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Law and Justice Interim Committee

61st Montana Legislature

June 18, 2010

TO: Law and Justice Interim Committee

FROM: David S. Niss, Staff Attorney

RE: MSPOA Peer Review Program

I
Introduction

Based on a request by Representative Ebinger[1], the Law and Justice Interim Committee has asked for a report on the jail "peer review" program conducted by the Montana Sheriffs and Peace Officers Association (MSPOA)[2] (Rep. Ebinger was the sponsor of HB 60 in the 61st Legislature [Attachment A], creating a jail suicide prevention pilot program). The purpose of this memorandum is to present the status of the peer review program in context with other information about jail suicides obtained this legislative interim and last.

II
Discussion

a. Method of inquiry

The method of inquiry that forms the basis for this staff report was to first ask the MSPOA for a report on the status of the peer review program[3] and, after the MSPOA report was received, to ask followup questions based upon the MSPOA response. All inquiries were made exclusively by e-mail in order to document the questions and responses. Unfortunately, this report is unfinished because of a lack of information and because the results of the peer reviews

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

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

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

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

b. Method of the peer review of jails by MSPOA

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

(1) The voluntary jail standards of the MSPOA[5] are divided into "core" and "noncore" standards, with "core" standards shown in the voluntary standards in bold print. There are approximately 113 numbered "core" standards of apparently equal weight or importance, "core" standards being those standards required by "law, ARMS, case law, professional standards."[6] However, five of the six reviews conducted by the time of preparation of this memorandum have been "training" reviews in which only three chapters of the core standards were used for the review. These chapters were Chapters 1 (Administration), 7 (Security and Control), and 11 (Health Care Services).[7] The MSPOA has cautioned that these "training" reviews are not to be considered full reviews.[8]

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

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

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

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

[6]Id.

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

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

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

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

c. Results of peer review program

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

d. Staff concerns about the peer review program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> With strong data to indicate that suicides can be prevented, [Lindsay] Hayes emphasized that "the antiquated mindset that 'inmate suicidescannot be prevented' should forever be put to rest."

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

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

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

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

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

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

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

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

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

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

[16]National Study, p. 3.

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

the four of 2009 suicides were committed by hanging with jail-issued bed sheets[18], or of the victim. A suicide profile of Montana victims would show, if the National Study is reflective of Montana victims, that victims do not always suffer from mental illness but may feel ashamed, trapped, and desperate.[19]

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

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

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[18]See note 11.

[19]Id, pp. 1, 17, and 45.

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

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

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

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

[24]National Study, p. 48.

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

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

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

About suicide screening in general, the NCIA states:

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

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[25]Regarding the effectiveness of the program or meaningfullness of the approval, see footnote 14.

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

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

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

[29]Ibid.

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

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

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

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

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

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

(1) Was the inmate a medical, mental health, or suicide risk during any prior contact and/or confinement in this facility?

(2) Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates the inmate is currently a medical, mental health, or suicide risk?

(3) Has the inmate ever attempted suicide?

(4) Has the inmate ever considered suicide?

(5) Is the inmate being treated for mental or emotional health or emotional problems, or has the inmate been treated in the past?

(6) Has the inmate experienced a significant loss (e.g., relationship, death of family member or close friend, job)?

(7) Does the inmate feel there is nothing to look forward to in the immediate future (i.e., is the inmate expressing helplessness and/or hopelessness)?

(9) Is the inmate thinking of hurting/or killing himself or herself?

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

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

after a training review, might contribute to jail suicides.[33] For example, the Cascade County jail used its own standard, both before and after[34] its MSPOA training review, for cell checks that required a cell check only every hour instead of every 30 minutes as voluntary standard 07.01 requires. At the end of that one-hour period cell check, Mr. Grandbois was found hanging in his jail cell. However, there is evidence suggesting that even the county's own one-hour standard for cell checks, used by Cascade County notwithstanding the 30-minute check required by standard 07.01, may not have been followed.[35] Whether compliance with the MSPOA standard for 30-minute cell checks after the peer review and before the suicide could have saved Mr. Grandbois will probably never be known.

III
Conclusion

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

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

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

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

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

(a) do nothing;

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

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

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

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

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

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

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

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

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

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

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

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