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THERAPEUTIC JURISPRUDENCE AND CORRECTIONS: A GLIMPSE

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I. Introduction

To our knowledge, therapeutic jurisprudence has not yet had a long visit with the world of jails and prisons. The authors, on the other hand, do regularly visit those institutions in various roles: as professor, as researcher and writer, as clinician, as administrator, and as consultant.

We are novices at therapeutic jurisprudence but have extensive experience in the world of law, corrections, and mental health. In this our first effort at trying therapeutic jurisprudence on for size, we first set out our broad understanding of therapeutic jurisprudence, along with a well-intentioned critique and a strong suggestion that at least one important research dimension seems lacking.

Thereafter, we describe some of the characteristics of corrections as they seem to impact on therapeutic jurisprudence analysis. For example, captives—our term for jail detainees and prison inmates—often seek judicial assistance in their expansion of their diminished liberty.[1] Therapeutic jurisprudence, on the other hand, speculates about an undue emphasis on deprivations of liberty associated with civil commitment of persons with mental illness.[2]

Finally, we attempt to put therapeutic jurisprudence into play within the area of custodial suicide, one of the many possible areas

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[1] *E.g.*, Washington v. Harper, 494 U.S. 210 (1990).

[2] *See* David B. Wexler, *Putting Mental Health Into Mental Health Law: Therapeutic Jurisprudence, in* ESSAYS IN THERAPEUTIC JURISPRUDENCE 3, 5 (David B. Wexler & Bruce J. Winick eds., 1991).

within corrections. At a minimum, we find that the therapeutic jurisprudence perspective keeps our feet to the fire; it insists that we look to consequences and not the elegance of a legal syllogism or the design of a study. Whether this is new, and whether this matters, is another story.

II. Therapeutic Jurisprudence Examined

We have been invigorated—and occasionally baffled—by our forays into the growing body of literature on therapeutic jurisprudence. One of us (FC) confesses to having been one of those "sixties" academic lawyers who observed civil commitments of the mentally ill, who interviewed judges, lawyers, and psychiatrists, and who walked through a few back wards of mental hospitals, even visiting the Alabama institutions involved in the landmark case of *Wyatt v. Stickney*.[3] The other (JD) has spent a career working in the public sector, as a psychologist and administrator within public institutions and agencies, and has frequently participated in class action litigation, often on the side of the government.

David Wexler is, of course, correct in pointing to the transcendence of liberty as a "sixties" value and the reflexive pursuit of procedural parallelism as both an analytical tool—the lawyer's penchant for reasoning by analogy—and as a basis for designing change.[4] However, an emphasis on personal autonomy and liberty, along with procedural hurdles and substantive rules of restraint, have over the years appeared remained worthy objective for both of us.

In our youth, what we saw and read convinced us that keeping as many people as possible out of the "mega-institutions" of the sixties was an eminently worthwhile objective. In a prior article, one of us pointed out the rolelessness, the futility of the lawyer's trial function and urged, *inter alia*, the development of a pre-hearing

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[3] 325 F. Supp. 781 (M.D. Ala. 1971) (finding inadequate treatment programs violative of patients' constitutional rights), *aff'd in part and rev'd in part sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

[4] Wexler, *supra* note 2, at 5-7.

attorney role.[5] That is, the article argued for the development and exploration of pre-hearing alternatives primarily aimed at securing treatment in the community when needed and the avoidance of civil commitment.[6] It posed parallels in the way some attorneys could "negotiate" juveniles and some adult offenders out of the incarcerating system and into something in the community that might be meaningful.[7] The article again betrayed a reflexive preference for liberty and autonomy over confinement[8] and even suggests an early admiration for Thomas Szasz.[9]

One further piece of nostalgia: Early on, we were convinced that procedural reformers often asked the wrong questions, indeed, posed answers in the form of questions. For example, arguing for a right to counsel in civil commitment was an easy analogical and precedential argument to make.[10] With *Gideon v. Wainwright*[11] and *In re Gault*[12] decided, and with the Court at least flirting with a functional versus formalistic analysis,[13] it was not difficult to focus on loss of liberty—as opposed to the formalism of criminal versus civil law—as the premise for procedural due process.

On the other hand, with civil commitment not formally within the strictures of the Sixth Amendment mandate that "[i]n all criminal prosecutions, the accused shall . . . have the Assistance of Counsel for his defence,"[14] it seemed that concentrating only on a right to

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[5] Fred Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424, 425 (1966).

[6] *Id.* at 452-53, 455.

[7] *Id.* at 455-56.

[8] *Id.* at 433.

[9] *Id.* at 436.

[10] *See In re* Gault, 387 U.S. 1, 34-35 (1967).

[11] Gideon v. Wainwright, 372 U.S. 335, 342-43 (1963) (holding indigent defendant in criminal state prosecution has the right to appointment of counsel under the Sixth Amendment).

[12] *Gault*, 387 U.S. at 41, 54-57 (holding that juveniles have a right to notice of charges, to counsel, to confrontation, to cross-examination, and to privilege against self-incrimination).

[13] *See* North Carolina v. Alford, 400 U.S. 25, 37 (1970) (stating that the Constitution is concerned with practical consequences and not formal categorizations of state law).

[14] U.S. CONST. amend. VI.

counsel analogue might not be the best strategy. That is, should we or should we not first flesh out the actual representational needs of the prospective patient—including the pre-hearing, hearing and post-hearing stages—and then search for an answer? That answer might have been counsel in a traditional sense, but with the development of new professional obligations or the invention of perhaps an entirely new sort of advocate. Thus, in the process of asking about needs—and what helps or doesn't—we have been flirting with therapeutic jurisprudence before it was named. The rarely articulated premise of the "due process" reformers of the sixties was that government—certainly in its liberty depriving functions—was the enemy. Government was to be feared most when it sought to help. If government was the enemy, and no matter how benevolent the liberty-depriving process claimed to be, then legal business had to be conducted at arms length. In contrast, a family model may be posed as the opposite of a government-as-enemy model, with some clear differences emerging. A family model posits shared values, common goals, informality, respect for the authority of the sovereign, and, if not a willingness to comply with rulings, at least a tacit agreement to do so.

David Wexler sees common ground between therapeutic jurisprudence and Professor Edward Rubin's "New Public Law".[15] To the extent that this new scholarship is aimed at legislators and administrators who, when given reasoned policy alternatives, will act in the public interest, it rests on a premise of shared values and common goals that we are not certain always exists. Indeed, in our experience with correctional agencies, we find that litigation and its threat of personal and financial costs to government agencies and officials are often the most important influences in achieving change.

We endorse the need to pursue scholarship beyond doctrinal analysis and the relentless pursuit of logical symmetry and we accept as valid the mandate of therapeutic jurisprudence to move from doctrinally grounded exegesis to empirically grounded speculation.[16] For us, a review of the therapeutic jurisprudence literature to date is

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[15] David B. Wexler, *Therapeutic Jurisprudence and Changing Conception of Legal Scholarship*, 11 BEHAVIORAL SCI. & L. 17, 17-19 (1993). *See* Edward L. Rubin, *The Concept of Law and the New Public Law Scholarship*, 89 MICH. L. REV. 792 (1991).

[16] Wexler, *supra* note 15, at 20-21, 29.

troubling. Therapeutic jurisprudence, as we understand it, expects legal scholars to *use* empirical data, not necessarily to generate it. It asks an astounding number of "what if" questions; such questions arise from speculation generated by a study of the available data.[17] It seeks to stimulate self-evaluation in terms of the workability of proposals, not simply acceptance by fellow scholars.[18]

In addition to our problems with the apparent willingness of some therapeutic jurisprudence scholars to accept the notion of a rational and perhaps even a concerned legislature and of legislative and administrative good will and responsiveness to reason,[19] there is an important "on the ground" dimension that seems to be missing in the therapeutic jurisprudence literature. Relying on the formal description of a process or on analytical speculation often creates what Malcolm Feeley refers to as the "fallacy of formalism."[20] If therapeutic jurisprudence scholars are indeed interested in change—as opposed to multi-dimensional speculation about change—then it is not enough to simply enlarge the law library collection. Out of the stacks you must go; you must walk the halls and talk with the "folks." The future of therapeutic jurisprudence, then, is not entirely in speculation, but also in investigation.

Reduced to its basics, therapeutic jurisprudence seeks to expand the scope of the marriage of law and the behavioral sciences,[21] to move from the study of law itself to the practical study of the therapeutic or counter-therapeutic consequences of the law.[22] It asserts that the "rights" approach to improvements in the quality of

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[17] *See, e.g.*, David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research*, 45 U. MIAMI L. REV. 979, 990-91, 993-94 (1991) (stating that therapeutic jurisprudence asks various questions such as the proper rationale for and therapeutic consequences of a patient's right to refuse treatment and treatment of incompetent death row inmates).

[18] Wexler, *supra* note 15, at 19.

[19] *See id.* at 18-19.

[20] MALCOLM M. FEELEY, COURT REFORM ON TRIAL: WHY SIMPLE SOLUTIONS FAIL, 194-95 (1983).

[21] Wexler, *supra* note 15, at 19, 29; Wexler & Winick, *supra* note 17, at 1004.

[22] David B. Wexler, *An Introduction to Therapeutic Jurisprudence*, *in* ESSAYS, *supra* note 2, at 17, 30-31.

psychological life is dead, replaced by a more pragmatic focus on "results."[23]

Perhaps therapeutic jurisprudence is to "rights" what early twentieth century sociological jurisprudence was to legal positivism. In his 1922 Storrs Lectures at Yale Law School, Roscoe Pound traced the evolution of the philosophy of law and found that "[a]ttention was turned from the nature of law to its purpose, and a functional attitude, a tendency to measure legal rules and doctrines and institutions by the extent to which law they further or achieve the ends for which the law exists . . . ."[24]

III. Therapeutic Jurisprudence and the Relevant Characteristics of Corrections

With the foregoing as prologue, we turn now to our assigned task, one that asks us to ruminate on issues of therapeutic jurisprudence in the world of corrections. In order to do this, we must first turn to a brief examination of what rightly may be deemed therapeutic within the context of corrections. This consideration highlights one of the difficulties with therapeutic jurisprudence: the need to specify just what is therapeutic, who decides, with what authority, and by what means. In all candor, here we decide by speculation and with the very limited authority granted authors.

One might assert several different sets of "therapeutic" objectives within the liberty depriving world of corrections. For example, the stated "therapeutic" interests of many inmates might well begin and end with freedom: "Let me go and your therapy be damned." One might look at the issue from the narrow view of simply managing the institutions. From this perspective, the long term reduction of criminal recidivism seems irrelevant. All that matters is maintaining control and allowing the staff to finish their shifts in good health. Inmates' achievement of literacy, for example, would be desirable only insofar as the classroom keeps them out of

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[23] *Id.* at 29.

[24] ROSCOE POUND, AN INTRODUCTION TO THE PHILOSOPHY OF LAW 91 (5th ed. 1937).

trouble during the day. Medical care would be exclusively palliative in nature, and pain killers would rule the formulary.

To the outside world, of course, such a view of prison either is or should be unacceptable, if for no other reason than that the vast majority of prisoners will soon be released. To the "free world," the therapeutic interests of corrections are likely to be quite different than to inmates or their managers. An informed community would most value a prison system whose parolees are least likely to reoffend and from which no inmates escape to terrorize surrounding towns.

Certain communities have other interests as well. The importance of correctional facilities in the American economy cannot be overstated. The recent explosion in prison census has created thousands of jobs,[25] in some cases actually saving towns from economic collapse.[26] In those communities that are not directly affected by the economic benefits of prison expansion there may exist exactly the opposite "therapeutic" interest; for them, the growth in prisons has meant higher taxes and budget deficits, with no reduction in crime and no end in sight. Our point here is that self-interest—whether or not ultimately endorsed as therapeutic—consistently leads to competition over divergent ends. The invention and enforcement of constitutional norms have served as leveling devices in corrections. These norms often mediate between competing self-interests and do so without an explicit regard for therapeutic outcomes.

At the risk of appearing cynical, we might suggest that left to the self-interests of government and its constituencies—that is, absent constitutionally derived substantive and procedural rights—mental health services in prisons likely would be reduced to that necessary to manage prisons quietly and perhaps safely, at least for the staff. Certainly, the longer, wiser view would suggest otherwise; well-programmed prisons may yet succeed in reducing recidivism and

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[25] *See* BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, 1992 STATISTICAL ABSTRACT OF THE UNITED STATES 198 (112th ed. 1992) (prison population increased from 329,821 in 1980 to 774,375 in 1990.).

[26] *See* Sue McMillin, *It Doesn't Have Growth Locked Up*, CHI. TRIB., June 14, 1992, at 1E.

ultimately creating safer communities.[27] But when has the American public taken the longer view?

We believe that constitutionally grounded procedural and substantive rights have enduring value in American correctional institutions. By clearly establishing the level below which services may not descend, the courts lead us to where our various and collective senses of what is therapeutic may not. Values such as providing medical and mental health care for those captives who are in pain, notice and a hearing for those who are accused, access to the courts, freedom from gratuitous punishment are so basic as to exist outside the debate on therapeutic value.[28] On the other hand, the modality, duration, and location of medical and mental health care are issues that may well benefit from therapeutic jurisprudence analysis.

Elsewhere, we have posited three objectives, located within the constitutional mandate, that government must provide in order to meet the mental health care needs of captives:

> 1. to reduce the disabling effects of serious mental illness in order to maximize each inmate's ability to participate in rehabilitative programs within the prison if he or she so chooses;
> 2. to reduce the needless extremes of human suffering caused by mental illness; [and]
> 3. to help keep the prison safer for staff, inmates, volunteers, and visitors.[29]

For those inclined to therapeutic jurisprudence who also accept our view that one must leave the library, you must talk with the captives and the captors in the enclosed world of jails and prisons. You must talk most with the captors in closest contact with

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[27] *See* Paul Gendreau & Robert R. Ross, *Revivification of Rehabilitation: Evidence From the 1980s*, 4 JUST. Q. 349, 350-51 (1987) (rehabilitating offenders reduces recidivism).

[28] *See* Connie Mayer, *Survey of Case Law Establishing Constitutional Minima for the Provision of Mental Health Services to Psychiatrically Involved Inmates*, 15 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 243, 244-45 (1989).

[29] Fred Cohen & Joel Dvoskin, *Inmates With Mental Disorders: A Guide to Law and Practice*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 462, 462 (1992).

the captives. You must do this to enrich your grasp of the issues and to obtain a sense of who wants what and how to deal with those wants. The nice syllogisms of law and the rapid fire "what ifs" of therapeutic jurisprudence will be importantly affected by this experience.

In the world of prisons and jails, we argue that no matter how elegant and seemingly complete a plan for change, no matter how reasoned the law upon which it rests, to the extent deputy sheriffs, correctional officers, nurses, and sergeants are not committed to the plan, it can be easily subverted. We have come to believe that using the law—for example on medical or psychiatric care, or suicide prevention—as a club within a preventive law model and involving line staff both in the definition of the problem and in the formulation of a plan for change, one can bring about workable, even therapeutic, results.

We have both been retained by a number of states as litigation strategists, consultants, or expert witnesses, often to assess the constitutionality of their prison mental health systems and, in some cases, to then devise plans to remedy that which requires fixing. Obviously, constitutional minima are not always the equivalent of good public policy; nevertheless, in achieving change, it is a good place to start. Working with government after the government is faced with a law suit allows one to borrow the energy generated by someone else's legal club, a club which may then be used derivatively as a positive way to achieve change.

A consultant may say to prison officials (indeed, each of us has): "You must never again use that cell as a mental health observation cell; you must never use this room for reception and classification—it is degrading, inhuman and impairs the process. I also think it is unconstitutional." Not infrequently, the rooms are shut and a clear therapeutic result is achieved.

Why do prison officials, with long experience and training in their profession, make these significant changes in policy on the word of a consultant? Not infrequently, these same suggested changes had been recommended by their own mental health staff members for years but with no action. Is it because the consultant is a more credible source of appropriate information? Since one of us is an attorney with no clinical credentials and the other a clinician with no legal credentials, such a view is unlikely. Rather, it is the

consultant's derived credibility *vis a vis* the courts that causes action.

The effective consultant in such cases knows the applicable law, but more importantly has seen the law in action in other states and counties. This knowledge of the law and practice is placed to work for the client. After an overall assessment of the system, the next task is to identify legally relevant issues, and work with in-house staff to design practical solutions. Only then will the effective consultant set about the task of accomplishing change. In the context of ongoing or impending litigation, and the threat of faring poorly, the consultant uses persuasion, and perhaps even threats, to convince the agency to change.[30]

While the threat of litigation may be useful in motivating government officials toward "therapeutic" ends, the litigation itself is quite another matter. For a variety of reasons, for captors and captives alike, the process of federal class action litigation can be painful and destructive, even if it eventually brings about positive change. The process itself may accurately be termed antitherapeutic.

Foremost among the negative effects of litigation is the expenditure of potentially vast sums of money.[31] In large class actions, litigation costs alone, independent of any substantive expenses pursuant to settlement or adverse decisions, can reach into the millions of dollars.[32] These expenses include the review of tens of thousands of pages of documents, tours, meetings, depositions of expert witnesses, legal fees of plaintiffs who ultimately prevail, and hours upon hours of overtime expense to prepare documents.[33] Many prisons assign staff members full-time as litigation coordinators for years in order to coordinate one suit. The sums of money spent exclusively on the *process* of litigation could be otherwise aimed at improving the conditions which occasioned the lawsuit in the first place.

Equally negative are the effects on staff morale. The specter of constant, pervasive, seemingly malevolent scrutiny affects staff at

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[30] *Id.* at 467.

[31] Vincent R. Johnson, *Ethical Limitations on Creative Financing of Mass Tort Class Actions*, 54 BROOK. L. REV. 539, 547 (1988).

[32] *Id.* at 570.

[33] Robert G. Doumar, *Prisoners' Civil Rights: A Pompous Delusion*, 11 GEO. MASON U. L. REV. 1, 19-22 (1988).

all levels of the organizational chart. Trust between inmates and staff, which may have already been thin, may erode even further as staff begin to assume that every complaint is raised with the inmate's eye on a "payday" in court. Finally, staff anger and fear can unfortunately result in incidents of violence.[34]

It may seem contradictory to defend the continued need for judicially defined and enforced constitutional minima of substantive and procedural rights while at the same time warning of the negative effects of the litigation process. The answers to this dilemma require action by all three players in the drama: government officials, plaintiffs (and their counsel), and the courts themselves.

For those who run prisons, the best way to avoid litigation is to reduce the chances that it will succeed by building service systems that clearly exceed constitutional minima. In the case of mental health services, we have elsewhere argued for a cost effective system of services which clearly exceed any reported constitutional requirements.[35] In order to accomplish this, it is first necessary to know clearly what those minima are, whether by the ongoing education of staff in applicable legal mandates or by bringing in consultant experts.[36] This knowledge must then be used to educate the appropriate officials on the logic which supports service enhancements as insurance against litigation.

For plaintiffs and their attorneys, it is useful to focus on the long-range goal of systems change, recognizing that voluntary and collaborative changes will be accomplished with greater enthusiasm and ultimately will last longer than compulsory changes achieved through prolonged litigation.

For the courts, one of the most important roles may actually be the simplest: correctional officials and inmates alike have a need for, and a right to, *clarity* about the rules of engagement.[37] Asked to

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[34] *See* Cohen & Dvoskin, *supra* note 29, at 463 (stating that the absence of mental health services leads to increased staff stress and increases the likelihood of violence between the staff and untreated inmates).

[35] *See id.* at 463-64.

[36] *See generally* FRED COHEN, NATIONAL INSTITUTE OF CORRECTIONS, U.S. DEP'T OF JUSTICE, LEGAL ISSUES AND THE MENTAL DISORDER (1988) (discussing various issues involved with the incarceration of the mentally disordered).

[37] *See* Walter J. Dickey, *The Promise and Problems of Rulemaking in Corrections: The Wisconsin Experience*, 1983 WIS. L. REV. 285 (1983).

hit a moving target, many officials will simply refuse to improve anything until the standards of care are clear and stable. Thus, if standards are unclear or in constant flux, it will be difficult, if not impossible, for correctional officials to gain access to the resources necessary to meet them. Inmates may also be negatively affected, since they will not know what to expect from their captors if every apparent gain is met with arguments for even higher standards. In other words, if government officials may be caricatured as generally providing too little, plaintiffs may be equally caricatured as asking for too much too often.

To the extent that therapeutic jurisprudence scholars are interested in generating questions and concerned more with impact than legal symmetry, they clearly have a place in the world of corrections. With perhaps a million people in prison and jails,[38] two and a half million under correctional supervision[39]—about one percent of the nation's adult population—and with a large number of this total group believed to be substance abusers,[40] sex offenders,[41] or mentally ill,[42] there is a strong case for seeking therapeutic ends or at least avoiding the anti-therapeutic consequences of correctional interventions.

Whether alcoholism, drug addiction, or a proclivity to commit sex offenses should be "medicalized" and then shoehorned into the Eighth Amendment right to medical/psychiatric care for serious

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[38] As of Dec. 31, 1991, there were 789,347 people in prison and as of June 30, 1988 there were 343,569 people in jail. BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, 1992 SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS, 596, 608 (1993). *See* Janny Scott, *Finding the Right Road to a Drug Free America*, LOS ANGELES TIMES, Feb. 14, 1993, at M3; Howard Goodman, *A Crushing Load for Corrections Officers Cases Are Doubling, Sometimes Tripling*, PHILADELPHIA INQUIRER, Apr. 20, 1992, at A1.

[39] As of Dec. 31, 1990, there were 2,670,234 people on probation in the United States. U.S. DEP'T OF JUSTICE, *supra* note 38, at 567.

[40] In 1989, 58.1% of jail inmates had used drugs on a regular basis. *Id.* at 602. In 1991, 62.2% of all state prison inmates had used drugs on a regular basis. *Id.* at 626.

[41] In 1991, 9.4% of state prison inmates had committed rape or other sexual assault. *Id.* at 623.

[42] Ralph Slovenko, *The Hospitalization of the Mentally Ill Revisited*, 24 PAC. L.J. 1107, 1119 n.72 (1993) (estimating that more than 7 percent of national jail population is seriously mentally ill).

disorders is an issue beyond the purview of this paper.[43] However, to the extent that correction programs expand to treat appropriate disabilities such as substance abuse,[44] then to that extent the playing field for therapeutic jurisprudence would have expanded.

Let us describe some of the broad features of corrections that should be part of any therapeutic jurisprudence analysis. Earlier we noted the basic premise that jails and prisons do not exist primarily to help their residents.[45] They, therefore, lack the therapeutic rhetoric more easily available to facilities for juveniles[46] and mental hospitals.[47]

Jails and prisons house a variety of people and serve a broad range of functions (especially jails) ranging from pre-trial detention, the confinement of probation and parole violators, persons serving misdemeanor or felony sentences, persons awaiting transportation—and more. Security, in our view, is the overriding concern of custodians and while no one is placed in confinement *for* the security of the facility, security becomes the paramount concern of facility operatives.

The politics surrounding jails and prisons are complex; funding for nonsecurity staff is often seen, at best, as a necessary

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[43] Estelle v. Gamble, 429 U.S. 97 (1976) (establishing Eighth Amendment right to care). As one of us (JD) has argued elsewhere, to spend limited prison mental health resources on institutional sex offender treatment is poor public policy for several reasons. First, there is no evidence that prison based sex offender treatment programs work to reduce recidivism. Second, due to the strong reward system for participation, there is a high probability that performance will be less that sincere. Third, "successful" completion of such programs may well result in earlier return to the community with no decrease in risk. Fourth, with resources so limited, it makes more sense to treat parolees who are already free, and thus have little incentive to participate except for an honest desire to change or a fear of reoffending. Joel A. Dvoskin, *Taking Issue: Allocating Treatment Resources for Sex Offenders*, 42 HOSPITAL & COMMUNITY PSYCHIATRY 229, 229 (1991).

[44] *See* Mayer, *supra* note 28, at 253 (prisons required to screen inmates for substance abuse problems). The authors view this as desirable but not mandated.

[45] *See supra* text accompanying note 25.

[46] *See* Barry C. Feld, *The Juvenile Court Meets the Principle of Offense: Punishment, Treatment, and the Difference It Makes*, 68 B.U. L. REV. 821, 895 (1988) (stating juvenile correctional facilities are not as uniformly bad as adult prisons).

[47] Valerie J. Wilkinson, *1986 Amendments in Georgia's Mental Health Statutes: The Latest Attempt to Provide a Solution to the Problem of the Chronically Mentally Ill*, 36 EMORY L.J. 1313, 1324 (1987).

evil.[48] No politician campaigns on a note of positive reform here; voters are not romanced with pleas for a more therapeutic or humane prison environment.[49] Far more likely are appeals to "law and order," claims that in order for our children to be safe, we must lock up more and more people.[50] There is little pretense today of any interest in rehabilitation.[51]

Captives have a constitutional right to medical and mental health care for their serious disorders[52] and they have a constitutional right to an environment which does not threaten their lives.[53] The duty to provide appropriate care and protection has common law roots and modern constitutional application here.[54] The avoidance of needless pain and suffering is the core constitutional value involved.[55] These duties often converge and later in this article, when we attempt to apply therapeutic jurisprudence analysis to custodial suicide issues, we shall see that one's theory on the etiology of suicide will determine which legal duty is arguably involved.[56]

It is custody *per se*, not its rationale, that creates these duties; duties which are not mandated for those of us fortunate enough to remain out of jail or prison.[57] If we are not in official custody we have no right to medical or mental health care and no right to

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[48] *See* Mayer, *supra* note 28, at 255-68 (discussing adequacy of mental health care in prisons).

[49] *See* Harry Berkowitz, *Five Days Campaign Countdown*, NEWSDAY, Oct. 29, 1992, at 19.

[50] *See, e.g.*, *Prisons: The Case for Incarceration*, PHOENIX GAZETTE, Jan. 21, 1993, at A14 (quoting Attorney General William P. Barr that there is no better way to reduce crime than to "identify, target, and incapacitate those hardened criminals . . . .").

[51] *See, e.g.*, Alvin E. Bessent, *Cuomo's Anticrime Plan: Police, Prisons, New Laws*, NEWSDAY, May 9, 1989, at 5.

[52] Mayer, *supra* note 28, at 244.

[53] *Estelle*, 429 U.S. at 102.

[54] *See* DAVID RUDOVSKY ET AL., AMERICAN CIVIL LIBERTIES UNION, THE RIGHTS OF PRISONERS 1 (4th ed. 1988).

[55] Fred Cohen & Joel Dvoskin, *Inmates With Mental Disorders: A Guide to Law and Practice*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 339, 340 (1992).

[56] *See infra* part V.

[57] DeShaney v. Winnebago County Dep't of Social Servs., 489 U.S. 189 (1989) (due process limits a state's power to act but does not guarantee minimal levels of protection for the general public).

physical security.[58] While captives are owed these duties, their impaired legal status, the overarching concern for security (which is repeatedly validated by judicial deference to correctional decision makers),[59] and the daunting doctrinal and procedural rules imposed upon captives make these governmental duties less than demanding. The constitutional minima alluded to earlier is, indeed, a basement floor.

The potential for subverting security or achieving some measure of secondary gain are the practical, preliminary hurdles for captives seeking mental health care. To receive treatment for an illness, a captive must recognize symptoms, decide to seek relief, and present to the authorities a claim of illness—strategies which vary greatly by race, sex, class and setting. Captives are greatly impaired in their ability to define for themselves the nature of their problem, to select a care giver, or to select or reject a given course of treatment.

In analyzing the professional judgment standard which has evolved from *Youngberg v. Romeo*,[60] Professor Susan Stefan writes:

> It is difficult to imagine a relationship farther from the voluntary, private professional-client model than the relationship between a prisoner or pretrial detainee and prison or jail officials.
>
> . . . Not only has the *Youngberg* standard been imported into challenges to the adequacy of psychiatric care in prisons and jails, but it has also been applied to cases challenging medical care without a mental health component. Some courts have applied *Youngberg's* professional judgment to wrongful death actions arising from inmate suicides.[61]

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[58] *Id.* at 200.

[59] *See, e.g.*, Procunier v. Martinez, 416 U.S. 396, 405 (1975) (stating that courts are not equipped to deal with prison administration and reform).

[60] 457 U.S. 307 (1982).

[61] Susan Stefan, *Leaving Civil Rights to the "Experts": From Deference to Abdication Under the Professional Judgment Standard*, 102 YALE L.J. 639, 704-05 (1992).

The Court's adoption and expansive use of the professional judgment standard, when linked to judicial deference applied to all manner of decisions involving facility and population management, and the increasingly onerous mental state requirements imposed on the constitutional claims of captives,[62] underscores the minimal autonomy and liberty remaining with penal captives. Thus, therapeutic jurisprudence concerns in the correctional setting are not so easily dichotomized into liberty and autonomy versus therapeutic results. Indeed, for captives the issue is more likely to be strategies to minimally expand, as opposed to preserve, liberty and autonomy.[63]

If a jailor intentionally fails to provide an inmate with food or water and the inmate dies as a result, who would dispute this as murder? If somewhere along in the starvation or dehydration process the inmate demonstrated symptoms of serious mental illness and received no mental health care, would we accuse the jailor only of a failure to provide the basics necessary to sustain life? Is there an independent cause of action for a failure to provide mandated mental health care? Would it matter?

In a section 1983 law suit,[64] both potential claims would be grounded in the Eighth Amendment and both would require a showing of deliberate indifference to the respective rights involved.[65] These observations and questions serve as a segue to our final section. This section will intertwine these matters with our encounter with custodial suicide.

IV. Custodial Suicide: An Exercise in Therapeutic Jurisprudence

We concede what the reader will recognize; it is something of a stretch from our initial grappling with the meaning of therapeutic

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[62] *Id.* at 690-91 (explaining that the *Youngberg* standard commands courts to presume the validity of professional judgments).

[63] *See* Youngberg v. Romeo, 457 U.S. 307, 315 (1982) (respondent arguing for extension of his liberty interest to include safety, freedom of movement, and training).

[64] 42 U.S.C. § 1983 (1988) (establishing civil liability for deprivation of constitutional rights under color of law).

[65] *See Estelle*, 429 U.S. at 104.

jurisprudence and its implications to looking at corrections through the eyes of therapeutic jurisprudence to present topic: custodial suicide. This no-frills section represents our effort to more specifically apply therapeutic jurisprudence analysis to a concrete, emotionally charged subject within corrections.

We are amateurs at this and, in effect, are displaying our early notes albeit with a bit of polish. Thus, we approach therapeutic jurisprudence and custodial suicide without a clear blueprint and some uncertainty. We did learn that the manipulation of legal doctrine needs to be joined with our earlier "on the ground" approach and we do give that a run.[66]

When a captive takes his or her own life—and this happens about 400 times a year in jails and at least 100 times a year in prisons[67]—what are the legal issues involved surrounding liability? And where might a therapeutic jurisprudence perspective be of some value? Clearly, no rational person will view such a suicide as therapeutic, particularly since so many are accomplished while the victim is under the influence of some drug and experiencing the initial terror of confinement.

In a recent article, Cohen summarized the applicable federal case law as follows:

> 1. Custodians—whether they be police at a lockup, sheriffs at a jail or correctional officials at a prison—are not insurers of the life and safety of those in their charge. While there clearly are constitutional duties to preserve life and to provide medical or mental health care, these duties will not translate into some guarantee of safety, health, or the continuity of life.
> 2. The standard for liability in the federal courts is deliberate (sometimes referred to as reckless)

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[66] *See supra* text accompanying notes 20-24.

[67] *See* BUREAU OF JUSTICE, *supra* note 38, at 669 (134 suicides in state and federal correctional facilities in 1990). However, the National Center on Institutions and Alternatives (NCIA) conducted a survey which determined the number of jail suicides in 1985 and 1986 to be 453 and 401 respectively. Lindsay M. Hayes, *National Study of Jail Suicides: Seven Years Later*, 60 PSYCHIATRIC Q. 7, 15 (1989).

> indifference which, at a minimum, means culpability beyond mere negligence. The defendants must be shown either to have had knowledge of a particular vulnerability to suicide or be required to have known; this knowledge must create a strong likelihood, as opposed to the possibility, of suicide; and this "strong likelihood" must be so obvious that a lay person would easily recognize the need for some preventive action. Parenthetically, the courts seem to be unaware of the fact that they are borrowing the "obvious to a layman" phrase from prison and jail mental health cases which state that a mental illness or medical need is serious if it would be obvious to a lay person that treatment was needed.
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> A custodial suicide *per se* is *not* conclusive proof of deliberate indifference. If it were then custodians would in fact be required to provide suicide-proof institutions.
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> 3. The general right of detainees to receive basic medical or mental health care does *not* place upon jail officials the responsibility to screen every detainee for suicidal tendencies. A high percentage of detainees arrive at a lockup or jail under the influence of alcohol or some other drug and judicial decisions now hold that being "under the influence" *alone* does not enhance the custodian's duty to screen or to take extraordinary suicide preventive measures.[68]

The issue of special relevance to therapeutic jurisprudence we wish to explore relates to the requirement that one "knew or should have known" of the risk and the suggestion that where there is no legally imposed duty to develop suicide-relevant information, the federal courts place a premium on ignorance. This plainly discourages the wider adoption and use of reasonably easy to use and accurate suicide screening and assessment instruments and even

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[68] Fred Cohen, *Liability for Custodial Suicide: The Information Base Requirements*, JAIL SUICIDE UPDATE, Summer 1992 at 1, 2 (footnotes omitted).

encourages the manipulation of records to avoid use of the term "suicide risk."

In *Cruzan v. Director, Missouri Dep't of Health*,[69] the Supreme Court reaffirmed the right of a competent, unconfined person to refuse forced administration of life saving interventions.[70] The Court accepted the power of the state to impose procedural hurdles in safeguarding decisions by incompetents as to the continuity of life.[71] When a person is in custody, these issues are quite different. The custodian has an unequivocal duty to preserve life which clearly extends to preventing suicides.[72] Thus, while the general, preventive duty is clear, it is the scope and implementation of the duty which raise problems.

Absent a present, credible threat to commit suicide or actual knowledge that the individual has in fact attempted suicide, the federal courts are extremely reluctant to impose liability. In *Edwards v. Gilbert*,[73] the court stated flatly, "[i]n the absence of a previous threat or an earlier attempt at suicide, we know of no federal court in the nation or any other court within this circuit that has concluded that official conduct in failing to prevent a suicide constitutes deliberate indifference."[74]

For our purposes we may put aside the many questions related to the appropriate measures to be taken when there is reason to take seriously a suicide threat; measures ranging from close to intensive observation, special cell placement, removal of items of clothing which may be used to cause death, avoidance of single-celling, and the like. The anterior question is when should (or must) those precautions be taken? We certainly would not argue that such precautions are necessary for every detainee or for every inmate. If all captives were ordered to be placed under close, illuminated

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[69] 497 U.S. 261 (1990).

[70] *Id.* at 278.

[71] *Id.* at 280-81.

[72] *See* Martinez v. Turner, 977 F.2d 421, 423 (8th Cir. 1992) (permitting the force feeding of inmate when life or health is in danger). *But see* Thor v. Superior Court, 855 P.2d 375 (Cal. 1993) (denying a doctor's petition to surgically implant feeding and medication tubes into a mentally competent quadriplegic prisoner who refused life-sustaining treatment).

[73] 867 F.2d 1271 (11th Cir. 1989).

[74] *Id.* at 1275 (footnote omitted).

observation, twenty-four hours a day, *and if those orders were effectively carried out*, then presumably custodial suicides could be eliminated. This blunderbuss approach would sacrifice the already minimal claims to freedom and privacy enjoyed by captives, and doubtlessly would create a needless array of severe management and personnel allocation problems. Thus, a plainly desirable—even therapeutic—outcome is outweighed by the considerable loss associated with the means required.

The issue, then, lies somewhere between all and none; between taking all captives' privacy and dignity and attempting to locate and reasonably protect the "at risk" population.

The goal of preserving the life of captives seems to be so clearly a dominant value as to need no debate.[75] To reiterate, the general duty of custodians to preserve life is clear; the trick is to determine the trigger for, and the dimensions of, that duty.[76] More particularly, should it include a duty to develop suicide relevant information, a duty to share such information, and a further training-type duty to know how to interpret certain behavior or signs as creating a suicide threat? We would answer yes to all three questions and assert further that use of therapeutic jurisprudence analysis dictates that answers.

Therapeutic jurisprudence analysis, with its emphasis on outcomes, cannot entirely eschew doctrinal analysis. In the case of custodial suicide, where the fatal act is carried out by the victim, one must think through the basic components of culpable omissions. Thus, before we take on each of these questions, we will display our doctrinal note pad on omissions.

With the legal duty defined here as preventive, liability analysis always will involve the question of a culpable omission. Since a section 1983 claim[77]—either to treatment or safety—requires

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[75] *See, e.g.*, Simmons v. City of Philadelphia, 947 F.2d 1042, 1067-68 (3d Cir. 1991) (holding that a municipality has a constitutional duty to provide persons in custody some quantum of care and protection).

[76] *E.g.*, McLauglin v. Sullivan, 461 A.2d 123, 125 (N.H. 1983). *See* Fred Cohen & Joel Dvoskin, *Inmates With Mental Disorders: A Guide to Law and Practice*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 339, 345 n.12 (1992).

[77] 42 U.S.C. § 1983 (1988).

that the defendant act, or fail to act, with deliberate indifference,[78] we must somehow fit these omissions into the domain of deliberate indifference.

An omission is defined by a specific act or acts which if done would have satisfied the actor's obligation.[79] Failure to obtain relevant information will not by itself impose liability, except perhaps as a violation of local law requiring this activity.[80]

Our concern is not with employer-employee consequences. Rather, it is with the failure to seek information which, if obtained, would likely have alerted the custodian and would be causally related to a preventable suicide. If legal causation is an important policy question, as an assignment of blame, then given the custodian's relationship in time and space to the captive, given the general duty of care and *de facto* dependance by the captive on the custodian, doctrinal manipulation on the causation issue is relatively easy.[81]

We expand duty to encompass enlarged notions of liability. Enlarged notions of liability may create inducements to prevent the tragedy of custodial suicide.

We have not read about a fellow captive being sued or criminally charged with failure to prevent a suicide or to interrupt one in process. The issue here is not only the likelihood of a captive being judgment proof; it is probably because we never thought about it and, more importantly, because suicide prevention is the legal obligation of the custodian and only the moral obligation of the fellow captive.

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[78] *Estelle*, 429 U.S. at 106 ("[P]risoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference."); *Simmons*, 947 F.2d at 1064 (requiring a § 1983 claimant to show "policymakers" deliberately chose or acquiesced to long standing policy of inaction).

[79] *See, e.g.*, MODEL PENAL CODE § 2.01(3)(b) (1985) (stating the liability for the commission of an offense may not be based on an omission unaccompanied by action unless a duty to perform the omitted act is otherwise imposed by law).

[80] *E.g.*, N.Y. PENAL LAW § 15.10 (McKinney 1987).

[81] *Cf.* Bishop v. Stoneman, 508 F.2d 1224, 1226 (2d Cir. 1974) (holding that a series of incidents that are closely related in time *may* disclose a pattern of conduct amounting to deliberate indifference by prison officials). *See generally* Charles M. Holt, *Sheriff's Liability for Prisoner Suicide*: Hemly v. Bebber, 64 N.C. L. REV. 1520 (1986) (analyzing the criteria reviewed when determining custodial liability for prisoner suicides).

It is not difficult to establish that it is negligence for a jailor to fail to check a jail's easily obtainable master files for evidence of prior suicide attempts, for an earlier shift with knowledge of suicide threats to overlook sharing this information with the incoming shift, or for an arresting officer to fail to inform the booking officers of his knowledge of the arrestee's suicide attempts. However, to establish section 1983 liability, the trick is to characterize such omissions as deliberate indifference.[82]

Deliberate indifference is the constitutionally mandated mental element for liability in prisoner health care litigation as well as a "duty to protect." *Estelle v. Gamble* established this culpability requirement, although a search of all Supreme Court decisions reveals no prior reference to deliberate indifference or to any close variation of the phrase.[83] Given the novelty of the phrase one might have expected some effort at definition. Instead, the *Estelle* decision labored only to explain what deliberate indifference was not.

> [A]n inadvertent failure to provide adequate medical care cannot be said to constitute "an unnecessary and wanton infliction of pain" or to be "repugnant to the conscience of mankind." Thus, a complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner.[84]

The avoidance of needless pain or death is at the core of deliberate indifference and the necessary bridge to the harm requirement.

One of the most intriguing discussions of deliberate indifference, which culminates in the most defense-oriented definitions, is by Judge Richard Posner in *Duckworth v. Franzen*.[85]

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[82] *See generally* City of Canton v. Harris, 489 U.S. 378 (1989) (discussing level of inadequate training needed to establish municipal liability for failure to train police).

[83] Search of Westlaw S.Ct. and S.Ct. Old databases (Nov. 11, 1993).

[84] Estelle v. Gamble, 429 U.S. at 105-06.

[85] 780 F.2d 645 (7th Cir. 1985).

After marking off negligence, recklessness, and deliberateness as the three traditional mental elements to be consulted in order to determine deliberate indifference, Judge Posner states:

> If the word "punishment" in cases of prisoner mistreatment is to retain a link with normal usage, the infliction of suffering on prisoners can be found to violate the Eighth Amendment only if that infliction is either deliberate, or reckless in the criminal law sense. Gross negligence is not enough. Unlike criminal recklessness it does not import danger so great that knowledge of the danger can be inferred; and we remind that the "indifference" to the prisoner's welfare must be "deliberate" implying such knowledge.[86]

More recent decisions from the Seventh Circuit support the *Duckworth* formulation and, indeed, actually may increase the burden for plaintiffs. For example, in *Salazar v. City of Chicago*[87] the court reiterated the "reckless in a criminal sense" formulation emphasizing the need for "'complete indifference to risk—when the actor does not care whether the other person lives or dies, despite knowing there is a significant risk of death.'"[88]

In *Langley v. Coughlin*,[89] a prison mental health case, the federal magistrate took a bit more expansive view of deliberate indifference, stating:

> [A]n isolated and inadvertent error in treating even a serious medical need would not constitute a violation since the Eighth Amendment does not constitutionalize the law of medical malpractice. On the other hand, a serious failure to provide needed medical attention when the defendants are fully aware of that need

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[86] *Id.* at 652-53 (citations omitted).

[87] 940 F.2d 233 (7th Cir. 1991).

[88] *Id.* at 238 (quoting Archie v. City of Racine, 847 F.2d 1211, 1219 (7th Cir. 1988)).

[89] 715 F. Supp. 522 (S.D.N.Y. 1989).

> could well constitute deliberate indifference, even if they did not act with a punitive intent.
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> . . . [W]hile one isolated failure to treat, without more, is ordinarily not actionable, it may in fact rise to the level of a constitutional violation if the surrounding circumstances suggest a degree of deliberateness, rather than inadvertence, in the failure to render meaningful treatment. Moreover, the inference of such indifference may be based upon proof of a series of individual failures by the prison to provide adequate medical care even if each such failure—viewed in isolation—might amount only to simple negligence.[90]

"Two key points may be discerned from the above excerpt. First, deliberate indifference may be shown by a series of negligent acts or omissions which then may cumulate to become a constitutional violation. No single act or omission need attain deliberate indifference . . . ."[91]

Where a jail has experienced a number of suicides (as in the Upper Darby, PA cases[92] and the recently reported forty-seven Mississippi jail suicides[93]) then clearly there is notice that a problem exists. Whether that problem is a failure to screen, failure to take minimal precautions, or even design failure is not clear.

This, of course, is not the same type of notice as that provided by a captive's shouts of wanting to die. But it is plain enough to construct at least the duty to screen for suicide risk. When the general screening produces a history of mental hospitalization or prior suicide attempts, a custodian should have the duty to go further, discover more facts through a detailed history, and perhaps institute

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[90] *Id.* at 536 (citations and footnotes omitted).

[91] Cohen & Dvoskin, *supra* note 76, at 343.

[92] Colburn v. Upper Darby, 838 F.2d 663, 672 (3d Cir. 1988) (reversing dismissal of complaint because allegation that local officials inadequately monitored jails stated sufficient cause of action where three suicides occurred in police custody in three years), *cert. denied*, 489 U.S. 1065 (1989).

[93] Michael Isikoff, *Reno Orders Probe of Hangings in Mississippi Jails*, WASH. POST, Apr. 15, 1993, at A3.

precautions. Beyond the individual scream and a history of successful custodial suicides, there is data that allows construction of an "at risk" profile.

The best data on jail suicides comes from the Nation Center on Institutions and Alternatives (NCIA) located in Alexandria, VA. NCIA's 1986 study replicated a study it conducted seven years earlier[94] and the key indicators were virtually the same: fifty percent of jail suicides are completed within the first twenty-four hours of confinement; twenty-seven percent in the first three hours.[95]

Two of every three victims were in isolation and ninety-four percent died by hanging.[96] Ninety percent were detainees and sixty percent were intoxicated when confined.[97] In police holding facilities, sixty-four percent died within three hours of confinement.[98] In jails, eighty-nine percent of the victims were not screened for suicidal behavior, while in lock-ups, ninety-seven percent were not.[99] The average age of a suicide victim is thirty and the detention is almost always for a non-violent crime.[100]

The data scream at us: the relatively young, intoxicated or drugged, isolated, white, non-violent inmate in the initial hours of confinement commits suicide by hanging. He hasn't been screened and, obviously, has not been watched closely enough.

A more recent, albeit small scale, study argues that there may indeed be more than one suicide profile.

> Thus, in all likelihood, there is not one profile but rather a variety of suicide profiles. One is probably composed of first-time arrestees who are

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[94] *See* Hayes, *supra* note 67, at 7.

[95] *Id.* at 20.

[96] *Id.* at 20, 19.

[97] *Id.* at 12, 19.

[98] *Id.* at 20.

[99] *See* Hayes, *supra* note 67, at 21.

[100] *Id.* at 18. Space does not permit a more complete summary of NCIA's data. However, there are some interesting anomalies: black inmates account for 41% of jail population, but only 16% of all suicides. *Id.* at 13, 18. Most victims are single and the hours between midnight and 3 a.m. are the most dangerous. *Id.* at 18, 19.

> intoxicated at the time of arrest, who are overwhelmed by the stress of the jail environment, and who attempt shortly after incarceration. Recently, several studies have been published which indicate a much higher prevalence of panic disorders and attacks in the general population, as well as indicate a link between panic attacks and suicide attempts. Given the stress of the jail environment, this may have specific application to this particular subgroup, whose existence is well documented in the two NCIA studies.
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> An additional profile encompasses the inmate who is vulnerable to any changes in his support system and who attempts suicide. Another is the inmate arrested for more serious charges and who attempts after several months, usually in relation to a court date. Undoubtedly others will also be identified. While other studies have postulated or identified these groups, the present study has accumulated further evidence to support their existence and added insight into an important variable—the presence of significant mental disorders and a chronic history of both suicide attempts and mental illness which make these two groups more vulnerable and at risk.[101]

This data does suggest that the risk—and the profile—changes somewhat as time in confinement is extended. For the earliest stages of confinement the remedy is plain and inexpensive: intake screening and suicide prevention training of officers.

Every set of standards and accreditation procedures of which we are aware calls for policy and procedure mandating screening and subsequent evaluation when indicated.[102] Some thirty-six states have adopted jail standards but "most states lack even the basic criteria for

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[101] Larry D. LeBrun, *Characteristics of Male Suicide Attempts in the Sacramento County Jail, 1985-87*, JAIL SUICIDE UPDATE, Fall 1989 at 1, 3.

[102] *See, e.g.*, *National Standards of Jail Suicide Prevention*, JAIL SUICIDE UPDATE, Summer 1989 at 1, 1 (discussing the need for standard of suicide prevention in jails).

suicide prevention."[103] Only eight states' jail standards specify suicidal behavior inquiry on their intake screening.[104]

The presence or absence of standards does not correlate with constitutional mandates. With the results so tragic, with the number of deaths sufficiently high and with prevention so easy and inexpensive, the case for deliberate indifference when there is no screening/evaluation seems clear. However, when the federal courts require actual knowledge of risk there is a powerful disincentive to acquire relevant, preventive information.

Most civil suicide cases are settled but, of course, that still expends public money and personal tragedy remains, including the trauma often experienced by staff.[105] Despite the stereotype of correctional officers as unfeeling or cynical, it has been our consistent experience that "successful" suicides in correctional settings have a devastating emotional effect on the staff involved.[106] In part, this may be due to the incident review, investigation, and possible sanctions for failing to perform their duty to keep each inmate alive. But to an equal or greater extent, one hears about feelings of guilt ("he died on my watch; I was supposed to be there"), loss, sadness, and even anger that sound eerily similar to what surviving family members express in similar situations.

V. Conclusion

Finally, one's diagnosis on the cause of suicide will dictate the nature of the legal obligation. However, in the earliest stages of custodial obligation—certainly the first forty-eight hours—the initial obligation is preventive and if the initial crisis passes and the episode seems situational and not linked with mental illness, that may be the

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[103] *State Standards and Suicide Prevention: A Report Card*, JAIL SUICIDE UPDATE, Summer 1989 at 4, 4.

[104] *Id.*

[105] *Cf.* Lewis L. Laska, *Medical Malpractice Cases Not to File*, 20 MEM. ST. U. L. REV. 27, 59 (1989) (verdict in suicide/medical malpractice case is rare).

[106] *See* Paul J. Heald, *Retroactivity, Capital Sentencing, and the Jurisdictional Contours of Habeas Corpus*, 42 ALA. L. REV. 1273, 1331 (1991) (discussing the stress of being a correctional officer as a mitigating factor in death penalty cases).

end of the obligation. If the diagnosis is that the suicidal captive is seriously mentally ill then, along with a preventive obligation, there is a treatment obligation. The longer the confinement the more likely the preventive obligation will merge into the treatment obligation.

We have walked the halls of many prisons and jails and one of us bears heavy oversight responsibility for captives whose suicide potential is a constant concern. Thus, this exercise is, in fact, one that flows from the library as well as the real world walk we earlier recommended.

Custodial suicide initially seemed like a good candidate for a therapeutic jurisprudence exercise because we were bedeviled by the federal courts' narrow and seemingly insensitive approach to the deliberate indifference standards for section 1983 liability. The "know or should have known" part of the equation has been resolved essentially in favor of an actual knowledge requirement whereas a more generous view of "should have known" would have expanded liability potential but also likely stimulated ameliorative measures.

Plainly, if the reduction of custodial suicides is a therapeutic end to pursue, to the extent that the federal courts are seen as the focus for this objective—and, of course, that is open to reasonable debate—then "should have known" must be pried open and new content poured in. This new content must discourage willful or reckless ignorance and encourage reasonable efforts to identify and then react to the at-risk captive population.