

SUICIDE PREVENTION IN JAILS AND LOCKUPS

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ABSTRACT

Suicide prevention has been a major concern for Jail Administrators for some time. Besides the obvious loss of life, suicide cases can cast a negative image on the department as well as create a financial liability. The public only sees the end result, whether they are sitting in a courtroom participating in the inevitable litigation as jurors, or sitting at home reading the Sunday morning exposé on in custody deaths at their local Jail.

The Sheriff's Department is responsible for the custodial care of pre trial detainees, those without bond, unable to post bond, and those serving short term sentences as prescribed by the courts. The purpose of this research project was to attempt to reduce, to the extent possible, the risk of potential suicide in the inmate population of the County Jail.

I reviewed current literature on suicide in Jails and lockups as well as looking at the three Jails in the county and their reported suicide attempts in the years 2000, and 2001. I also looked at the current suicide response policy.

The question was, could we identify a means of suicidal prevention beyond what was in place; more specifically, was there a better means of identification of at risk inmates we could make use of to do a better job at prevention?

I first looked at the policies and practices we have in place and then went out to the existing research for comparison. I also looked at the Jail facilities in the County and the numbers of reported suicide attempts as a percentage of total bookings for the years studied.

What I found was that we were doing well in some areas and needed improvement in others. The intake screening, medical, social, and psychiatric staffs are in place in the system and doing an adequate job. The research suggested, and we are not an exception, that the weakness many times is in the security staff training and awareness of how much of an impact they can have in preventing suicide attempts.

My recommendations are that the jail staff receives more awareness training in what to watch for while on security rounds. This includes the fact that inmates can be manipulative and suicidal. Also, that a new Suicide Prevention and Response Policy be written taking into account these findings. Finally, that isolation is on its own a risk factor for those inmates predisposed to suicidal ideation as well as a causal factor for those that may not have been considered suicidal.

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INTRODUCTION

The term, "Suicide" was first recorded as being used in the year 1177 and interestingly enough it is an act that is only known to exist in people (International Encyclopedia of the Social & Behavioral Sciences [IESBS], 2001). No other place in the animal kingdom is there a record of another species taking its own life, that is, purposeful self kill (IESBS, 2001). As society has struggled to understand this unique problem in ancient and modern times so has the criminal justice system in their jails and lockups.

In the late nineteenth century one Prison Wardens effort to discourage suicide attempts was to advertise to the prisoners that they could expect "physical chastisement" as their punishment for the suicide attempts (Hayes, 1995). In many ways we have come far in the field of corrections, however, our response and attention to the subject of suicide is still very much a concern for Jail Administrators.

According to Hayes & Rowan (1988), Suicide is nine times greater in detention facilities than that of the general population (p. 11). Also, suicide is the number one cause of death in jails with more than 400 per year across the country (Hayes, 1995). This issue must be addressed, for the obvious loss of life, the expense of litigation, and the maintenance of our image of professionalism.

With families that are trying to cope with the arrest and detention of a loved one, the added tragedy of an in custody death is many times unfathomable and unbearable as the detention facility is at a loss to provide definitive answers. The usual progression is that the family looks for the answers in the courtroom. Unless the department can say they did everything they could and then explain the process, it can mean a judgement against the department. When the public becomes aware of these verdicts it most

certainly detracts from the image of professionalism. Police agencies have worked very hard since the 1960s to establish standards, become professional, and respond to the needs of the public. No where is this more important than when they deprive someone of their liberty and are charged with their care.

Detention facilities are responsible to provide for the proper custodial care of inmates in their charge. It is up to the facility to be proactive in reducing the instances of suicide in their jails.

I have reviewed a number of contemporary articles on suicide to see what the current trend is on prevention. I wanted to specifically determine what, if any, risk factors go beyond the widely accepted. And more importantly, have jails recognized this information by acknowledging it in their policies and procedures? Some of the known suicide risk factors for prisoners are; the first 24 hours of incarceration, drug or alcohol use at the time of arrest, past suicide attempt, and current psychological malady or condition. It should be noted that to know the inmate history the institution must do screening.

Drug use, a past attempt at suicide, and an existing psychological condition such as depression are common general risk factors in all suicides and not limited to those in jails. They are by no means an inclusive list, as I would estimate there are as many unique factors as there are suicides and jail facilities can only look at known factors after an event. Further, the first twenty-four hours at a lockup is a unique factor, however, common to jails (Lindsay & Hayes, 1988).

I also looked at our current policy on suicide and checked to see that we were using all the resources we could on prevention, and identification of those at risk. More

specifically, I checked to see if we were using the line staff to their full potential as they interact with the inmates twenty-four hours, and seven days a week.

BACKGROUND AND SIGNIFICANCE

Jails and lockups must safeguard those individuals entrusted to their care. Over the years complex intake and classification systems have been developed to better manage an inmate population. This is especially true in large jails where innovative personal, or in some cases, a court order was the impetus for the development of these systems.

In today's society we talk about "service" and the "customer." Most businesses focus their time and attention there and this allows them to attend to the bottom line, profit. Modern management schools have applied this concept to policing, and in many ways it fits. Certainly we do not make a profit, however, we do have a customer base – the public. Whether we patrol their neighborhood or have them in temporary custody, our service (product) to the public could be said to be one of protection and care. How we choose to deliver that service will directly impact our success and image as a profession.

This is certainly true in Wayne County. We have a complex intake and classification system designed by caring people, but the effects of a court order added some urgency. Likewise a suicide policy is in place. In our County there is room for improvement and I would suggest in others as well. We have already shown that suicides are occurring at a rate of over 400 per year in detention facilities around the Country (Hayes, 1995) and we know that this is a rate much higher than the general population

(Yan He, Felthous, Holzer, Nathan, Veasey, 2001). Jail suicide, our prevention methods and response will continue to be an issue in the future.

LITERATURE REVIEW

There is a great variety and number of resources available on the topic of suicide. When one limits the subject to jail suicide the number dwindles, however, there is a body of research and thinking on the topic that spans the organized societies of the globe.

Mentioned in some of the research on jail suicide in the United States is Mr. Lindsay M. Hayes of the *National Center on Institutions and Alternatives* (NCIA). The (NCIA) conducted national studies on jail suicide in 1981 and 1988. Much of the information from these studies is supported in the other articles and publications that have been reviewed for this paper. Of note from the (NICA) is the awareness that human interaction and communication are important factors in prevention. Hayes (1988) states, "... experience clearly demonstrated that almost all jail suicides can be averted with implementation of a prevention program that includes written rules and procedures, staff training, intake screening, communication between staff, and human interaction" (p. xii).

The notion of human contact is important as it can be seen as the common thread in prevention. Loss of contact with family and or friends, i.e., human contact, can lead to isolation and hopelessness which can lead to depression all of which are characteristics of suicidal ideation. The point here is that the jail staff can serve in this roll and step in to fill the void of lost social affiliation.

It should be noted that isolation can be a state of mind and not necessarily physical as in a single cell in a jails disciplinary isolation unit. However, physical

isolation can also be a risk factor. In his study Hayes (1988), reports that 66.9% or 2 out of three inmates were in isolation cells before their suicides (p. 32).

Another important point covered in Hayes' (1988) research is the fact that without the human component of contact and intervention other "quick-fix" solutions only treat the symptoms inmates present (p. 5). Here, he is specifically referring to reactionary measures like installing a camera to view a cell area, or the use of a suicide gown. In other words your success rate in prevention will be greater with a total program of screening, monitoring, contact, and intervention.

A report on prisons in England and Wales titled, *Report of Her Majesty's Chief Inspector of Prisons* written by David Ramsbotham (2001) indicated that in his assessment of their suicide prevention measures he stated, "Successful prevention measures depend on understanding staff reaching out to prisoners, not waiting for prisoners to come to them" (p. 13). This seems to summarize the importance of this component of prevention, that the staff walking around the jail can be the first contact and monitoring point in suicide prevention.

Another publication, *Criminal Justice and Behavior* reported on the issue of staff and suicide prevention. Correia (2000) states that, "One of the first lines of defense is to have all institutional staff recognize that suicide prevention is an important task that is shared by all within the institution" (p. 582). This seems simplistic on its face but it can be a revolution in thinking when an administrator asks why the cameras, isolation cell, and suicide gowns have had little impact on suicide attempts in the facility.

Another study in the *Journal of Research in Crime and Delinquency* touched on the subject of staff. Wooldredge and Winfree (1992) reported that, "Inmate suicides also

became less prevalent in jails where the ratio of staff to inmates increased” (p. 1). This seems to suggest that simply adding bodies increased contact with the inmate population. Certainly it must be more than a body. The research shows that one on one contact is more important.

Jail staff will invariably come across an inmate exhibiting behavior described as “acting out” or “manipulative” and dismiss it as an attempt to gain something from them. This type of behavior must be recognized as potentially suicidal. In the *Jail Suicide/Mental Health Update*, a publication of the (NCIA) Ivanoff and Hayes (2002) state that, “Although the majority of inmates that engage in self-injurious behavior do not go on to commit suicide, a history of such behavior places them at greater risk of suicide” (p. 2). This is an important risk factor that many administrators may not recognize.

Criminal Justice and Behavior published an article by (Dear, Thompson, & Hills, 2000) an Australian study, where they addressed the issue of not properly recognizing a manipulator as suicidal stating that, “The potential consequence of a false negative (an unexpected death) is far more dire than the potential cost of a false positive (managing a non-suicidal prisoner as though he or she were suicidal)” (p. 174). Close monitoring will be necessary by jail staff in all cases of manipulative, histrionic, acting out by the inmate. Clearly an inmate can be acting out and suicidal.

PROCEDURES

This research was conducted reviewing periodicals and publications on the topic of suicide specifically to determine additional risk factors beyond the widely known and to look at the current body of knowledge to seek improvement in the jail's suicide prevention program. Suicide continues to be an important topic of interest both with researchers and jail staff, as much of the literature is quite recent. The articles and studies overwhelmingly supported and outlined the importance of staff involvement and interaction with the inmates as a way of reducing the suicide risk.

Further, the purpose of the article reviews was to determine if identified manipulative self-harm behavior was also a possible suicide risk. There was much discussion about this point and the commonality here is the fact that these types of inmates at the very least need to be carefully evaluated and monitored for the risk of suicide.

Once improvements are made to a prevention program it will be important to check for a reduction in the numbers of suicide attempts in the facility. To gauge this, I recorded the number of reported suicide attempts in the Wayne County jail facilities for the years 2000 and 2001. This information was gathered from the jail reporting database. When a suicide attempt is made the officers write and record a report that should be titled "Suicide Attempt." A number is attached to this term allowing a search of the reports by code number. A count of the reports gives us the number of reported suicide attempts for a particular facility in a specified time frame. This number will be tracked after the proposed changes and improvements are made based on the recommendations of this report to check for a reduction of attempts over time.

It should be noted and carefully considered that not all suicides may have been reported in the jail database. Some inmates may make an ambivalent attempt and discontinue on their own. Staff may report other than on the computerized form or title the report improperly (other than suicide) causing that event to be missed in the count. Other than an inmates failed attempt not being reported, the count may be increased through officer awareness training, however, the possibility of improper reporting would still exist.

Results

At the beginning of this project I had a general impression that I would be able to identify several specific characteristics through research that one could easily identify to prevent suicide attempts. However, it soon became clear that there are as many reasons for suicide attempts as there are suicide attempters. Of course there are general categories and characteristics that may indicate a predisposition or risk as we have discussed, but it appears that few people actually attempt suicide. In the Wayne County Jail, less than one percent of the booked prisoners actually attempted suicide in 2000 and 2001. It is important to remember that any suicide attempt is unacceptable and our goal is always zero successful suicides.

What was demonstrated over and over again in the research was that beyond the generally known risk factors such as the first 24 hours after arrest, alcohol or drug use, a history of suicide attempts, and psychological condition such as depression, was the idea of human contact. Tied to this concept is isolation. Isolation is a risk factor mentioned in

much of the research and when it is tied to human contact it can mean physical isolation, or mental isolation, or both. An inmate, who is withdrawn and quiet, not speaking to staff other inmates or family members or an inmate who is isolated in a cell alone can exhibit these characteristics.

This discussion brings us back to the idea of staff interaction. Already mentioned was a study that indicated just adding staff reduced suicide attempts. The focus now changes to what is being done regarding awareness in this area. In other words, is the staff aware of the impact they can have on reducing suicide risk through contact and interaction as well as watching for other indicators and risk factors?

A review of a jail response policy revealed that it was generally just that, a guide to the response to the suicide attempt with very little mention of the importance and proactive nature of prevention. This subject, prevention and identification is taught when officers are trained by psychiatric staff initially and through in-service classes. In a large organization it is important that this additional aspect of prevention be included in the policy indicating its importance to the organization.

Also revealed in the literature review and cited earlier was a concept not as widely known as a characteristic of suicidal ideation being manipulative and self-harm behavior. Jail administrators are aware of this behavior and generally refer to it as a discipline problem and it is respond to and treated it as such. The idea that some manipulators can be suicidal should be included in a prevention document or policy. These inmates should never be summarily dismissed as a recalcitrant disciplinary problem, isolated and ignored by staff.

DISCUSSION

Clearly any suicide policy for a jail or lockup must be more than a response to an attempt. It must include the important role all jail staff play in prevention. Correia (2000) states in the strongest terms that the staff are the first line of defense in prevention. Further that they may be the most important factor by their mere presence and interaction with the inmate. All staff must recognize this role including security, medical, psychiatric, social workers, dentist, clerical, maintenance, volunteers, and visitors alike. All those that come in contact with the inmates are able to report to the psychiatric staff an inmate they view to be at risk. He further states that, "...mental health professionals are unlikely in many instances to be the ones first alerted to a potentially suicidal inmate" (p. 583). This is true because the jail staff is responsible for the custodial care of the inmates, and spends the greatest amount of time in direct contact with them. In his article he also outlines the need for training in this area, as the officers are most likely to be the first ones aware of an inmate considering suicide. Wayne County does introductory and up date training in this area, but because of its importance it should be stressed in policy as well.

In their study, Wooldredge and Winfree (1992) indicated that they found that suicides decreased when staff were added in one facility. It appears that simply adding staff increases contact with the inmates thus increasing communication. This is support for human contact as an important factor. They also point to the staff to inmate ratio as further evidence of human contact and its effect, "Lower degrees of crowding may enhance the staff's ability to target and supervise inmates at higher risks of committing

suicide as well as those with physical problems” (p. 467). This also seems to indicate that if staff can not be added working on reducing overcrowding can be one way to reduce suicides.

This notion of human interaction is a theme in much of the research (Hayes 1995; Ramsbotham 2000; Hayes & Rowan 1988). The significance of this can not be overstated. Inmate contact and staff interaction should be the basis and starting point in any prevention program and policy.

If an interactive program of inmate contact for suicide prevention is to become of paramount importance, the question then becomes how? Moreover, how do suicidal behavior and ideation, that is, acting out, isolation, and other warning indicators come to our attention, and get acted upon reducing the threat level? Further, a statement and policy regarding prevention is important, as we have discussed, it sets a tone and standard. However, this is not enough on its own. The training and actions of the staff will be thoroughly examined by the courts after an in custody death from suicide (Lee, 2003).

With the goal of identification of an at risk inmate for a possible attempted suicide in mind, and knowing through research that all of those in contact with the inmates are responsible for reporting, it may be helpful to look at avenues of the reporting process as an interactive model.

Figure 1 is a visual suicide diagnosis model I call the Diagnosis Triad. There are three major interactive circles with related sub categories that relate to a particular line of observation and reporting on an inmates mental condition as observed by staff.

Figure 1. The Diagnosis Triad.

- The function and relatedness of reporting avenues for inmate behavior characteristic of suicidal ideation.

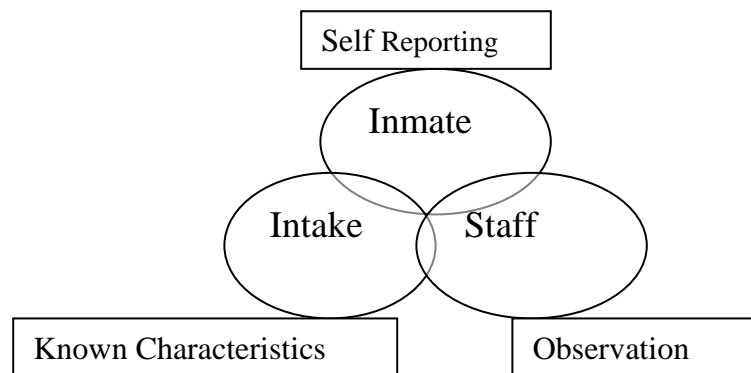


Figure 1: The inmate may self-report on their condition. Jail intake staff search records for past psychiatric treatment. Jail security staff, through interaction and observation may refer inmates to the psychiatric staff based upon behavior.

The Diagnosis Triad is a visual representation of informational reporting avenues and related sub categories.

The top circle of the model consists of the “Inmate.” This could be simply described as the inmate reporting on his condition. At any time inmates are able to come forward and report depression or suicidal ideation to the staff. This information is then

referred to the appropriate psychiatric staff of doctors, nurses, or social workers. There is a danger that self-reporting will be ignored by the jail staff. This self-reporting function of the individual inmate should not be discounted as a histrionic episode of acting out and all incidents of self-reporting should be taken seriously. As discussed earlier, manipulative and self-harm behaviors may be viewed as ways to influence the staff and obtain things like cell and housing changes. While this may be true, research has shown that they may also be truly suicidal (Dear, Thompson, & Hills, 2000).

The inmates can be an overlooked resource in reporting depression and signs of suicide regarding their own condition, and can be similarly dismissed as a source of reporting on behalf of others. It is necessary that they be identified as a mechanism for reporting on the condition of others as they make up part of a complete reporting function. The inmates spend all of their time together and are in many ways in a better position than the officer to report on another inmate's well being or general mood.

At the bottom left of the Diagnosis Triangle is listed, "Intake." The jail intake area is generally the inmate's first contact with the staff and as such, an argument could be made that it has greater importance and should be listed at the top of the model. Without diminishing its importance, many times the intake staff only know what is self-reported by the inmate. Typical questions to the inmate would consist of statements like, "Do you have a history of mental illness?" "Have you ever been prescribed psychotropic medication?" If the inmate is non-responsive or withholds this information, and in the absence of other indicators like depression, the screening process can be flawed.

This crossing over or overlapping of responsibility for risk awareness shows the interactive nature of the triangle model, however, the intake screening is very important

and without it any prevention program will be less effective. Further, If possible the intake screening should also consist of a record search of all available information for past treatment in the facility or out.

At the bottom right of the Diagnosis Triangle is listed, "Staff." As discussed, this elemental resource may not be considered effective beyond response training measures and generally this response training is considered only for the security officers. The well-prepared facility in prevention of suicide will consider all staff as necessary elements in a total effort to reduce attempts in an appropriate way. The sphere of influence and effectiveness that the staff has in an interactive process of prevention can not be overstated.

All jail staff has the ability and responsibility to observe inmate behavior as they go about their daily routine. Observation should in fact become part of that routine regardless of the specific duties that are carried out. For instance, from the cook in the jail to the Librarian, they all have the opportunity to observe and report unusual behavior or signs of withdrawal and depression.

Where the resources of the Triad merge (Inmate, Intake, and Staff) the staff is working together resulting in the formation of a powerful tool in the prevention of inmate suicide.

RECOMMENDATIONS

Clearly the suicide prevention effort must begin with a trained and informed staff. The employees of the institutions are the first line of defense (Correia, 2000). The security staff may well be the focus of prevention training as they interact closely with

the inmates on a daily basis. However, as has been demonstrated in this paper other than security officers, the support staff are important resources that should be utilized in a complete effort on suicide prevention. This would be all others whom come in contact with prisoners in the jail, for example, Clergy, Social Workers, Dentist, Volunteers, Custodial Workers, Maintenance Workers, and Visitors.

It is my recommendation that awareness training be expanded and offered to all jail employees.

It is my recommendation that the awareness training include what to watch for while employees are interacting with the inmates. This should include the fact that inmates labeled as manipulators may also be suicidal (Dear, et al., 2000). Also, it should be noted that inmates who self harm may also become suicidal (Correia, 2000). In other words, do not dismiss poor inmate behavior as manipulation, watch for other risk factors coupled with what is traditionally labeled as self harm or manipulative histrionic outbursts that may develop into suicidal ideation. This watch should include isolation in inmate housing as an important risk factor that should be considered in the overall evaluation.

Any jail response policy must include a section outlining not just the less commonplace, less traditional risk factors, but must also stress the need for employee interaction with the inmates (Hayes & Rowan, 1988). Without the interaction by the jail staff the inmate assessment will not take place efficiently and effectively, as outlined in the Diagnosis Triad model for monitoring the prisoner condition. See appendix B for a sample draft policy.

I have included an appendix listing reported suicide attempts in the Wayne County Jail System for the years 2000 and 2001, see appendix A. The purpose of this information is for future research relating to the effectiveness of a revised suicide prevention and response policy. Further these numbers also indicate the effectiveness of the current programs and screening in place as they show less than one percent of the booked population attempt suicide. This is good news but a proactive program should be in place at any facility in an attempt to reduce these numbers to zero. Improved training monitoring and reporting should reduce reported attempts throughout the jail system.

APPENDIX A

Reported Suicide Attempts At County Jail		
	Year	Year
	2000	2001
Jail 1	23	24
Jail 2	41	53
Jail 3	8	23
Total	72	100
Prisoners Booked	38417	39095
Percent of Booked Prisoners Reported as Attempting Suicide	.18%	.25%

APPENDIX B

SUICIDE PREVENTION AND RESPONSE POLICY

DRAFT

Sample Policy
Jail Operations Manual

Document No:

Issue Date:

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Section: Emergency Response
Title: Suicide Prevention and Response
Reference: Jail Security Rounds
Authorizing
Signature:

A. Policy:

All employees of the Department while assigned to duties within any of the jail facilities shall be responsible for the care and custody of the inmate population. As such, employees while interacting with inmates, shall to the extent possible monitor behavior, report and refer inmates who appear to be potentially suicidal to Psychiatric Nurses, Doctors, or Social Workers.

Jail Security Rounds are to be made per policy with a conscientious effort to prevent suicide.

B. Definition(s):

Suicide – A term meaning Purposeful, willful self kill; an act that is only known to exist in humans.

Security

Rounds – A prisoner and facility check made within a specified period of time that should vary with short irregular intervals.

C. Procedure:

1. Making Security Rounds is probably the most important duty of a Jail Officer. By interacting with the inmates and observing the environment, the officer can assess the general mood of the inmates and check the physical security of the building.

The intake staff interviews inmates when they first arrive at the jail. During the interview they attempt to determine if the inmate has any

unusual personal problems, such as mental illness, homosexuality, or is potentially suicidal. These problems may be missed at intake or may not exist until after the inmate has been incarcerated for a period of time. Many times the officer working the housing area will be the first to notice a change or problem with an inmate and become the first line of defense in preventing a suicide attempt. At this point the officer shall notify the appropriate medical/psychiatric staff member to respond.

2. Gathering information on a potentially suicidal inmate:
 - a. An inmate may come forward and report his condition as “suicidal.”
 - 1) All instances of self-reporting shall be taken seriously and referred to the appropriate staff member.
 - 2) Never assume that the inmate is attempting to manipulate you or the “system” for gain. While this may be true, studies have shown inmates that “act out,” “self-harm,” and attempt to manipulate staff may also be suicidal.
 - b. An inmate may come forward to report the condition of another as suicidal.
 - c. Intake screening officers may report an inmate as suicidal and make a referral to the appropriate staff. This becomes part of the inmate history that the housing officers should be aware of.
 - d. Any jail staff member may make a referral to the psychiatric Doctors, Nurses, or Social Workers advising them of an inmate that appears suicidal.
 - 1) All staff members including Clergy, Librarian, Social worker, Cook, Dentist, maintenance Worker, and Officers that interact with the inmates have the ability and responsibility to report suicidal behaviors to the appropriate staff.
 - 2) Visitors may also wish to report suicidal behavior to the staff. Their reports should be taken seriously and reported to the psychiatric staff for evaluation as well.
 - e. The following behaviors and conditions may indicate closer monitoring of an inmate for suicide risk. This is not an inclusive list as the officer must use their judgement in making referrals:
 - 1) The first 24 hours of detention

- 2) Under the influence of alcohol or drugs
 - 3) Past suicide attempt
 - 4) Existing psychological condition such as depression
 - 5) Withdrawal from others, social or physical isolation
 - 6) Acting out or self-harming behavior
3. In the event that a suicide attempt is made the following steps are to be taken.
- a. Prior to entry on to the ward, all other inmates are to be locked down.
 - b. A floor officer is to pull the alarm and stand by as the other officers(s) on duty enter the ward. Begin first aid / CPR if appropriate in anticipation of the arrival of medical personnel.
 - c. A shift commander is to respond and take charge of the scene.
 - d. Upon response, medical personnel are to initiate or continue resuscitation efforts initiated by security officers without delay.
 - e. The Shift Commander will arrange, in consultation with the medical staff, transportation to the nearest emergency room facility.
 - f. All reports will be completed in a clear, concise and legible fashion and include all relevant and pertinent facts.

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