.89 suicides per 100,000 people in 1993 to 16.00 in 2016 (Ministry of Health and Welfare, 2017a). Suicide is the second leading cause of death among young people 15 to 24 years of age, the third among those 25 to 44 years of age, and the 12th in the general population (Ministry of Health and Welfare, 2017a). It is not only a leading cause of premature mortality, but it also impacts on other people and the community. Lukas and Seiden (2007) argued that a suicide may directly affect seven to ten people germane to each death. These affected people frequently experience psychological and physical disturbances, including depression, posttraumatic stress, social stigma, physical disorders, and heightened suicide risk (Jordan et al., 2005; Swanson & Colman, 2013). Hence, there is no doubt that suicide prevention is important.

Due to its convenience and anonymity, the hotline has become one of the most popular suicide preventive and crisis interventions in the world (Hale, 2001; Krysinska & De Leo, 2007). The Taipei Lifeline Association (TLA) has been undertaking the An Hsin Hotline—Taiwan National Suicide Prevention Hotline (NSPH) from the Department of Health (reformed to the Ministry of Health and Welfare in 2013) since 2009. The NSPH offers telephone counseling and crisis intervention services with toll-free lines operating 24 hours a day, seven days a week. More than two hundred trained volunteers work for the NSPH. All volunteers receive training in psychology, suicide theories, risk assessments, telephone counseling skills, and practicums. Once they pass the training and evaluations, they receive continuous training and supervision from mental health professionals. Many people are willing to contact the NSPH for help. The total number of telephone calls per year rose from 61,284 in 2009 to 68,303 in 2011, and then to 67,773 in 2016; the total number of telephone calls with suicide ideation, plans, and attempts rose from 6012 in 2009 to 11,875 in 2011, and then to 11,079 in 2016; and moreover, the total number of intervened suicide attempts rose from 145 in 2009 to 475 in 2011, and then to 295 in 2016 (Chiang, 2013; Su, 2017).

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There has been some solid evidence to prove the efficacy of the crisis hotlines. Consistent with the nature of the crisis interventions that highlights immediate interactions rather than long-term influences (Meichenbaum, 2005), contemporary efficacy studies tend to focus on the proximal effects of the crisis hotlines. After analyzing 617 suicidal calls to two Canadian suicide prevention centers, Mishara and Daigle (1997) indicated that from the beginning to the end of those calls, 14% of the callers decreased their depressive mood, and 27% lowered their suicidal urgency. King et al. (2003) evaluated 100 calls to the Kids Help Line of Australia and revealed that there were significant improvements in the callers' mental state, suicidal ideation, and suicide risk during the course of the telephone session. Kalafat, Gould, and their colleagues (Gould et al., 2007; Kalafat et al., 2007) assessed 1617 calls to eight United States crisis centers and concluded that from the beginning to the end of the calls, the callers' confusion, depression, anger, anxiety, helplessness, overwhelms, and hopelessness were significantly subsided. After analyzing the data from 87 callers to the Rethink Mental Illness helpline, Tyson et al. (2016) proved the service to be effective in reducing suicidal and self-harming thoughts in the callers. All of the above show immediate positive effects of the crisis hotlines.

The efficacy of Taiwan NSPH, however, remains unknown for lack of any empirical evaluations. The purposes of this study are to understand two simple yet important questions: Who does the NSPH serve? Is the NSPH effective at alleviating the callers' emotional distress and suicidality?

2. Methods

2.1. Analytical data

With corporate support and sponsorship, the TLA has implemented a computerized information system called eSOS to manage incoming telephone calls and track counseling records. The system records all incoming numbers and conversations. Volunteer helpers have to identify the caller's suicide status on each call and to mark it down as non-suicidal (those who give a negative answer on the question of suicide ideation), suicidal (those who give affirmative answers on the questions of suicide ideation or suicide plan, yet have no suicide attempt in progress), or acute suicidal (those who give an affirmative answer on the question of a suicide attempt in progress, such as wrist-cutting, burning charcoal in a closed room, standing on the edge of a tall building). The volunteers also document the callers' personal information (e.g. their gender, age, major issues of each call) if mentioned in the conversations. All callers are notified of the recording at the beginning of the calls and have given their consent to the recordings. The Central Regional Research Ethics Center, Taichung, Taiwan approved this study to waive the requirement for obtaining informed consent from the callers.

According to the 2009 to 2011 archival data drawn from the eSOS database, the NSPH received 201,368 calls. To be more precise, there were 61,284 calls in 2009, 71,781 in 2010, and 68,303 in 2011. A group of TLA interns helped to match the two hundred thousand odd calls by telephone numbers and caller names (if recorded), and then identified 63,696 different callers. On average each person made 3.16 telephone calls, whereas 51.47% (n = 32,786) made only one telephone call during the study period. Considering that the repeat callers result in higher levels of frustration and burnout among the hotline volunteers than their one-time counterparts do (Kinzel & Nanson, 2000), the study excluded the repeat ones and was restricted to the one-time callers. Among those one-time callers, 36.57% (n = 11,990) of the recorded conversations lasted more than 10 minutes, affording enough information for analysis. Without outside funding, only a total of 300 telephone records, including 100 acute suicidal callers, 100 suicidal callers, and 100 non-suicidal callers, were randomly selected from the 11,990 one-time callers using the Statistical Program for the Social Sciences for further investigations.

2.2. Measures

2.2.1. Modified mental state rating scale

The modified mental state rating scale (MSRS) is an observational checklist measuring the caller's level of emotional disturbance based on the works of Kalafat et al. (2007), King et al. (2003), and Mishara et al. (2007). The feasibility of practical use in the context of a crisis hotline was also taken into consideration based on input from the TLA senior workers and volunteers. The MSRS consisted of six checklist items, including feelings of confused/ambivalent, overwhelmed/tired, angry/irritable, sad/tearful, helpless, and guilty/shameful. The items were each rated on a five-point scale: not at all, a little, moderately, quite a bit, extremely. Higher scores indicated heightened emotional distress. Cronbach's alpha coefficient was 0.88 in this study, indicating high internal consistency among the six items.

2.2.2. Modified suicide risk scale

The modified suicide risk scale (SRS) is an observational checklist shaped by Gould et al. (2007) study on the proximal changes in suicidality during the course of the telephone session. Gould and colleagues developed three subscales—intent to die, hopelessness, and psychological pain—as the major outcomes based on literature review of the published evidence and input from the telephone crisis workers. Each subscale was assessed by two checklist items. The items were each rated on a five-point scale: not at all, a little, moderately, quite a bit, extremely. Higher scores indicated intensifying suicidal urgency. Cronbach's alpha coefficient was 0.95 in this study, indicating high internal consistency among its six items.

2.3. Analytical procedures

To better understand who were using the NSPH services, the first thing we did was to generate descriptive statistics about the gender, age and administrative unit (i.e. county and city) distribution of the callers, because researches showed significant differences in the geographical and demographical distribution of suicides in Taiwan (Chang et al., 2011; Chuang & Huang, 2007; Lee et al., 2014). Taking the unequal distribution of population into account, we further calculated the county/city caller rates by dividing the caller counts by the residential population drawn from the National Household Registration System (Ministry of the Interior, n.d.). For the purpose of comparison, the gender and age distribution of suicide deaths and the county/city distribution of suicide rates were drawn from the National Suicide Statistics (Ministry of Health and Welfare, 2017b).

To examine if the NSPH was effective in alleviating the callers' emotional distress and suicidality, we evaluated the changes in the MSRS and SRS scores from the beginning to the end of the 300 selected telephone calls. First, twelve independent raters were recruited for training in the use of the MSRS and SRS, and then undergone practice until the inter-rater agreement statistic (i.e. Cohen's kappa) was higher than 0.80. Only after all the training and practice would they be allowed to rate the callers' mental status and suicide risk at the beginning and at the end of the 300 calls. The beginning of a call was referred to as the first 10 min of a telephone conversation, and the end, the last 10 min of a telephone conversation. If a call lasted for less than 20 min, the beginning of the call was considered as the first 5 min of the telephone conversation, and the end, the last 5 min of that telephone conversation. There was a quality control check during the rating process. All raters rated one specific telephone conversation halfway through their tasks to make sure that the inter-rater agreement statistic (i.e. Cohen's kappa) was still higher than 0.80. A repeated measures ANOVA was then conducted to examine if there were significant changes in the emotional distress and suicidal urgency from the beginning to the end of a call on the non-suicidal, suicidal, and acute suicidal callers.

Table 1
The gender and age distribution of the NSPH callers and the national suicide deaths, 2009–2011.

NSPH sample			National suicide deaths		
Gender[a]			**Gender**		
Male	23,203	(41.41%)	Male	7829	(68.32%)
Female	32,852	(58.59%)	Female	3630	(31.68%)
Age[b]			**Age**		
~19	1568	(4.44%)	~14	16	(0.14%)
20–29	6906	(19.56%)	15–24	501	(4.37%)
30–39	10,736	(30.41%)	25–44	4225	(36.87%)
40–49	9412	(26.66%)	45–64	4149	(36.21%)
50–59	5111	(14.48%)			
~60	1572	(4.45%)	~65	2516	(21.96%)

[a] Based on 56,055 callers (88.00% of the total 63,696 callers) with valid gender data.
[b] Based on 35,305 callers (55.43% of the total 63,696 callers) with valid age data.

3. Results

3.1. Gender, age, and county/city distribution of the callers

Demographic characteristics of the 63,696 callers and the 11,459 suicide deaths in the period 2009–2011 are shown in Table 1. In terms of gender, 56,055 callers (88.00%) had recorded data. Among them, there were more female callers (n = 32,852, 58.59%) than males (n = 23,203, 41.41%), even though men were twice more likely to die by suicide than women in the general population. In terms of age, only 35,305 (55.43%) had recorded data. Among the data, the largest age cohort was callers between 30 and 39 years of age (n = 10,736, 30.41%), followed by those between 40 and 49 (n = 9412, 26.66%), then between 20 and 29 (n = 6906, 19.56%), then between 50 and 59 (n = 5111, 14.48%), then above 60 years old (n = 1572, 4.45%), and lastly, those under 19 years old (n = 1568, 4.44%). It should be noted that while the elderly were twice more likely to die by suicide than the general population and contributed to about one-fifth of the suicide deaths, only a small percentage of the callers were above 60 years of age.

There were 46,266 callers (72.64%) with identified residential telephone numbers or recorded address. The county/city distribution of the callers, caller rates, and suicide rates are shown in Table 2. Taipei City, Taipei County, and Taoyuan County, all located in northern Taiwan, together contributed to more than half of the callers (n = 24,667, 53.32%). The top three administrative areas with the highest caller rates, i.e. Taipei City, Taoyuan County, Keelung City, are also located in northern Taiwan. Moreover, six out of the seven northern administrative areas are on the top 10 highest caller rates list. There appears to be no relationship between the caller rates and suicide rates. Take, for example, Keelung City and Hualien County. The two areas had the highest and the second-highest suicide rates, but differed very much in the caller rates. However, those with low caller rates but high suicide rates (i.e. Chiayi County, Pingtung County, Taitung County, Nantou County, Miaoli County, Hualien County) are mostly rural counties and have lower than average household incomes (Directorate-General of Budget, Accounting and Statistics, 2012).

3.2. Proximal outcomes of the caller's emotional distress and suicidality

The MSRS and SRS scores at the beginning and at the end of the calls on the non-suicidal, suicidal, and acute suicidal callers are shown in Table 3. Results of the repeated measures ANOVA on the MSRS indicate a statistically significant effect of time, $F(1, 297) = 230.23$, $p < .001$, $\eta p^2 = 0.44$, as well as a statistically significant effect of time-by-group interaction, $F(2, 297) = 4.47$, $p = .012$. The post hoc Tukey's HSD test was conducted to assess further differences among the three groups. All

Table 2
The county/city distribution of the NSPH callers, caller rates and the national suicide rates, 2009–2011.

	Caller counts		Caller rates and rankings		Suicide rates and rankings	
Northern Taiwan						
Keelung City	1027	(2.22%)	266.31	(3)	24.87	(1)
Taipei County	7793	(16.84%)	200.75	(6)	16.33	(16)
Taipei City	11,074	(23.94%)	422.50	(1)	12.48	(23)
Yilan County	850	(1.84%)	184.72	(8)	19.63	(7)
Taoyuan County	5800	(12.54%)	291.61	(2)	15.58	(18)
Hsinchu County	763	(1.65%)	149.18	(13)	16.87	(13)
Hsinchu City	969	(2.09%)	233.34	(4)	14.47	(21)
Central Taiwan						
Miaoli County	676	(1.46%)	120.41	(18)	18.90	(9)
Taichung County	2672	(5.81%)	160.56	(12)	15.48	(19)
Taichung City	2222	(4.82%)	145.80	(14)	13.92	(22)
Changhua County	1631	(3.53%)	124.58	(17)	14.78	(20)
Nantou County	629	(1.36%)	119.88	(19)	20.23	(5)
Yunlin County	725	(1.57%)	100.74	(22)	16.80	(14)
Southern Taiwan						
Chiayi County	521	(1.13%)	95.64	(23)	20.77	(4)
Chiayi City	574	(1.24%)	210.28	(5)	15.63	(17)
Tainan County	1327	(2.87%)	180.35	(9)	21.19	(3)
Tainan City	1842	(3.98%)	161.73	(11)	16.33	(15)
Kaohsiung County	1494	(3.23%)	180.26	(10)	18.48	(10)
Kaohsiung City	2773	(5.99%)	142.70	(15)	17.90	(11)
Pingtung County	922	(1.99%)	105.14	(21)	19.43	(8)
Eastern Taiwan						
Hualien County	476	(1.03%)	140.15	(16)	21.67	(2)
Taitung County	253	(0.55%)	109.49	(20)	20.17	(6)
Outer Islands						
Penghu County	90	(0.19%)	93.63	(24)	17.03	(12)
Kinmen County	47	(0.10%)	49.41	(25)	9.17	(24)
Lienchiang County	19	(0.04%)	191.32	(7)	6.77	(25)

Note: Based on 46,266 callers (72.64% of the total 63,696 callers) with recorded data in administrative unit.

Table 3
Emotional distress and suicidality at the beginning and at the end of the 300 calls.

		Beginning of the call		End of the call	
Scale	Suicide status	M	SD	M	SD
MSRS	Non-suicidal	13.72	2.75	11.33	2.88
	Suicidal	18.37	3.39	14.82	3.38
	Acute suicidal	16.37*	5.29	13.77	5.36
SRS	Non-suicidal	10.93	3.25	8.88	2.52
	Suicidal	19.87*	5.07	15.49	4.32
	Acute suicidal	22.36	6.11	16.53	7.73

groups are statistically significantly different from each other at the 0.001 level. That is to say, the suicidal callers had the highest scores on the MSRS, followed by the acute suicidal and then the non-suicidal callers. Moreover, the MSRS scores plummeted significantly over time (i.e. from the beginning to the end of the calls), and time alone accounted for 44% of the variance of change in the MSRS scores. The interaction of time and group from the repeated measures ANOVA is significant, suggesting that the groups may be changing over time in different ways (see Fig. 1).

We also achieved a result of $F(1, 297) = 230.40$, $p < .001$, $\eta p^2 = 0.44$, on main time effect, and a result of $F(2, 297) = 14.72$,

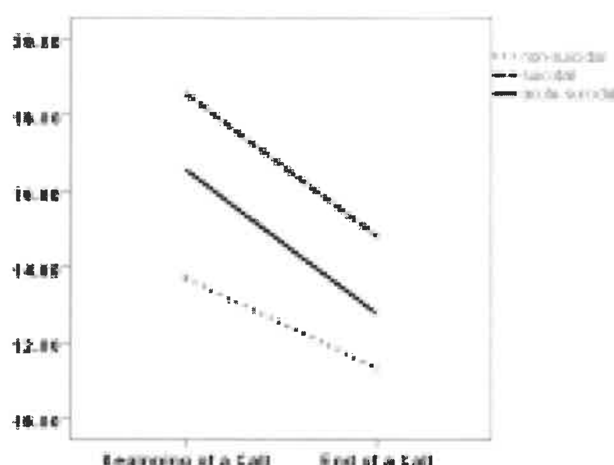

Fig. 1. Callers' emotional distress from the beginning to the end of their calls.

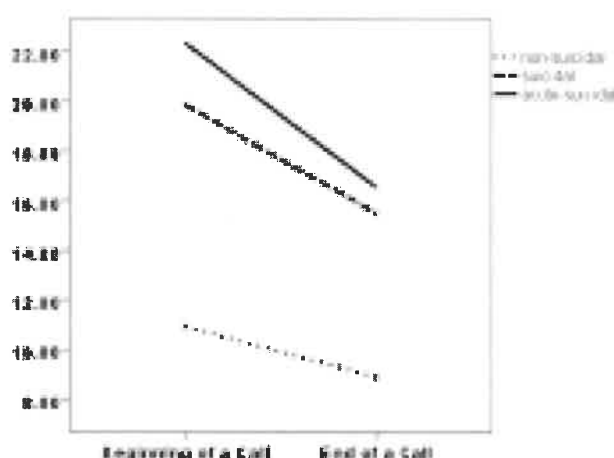

Fig. 2. Callers' suicidality from the beginning to the end of their calls.

$p < .001$, on time-by-group interaction for the repeated measures ANOVA on the SRS. Results of the post hoc Tukey' HSD test further reveal statistically significant differences among all groups of the callers at the 0.001 level. In other words, the acute suicidal callers had the highest scores on the SRS, followed by the suicidal, and then the non-suicidal callers. In addition, the SRS scores decreased significantly from the beginning to the end of the calls, and 44% of the variance of change in the SRS scores was accounted for by time alone. The interaction of time and group from the repeated measures ANOVA is significant, suggesting that the groups may be changing over time in different ways (see Fig. 2).

4. Discussion

This study represents the first-ever examination of the proximal effectiveness and the caller profiles of the suicide prevention hotline in Taiwan. Two key findings emerged from our data. First and foremost, like other evaluation results, the telephone crisis services prove to have an immediate positive impact on the callers' emotional distress and suicidality. The significant outcomes are not undermined by the suicide risk status of the callers, that is, disregarding whether the callers are suicidal or not, the hotline services are able to help them feel less disturbed and lower their suicidal urgency in just one telephone call.

The second key finding is that learning from the gender, age, and spatial distribution of the callers, the service has its limitation in reaching certain populations. Men, the elderly, and people living outside northern Taiwan are less likely to utilize the service. The higher proportion of female callers may reflect the fact that even though men are two-times more likely to die by suicide than women, women do report more suicide attempts than men (Ministry of Health and Welfare, 2017b). It is also consistent with the literature that men are less likely than women to seek help from the telephone helpers or the mental health specialists (Mackenzie et al., 2006; Ohtaki et al., 2017; Rickwood et al., 2007). Rickwood and colleagues further argued that men show even greater unwillingness to seek help when experiencing suicidal thoughts. Men's underutilization of mental health services may be a result of the traditional concept of masculinity. For men to admit that they need help and to openly express their feelings and emotions are in contravention of the traditional ideal of how men are supposed to behave. We also found that only a small percentage of the callers are above 60 years of age. Even though the elderly have the highest suicide rates of all age groups in Taiwan as well as in many other countries, a study showed that only a small proportion of them with suicidal thoughts or behaviors would actually seek help (Mackenzie et al., 2006). We have similar concerns about another finding of the present study that people outside the more developed and densely populated northern Taiwan are less likely to call the suicide prevention hotline, especially for those living in several rural counties with high suicide rates. It may be due to differences in the help-seeking attitudes that elderly and nonurban residents express greater stigma of help-seeking behaviors than their younger and urban counterparts (Judd et al., 2006).

In addition, our data reveal an unexpected finding that the callers with an ongoing suicide attempt are less emotionally distressed than those with only suicidal thoughts. This phenomenon verifies a rare finding in the literature (Reisch et al., 2010) as well as many practitioners' observations that sometimes individuals feel relieved after deciding to attempt suicide or after attempting suicide. The former (i.e. feeling relieved after deciding to attempt suicide) may be a result of the frontal lobe mechanisms of mood regulation. Radorf and Hare (2014) found that the dorsolateral and ventromedial sectors of the prefrontal cortex show increased activity during decision-making. Considering the critical role of the two sectors in affect regulation (Koenigs & Grafman, 2009), it is plausible that people do feel less disturbed after they make the decision to attempt suicide. The latter (i.e. feeling relieved after attempting suicide) may be explained by the gate control theory of pain (Melzack, 1999). The theory states the role of the spinal pathways and the brain in the processing of pain. Specifically, brain centers could close the gating mechanisms in response to the physical pain caused by the ongoing suicide attempts and thus decrease the psychological pain.

There are some limitations that are important to mention and demonstrate the need to view our results with some degree of caution. The first and most important limitation is that only a small proportion of the telephone records were selected for the proximal outcome evaluation because of a lack of funding. The small sample size may undermine the reliability of our research findings. Another limitation is that we did not take blind assignment for the MSRS and SRS ratings. Since the raters listened and rated both the beginning and the end of the same telephone session, they might expect some kind of improvements, which could be a threat to the internal validity. Lastly, we were unable to differentiate between the suicidal callers engaging in varying levels of self-harm and suicidal behavior. Further evaluation is needed to determine if the telephone crisis services are equally effective for both people engaging in non-suicidal self-injury and people attempting suicide.

5. Conclusion/recommendation

Our results have meaningful clinical implications. The significant decreases in the emotional distress and suicidality found during the course of the telephone session provide empirical evidence that the

hotline is a useful suicide preventive and crisis intervention service. In light of the positive proximal outcomes, the disproportionate distribution of the callers suggests that greater efforts are needed to make the telephone crisis services more agreeable to men, the elderly, and people living outside northern Taiwan. The unexpected finding that people with an ongoing suicide attempt are less emotionally distressed than those with only suicidal thoughts should help practitioners to better understand the function of suicidal behavior. Just as Henry A. Murray asked Edwin S. Shneidman, "What is suicide but an effort to stop the unbearable flow of negative affects" (Shneidman, 1998, p. 245).

Ethics approval

This study has received approval from the Central Regional Research Ethics Center, Taichung, Taiwan (cRREC-101-075).

Conflict of interest

The authors declare that there is no conflict of financial interest or benefit.

Submission declaration

It has not been published and is not under consideration for publication elsewhere.

Contributors

F.F.-T. Shaw and W.H. Chiang designed and directed the project together. F.F.-T. Shaw performed the comparison of the demographic characteristics of the hotline callers and general population. W.H. Chiang performed the rater training and the efficacy analysis. F.F.-T. Shaw wrote the manuscript.

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Supplementary material

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References

[illegible]
Chiang, W., 2013. 2011 An Hsin Hotline annual report. 2011 Taipei Lifeline Association Annual Report. Retrieved from [illegible] report/101_annual report.pdf.
[illegible]
Directorate-General of Budget, Accounting and Statistics, 2012. Year 2011 average family income and expenditure per household by areas. Retrieved from [illegible].
Gould, M.S., Kalafat, J., Munfakh, J.L.H., Kleinman, M., 2007. An evaluation of crisis hotline outcomes. Part 2: suicidal callers. Suicide Life Threatening Behav. 37, [illegible].
[illegible]
Kalafat, J., Gould, M.S., Munfakh, J.L.H., Kleinman, M., 2007. An evaluation of crisis hotline outcomes. Part 1: nonsuicidal crisis callers. Suicide Life Threatening Behav. 37, [illegible].
[illegible]
Ministry of Health and Welfare, 2017. Leading causes of death (2016). Retrieved from [illegible].
Ministry of Health and Welfare, 2017. National suicide statistics. Retrieved from [illegible].
Ministry of the Interior, (n.d.). Household registration data statistics. Retrieved from [illegible].
[illegible]
Su, D., 2017. 2016 An Hsin Hotline annual report. 2016 Taipei Lifeline Association Annual Report. Retrieved from [illegible].
Shneidman, E.S., 1998. Further reflections on suicide and psychache. Suicide Life Threatening Behav. 28, [illegible].
[illegible]