

TRAINING
CURRICULUM

ON

SUICIDE DETECTION

AND

PREVENTION

IN

JAILS AND LOCKUPS

Second Edition

March 1995

TRAINING CURRICULUM ON SUICIDE DETECTION AND PREVENTION IN JAILS AND LOCKUPS

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PREFACE

This manual was originally published in February 1988 as a result of a project funded by the National Institute of Corrections, U.S. Department of Justice. In the span of seven years, the author have since conducted numerous jail suicide prevention training seminars throughout the country and have continued to revise and fine-tune the manual. We believe this second edition of the *Training Curriculum on Suicide Detection and Prevention in jails and Lockups* provides the most comprehensive and up-to-date instruction on jail suicide prevention.

The curriculum is intended to equip law enforcement, jail administrators and their staff, and contract mental health/medical personnel with basic understanding of suicidal behavior as it relates to the facility environment. Most experts agree that with sufficient training, jail personnel cannot only thwart a suicide, but avoid the potential for serious disciplinary and legal repercussions that follow.

This manual is designed for use in both jails and police lockups. The reasons are numerous, Suicide prevention begins at the point of arrest. In addition, the act of suicide has no exact time frame, and thus can occur in either a lockup or jail. Although research indicates that the majority of suicides occur within the first 24 hours of incarceration, many suicides occurs after this time period. Finally, issues of intake screening, custodial care, supervision, and other liability concerns, as well as their relationship to jail suicide, are equally present in both types of facilities. Thus, for purposes of training, this curriculum categorizes jails and police lockups into one generic term - jail, because the first minute of an individual's incarceration is as important as his/her last.

Experience has clearly demonstrated that most jail suicides can be averted with implementation of a comprehensive prevention program that includes staff training, intake screening, communication between staff, appropriate and safe housing, frequent observation, prompt intervention, and human interaction between staff and inmates. The key to prevention remains capable and properly trained staff - the backbone ingredient of a facility. Future successful prevention efforts, however, will not come to fruition without pro-active jail and law enforcement administrators who not only maintain an awareness of jail suicide as a national problem, but take the initiate to prevent such an occurrence in their own facilities.

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March 1995

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- G. Transparencies (Optional Enclosure)

LESSON PLAN

COURSE TITLE: SUICIDE DETECTION AND PREVENTION IN JAILS AND LOCKUPS

TIME FRAME: 10 to 12 Hours

SPACE REQUIREMENTS: Classroom style sufficient for all participants

INSTRUCTOR MATERIALS & EQUIPMENT

- 1) Training Curriculum
- 2) Overhead projector
- 3) Transparencies
- 4) Chalk board or flip chart and stand
- 5) Chalk, colored marking pens
- 6) Masking tape
- 7) TV/VCR

TRAINEE MATERIALS: 1) Writing pads
2) Pen or pencil

PARTICIPANT LEARNING OBJECTIVES:

At the completion of the training session, participants will be able to:

- 1)
 - Explain the extent of the suicide problem nationally in jails and lockups.
 - Name at least four obstacles to preventing jail suicides.
 - Identify several factors in a pro-active stance toward neutralizing litigation.

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- 2) • Outline at least five myths and accompanying facts about jail suicide.
- 3) • List at least five characteristics in a “typical profile” of inmates who committed suicide as documented in national jail suicide research.
 - Explain the main purpose of the suicide victim profile.
 - Name at least two formal phases of the criminal justice process which may be at least, if not more, important than the victim profile in detecting potentially suicidal behavior.

Describe the benefit(s) of locally/regionally developed suicide victim profiles.
 - Cite at least two differences in characteristics between the typical jail inmate and the national jail suicide victim profile.
- 4) • Describe at least four factors of the jail environment that have an impact on suicide.
- 5) • Identify at least four pre-disposing factors in jail suicides.
- 6) • List at least six periods of high risk for suicides occurring in jails.

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- 7) • Name at least 10 signs and symptoms of potentially suicidal behavior in inmates.
- Identify at least eight signs and symptoms of depression.
- Outline at least three symptoms of agitation.
- 8) • Name at least four situational factors which can have an impact on suicidal behavior.
- 9) • Identify at least four current or recent stress factors which can influence suicidal behavior in inmates.
- 10) • Give at least two reasons why law enforcement officers working the streets need training in the signs and symptoms of suicidal behavior in inmates.
- Name the two most effective approaches for training law enforcement officers in suicide prevention.
- 11) • Cite at least six conditions for which medical and mental health clearance should be requested prior to admitting an arrestee to the jail.
- Name at least three reasons why the confinement of intoxicated persons in jails may be risky.

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- Outline the three aspects of intake screening.
 - List at least four benefits of intake screening.
 - Describe at least four medical conditions displayed by arrestee which can be observed at booking.
 - Name at least four elements of a successful intake screening interview.
 - List at least eight observational factors and interview questions pertaining to suicide screening.
 - Identify at least four factors and principles in assessing suicidal behavior.
- 12) • Explain the difference between a low risk and high risk suicidal inmate.
- Explain the recommended system for housing both low risk and high risk suicidal inmates.
 - Explain the recommended system for supervising both low risk and high risk suicidal inmates.
- 13) • Name at least 10 of the 26 principles of good discipline

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and inmate management which can have an impact on suicide prevention.

- List at least three bridges to communicating with suicidal inmates.
 - List at least three barriers to communicating with suicidal inmates.
 - Describe two critical factors in dealing with manipulative inmates.
- 14) • Describe at least three immediate steps in the proper handling of an inmate who is found hanging.
- Outline at least four aspects of first aid for a hanging victim.
 - Identify at least two pieces of equipment utilized in rescuing suicide victims which should be stored in housing units,.
- 15) • Name at least two desired outcomes of an administrative review.
- Explain the rationale for a psychological autopsy. .
 - Explain the need for critical incident stress debriefing.

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- 16) • Outline the differences between direct and remote supervision jails and their impact on suicide prevention.
- List at least 10 aspects of jail architecture which help make a facility suicide-resistant or protrusion-free.
- 17) • Explain at least five controversial issues in jail suicide prevention.
- 18) • Explain the difference between a tort action and a civil rights action.
- List at least three deficiencies for which a facility and/or staff can be found liable in a jail suicide.
- 19) • List the eight components of a written jail suicide prevention plan.
- Identify the two key factors in jail suicide prevention.

1. INTRODUCTION

Chapter 1-1

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TRANSPARENCY 1-1 A. A LEADING CAUSE OF DEATH IN JAILS AND LOCKUPS

Suicide is a leading cause of death in our nation's jails and lockups. In some urban jail facilities, AIDS-related deaths outnumber deaths by suicide.¹ To date, there have been only two comprehensive national studies on jail suicide. The National Center on Institutions and Alternatives (NCIA) documented 419 jail suicides as occurring in 1979. Subsequent research by NCIA yielded 453 suicides in 1985, and 401 in 1986: Based upon this research, it was determined that *the suicide rate in county jails is approximately nine times greater than that of the general population*. Unfortunately, more recent national data is not available. Yet while it is estimated that the number of jail suicides has remained relatively stable over time, such deaths have created increased publicity, public awareness, and, ultimately, litigation against the facilities, their individual personnel, city governments, county commissioners, etc.

B. OVERCOMING OBSTACLES TO PREVENTION

Experience has shown that negative attitudes often impede meaningful jail suicide prevention efforts. Such attitudes form obstacles to prevention, and can be seen on both a local and universal basis. Simply stated, obstacles to prevention are empty excuses that jail suicides can not be prevented.

¹Bureau of Justice Statistics, *Jail Inmates 1992*. Washington, D.C.: U.S. Department of Justice, August 1993.

²George M. Camp and Camille G. Camp, *The Corrections Yearbook*, South Salem, NY: Criminal Justice Institute, 1993.

³Lindsay M. Hayes and Barbara Kajdan, *And Darkness Closes In... A National Study of Jail Suicides*, Washington, D.C.: National Center on Institutions and Alternatives, October 1981.

⁴Lindsay M. Hayes and Joseph R. Rowan, *National Study of Jail Suicides: Seven Years Later*, Alexandria, VA: National Center on Institutions and Alternatives, February 1988.

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For example; a *local obstacle* might sound something like this:

TRANSPARENCY 1-2

- “We did everything we could to prevent this death, but he showed no signs of suicidal behavior;”
- “There’s no way you can prevent suicides unless you have someone sitting watching the prisoner all the time, and no one can afford to be a baby-sitter;”
- “We didn’t consider him suicidal, he was simply being manipulative and I guess it just went too far;”
- “We aren’t mind readers nor trained to be psychiatrists;”
- “If someone really wants to kill themselves, there’s generally nothing you can do about it;” and
- “Suicide prevention is a medical problem...it’s a mental health problem...it’s not our problem.”

Then there are universal obstacles to prevention - regressive attitudes that are far more dangerous because of their far-reaching ability to negatively influence correctional policy on a larger scale. We often find the roots of this attitude in the world of academia:

- “Statistically speaking, suicide in custody is a rare phenomenon, and rare phenomena are notoriously

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difficult to forecast due to their low base rate. We cannot predict suicide because social scientists are *not* fully aware of the casual variables involving suicide;”

- “Demographic profiles of custodial suicide victims are of little value for prediction because they often mirror the characteristics of typical jail inmates;”
- “Even those skilled mental health professionals, who have the time for extensive personal interaction with troubled individuals, either cannot forecast suicide or are unable to prevent patient suicide even if it had been somewhat anticipated;” and
- “Jail suicides are extremely difficult to predict due to their spontaneous nature.”

A primary purpose of this curriculum will be the presentation of training material that successfully defuses these obstacles to prevention, and prepares us to be in the best position to prevent jail suicides,

TRANSPARENCY 1-3**C. ALMOST ALL JAIL SUICIDES CAN BE PREVENTED**

Most experts agree that liability can be neutralized by “pro-active” policies by states, counties, municipalities and their respective jail administrators. In defending lawsuits, a prevention program (with accompanying written policies and procedures) is critical, and includes:

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capable and properly trained staff, intake or admission screening, classification, and increased monitoring. Such a program, coupled with compliance with state and national jail standards and a working knowledge of “state-of-the-art” prevention measures, can sufficiently thwart successful litigation.

"As more and more jail administrators use the implications of correctional law to become pro-active managers who document their problems, develop adequate policies and procedures, and initiate viable training programs, those who cling to the old philosophies will assuredly become more and more at risk in civil court actions."⁵

Within the legal arena, the U.S. Supreme Court ruled in 1989 that a municipality may, in certain circumstances, be held liable under the federal Civil Rights Act (42 U.S.C., Section 1983) for constitutional violations resulting from its failure to train employees. In the non-jail suicide case of *Canton v. Harris* [109S. Ct. 1197 (1989)], the Court stated that “the inadequacy of police training may serve as a basis for Section 1983 liability only where the failure to train in a relevant respect amounts to deliberate indifference to the constitutional rights of persons with whom the police come into contact.”

Applying the failure to train teachings of *Canton* to a jail suicide case, one court has stated that in order to succeed,

⁵Paul Embert, “Correctional law and Jails.” in D. Kalinich and J. Klofas (Ed?;.), *Sneaking Inmates Down the Alley*, Springfield, IL. Charles C. Thomas, 1986, 82

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a plaintiff must: “1) identify specific training not provided that could reasonably be expected to prevent the suicide that occurred, and 2) ...demonstrate that the risk reduction associated with the proposed training is so great and so obvious that the failure of those responsible for the content of the training program to provide it can reasonably be attributed to a deliberate indifference to whether (the inmates) succeed in taking their lives”

Experience has clearly demonstrated that almost all jail suicides can be prevented. The intent of this manual is to equip law enforcement and jail staff, contracted mental health/medical personnel, jail standards and regulatory agencies, training academies, individual correctional trainers, financing bodies and colleges and universities with a basic understanding of jail suicide behavior. With capable staff and sufficient orientation and training, jail facilities can not only avoid a suicide, but also the serious repercussions that follow.

C. LESSON OBJECTIVES

INSTRUCTOR’S NOTE: Prior to using each curriculum chapter, review LESSON OBJECTIVES outlined earlier. They are numbered to correlate with chapter headings.

⁴*Colburn v. Upper Darby Township*, 946 F. 2d 1017, 1030 (3rd Cir., 1991)

2. FACTS AND FICTION OF JAIL SUICIDE

Chapter 2-1

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Many of us have preconceptions about suicide. Let us do an exercise which will clarify some important issues.'

TRANSPARENCY 2-1 A. MYTH: PEOPLE WHO MAKE SUICIDAL STATEMENTS OR THREATEN SUICIDE DON'T COMMIT SUICIDE.

FACT: Most people who commit suicide have made either direct or indirect statements indicating their suicidal intentions.

EXPLANATION: Research has shown that of any 10 persons who kill themselves, eight have given definite warnings of their suicidal intentions. These warnings may be direct statements, e.g., "I'm going to kill myself," while other statements may be more subtle and indirect, e.g., "You won't have me to worry about anymore," "You'd be better off without me," or even a simple "Good-bye." These statements maybe made in a serious, sarcastic, or even joking manner; they may be made to you, the officer, to relatives or friends, or even to other inmates. The point is that, people planning to commit suicide often speak about their plans and feelings; it is crucial that these indicators not be ignored.

⁷See New York State Office of Mental Health, Commission of Correction, Ulster County Community Mental Health Services, and Division of Criminal Justice Services - Bureau of Municipal Police, *Suicide Prevention and Crisis Intervention in County Jails and Police Lockups - Trainer's Manual*, Albany, NY: Authors, March 1986. **See also** New York State Office of Mental Health, Department of Correctional Services, and Commission of Correction, *Suicide Prevention and Intervention in State Prisons - Trainer's Manual*, Albany, NY: Authors, 1994.

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- B. **MYTH:** SUICIDE HAPPENS SUDDENLY AND WITHOUT WARNING.

FACT: Most suicidal acts represent a carefully thought out strategy for coping with various personal problems.

EXPLANATION: Studies reveal that the suicidal person gives many clues and warnings regarding his suicidal intentions. Particularly within the jail environment, it is difficult to attempt suicide on impulse. Plans must be made regarding the best method and best time.

- C. **MYTH:** PEOPLE WHO ATTEMPT SUICIDE HAVE GOTTEN IT OUT OF THEIR SYSTEMS AND WILL NOT ATTEMPT IT AGAIN.

FACT: Any individual with a history of one or more prior suicide attempts is at much greater risk than those who have never made an attempt.

EXPLANATION: If a person has made a serious attempt on his life, psychological barriers or taboos against taking one's life have been broken. Other attempts then become easier. Although some attempts may seem minor and merely attention-getting behaviors, they are calls for help. If these calls for help are ignored, other more serious attempts are likely.

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- D. MYTH: SUICIDAL PEOPLE ARE INTENT ON DYING.

FACT: Most suicidal people have mixed feelings about killing themselves. They are ambivalent about living, not intent on dying, and most suicidal people want to be saved.

EXPLANATION: Since most people give definite warning signs of their suicidal intention, it is evident that on some level they wish to be saved. They may not be intent on dying, but at that particular time, they see no other choice.

- E. MYTH: ASKING ABOUT AND PROBING INMATES ABOUT SUICIDAL THOUGHTS OR ACTIONS WILL CAUSE THEM TO KILL THEMSELVES.

TRANSPARENCY 2-2

FACT: You cannot make someone suicidal when you show your interest in their welfare by discussing the possibility of suicide.

EXPLANATION: Questioning an inmate in a concerned, non-judgmental manner will encourage the person to discuss his existing ideas. This, in turn, may help to relieve the psychological pressure the inmate is feeling. In addition, bringing the inmate's thoughts into the open can enable the officer to obtain help for the inmate.

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F. MYTH: ALL SUICIDAL INDIVIDUALS ARE MENTALLY ILL.

FACT: Although the suicidal person is extremely unhappy, he is not necessarily mentally ill.

EXPLANATION: It is often believed that people must act “crazy” to be suicidal. It is important for officers to know that studies of hundreds of suicide notes indicate that, although the suicidal person is unhappy and depressed, he is not necessarily mentally ill. We are defining “mentally ill” as being psychotic, i.e., out of touch with reality, behaving in a bizarre manner, having delusions or hallucinations. It is important to remember that a “normal” person can be suicidal.

G. MYTH: THE RATE OF SUICIDE IS LOWER IN A JAIL SETTING.

FACT: The rate of jail suicide is several times greater than in the general population.

EXPLANATION: Because of the structure and the supervision available, jails and lockups may seem unlikely places to commit’ suicide. However, because of the inherent stress of incarceration, a person is more likely to see suicide as the only choice. When people are in jail, their options are limited, their control is reduced, their future is more unpredictable, and they may

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develop a sense of hopelessness. All of these factors increase the likelihood of suicide.

- H. MYTH: INMATES WHO ARE REALLY SUICIDAL CAN BE EASILY DISTINGUISHED FROM THOSE WHO HURT THEMSELVES BUT ARE JUST BEING *MANIPULATIVE*.

FACT: Manipulative goals as a motive for self-injury are not useful in distinguishing more lethal attempts from less lethal attempts.

EXPLANATION: Experts suggest that the behavior of those that attempt suicide of widely varying lethality does not allow us to safely distinguish those with the most determined efforts to die from those who simply want our attention. Remember, even if you feel the threat or actual attempt was a manipulative gesture, the inmate, if not adequately supervised, could kill him/herself by accident. “In addition, inmates who self-mutilate themselves may also periodically become suicidal. In other words, simply because an inmate has a history of non-fatal self-mutilation, does not mean that they will never become suicidal.

- I. MYTH: IF SOMEONE REALLY WANTS TO KILL HIM/HERSELF,. THERE’S GENERALLY NOTHING WE CAN DO ABOUT IT.

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FACT: As will be shown throughout this training session, almost all jail suicides can be prevented.

EXPLANATION: Overcoming this “obstacle to prevention” is perhaps the greatest challenge in suicide prevention training. Most “pro-active” jail administrators believe that a comprehensive suicide prevention program can thwart most suicides, and they adhere to the philosophy that - “I will not tolerate a suicide in my facility.”

3. NATIONAL JAIL SUICIDE RESEARCH

Chapter 3-1

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TRANSPARENCY 3-1 - A. **AND DARKNESS CLOSES IN...A NATIONAL STUDY OF JAIL SUICIDES**

In October, 1981, the National Center on Institutions and Alternatives (NCIA) completed the study - *And Darkness Closes In...A National Study of Jail Suicides* for the National Institute of Corrections. The study, the first national view of the problem, documented 419 suicides occurring in jails and lockups during 1979, the year selected for analysis. From demographic data collected on 344 of these suicides, a profile of the “typical” victim was constructed.

The victim was most likely to be a 22-year-old White, single male. He would have been arrested for public intoxication, the only offense leading to his arrest, and would thereby be under the influence of alcohol and/or drugs upon incarceration. Further, the victim would not have had a significant history of prior arrests. He would have been taken to an urban county jail and immediately placed in isolation for his own protection and/or surveillance. However, less than three hours after incarceration, he would be dead. He would have hanged himself with material from his bed, i.e., sheet or pillowcase. The incident would have taken place on a Saturday night in September, between the hours of midnight and 1:00 a.m. Jail staff would have* found the victim, they say, within 15 minutes of the suicide. Later, jail records would indicate that the victim did not have a documented history of mental illness or previous suicide attempts.

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TRANSPARENCY 3-2

The scenario described above, according to the study, reflects a “hypothetical construct” based on those characteristics appearing most often in jail suicide victims. Data also revealed that 73.6% of the suicide victims were charged with crimes that fell within the non-violent category. Alcohol/drug related offenses accounted for over 30% of these charges. In regard to the presence of intoxication upon arrest and confinement, almost 60% of the suicide victims were under the influence of alcohol and/or drugs at the time of arrest and incarceration. Two out of every three inmates who committed suicide were being held in isolation. Over 50% of all suicide victims in the study were dead within the first 24 hours of incarceration, with 27% of all suicides occurring within the first three hours.

In addition, over 88% of victims under the influence of alcohol and/or drugs at the time of incarceration committed suicide within the first 48 hours of confinement, with over half of those victims being found dead within the first three hours of confinement. In addition, 68% of the victims placed in isolation committed suicide within the first 48 hours of incarceration, with over 30% of these victims dying within the first three hours of confinement.

B. A WORD ABOUT SUICIDE VICTIM PROFILES

As we attempt to come to grips with the problem of jail suicides, prevention efforts are sometimes geared toward quick-fix solutions. Such Band-Aid approaches as television monitors, tearaway gowns and blankets, and other “prevention tools” are insufficient attempts to

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solve a problem that necessitates devotion of greater energies. Although these tools can be a necessary part of jail suicide prevention, experts agree that their use should never be utilized to overshadow or be a substitute for intake screening, classification, counseling, referral or supervision/monitoring.

TRANSPARENCY 3-3

Suicide profiles have also fallen victim to quick-fix, superficial prevention techniques. At times these profiles are simply a mirror of a jail's inmate population. Other times they can be seemingly contradictory. Used without jail suicide awareness training, they are misleading.

When NCIA constructed and released its victim profile from resulting 1979 jail suicide data, it was as equally praised as criticized. While appearing and publicized in many training manuals throughout the country, the profile was maligned for misleading jail personnel into believing that profiles predict and prevent all suicides. Further, critics charged that many of the characteristics appearing in the suicide profile also fit the pattern of a typical jail inmate, and, therefore, such a profile was not useful as a predictive tool. NCIA's primary objective, that of "sensitizing" jail personnel to those characteristics or variables appearing most often in jail suicide victims became lost in the controversy.' Quick-fix advocates embraced NCIA's profile, while foes argued that not all jail suicides occur on Saturday nights in September. Both camps missed the point.

NCIA's suicide victim profile was not meant to be a death certificate of all inmates that commit suicide in our nation's

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jails. Nor was it intended for jail personnel to ignore those inmates that, while exhibiting some suicidal tendencies, did not fit all or most of the profile's various demographic variables. The profile's intent was and remains, simply ***to sensitize jail personnel to those characteristics appearing most often in jail suicide victims, while acting as a supplement to the existing warning signs and behaviors that are observed in the detection of suicidal behavior at the point of arrest, during transport to the jail, at booking/intake, and during confinement. In essence, to ignore more revealing signs of potentially suicidal behavior because the individual did not fit the profile, would not only be foolish, but negligent.***

Further, while some of the profile's variables mirror the typical jail inmate, i.e., sex, age, marital status, etc., there are appreciable differences with other variables. As can be seen in Table 1, while Black inmates comprise 44% of the jail population, they account for only 22% of the jail suicides. Approximately 51% of jail inmates are housed as detainees, yet 91% of all suicide victims were detainees. While 31% of jail inmates are intoxicated upon arrest, almost 60% of jail suicide victims were intoxicated upon arrest. Finally, while the average length of stay in jail is approximately 6 to 11 days, 50% of all jail suicide victims are dead within the first 24 hours of incarceration, and 27% commit suicide within the first three hours.

It is recommended that suicide victim profiles be developed for each jail facility, thus sensitizing staff to those suicide characteristics more descriptive of their local environment.

TABLE 1

CHARACTERISTICS	JAIL INMATE PROFILE*	NCIA 1981 SUICIDE VICTIM PROFILE**
SEX		
Male	91%	97%
Female	9	3
RACE		
White	40%	67%
Black	44	22
Other	16	11
AGE		
18-24	40%	(18-27) 54%
25-34	39	(28-37) 27
Other	21	(Other) 19
MARITAL STATUS		
Single	54%	54%
Married	21	30
Separated / Divorced / Widowed	25	16
JAIL STATUS		
Detained	51%	91%
Sentenced	49	9
INTOXICATION	31%	60%
LENGTH OF INCARCERATION (AVERAGE)	6-11 Days***	24 Hours (50%) 3 Hours (27%)
OFFENSE		
Violent	24%	27%
Property	30	22
Alcohol / Drug Related	33	30
Minor Other	13	21
PRIOR RECORD	80%	53%

*See Bureau of Justice Statistics, *Jail Inmates 1992, Women in Jail 1989, Jail Inmates 1986 and Jail Inmates 1983*.

**See *And Darkness Closes In...A National Study of Jail Suicides, 1981*. Based on 1979 jail suicide data.

***See Bureau of Justice Statistics, *Jail Inmates 1982*; B. Jaye Anno, *Analysis of Jail Pre-Profile Data*. Washington, D.C., Blackstone Associates, June 1977; and Kimme Planning and Architecture, *The Nature of New Small Jails: Report and Analysis*. Champaign, Illinois, October 1985. Estimate for average length of incarceration in holding facilities not available.

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In conclusion, when utilized in conjunction with staff awareness training and intake screening, a victim profile can be a valuable tool in jail suicide prevention.

**TRANSPARENCY 3-4 C. NATIONAL STUDY OF JAIL SUICIDES:
SEVEN YEARS LATER**

In 1988, NCIA completed a replication of its prior National Study of Jail Suicides. Project staff identified 453 jail suicides as having occurred in 1985, and 401 in 1986 (see Table 2). The study subsequently collected demographic data on 339 of the 1986 victims. As can be seen in Table 3, the 1986 findings are strikingly similar to the prior (1981) study.

D. HIGHLIGHTS OF 1986 JAIL SUICIDE DATA:

- 72% of victims were white.
- 94% of victims were male.
- Average age of the victim was 30.
- 52% of victims were single.
- **75%** of victims were detained on non-violent charges, with 27% detained on alcohol/drug related charges.
- 46% of holding facility suicide victims were held on alcohol/drug related charges.
- 89% of victims were confined as detainees.

TABLE 2
JAIL SUICIDES BY STATE, 1985-1986

STATE	1985	1986	TOTAL
Texas	48	46	94
California	37	32	69
New York	31	25	56
Illinois	26	25	51
Ohio	20	19	39
Florida	20	15	35
Michigan	24	9	33
Pennsylvania	15	18	33
Virginia	10	18	28
New Jersey	13	14	27
Oklahoma	16	10	26
Georgia	14	10	24
Massachusetts	15	9	24
North Carolina	15	7	22
Indiana	12	8	20
Oregon	11	5	16
Tennessee	6	10	16
Alabama	6	9	15
Kentucky	11	3	14
Maryland	3	11	14
Missouri	10	4	14
Arizona	7	5	12
Arkansas	3	9	12
Colorado	2	10	12
Louisiana	4	8	12
South Carolina	6	6	12
Kansas	2	8	10
Montana	7	3	10
Minnesota	5	4	9
Washington	4	4	8
Wisconsin	4	4	8
Connecticut	2	5	7
Mississippi	4	3	7
South Dakota	3	4	7
Alaska	5	1	6
Idaho	3	3	6
Utah	5	1	6
New Hampshire	3	2	5
New Mexico	4	1	5
District of Columbia	3	1	4
Iowa	3	1	4
Nevada	3	1	4
West Virginia	2	2	4
Wyoming	2	2	4
Nebraska	1	2	3
Delaware	1	1	2
Hawaii	1	1	2
Maine	1	1	2
North Dakota	0	1	1
Rhode Island	0	0	0
Vermont	0	0	0
TOTAL	453	401	854

TABLE 3
NCIA'S NATIONAL STUDIES OF JAIL SUICIDE: DEMOGRAPHIC
CHARACTERISTICS OF JAIL SUICIDES FROM 1979 AND 1986

CHARACTERISTICS	1979 DATA	1986 DATA
<u>RACE</u>		
White	67%	72%
Black	22	16
Other	11	13
<u>SEX</u>		
Male	97%	94%
Female	3	6
<u>AGE</u>		
17 and Below	5%	4%
18-22	29	16
23-27	25	27
28-32	16	21
33-37	10	15
38 and Above	15	17
<u>MARITAL STATUS</u>		
Single	54%	52%
Married/Common-Law	30	30
Separated/Divorced/Widowed	16	18
<u>MOST SERIOUS CHARGE</u>		
Alcohol/Drug Related	30%	27%
Serious Property	22	20
Minor Other	21	28
Violent/Personal	27	25
<u>JAIL STATUS</u>		
Detained	91%	89%
Sentenced	9	11
<u>PRIOR CHARGES</u>		
One or More	53%	78%
None	47	22

CHARACTERISTICS	1979 DATA	1986 DATA
<u>INTOXICATION</u> (At Time of Incarceration)		
Alcohol	39%	44%
Drugs	9	7
Both	11	9
Neither	41	40
<u>TIME OF SUICIDE</u>		
12:00 Midnight - 3:00 a.m.	20%	18%
3:00 a.m. - 6:00 a.m.	15	14
6:00 a.m. - 9:00 a.m.	11	11
9:00 a.m. - 12:00 p.m.	7	10
12:00 p.m. - 3:00 p.m.	7	10
3:00 p.m. - 6:00 p.m.	12	11
6:00 p.m. - 9:00 p.m.	13	14
9:00 p.m. - 12 Midnight	15	12
<u>METHOD</u>		
Hanging	96%	94%
Other	4	6
<u>INSTRUMENT</u>		
Shoelace	3%	5%
Belt	9	2
Other Clothing	32	34
Bedding	44	48
Towel	5	4
Other	7	7
<u>TIME SPAN</u> (Between Suicide and Finding Victim)		
Less than 15 Minutes	36%	42%
15-30 Minutes	31	32
30-60 Minutes	16	15
1-3 Hours	11	8
Over 3 Hours	3	3
<u>ISOLATION</u>		
Yes	68%	67%
No	32	33

CHARACTERISTICS	1979 DATA	1986 DATA
<u>PRIOR SUICIDE ATTEMPTS</u> (Known to Officials)		
Yes	17%	16%
No	83	84
<u>PRIOR MENTAL ILLNESS</u> (Known to Officials)		
Yes	30%	19%
No	70	81
<u>LENGTH OF INCARCERATION</u> (Prior to Suicide)		
0-3 Hours	27%	29%
4-6 Hours	9	9
7-9 Hours	4	4
10-12 Hours	4	2
13-18 Hours	3	2
19-24 Hours	4	5
25-48 Hours	6	6
3-14 Days	14	15
15-30 Days	8	8
2-4 Months	13	12
5-7 Months	5	6
8-12 Months	2	1
More Than 1 Year	1	1
<u>FACILITY TYPE</u>		
Detention (Over 48 Hours)	73%	70%
Holding (0-48 Hours)	27	30

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TRANSPARENCY 3-5

- 78% of victims had prior charges, yet only 10% were previously held on personal/violent offenses.
- 60% of victims were intoxicated at the time of incarceration.
- 82% of holding facility suicide victims were intoxicated at the time of incarceration.
- 30% of suicides occurred during a six-hour period between midnight and 6:00 a.m.
- 94% of suicides were by hanging; 48% of victims used their bedding.
- Two out of three victims were in isolation.
- 51% of suicides occurred within the first 24 hours of incarceration; 29% occurred within the first three hours.
- 64% of holding facility suicide victims died within the first three hours.
- 69% of suicides were in detention facilities (over 48 hours); 66% of the suicides occurred in urban jails..
- 89% of victims were not screened for potentially suicidal behavior at booking.

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E. LOCALIZED STUDIES

INSTRUCTOR'S NOTE: Each jurisdiction needs to analyze data from its own prior suicides in order to compare and contrast the data from the national studies.

4. WHY JAIL ENVIRONMENTS ARE CONDUCTIVE TO SUICIDAL BEHAVIOR

Chapter 4-1

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TRANSPARENCY 4-1 - Certain unique characteristics of jail environments make them ideal suicide-prone settings:

A. AUTHORITARIAN ENVIRONMENT

Persons not used to being regimented can encounter traumatic difficulty in the jail setting. Based upon interviews with suicide attempt victims, this factor alone can trigger a suicide attempt.

B. NO APPARENT CONTROL OVER THE FUTURE, INCLUDING FEAR AND UNCERTAINTY OVER THE LEGAL PROCESS'

Following incarceration, many jail inmates experience feelings of helplessness and hopelessness. They feel powerless and overwhelmed.

C. ISOLATION FROM FAMILY, FRIENDS AND COMMUNITY

For incarcerated individuals, support from family and friends may seem far away, especially with restricted visiting and telephone privileges:

D. THE SHAME OF INCARCERATION

Feelings of shame (often found in misdemeanants) are often inversely proportionate to the gravity of the offenses committed. Frequently, such feelings develop in those persons who have never been arrested before or who have a limited arrest history. As noted in the list of characteristics of the NCIA national study of jail suicides, 75% of the victims were arrested for non-violent offenses. It is not uncommon for jail suicides to be committed by intoxicated persons held under

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“protective custody” until sober, or by individuals arrested for traffic violations, disturbing the peace or other minor offenses.

E. DEHUMANIZING ASPECTS OF INCARCERATION

Viewed from the inmate’s perspective, confinement in even the best of jails is dehumanizing. Lack of privacy, association with acting-out individuals, inability to make your own choices in the regulation of your life, and strange noises and odors can all have a devastating effect. Many facilities are old, with a substandard environment. Common overcrowding creates stress.

F. FEARS

Fears, based on stereotypes of jails seen on television and in movies, and stories carried by various media, heighten anxieties on the part of some individuals about other inmates and, sometimes, about staff.

G. OFFICER AND -OTHER STAFF INSENSITIVITY TO THE ARREST AND INCARCERATION PHENOMENON; “VICTIM OF ENVIRONMENT”

Most, if not, all persons working in the criminal justice field have never personally experienced the trauma of arrest and incarceration, not even to the indignity of a traffic ticket.

Experience has shown that, in many instances, the longer people work in the criminal justice field, the more insensitive they can become to the emotional effects of

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arrest and incarceration, particularly for the first-time arrestee.

This is considered, one of the factors which influences suicides in jails. As born out in litigation testimony, officers (and some mental health/medical staff) often overlook signs and symptoms because of their own insensitive attitudes and thinking, wherein they have become “victims of their own environment.”

TRANSPARENCY 4-2

A motorist who is stopped for a traffic violation will often become greatly upset. Some almost panic: Experienced law enforcement officers have told many stories about the emotional reactions of some motorists whom they have stopped to alert only about mechanical defects of their car. To allay the motorist’s instant fear, the officer must immediately tell them that they have done nothing wrong.

One myth is that *knowledge* of a system implies sufficient understanding of how it actually operates. However, such has not proven to be the case. In one state, an experienced criminal court judge, on the bench for over 10 years, was required to tour a correctional institution as part of an orientation program mandated by the chief justice of the state supreme court. The judge later dramatically described how chills went up and down his spine when that first steel door clanged shut behind him! He then had an emotionally and drastically different picture of a prison than he had previously from reading books and listening to “second-hand” reports.

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Criminal justice personnel need to continually remind themselves that arrest and incarceration quite often can -traumatize arrestees and inmates. *Awareness* of this factor is essential in that its recognition will help further working relation&tips between staff and arrestees/inmates, reduce stress of all involved and, in some instances, even save lives.⁸

It is recommended that mental health/medical personnel from community agencies who work with jail inmates on either a part-time or full-time basis spend at least one day in the jail for on-the-job orientation. Those personnel who have had such an experience stress that they were better workers for the effort and more appreciative of how the jail environment can influence suicidal behavior. In addition, the experience will better enable community workers to deal with manipulative inmates.

Finally, mental health/medical personnel should never make recommendations regarding the housing and supervision of suicidal inmates without first having a good working knowledge of the facility, as well as its policies and procedures.

⁸See Virginia Department of Mental Health and Mental Retardation, "The Arrest and incarceration Phenomenon," *Mental Health Education for Police, Jail and Mental Health Professionals* (Chapter VII), Richmond, VA: Author, June 1986.

5. PRE-DISPOSING FACTORS OF SUICIDAL BEHAVIOR

Chapter 5-1

TRAINING ACTIVITIES

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TRANSPARENCY 5-1 - In examining potentially suicidal behavior, the following pre-disposing factors are commonly found:

A. RECENT EXCESSIVE DRINKING AND/OR USE OF DRUGS

In many instances, when intoxicated persons sober up, depression sets in. However, a number of persons with blood alcohol levels in excess of the legal limit commit suicide while still intoxicated. For some individuals, even a small amount of alcohol (under the legal limit) or drugs can have a depressing effect, influencing suicidal behavior.

B. RECENT LOSS OF STABILIZING RESOURCES

- 1) Wife/loved one; for a juvenile this could be a peer who may be missed more than a parent.
- 2) Job; or expulsion from school.
- 3) Home; or farm.
- 4) Finances.

C. SEVERE GUILT OR SHAME OVER THE OFFENSE

As previously noted, while some inmates involved in *serious* crimes commit suicide, most who take their own lives in jails are charged with minor offenses or civil violations. For most suicidal inmates, therefore, the guilt or shame may well be inversely proportionate to the seriousness of the offense. Persons of high status in the

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community who commit shameful crimes, such as child molestation or sexual assault, especially need close attention.

D. SAME-SEX RAPE OR THREAT OF IT

In interviews with inmates who were prevented from committing suicide, many of them said that they had been raped or leaned on heavily for sexual favors.

E. CURRENT MENTAL ILLNESS

Persons who are depressed or suffer from delusions/hallucinations, with voices telling them what to do are prime subjects for suicide.

F. POOR HEALTH OR TERMINAL ILLNESS

While mainly a problem of the elderly, persons of all ages succumb to the depression of serious illness, e.g., AIDS.

G. APPROACHING AN EMOTIONAL
BREAKING POINT

Each of us has our breaking point, although that point differs within each of us, according to duration of stress time and situation.

6. HIGH RISK SUICIDE PERIODS

Chapter 6-1

TRAINING ACTIVITIES

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TRANSPARENCY 6-1 -

Experience has shown that there are certain high risk periods for the inmate which correlate with phases of his/her incarceration or steps in the criminal justice process. Some of these periods include:

A. THE FIRST 24 HOURS OF CONFINEMENT

This is the most crucial period, specifically the first three hours, according to the NCIA studies referred to earlier.

B. INTOXICATION/WITHDRAWAL

Depression frequently sets in when the inmate sobers up. Although alcohol is initially a stimulant, its effect is' limited, and it soon becomes a depressant for many people, particularly those who drink because of problems.

C. WAITING FOR TRIAL

The agony of the unknown, and just plain waiting, produce great anxiety and pressure on many people.

D. SENTENCING

The day of reckoning, particularly when awaiting or responding to a sentence just handed down, constitutes the breaking point for some inmates. Included in this group is the serious repeat offender who knows what kind of life to expect in prison and cannot bear the thought of returning.

E. IMPENDING RELEASE

This phase catches many jail staff off guard because, like ordinary people, they consider that release from jail is something to look forward to. The problem is that, for a suicidal inmate, the stigma of facing family and/or friends

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and fellow workers upon release may be too great. Severe guilt/shame outweighs what ordinary people see as the positives.

F. HOLIDAYS

Holidays often mean loved ones gather together; this adds to the loneliness of confined persons. Personal holidays (i.e., children's birthdays, anniversaries, etc.) can be tough days for some inmates.

G. DARKNESS

Since suicide is a very private act, the hours of darkness (with an accompanied decreased staff support) produce many suicides.

H. DECREASED STAFF SUPERVISION

Many jails have less staff on duty during weekends, nights and holidays. Fewer programs and activities also affect the jail atmosphere. A number of suicides also occur during *shift change*, when outgoing staff are getting prepared to leave the building and thus less -attentive, and incoming staff are reviewing logs and other paperwork while being briefed on highlights from the previous shift.

I. BAD NEWS OF ANY KIND

Arresting officers, jailers and mental health workers should be aware of some crises which can greatly disturb an inmate. Some examples: "Dear John" letters; a restraining order by a wife prohibiting the husband's return home; getting that "pink slip"; notice of foreclosure on home or farm; a death notice; divorce proceedings; visits or lack of visits; and, disturbing news of any kind from loved ones.

7. SIGNS AND SYMPTOMS OF SUICIDAL BEHAVIOR

Chapter 7-1

TRAINING ACTIVITIES

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- TRANSPARENCY 7-1** - Experience has shown that certain signs and symptoms exhibited by the inmate often *foretell* a possible suicide and, if detected, could often prevent a death. What the individual says and does at the time of *arrest*, during *transport* to the jail, at *booking/intake*, and during *confinement* are vital in detecting suicidal behavior. The following are warning signs and symptoms of suicidal behavior (the first several are usually the key ones):
- A. Current depression or paranoia.
 - B. Expresses or evidences strong guilt and/or shame over offense.
 - C. Talks about or threatens suicide; makes statements that are death-related and/or are of finality nature, e.g., “I’ve had it. I can’t take it anymore.”
 - D. Under influence of alcohol/drugs; depression sets in when sobering up; fear of going through withdrawal again.
 - E. Officer’s knowledge of previous suicide attempts and/or history of mental illness. Although all prior history is important, recent prior history is a critical sign of potentially suicidal behavior.
 - F. Severe agitation or aggressiveness (if the latter occurs when the inmate is sober, it, too, can indicate a suicide problem).

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PRESENTATION GUIDE**TRANSPARENCY 7-2**

- G. Projects hopelessness or helplessness or no sense of future.
- H. Expresses unusual or great concern over what will happen to them, i.e.; “What will my wife say?” and “What will my employer say?” There may be extreme anxiety.
- I. Noticeable mood and/or behavior changes.
- J. May act very calm once decision is made to kill self.
- K. Speaks unrealistically about getting out of jail.
- L. Has increasing difficulty relating to others.
- M. Does not effectively deal with present - preoccupied with past.
- N. Begins packing belongings.
- O. Starts giving away possessions.
- P. May try to hurt self: “attention-seeking” gestures. Regardless of how many times an inmate exhibits deliberate self-harm, each gesture must be considered as the first real attempt.
- Q. Paranoid delusions or hallucinations.

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Depression is the single best indicator of potential suicides. Approximately 70 to 80% of all suicides are committed by persons who are severely depressed. The following are common signs and symptoms of depression:

TRANSPARENCY 7-3

- A. Feelings of inability to go on - hopelessness or helplessness. (Arresting, booking and supervising officers can pick up on these key signs or symptoms by observing and talking with inmates.)
- B. Extreme sadness and crying.
- C. Withdrawal or silence.
- D. Loss or increase of appetite and/or weight.
- E. Pessimistic attitudes about future.
- F. Insomnia or awakening early; excessive sleeping.
- G. Mood and/or behavior variations.
- H. Tenseness.
- I. Lethargy - slowing of movements or non-reactive.
- J. Loss of self-esteem.
- K. Loss of interest in people, appearance or activities.
- L. Excessive self-blaming.

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M. Strong guilt feelings.

N. Difficulty concentrating or thinking.

Agitation frequently precedes suicide; its symptoms are:

A. High level of tension.

B. *Extreme* anxiety.

C. Strong emotions:

- guilt
- rage
- wish for revenge

TRANSPARENCY 7-4

Suicide may follow agitation as a means of relieving tension or pressure.

Psychotic Conditions - Their Impact on Suicides

Some jail inmates suffer from delusions and hallucinations; such persons are prime candidates for suicide; they may have visions; voices may tell them to take their own lives. They may be overly aggressive and dangerous to others, driven by delusions or hallucinations. Please refer to Chapter 13 for details on managing these inmates.

8. SITUATIONAL RISK FACTORS OF SUICIDAL BEHAVIOR

Chapter 8-1

TRAINING ACTIVITIES

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TRANSPARENCY 8-1

The following are some of the situational factors which affect jail suicides:

- A. Minor or insignificant arrest history.
- B. Juvenile (anyone under 18, whether or not waived to adult court).
- C. Persons with high status in community.
- D. Prior suicide by close family member or loved one.
- E. Previously imprisoned and facing new serious charges and long prison term; victims of same sex rape during prior incarceration can be high suicide risks.
- F. Prior suicide attempt in jail or community, particularly of a recent nature; “copycat.” Caution: An attempt or completed suicide can trigger other incidents within the facility. Extra precautions should be taken with vulnerable inmates.
- G. Harsh, condemning, rejecting attitudes of officers, e.g., “We’ll give you the rope whenever you’re ready.” (This statement was made by an officer when he became irritated by the inmate’s suicidal gestures; unfortunately, the inmate did commit suicide.)

Some jails reduced their prior high incidence of suicides and /or suicide

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attempts noticeably after the administration was changed and/or there was a heightened emphasis on the humanistic approach - more capable, well-trained officers.

- H. Prior experience with the pain and suffering of alcohol/drug withdrawal and reluctance to undergo this ordeal again.

9. CURRENT AND RECENT STRESS SITUATIONS

Chapter 9-1

TRAINING ACTIVITIES

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TRANSPARENCY 9-1 - Each of us has our own “breaking point.” Many suicides would never have occurred an hour, day, week or month later, had not one or more of the following stress factors entered into that person’s life:

- A. Actual loss (or threat of loss) of loved one, e.g., spouse, fiancée, close friend, etc.
- B. Recent job loss or failure.
- C. Recent, pending, or threatened divorce, separation or breakup.
- D. Rejection by peers (especially true of juvenile offenders).
- E. Serious business or financial loss.
- F. Discovery of major health problem.
- G. Victim of same-sex rape or seriously threatened.
- H. Committed heinous crime or one of passion or a revolting sex crime (must be put into the context that approximately three-quarters of the jail suicides are committed by persons charged with non-violent crimes, misdemeanors, or civil violations).

10. ARRESTING AND INVESTIGATIVE OFFICERS AND SUICIDE PREVENTION

Chapter 10-1

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TRANSPARENCY 10-1

“Law enforcement has evolved into a professional service with primary goals focused on protecting the lives and rights of people.”

The arresting officer on the street plays a critical role in the prevention of jail suicides. So does the officer who does follow-up investigative work, particularly in heinous crimes involving interviews with relatives and significant others.

At arrest and while transporting the arrestee to the jail, the arresting officer is the first official in position to observe signs and symptoms of a potential suicide. Arrestees may make comments, gestures, or display actions, i.e., crying, becoming severely agitated depressed, etc. The sobering-up period is a particularly crucial time.

Arresting and law enforcement personnel engaged in investigative activities should be trained to identify the characteristics of a subject who is potentially dangerous to himself and others, and be aware of supportive resources provided by mental health professionals in order to deter and prevent destructive behavior.

The police officer, properly trained, can be ‘the major factor in suicide prevention. We know this because in jail suicide litigation, various expert witnesses have

‘Henry E. McInturff and Stephen R. Band, “The Complete Investigator: Recognizing the Potential for Suicide are Violence,” FBI Law Enforcement Bulletin, September 1985, 20.

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observed that police officers have been instrumental in alerting booking officers about a potential suicide. Contrarily, it has also been shown that information from the police officers; which might have prevented the suicide was not disclosed or made known until after the suicide.

For decades, many law enforcement officers have been successfully trained in detecting possible diabetic emergency situations. Now, awareness training in signs and symptoms of suicide is urgently needed.

Implementation of Training

The most effective approach in training police officers seems to be through *entrance* training in the various state, regional or local academies. Unfortunately, even today many training academies provide only a brief overview of suicide prevention lasting but a few minutes and buried under the heading of “dealing with disturbed persons.” It is strongly recommended that detention and correctional administrators acquaint top law enforcement officials with the existence of this training package and the urgent need for street officers to receive suicide prevention training.

Re-training should be conducted periodically, preferably at least every two years on an in-service basis. Roll call training is one important means of implementing suicide prevention refresher training.

Various law enforcement agencies that have already implemented this training among their personnel have done so for two basic reasons:

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- A. To help *prevent* suicides in their own lockups and county jails to which they transfer arrestees.
- B. To prevent lawsuits against their agencies, based on the principle of *foreseeability*, upon which courts can be expected to hold them liable, just as they have held jails liable. With the training resources available today, law enforcement agencies cannot excuse themselves by claiming they could not *foresee* the suicide, when the facts reveal that, if *properly* trained, the officers could have been able to both *foresee* and *prevent* the act, (see Chapter 18).

Suicide prevention training may also benefit the officer in his work in the community, where he can expect to encounter suicides and attempts.¹⁰

¹⁰Ibid., 18-20

11. ASSESSING SUICIDAL RISK: SPECIAL ASPECTS OF HEALTH CLEARANCE AND RECEIVING SCREENING

Chapter 11-1

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TRANSPARENCY 11-1

Experience has clearly shown that *properly-trained* correctional officers/jailers can effectively assess most potentially suicidal inmates at booking; many others are detected while officers are supervising inmates in the general inmate population.

Many jails report reductions in suicides following *awareness* training of booking officers in suicidal symptoms and implementation of sound inmate management procedures.

NCIA's most recent research indicates that 89% of victims were not screened for potentially suicidal behavior at booking.

A. **REFUSAL AT ADMISSION OR REQUIRING WRITTEN HEALTH CLEARANCE**

While refusals at admission are not as common for suspected cases of mental illness (including suicide) as they are for medical traumas, they-do occur and should be pursued when indicated:

1) **Prisoners Who Seem Very Confused or Disoriented**

Such a prisoner may be mentally ill, emotionally disturbed. Or he may be suffering from an adverse drug reaction. He may have recently suffered a severe head injury. Or he may be very ill. If a prisoner seems very confused, if he doesn't seem to know who he is or where he is or what is happening, have him professionally evaluated before you accept him. He may be just

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momentarily confused, or he may be in need of medical or psychiatric treatment. It is not your job to diagnose his problem; it is your job to have him examined and evaluated before you admit him to your custody.¹¹

Caution should be exercised, particularly with known cases of depression, paranoid schizophrenia or “persecution complex,” and manic depressive illnesses. The main signs and symptoms to look for are hallucinations (hearing and seeing things which do not exist), severe depression, withdrawing or no! communicating, or some form of erratic behavior.

Some jails refuse admission of arrestees with prior histories of mental illness (often within the past year), as well as those arrestees who threaten suicide and/or have a prior history of suicidal behavior. Referral for clearance, initiated through a Prisoner Medical Clearance Form (see Appendix A for sample), also acts as an indicator that “someone cares” and may prevent a suicide attempt.

2) Medical Risk

Experience has shown that some persons with an unattended medical problem can be greater suicide risks. Hence, appropriate *medical* attention, which will reduce anxieties, is a suicide prevention factor and should be pursued expeditiously.

¹¹American Medical Association (in cooperation with the Department of Governmental Affairs, University of Wisconsin), *Training of Jailers in Receiving Screening and Health Education* (Unit II), Chicago, IL: Author, March 1978, 13.

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TRANSPARENCY 11-2

The following are various medical conditions for which written clearance by a physician should be sought prior to admitting an arrestee:¹²

- 1) Prisoners who are unconscious or semi-conscious.
- 2) Prisoners with any significant external bleeding.
- 3) Prisoners with any obvious fractures (broken bones).
- 4) Prisoners with any signs of head injury.
- 5) Prisoners who may have neck or spine injury.
- 6) Prisoners with any other sort of severe injury.
- 7) Prisoners who cannot walk under their own power.
- 8) Prisoners displaying any signs or symptoms of possible internal bleeding.
- 9) Prisoners with severe abdominal pain.
- 10) Prisoners displaying signs of significant drug/alcohol abuse, e.g., blood alcohol level of .275 or more.

¹²Ibid., 1-14

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It should be pointed out that, regardless of the alcohol level, Standard 72.5.6 of the Commission on Accreditation for Law Enforcement Agencies stresses:

“The holding facility is not normally equipped to provide treatment to persons under the influence of drugs or alcohol, and such persons should be detained in other facilities, when available. When these facilities are not available, special consideration should be given to ensuring that the potential for detainees to injure themselves or others is minimized. Such detainees should remain under close observation at *all times* by facility staff. (Mandatory)““?

TRANSPARENCY 11-3

Inmates can choke on their own vomit. Aspiration- pneumonia has approximately a one-third casualty rate; injuries to intoxicated prisoners and victimization are constant problems; and intoxication, when coupled with other signs and symptoms of suicidal risk, greatly increases the likelihood of a suicide attempt.

¹³Commission on Accreditation for Law Enforcement Agencies, *Standards for Law Enforcement Agencies*, Fairfax, Author, May 1987, 72.

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- 11) Pregnant women in labor.
- 12) Pregnant women with other serious problems.
- 13) Prisoners who claim that they need certain types of medication, but who do not have such medication with them.

**B. ADMISSION RECEIVING SCREENING:
WHAT? WHEN? BY WHOM?**

Initial health screening for medical, mental health, and suicidal behavior problems upon admission is considered by many health care professionals as the most important aspect of the entire health care system. Most cases of potential suicide can be detected through in-depth receiving screening.

Such screening is not meant to be an extensive, time consuming evaluation of an inmate's health needs. It should be utilized by the booking officer or other jail personnel as a form of triage.

1) What?

Receiving screening consists of three aspects:

- a.** *Observation* by the arresting/ transportation and booking officers, or, as in some jails, by health care personnel.

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Please refer to Appendices B, C, and D for sample receiving screening forms outlining this part of the concept.

Appendix B is the format followed by many jails which do receiving screening; it covers *basic* medical, mental health and suicide prevention screening.¹⁴

TRANSPARENCY 11-4

Appendix C is also a sample of an intake screening form utilized in numerous jails throughout the country. It covers medical and mental health areas, prior risk within the facility, and,, *expanded inquiry* of current suicide risk.¹⁵

Appendix D is exclusively utilized for suicide detection and prevention.¹⁶ Currently administered within

¹⁴Originally developed by the Jail Project of the American Medical Association, Chicago, Illinois, 1977, and later revised by American Health Care Consultants, Chicago, Illinois. Further revisions were made by Juvenile and Criminal Justice International.

¹⁵Developed by the National Center on Institutions and Alternatives, Mansfield, Massachusetts, April 1992.

¹⁶Developed by the New York State Office of Mental Health, Commission of Correction, Ulster County Community Mental Health Services, and Division of Criminal Justice Services - Bureau of Municipal Police, Albany, New York, March 1986

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all jails and lockups throughout New York State, as well as other jurisdictions throughout the country, it can be accompanied by, or incorporated into a form for *total* health screening.

Total health screening is the best suicide detection and prevention approach, because as mentioned earlier, undetected, unattended medical problems and resulting anxieties can have an impact on potential suicide.

b. **Examiner-Arrestee Questionnaire**

This aspect consists of questions on a variety of suicide, medical and mental health matters.

Please refer to Appendices B, C, and D for details.

c. **Disposition and Referral Guidelines**

See Appendices B, C, and D. This is an extremely important

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step because it documents what the booking officer or other personnel observed or *ascertained* from the questions -a key factor in effective follow-up and *lawsuit prevention*. Each sample form contains guidelines for disposition.

2) When?

Receiving screening should be conducted *immediately: upon arrival* at the jail and holding facility. Deaths have taken place in holding pens and cells, waiting for receiving screening to be done the next morning when nursing and other registered or licensed professional staff come to work. Further, serious communicable diseases have been spread because of the delay.

TRANSPARENCY 11-5

3) By Whom?

All national correctional standards and most state jail standards require that receiving screening is to be performed by health care personnel (i.e., mental health/ medical staff) or health-trained correctional staff.

C. VALUES AND BENEFITS OF RECEIVING SCREENING

The practice of receiving screening is almost 20 years old. It has many proven benefits:

- 1) Potentially suicidal inmates are identified.

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- 2) Traumas, possible illnesses and infectious diseases are detected.
- 3) Possible drug and alcohol abuse and withdrawal can be assessed.
- 4) Early evaluation and treatment of chronic and acute mental illnesses can be effected.
- 5) Medication use is determined.
- 6) Legal liability protection; a number of lawsuits which were begun by inmates were dropped after their attorneys reviewed the results of receiving screening.
- 7) The process itself has been credited with preventing suicides when care, concern, and “non-robot” style interviewing are exhibited.

D. HOW RECEIVING SCREENING OPERATES

- 1) *Observation* by the officer or other staff while conducting the booking:
 - a. Inmate behavior, speech, actions, attitudes and state of mind.
 - b. Scars from previous suicide attempts.
 - c. Traumas or bruises, color and condition of the skin.

TRANSPARENCY 11-6

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- d. Visible signs of drug or alcohol use and withdrawal.
 - e. Medication use is determined.
- 2) The *questionnaire* serves as a beginning, and screeners are encouraged to ask follow-up questions to elicit additional information.

Experience in the American Medical Association Jail Project has clearly shown that, when interviews with inmates are properly conducted, over 90% of the responses will be truthful. What constitutes an effective interview?

- a. *Explaining*, as simply as possible, the rationale for what you're doing, i.e., "I'm going to ask you some questions about your health which we ask *all* inmates, because we are interested in your health and welfare," thus removing feelings of paranoia, or that the inmate is being "picked on."
- b. Asking questions in a common-sense manner, as privately as the setting permits.

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- c. Speaking in a normal, quiet, matter-of-fact tone.
- d. Using language the inmate can understand, including, if necessary, “street **language.**”
- e. Not being rushed, abrupt or sarcastic.
- f. If not understood, repeating question slowly and clearly.

TRANSPARENCY 11-7

An *effective* interview impresses upon the inmate the fact that “somebody cares.” After the trauma of arrest and incarceration, properly conducted receiving screening settles the inmate, relieving tension and anxieties. Jail administrators and officers who work where ‘there are good receiving screening systems testify to the positive effect on inmates and staff alike. The foundation of the process is the successful interview.

When an arrestee enters the facility intoxicated, some jail staff delay the entire screening process until the individual reaches sobriety. It is strongly recommended that the *observation* section of the screening process be performed in all cases, regardless of the use of intoxication or uncooperativeness.

Further, unless the inmate is so severely intoxicated to render the process meaningless, the *questionnaire*

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section of the screening process should be attempted because there are occasions when intoxicated individuals are more open and forthcoming than when sober. Remember, most suicides occur shortly after confinement, often before full sobriety sets in, therefore, a delay in this “fact-finding” process can have deadly repercussions.

Finally, if inmates do not participate in the intake screening process, either due to intoxication, uncooperative behavior, or other reasons, and remain in the facility, they should be placed under more frequent observation until such time as the intake screening process is completed.

E. SUICIDE RISK INQUIRY AND RECEIVING SCREENING

Screening inmates upon admission is considered the most important aspect of assessing potential suicide.

1) Modified American Medical Association (AMA) Form¹⁷

The following are observational and interview factors related to suicide risk taken from a modified version of the original AMA receiving screening form:

- Appears to be under the influence of alcohol or drugs?

¹⁷See Appendix B for a sample of the screening form in its entirety.

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- Are there visible signs of alcohol and/or drug withdrawal?
- Does arrestee appear to be despondent / depressed?
- Appears to 'be irrational/mentally ill?
- Behavior suggests risk of assault? (Experience has demonstrated that there is a correlation between violence and suicide: "Striking outward can turn to striking inward.")
- Is this the first time. . . arrested or detained?
- Have you had any previous mental or emotional problems for which you were treated?
- Were you ever hospitalized for any mental or emotional problems?
- Have you ever thought about or attempted to commit suicide?
- Is there anything special that we should

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know about you for your welfare or protection? (While primarily intended to elicit information about sexual behavior, this question also may serve as a “red flag” to reveal thoughts of possible suicide or other areas of concern. When perceived as a “we care” interview, it is not uncommon for the arrestee to correct earlier responses to screening questions or disclose further information that was previously held back.)

2) **NCIA’s Intake Screening Form¹⁸**

The following are additional observational factors and questions specific to suicide risk from the National Center on Institutions and Alternatives (NCIA)’s *Intake Screening Form*.

- Was inmate a medical, mental health, or suicide risk during any prior contact or confinement with department?

¹⁸See Appendix C for a sample of the screening form in its entirety.

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- Does arresting or transporting officer believe that inmate is a medical, mental health or suicide risk now?
- Have you ever attempted suicide?
- Have you ever considered suicide?
- Are you now or have you ever been treated for mental health or emotional problems?
- Have you recently experienced a significant loss (job, relationship, death of family member/close friend, etc.)?
- Has a family member/close friend ever attempted or committed suicide?
- Do you feel that there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?
- Are you thinking of killing yourself?

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3) **New York State Form¹⁹**

The following are additional observational factors and questions from the *Suicide Prevention Screening Guidelines*.

TRANSPARENCY 11-9

- Arresting or transporting officer believes that detainee may be a suicide risk.
- Detainee lacks close family or friends in the community.
- Detainee has experienced a significant loss within the last six months.
- Detainee is very worried about major problems other than legal situation.
- Detainee's 'family or significant other has attempted or committed suicide.
- Detainee has psychiatric history.
- Detainee has history of drug or alcohol abuse.

¹⁹See Appendix D for a sample of the screening form in its entirety.

TRAINING ACTIVITIES

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- Detainee holds position of respect in community and/or alleged crime is shocking in nature.
- Detainee is thinking about killing himself.
- Detainee has previous suicide attempt.
- Detainee feels that there is nothing to look forward to in the future.
- Detainee shows signs of depression.
- Detainee appears overly anxious, afraid or angry.
- Detainee appears to feel unusually embarrassed or ashamed.
- Detainee is acting and/or talking in a strange manner.
 - A. Detainee is apparently under the influence of alcohol or drugs.

TRANSPARENCY 11-10

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B. If yes, is
d e t a i n e e
i n c o h e r e n t ,
or showing
signs of
withdrawal
or mental
illness?

- No prior arrests.

4) **Disposition**

Any clear “yes” answers to the above should alert staff to possible suicide potential. Generally, there will be several signs/symptoms upon which to make a disposition concerning housing and supervision.

F. **ASSESSMENT FACTORS AND PRINCIPLES
IN RECEIVING SCREENING**

During arrest, transportation, booking and supervision of inmates in the jail, officers also need to assess suicidal risk. The following are some factors and principles that need to be considered:

- 1) Determine either manually or by computer whether inmate was a suicide risk during any prior confinement in facility.
- 2) All suicide threats, regardless of number, must be taken seriously; all gestures of “manipulation” should be handled as the first real threat; avoid using the term “manipulative” - it is simply meaningless to our understanding

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and management of suicidal behavior in inmates.

- 3) Try to gauge the intensity of the stress and depression.
- 4) Determine impulsiveness; in general, the younger the inmate, the greater the impulsivity.
- 5) Explore the situation as far as possible: direct questions should be asked to explore any suicide plans for degree of risk; the more specific the plan, the higher the risk.
- 6) Determine means available to carry out suicidal act; if there is access to a way of implementing the plan, the risk is high.
- 7) Assess resources available to help prevent the act; referral to mental health services should be specified in the procedures and be seriously considered in cases of active suicide risk.

TRANSPARENCY 11-11

12. HOUSING AND SUPERVISING SUICIDAL INMATES

Chapter 12-1

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TRANSPARENCY 12-1 - In determining the most appropriate housing for a suicidal inmate, jails officials often tend to physically isolate and restrain the individual. These responses may be most convenient for staff, but they are detrimental to the inmate. The use of isolation, found in 67% of all jail suicides, not only escalates the inmate's sense of alienation, but also further serves to remove the individual from proper staff supervision. To every extent possible, suicidal inmates should be housed in the general population.

For purposes of housing and supervision, suicidal inmates are often categorized into two groups - *Zou*, and *high risk*.

A. LOW RISK SUICIDAL INMATES

Low risk suicidal inmates are those individuals not actively suicidal, but have expressed suicidal thoughts and /or have a prior history of self-destructive behavior. These inmates should be placed under *close watch* - and physically observed by staff at staggered intervals not to exceed every 15 minutes.

B. HIGH RISK SUICIDAL INMATES

High risk suicidal inmates are those individuals actively suicidal either by threatening and/or engaging in the act of suicide or other self-destructive behavior, and/or through a very recent suicide attempt. These inmates should be placed under constant *watch* - and physically observed by staff on a continuous, uninterrupted basis.

TRANSPARENCY 12-2

TRAINING ACTIVITIES

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c. OTHER ISSUES

- 1) All suicidal inmates should be housed in suicide-resistant, protrusion-free cells, see Chapter 16. Other than general population, preferred cells include those located in high traffic and visibility areas, including the booking area, receiving and discharge unit, near an officer's station, and infirmary (if available).
- 2) While belts, ties, shoelaces, suspenders should be removed, the inmate should be allowed to retain other clothing items unless his/her behavior dictates otherwise. If clothing is removed, a paper gown should be issued to the inmate.
- 3) In most instances, **constant watch** status should not necessitate the need to remove an inmate's clothing and/or apply restraints.
- 4) As required by national correctional standards, audio monitoring and/or closed circuit television should be utilized only as a supplement, and never as a substitute for staff observation.
- 5) The use of physical restraints (e.g., handcuffs, straitjacket, leather medical straps, etc.) and removal of clothing should be utilized only as a last resort for periods in which the inmate is physically engaging in self-destructive behavior.

TRANSPARENCY 12-3

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D. DECELERATION AND REMOVAL OF INMATES FROM SUICIDE WATCH

The following factors should be addressed prior to decelerating and/or removing an inmate from suicide watch.

- 1) Suicide watch inmates should be assessed on a frequent basis. If full-time mental health/medical staff coverage is available, inmates should be assessed every 24 hours. If full-time coverage is not available, inmates should be assessed at least every 7 days, although due to staffing considerations, constant watch inmates should still be assessed every 24 hours. All staff, including correctional, mental health, and medical personnel, should be consulted regarding assessment of future suicide watch needs.
- 2) Following an assessment, inmates originally placed under **constant watch** should be decelerated to close **watch** status for a reasonable period of time.
- 3) Following an assessment, inmates on close **watch** status should be removed from suicide watch and housed in general population (unless safety or security concerns dictate otherwise).
- 4) As aptly stated in the National Commission on Correctional Health

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Care's *Standards for Health Services in Jails* - "The mental status of any given inmate may vary greatly from day-to-day and sometimes from hour. to hour; therefore, it is imperative that staff have good observational skills and knowledge of signs and symptoms to look for. If any staff member has reason to feel that a person who is already on a precaution level should be moved to a higher level of precaution, the medical department should be notified, and the physician and/or psychiatrist again consulted."²⁰

²⁰National Commission on Correctional Health Care, *Standards for Health Services in Jails*, Chicago, IL: Author, 1992, 158

13. MANAGING POTENTIALLY SUICIDAL INMATES

Chapter 13-I

TRAINING ACTIVITIES

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TRANSPARENCY 13-1 A. GENERAL PRINCIPLES

Human interaction, i.e., good interpersonal communications, initiated by correctional officers or jailers who follow the Golden Rule (treat others as you want to be treated), and who have received “awareness” training, is vital in suicide detection and prevention. In addition, successful identification and management of suicidal inmates are greatly dependent upon capable staff with the appropriate *attitude* - “The best way to get others to respect you is to respect them first. Unless you convey this attitude, you will not get accurate information from the detainee about his situation...and this makes his safety and the officer’s all the more difficult...Keys to attitude: Be respectful; be considerate; be direct.”²¹

B. CHARACTERISTICS OF PROFESSIONAL CORRECTIONAL STAFF²²

What characteristics or traits do those officers possess who have good human interaction with inmates? Interviews with numerous jail officers reflected overwhelming agreement on specific *principles* of good discipline and inmate management. By practicing the following principles, a better overall climate or atmosphere will exist in the jail, helping minimize inmate problems of all kinds, including suicidal

²¹New York State Office of Mental Health, Commission of Correction, and Ulster County Community Mental Health Services, *Suicide Prevention and Crisis Intervention in County Jails and Police Lockups - Officer's Handbook*, Albany, NY: Authors, January 1985, 17

²²The basic material for this section was adapted from the “Curriculum on Professionalization of Correctional Officers/Jailers - With Emphasis on Suicide Prevention and Effecting Better Discipline/Custody,” *Juvenile and Criminal Justice International*, Roseville, MN: Author, 1984

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behavior. Hence, more effective management of potentially suicidal inmates, disturbed persons and general population inmates will be a reality.

1) Exhibits Fairness

Even at the peak of racial tension on America's streets, many inmates surveyed in jails and prisons said that *fairness* of officers mattered more to them than skin color. In fact, fairness in officers is ranked highest among all other attributes.

2) Shows No Favoritism

When correctional officers show *favoritism* among inmates, other inmates say *it is not fair*. Frequently the favorites picked are the sophisticated offenders. Potential negative fallout is that the officer who plays favorites loses the respect of the inmate body and the favored inmate is harassed and/or victimized.

3) Keeps Promises

Broken promises are lies to inmates and despised by fellow staff who must deal with the disgruntled inmate on a later shift. Follow the rule of "Never making a promise unless you plan to carry it out."

4) Uses Authority and Power Constructively

- Sees that the sanction or discipline fits the infraction.
- Refers more often to "we" than to "I" or "me."

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- Generally asks instead of orders the necessary things to be done.
- Does not stress, “I’m in charge; you listen to me.”

5) Admits Mistakes

The officer who admits his/her mistakes to peers **and** inmates alike is elevated, not lowered in the eyes **of** others, although admitting mistakes seems to be one **of** the more difficult things for officers to do.

6) No Put-Downs or is Not Condescending

Secure, self-confident officers do not have to resort **to** put-downs; they treat fellow workers and inmates on **an** “eyeball-to-eyeball” basis. They don’t make critical statements or slights:

- “Who are you to s p e a k ? ”
- “I’m on this side of the bars; you’re on the other side.”
- “You’re not very smart, or **you wouldn’t** be in here.”

7) No Washing of Dirty Linen - No Open Criticism of Staff

A lot of problems in detention facilities center **around** these negative characteristics. They are insidious and devastating. Examples:

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- ‘When Officer Brown is on, he can do it his way but I don’t think like he does.’
- “Mondays are bad days for Officer Jones; humor him that day.”

TRANSPARENCY 13-2**8) Answers Questions**

Some officers don’t or won’t answer appropriate questions; or, when they do, frequently counter with, “Why do you want to know?” or, “What business is it of yours?” Failure to provide inmates with answers whenever known breaks down good officer-inmate communications. Refusals to answer, in cases of **security** or other sensitive issues, should, of course, be courteous.

9) Asks, Not Always Orders That Something Be Done

Officers who are most respected by inmates **generally** ask instead of order that something be done. Experience demonstrates that, in most instances, both officers **and** inmates could be **asked** to do something; being ordered would be the exception. Being **asked a question by a** person in authority is like a “reverse **order.**” Most jail staff would **agree** that asking gets better **cooperation, as** you can always order if that doesn’t work. .

In addition, the process of asking shows respect for the person being addressed and increases the **chance that the** request will be carried out. The process will also result in fewer staff-inmate confrontations. Finally, staff who are

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asked their opinions have a feeling of ownership in decision-making.

10) Consistency

As viewed from both the inmates' and fellow officers' perspective, consistency is considered one of the most desired characteristics of good officers.

11) Talks With Us

Contrarily, some officers (and jails) follow the policy (written or unwritten) of not talking with inmates in matters legitimate or reasonable. In this atmosphere, the emotional environment is often tense and some jails adopt an informant system with its accompanying serious problems. Well managed jail systems practice "open communication."

12) We Look Up to Them

Water runs downhill, but gravity for human beings is uphill. Inmates are generally looking for good role models, contrary to what they may appear to be doing according to their behavior.

13) Are Team Workers

While this comment comes mainly from staff, many inmates are quick to pick out the 'Toner' or uncooperative member among staff personnel. This is often found in the "I-I-me-me" officer who puts him/herself before team efforts. As a result, other staff have to "pick up the pieces" and compensate for the few staff who are self-centered.

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14) Self-Confident, Not Arrogant

The self-confident officer sells only what he/she **can** deliver, in a positive manner; the arrogant person oversells, often times in an overbearing manner..

15) Demonstrates Sincerity and Honesty

Sincerity and honesty are not only two of the most important traits of good jail officers, but are the foundation of numerous other traits discussed in this chapter of the manual. Sincerity and honesty are demonstrated by officers who:

- Keep their commitments; do not break promises.
- Give factual answers; don't "make-up" answers which are later exposed.
- Listen attentively.
- Talk with inmates about their concerns.
- Say, "I don't know," and then find out the answer.

16) Gives Credit When Credit Is Due

Some jail officers and supervisors seem to be constantly looking for things that go wrong; most efforts of officers and supervisors should instead be devoted to seeking out **positives**, an approach increasingly stressed in

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business and industry, and patterned in part after **Japanese** industry. Officers, in turn, generally follow the practice of their superiors in dealing with inmates. Avoid the **attitude** of - “This is the way we’ve been doing it.”

17) Accepts Constructive Criticism; Is Not Defensive

In order to improve their own performances, **some** officers seek constructive criticism from their **superiors** and others; other officers accept accountability for their mistakes without trying to make excuses.

18) They Have Open Minds

New ideas or better ways of doing things are **actively** sought or, when presented, are fully considered.

19) Doesn’t Keep Threatening

Like many parents, some officers keep threatening, and inmates soon learn that a great deal of it is **bluff**; **this** produces poor respect and poor discipline.

TRANSPARENCY 13-3

20) Leaves Personal Problems at Home

Inmates readily recognize those officers who **come to** work “bent out of shape” due to psychological or **family** problems, excessive drinking or other **reasons**. **Respect** where this exists is hard, if not impossible **to-earn**.

21) No Yelling or Swearing

Some officers defend this on the grounds that “That’s all the inmates know.” However, such language means getting down to their level, not serving as that much needed positive role model.

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22) They Do More Than Is Expected of Them

The “average” officer generally will not make the top quarter of the ratings list, voted upon by fellow officers. **As** someone once said, “The two percent extra effort can make 100% difference.”

23) They Are Patient

It is felt that the patient officers are the secure officers who follow the Golden Rule.

24) Doesn't Give Up Easily

The officer who doesn't easily give up on an inmate, even when the inmate resists help, may be the sole factor of change in that inmate's life. This officer doesn't withdraw help and interest. This characteristic conveys the feeling that “someone cares” and can be a key factor in preventing a suicide.

25) Doesn't Preach

Inmates generally resist and resent “preachy,” judgmental officers, as do officers when supervisors follow that approach.

26) They Care

This characteristic is frequently mentioned, in part because of the contrast found in those staff who “care” and those who put themselves first and others second, **including** agency, supervisors and fellow workers. When inmates feel overwhelmed and depressed, and also **feel that their** “keepers” don't care about them as human beings, their suicidal feelings become very understandable.

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It cannot be over-emphasized that these principles, when followed in managing jail inmates, will make the officer a more effective agent of change, thus lessening the incidence of jail suicides and attempts. In fact, these principals are applicable to all staff that work with inmates, including mental health and medical personnel.

C. COMMUNICATING AND INTERACTING WITH SUICIDAL INMATES²³

Few suicides are actually prevented by mental health, medical or other professional staff. Because suicides usually are attempted in inmate housing units - often during evening hours and on weekends - they are generally outside the purview of program staff and must be thwarted by jail staff who not only demonstrate an intuitive sense regarding the inmates under their care, but by those who openly communicate and interact with suicidal inmates. The following staff responses form *bridges* to effective communication with suicidal inmates.

YOU SHOULD -

- 1) *Listen patiently.*
Encourage the suicidal inmate to talk and express his/her feelings. Allow the inmate to verbalize the extent of his/her suicidal plan.

²³Developed by the New York State Office of Mental Health, Commission of Correction, and Ulster County Community Mental Health Services, *Suicide Prevention and Crisis Intervention in County Jails and Police Lockups - Officer's Handbook*, Albany, NY Authors, August 1993 (Revised). Further modified by the National Center on Institutions and Alternatives

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TRANSPARENCY 13-4

- 2) *Trust your own judgment.* If you believe an inmate is in danger of suicide, act on your beliefs. *Don't let others mislead you into ignoring suicidal signals.*
- 3) *Maintain contact* (through verbalization, eye contact, and body language) *and conversation.* Don't be reluctant to express your concerns about the inmate.
- 4) *Try to keep the inmate's sense of the future positive.* For example, if, unknown to the inmate, there are family members /close friends that are concerned with the inmate's welfare (i.e., called the facility, attempting to arrange bail, hiring an attorney, scheduling a visit, etc.), share this information with the inmate.
- 5) *Stay with the suicidal inmate.* Do not leave the inmate alone if you believe he/she is in immediate danger to

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- 3) *Act sarcastic or make jokes about the situation.*
- 4) *Placate the inmate by making promises that you can't keep.*
- 5) *Challenge the inmate to make good on his/her threat. Attempts at reverse psychology is dangerous.*
- 6) *Ignore the suicidal risk or threat. If you feel uncomfortable with the situation, don't simply walk away - seek help!*

D. DEALING WITH MANIPULATIVE INMATES
Few issues challenge jail, mental health, and medical staff more than management of manipulative inmates.- It is not unusual for inmates to call attention to themselves by threatening suicide or even feigning an attempt in order to avoid a court appearance, or bolster an insanity defense; gain cell relocation, transfer to the local hospital or simply receive preferential staff treatment; or seek compassion from a previously unsympathetic spouse or other family member.

Manipulative behavior and suicide attempts can also be provoked by the presence of closed circuit television monitoring - wherein the inmate believes he/she has an attentive audience from which to persuade.

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themselves. Stay with the inmate until assistance arrives.

- 6) *Take all threats seriously and make the immediate referral.* It is not your responsibility to interpret the sincerity or lethality of a suicide threat or attempt. Remember, numerous manipulative gestures by inmates have resulted in accidental deaths. Involve others in the decision process - make the referral!

TRANSPARENCY 13-5

The following staff responses form *barriers* to effective communication with suicidal inmates.

YOU SHOULD NOT -

- 1) *Offer solutions or give advice.* Don't get caught up in trying to make a diagnosis or pinpoint the inmate's problems - you are not a social work counselor or mental health worker - nor expected to be.
- 2) *Become angry, judgmental or threatening to the inmate.*

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Although the prevailing theory is that any inmate who would go to the extreme of threatening suicide or even engaging in self-injurious behavior is suffering from at least an emotional imbalance that requires special attention, too often jail officials (with the support of mental health staff) conclude that the inmate is simply attempting to manipulate his/her environment and, therefore, such behavior should be ignored and not reinforced through intervention. Unfortunately, as previously described, too often a feigned suicide attempt goes further than anticipated and results in death.

Although there are no perfect solutions to the management of manipulative inmates who threaten suicide or engage in self-injurious behavior, several guidelines are recommended:

- 1) Utilize preventive steps (e.g., increased supervision) to discourage manipulative behavior.
- 2) Avoid isolation as a response to manipulative behavior - it could escalate the behavior and result in more *serious* gestures.
- 3) Determining whether an **inmate** is manipulative or actually suicidal is not your responsibility. You should simply observe and document the behavior.
- 4) Refer the inmate to mental health/medical personnel for assessment.

TRANSPARENCY 13-6

TRAINING ACTIVITIES

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- 5) **Avoid use** of the term “manipulation” in written documentation because, once recorded, it will be utilized by other staff involved in the **inmate’s** care.

E. SUICIDE ASSESSMENT AND MENTAL HEALTH REFERRAL

Obviously, when law enforcement and jail personnel have reason to believe that **an** arrestee or inmate may be suicidal, mental health personnel should be involved as soon as possible.

Many jails, however, do not have access to immediate mental health services; particularly at night and on weekends.

As previously stated, properly trained jail booking and supervisory officers have proven themselves **capable of** performing reliable suicide assessments and able to **act** upon their findings with appropriate **preventive** measures.

Properly trained jail staff, who manage inmates 24-hours a day, must be looked upon as the backbone of the entire jail suicide detection and prevention system.

In many “pro-actively” administered **facilities**, **jail staff** contact family members and significant others who **may** be able to help in suicide intervention. **This is** particularly true in small jails, where **mental health** services are often difficult, if not impossible, to obtain on a timely basis.

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If available, time-responsive mental health services should be regarded as invaluable support. A true *team* approach is the key to success in proper assessment, housing and supervision, and ultimately, termination of suicide watch precautions. As succinctly stated by one mental health clinician:

“The key to an effective team approach in suicide prevention and crisis intervention is found in throwing off the cloaks of territoriality and embracing a mutual respect for the detention officer’s and mental health clinician’s professional abilities, responsibilities and limitations. All of us, regardless of professional affiliation, need to make a dedicated commitment to come forward and acknowledge that suicide prevention and related mental health services are only effective when delivered by professionals acting in unison with each other. *Just as the security officer alone cannot ensure the safety and security of a jail facility, neither can the mental health clinician alone ensure the safety and emotional well-being of the individual inmate.*”²⁴

²⁴Margaret M. Severson, “Security and Mental Health Professionals: A (Too) Silent Partnership?,” *Jail Suicide Update*, Winter 1993, 5 (3): 3

14. INTERVENTION: STANDARD FIRST AID FOR HANGING ATTEMPTS

Chapter 14-1

TRAINING ACTIVITIES

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TRANSPARENCY 14-1

A jail facility's policy on intervention for suicide attempts should be threefold: *first*, all staff who come into contact with inmates should be trained in standard first aid, including cardiopulmonary resuscitation (CPR); *second*, any staff who discovers an inmate attempting suicide should immediately respond, survey the scene to ensure that security will not be breached, and initiate first aid, as well as alert other staff to call for emergency service; and *third*, upon arriving at the scene of a suicide attempt, staff should never presume an inmate is dead but should initiate appropriate first aid and continue life-saving measures until relieved by arriving medical personnel.

Jail staff can be held liable for not promptly and effectively initiating life-saving measures to inmates in the act of a suicide attempt. In *Heflin v. Stewart County* [958 F. 2d 709 (6th Cir. 1992)], the court ruled:

“There was clear evidence from which a jury could find that Heflin died as a proximate cause of the failure of Sheriff Hicks and Deputy Crutcher to take steps to save his life. They left Heflin hanging for twenty minutes or more after discovering him...The jailer should have cut the victim down immediately with one person holding the body up and the other cutting the noose.

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TRANSPARENCY 14-2

Officers should never stand by and let the hanging victim continue to hang in order to protect the 'scene of the crime.' Further, even though there were no vital signs, officers should never presume that death has already occurred. 'Dead' people are alive today due to CPR. On the contrary, officers should presume that the hanging inmate is alive and administer first aid until told by a physician to stop."

The overwhelming majority (94%) of jail suicides occur by hanging. A hanging attempt may affect any or all structures in the neck. These include the airway, spinal cord, and major blood vessels which bring the blood supply to the head. All of these must be considered in caring for the hanging victim.

A. DISPOSITION FOLLOWING A HANGING ATTEMPT

- 1) Cut down victim immediately, protecting head and neck as much as possible. Victim should be held up by one person while another cut's or removes the noose. Carefully place victim on the floor, preferably in hallway outside cell to allow room for easier intervention. Never place a hanging victim in a chair or on the bunk.

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CAUTION: Some jails fail to revive suicide victims because several minutes are spent trying to locate an instrument to cut the noose, which is sometimes thick and difficult to cut. Seat belt cutters, used by rescue squads, or other emergency rescue tools, are excellent for cutting through tough material. Some jails require officers to carry this instrument with them at all times, in a case attached to their belt.²⁵

- 2) At the same time, someone should be calling for medical personnel and/or an ambulance, as policy and procedures outline.
- 3) Give standard first aid through either rescue breathing and/or CPR, as appropriate.

B. RESCUE BREATHING AND CPR

The following abbreviated procedures for rescue breathing and CPR are recommended by the American Red Cross.²⁶

- 1) *Rescue Breathing* (if victim is not breathing)
 - a. Roll Person Onto Back
(roll victim toward you
by pulling slowly)

²⁵Commonly known as the "911 Rescue Tool," these emergency rescue tools can be obtained at most police uniform and accessory stores. For a listing of recommended tools, see the *Jail Suicide Update*, Fall 1992, 4 (3):8.

²⁶See American Red Cross, *Standard First Aid Workbook*, Washington, DC: Author, 1991.

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TRANSPARENCY 14-3

- b. Open Airway (If there is no evidence of head or neck trauma, the rescuer should use the head tilt-chin lift maneuver. If head and/or neck injury is suspected, the “jaw-thrust maneuver” *without head tilt* is the safest initial approach to opening the airway “because it usually can be accomplished without extending the neck. The head should be carefully supported without tilting it backward or turning it from side to side. If jaw thrust alone is unsuccessful, the head should be tilted backward slightly.”)

R E M E M B E R ’ A person who is not breathing needs oxygen immediately, therefore, opening the airway is the primary concern.

- c. Check for Breathing (look, listen, and feel for breathing for 3 to 5 seconds)

²⁷American Heart Association, “Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care,” Journal of the American Medical Association. 268 (16), October 28, 1992, 2186

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TRANSPARENCY 14-4

- d. Give 2 Full Breaths, pinch nose shut, seal your lips tight around victim's mouth, give 2 full breaths for 1 to 1-1 / 2 seconds each)
 - e. Check for Pulse at Side of Neck (feel for pulse for 5 to 10 seconds)
 - f. Begin Rescue Breathing (pinch nose shut, give 1 full breath every 5 seconds, look, listen and feel for breathing between breaths)
 - g. Recheck Pulse Every Minute (feel for 5 to 10 seconds, if victim has pulse but is not breathing, continue rescue breathing, If no pulse, begin CPR)
- 2) CPR (if victim is not breathing and has no pulse)
- a. Roll Person Onto Back (roll victim toward you by pulling slowly)
 - b. Open Airway (using either head tilt-chin lift or jaw-thrust maneuver as described above in rescue breathing) and Check for Breathing (look, listen, and feel for

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breathing for 3 to 5 seconds)

- c. Give 2 Full Breaths (pinch nose shut, seal your lips tight around victim's mouth, give 2 full breaths for 1 to 1-1/2 seconds each)
- d. Check Pulse at Side of Neck (feel for pulse for 5 to 10 seconds)
- e. Find Hand Position (locate notch at lower end of breastbone, place heel of other hand on breastbone, next to fingers, remove hand from notch and put it on top of other hand, keep fingers off chest)
- f. Give 15 Compressions (position shoulders over hands, compress breastbone 1-1/2 to 2 inches, do 15 compressions in approximately 15 seconds)
- g. Give 2 Full Breaths (pinch nose shut, seal your lips around victim's mouth, give 2 full breaths for 1-1/2 to 2 seconds each)

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TRANSPARENCY 14-1

- h. Repeat Compression/
Breathing Cycle (do 4
cycles of 15
compressions and 2
breaths, recheck pulse
after 1 minute. If no
pulse, give 2 full breaths
and continue CPR)

C. EMERGENCY RESCUE EQUIPMENT

At a minimum, it is highly recommended that each housing unit contain a first aid kit, emergency rescue tool for cutting, latex gloves, CPR pocket mask, and other infectious disease equipment.

D. CAUTION

Only a physician or other professional as designated by state law can pronounce an individual dead. Until such time, standard first aid and CPR should be initiated and continued until staff are relieved by qualified medical personnel.

15. FOLLOW-UP: ADMINISTRATIVE REVIEW, PSYCHOLOGICAL AUTOPSY, AND SUPPORT FOR STAFF

Chapter 15-1

TRAINING ACTIVITIES

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TRANSPARENCY 15-3

Every completed suicide, as well as suicide attempt that requires hospitalization, should be examined both by an administrative review and/or psychological autopsy in an effort to reduce the likelihood of future incidents. All staff involved in the incident should participate in each process. Ideally, the reviews should be coordinated by an outside agency to ensure impartiality.

A. ADMINISTRATIVE REVIEW

--- An administrative review, separate and apart from other formal investigations that may be required to determine the cause of death, should include:

1. A critical review of the circumstances surrounding the incident;
2. A critical review of jail procedures relevant to the incident;
3. A synopsis of all relevant training received by involved staff;
4. Pertinent medical and mental health services/reports involving the victim; and
5. Recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures.

TRANSPARENCY 15-2

B. PSYCHOLOGICAL AUTOPSY

If resources permit, a psychological **autopsy is** recommended to clinically examine the inmate's suicide.

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Whereas jail staff may perceive the purpose of an administrative review as “pointing fingers” and ascribing blame, the psychological autopsy process provides the opportunity for learning, emotional support for staff, and a sense of closure to the incident. A major part of the process will be interviewing jail staff, correctional, mental health, and medical; inmates who had contact with the victim; and family members/friends of the deceased, if available and willing to participate. The following data collection guide is recommended for the psychological autopsy process.²⁸

1. Identifying data for the deceased (name, age, marital status, ethnicity, etc.)
2. Details of the death (method, date, time, location, how discovered and by whom)
3. Deceased’s history
 - a. Social history (including legal history, adjustment to incarceration, and family/peer relationships)
 - b. Psychiatric history (including any history of suicide attempts,

TRANSPARENCY 15-3

²⁸See Anthony Spellman and Barbara Heyne, “Suicide? Accident? Predictable? Avoidable?: The Psychological Autopsy in Jail Suicides,” *Psychiatric Quarterly*, Summer 1989, 60 (2), 182-183.

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- any recent mental health treatment, and mental status prior to death, if known)
 - c. Relevant medical history, if any
- 4. Pre-disposing factors
 - a. Demographic factors (age, sex, and history of suicide attempts)
 - b. Psychiatric treatment history
 - c. Personality style of the deceased
 - d. Role of alcohol and drugs in the deceased's life style and death
 - e. Death trends in the deceased's family (suicides, fatal illness, ages at the time of death)
- 5. Precipitants (recent changes or losses in the deceased's life)
- 6. Clues to suicide prior to the inmate's death
 - a. Behavioral changes
 - b. Affective changes

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TRANSPARENCY 15-4

- c. Direct and/or indirect suicidal communications
- d. Fantasies, dreams, and/or preoccupations relating to death
- 7. Reactions of staff to the inmate's death
- 8. Recommendations for enhancing screening, referral and treatment services (procedural changes, staff education and training, enhanced communication between mental health and correctional staff, etc.)

C. SUPPORT FOR STAFF

An inmate suicide can be extremely stressful for staff. Being involved in such an incident often makes the person feel alienated. They may become ostracized by fellow staff and administration officials. Following a jail suicide, misplaced guilt often is displayed by the officer who wonders - "What if I had made my cell check earlier?"

All staff, including correctional, medical, and mental health, need to be assured by administration officials that they should never feel the need to bear responsibility for an inmate's **decision** to take his/her life. Staff are only expected to take reasonable measures to protect the inmate from acting on that decision if the decision was known, or should have been known.

Jail administration, possibly with mental health staff, involvement, should discuss with concerned staff their feelings stemming from the tragedy. Recognition of staffs'

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feelings and giving them a chance to express themselves may be all that is necessary to ward off any long-term negative aftereffects. However, professional counseling services may have to be provided to staff (through employee assistance programs or private sources), as severe guilt sometimes results, remaining for years, and leaving lasting scars. Counseling and/or supportive services should also be provided to any inmate that is affected by a jail suicide.

TRANSPARENCY 15-5

In some jurisdictions, a *Critical Incident Stress Debriefing* (CISD) process has been established to respond to traumatic and fatal incidents within jail facilities. A trained CISD team, made up of law enforcement officers, paramedics, fire fighters, clergy and mental health professionals trained in crisis intervention and traumatic stress awareness, are called immediately and conduct staff debriefings within 24 to 72 hours of the incident. The debriefings, usually 2 to 4 hours in length, provide staff with the opportunity to process their thoughts and feelings about the critical incident, create an understanding of critical stress symptoms, and develop ways of dealing with those symptoms.

Supportive services, professional counseling, and/or CISD debriefing for all staff must remain totally confidential, as well as separate and apart from the investigative process and issues of liability.

In sum, despite our best efforts, suicides do occur and yet staff sometimes blame themselves for “not having done better.” These feelings need to be recognized and dealt with openly. The key is immediate encouragement and support from administration officials.

16. THE IMPACT OF JAIL DESIGN ON INMATE MANAGEMENT AND SUICIDE PREVENTION - PROTRUSION-FREE ARCHITECTURE AND ENVIRONMENT²⁹

Chapter 16-1

TRAINING ACTIVITIES

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TRANSPARENCY 16-1 A. JAIL DESIGN

Poor jail design and layout influence many jail suicides. The ability to adequately supervise and monitor jail inmates is greatly influenced by jail design and layout.

American Correctional Association (ACA) Standard 3-ALDF-2C-01 requires that all general population cells and segregation cells (3-ALDF-2C-12) provide a minimum of 80 square feet, of which 35 square feet is unencumbered space. ACA Standard 3-ALDF-3A-03 requires officers to be stationed inside or immediately adjacent to housing areas so that they can respond immediately to any emergencies. ACA Standard 3-ALDF-4E-24 requires that officers be able to respond to scene within four minutes of any health-related emergency.

Jail structure which dictates that officers cannot be deployed to meet the above standards increases the risk of suicides occurring. An officer who supervises 32 cells which are positioned off a long hallway, cannot possibly observe those inmates as closely as the officer who stands in one location, in a pod or module, and has a good view of 32 cells.

Further, officers working inside the pod or module of a new generation jail are more likely to know their inmates better than officers observing the inmates in a remote

²⁹A major portion of this chapter was derived from Randy Atlas, "Reducing the Opportunity for Inmate Suicide: A Design Guide," *Psychiatric Quarterly*, Summer 1989, 60 (2): 161-171. Additions and modifications were made by the authors.

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TRANSPARENCY 16-2

surveillance jail, from outside the living area. Hence, the former will be more likely to pick up on behavior changes more quickly and efficiently - an important factor in detecting potential suicides. Further, the officer in a new generation jail will more likely have a closer, more concerned, mutual respect relationship with inmates, considered an important factor in jail suicide prevention.

Many years of experience have clearly demonstrated that jails seldom have adequate staff to provide the constant supervision needed for potentially suicidal inmates. It is, therefore, incumbent upon governmental financing and criminal justice bodies to see that jails, when *built*, will facilitate the most effective supervision possible of inmates. Proper jail design and construction do affect the incidence of jail suicides and costly lawsuits.

Further, with rising jail populations, proper jail design will permit inmates to be supervised more effectively, with proportionately fewer staff.

B. PROTRUSION-FREE ARCHITECTURE AND ENVIRONMENT

As a suicide prevention measure, the jail should make every effort to remove easy-access protrusions from cells and rooms. While it is more common for anchoring devices to be affixed to bars and grilles, *all* fixtures should be given attention, since beds, shelves, sprinklers, door handles, towel racks, water faucet lips, and ceiling lights have been used for this purpose. (Caution: Even in “suicide-resistant” cells, inmates have committed suicide through imaginative

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TRANSPARENCY 16-3

means, e.g., stuffing nose and throat with toilet paper, etc. Therefore, complacency should not accompany a facility with protrusion-free architecture.)

Since architecture plays an important role *in* the prevention of jail suicides, the following are certain aspects of the physical environment which should be addressed:

- 1) Avoid Isolation. Two of every three suicides occur in isolation. If specially-designed cells are utilized, there should be maximum staff supervision.
- 2) Special Management Units, Cells or Rooms (For Potentially Suicidal and Mentally Ill Inmates), Administrative Segregation and Holding Cells
 - a. Walls and doors constructed of steel bars should be covered on the inside from floor to ceiling with:
 - (1) One-fourth-inch scratch-resistant polycarbonate glazing, or
 - (2) Security screen or thin steel plate, with holes no more than 3/16 inches wide, or 16-mesh per square inch.

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This allows good ventilation, better noise and voice pickup and clear closed-circuit TV camera observation.

- b. Solid wall ceil fronts and doors (or those with peep holes) should be changed to large-vision panels of low-abrasion polycarbonate.
- c. Modify existing vents, ducts, grilles, light fixtures and any other protrusions with security screen, as outlined above.
- d . Ball-in-socket type clothing latches which cannot be jammed to be made rigid, should be used. The traditional, pull-down latch with side supports can be jammed and should not be used. Neither should U-shaped towel racks, which are also used as anchoring devices.
- e. A stainless steel combo toilet-sink, without the curved projection over

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TRANSPARENCY 16-4

the water spout, and with concealed plumbing and outside control valve, should be used. The sink section should not contain an anti-squirt slit, since suicide attempts have occurred when inmates have utilized this device as an anchor. Remove toothbrush holder.

- f. Beds should be a solid concrete slab with rounded edges or heavy molded plastic, totally enclosed underneath.³⁰

Typical steel beds with holes in the bottom, not built flush to the wall and open underneath, have often been used as anchoring devices. Lying flat on the floor, the inmate attaches the noose from above, runs it under his neck, turns over on his stomach and asphyxiates in up to 13 minutes.

- g. There should be no electrical outlets in the cells or rooms.

³⁰ Rooms or cells used for restraining inmates with four-point restraints should have beds built low to the floor with hitching rings or eye bolts anchored at floor level.

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- h. Light fixtures should be recessed in the ceiling and be tamper-proof. Some fixtures can be securely anchored in ceiling or wall corners when remodeling prohibits recessed lights.

Ample light for reading, at least 20 footcandles at desk level, should be provided. Low-wattage night light bulbs should be used, except in special, high-risk suicide units where sufficient lighting 24 hours per day should be provided to allow closed-circuit TV cameras to pick-up all movements and forms.

An alternative is to install an infrared filter over the ceiling light to produce total darkness, allowing inmates to sleep at night. Various cameras are then able to have total observation as if it were daylight. This filter should be used only at

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night because sensitivity can otherwise develop and produce aftereffects.

- i. Cells and rooms should be painted in pastel colors, not only for their psychological effect, but to make closed-circuit TV camera monitoring easier. To reduce camera glare and provide a contrast in monitoring, the headers above cell doors should be painted black or some other dark color.

Rooms should have a smoke detector mounted flush in the ceiling, with an audible alarm at the control desk. Water sprinklers in jail cells should not be exposed. Some have protective cones; others are flush with the ceiling and drop down when set off; some are the breakaway type.

TRANSPARENCY 16-5

- k. Rooms should have an audio monitoring intercom for listening to calls of distress. For

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suicide watch
purposes, intercoms
should be turned up
high as hanging
victims can often be
heard to be gurgling,
gasping for air, body
hitting the wall or bars,
etc.

- l. A suicidal observation room or housing unit should be located as near as possible to a control or nursing station to allow for good audio and visual monitoring.
- m. Modesty shields or screens should (1) have triangular, rounded or sloping tops to prevent noose-anchoring and', (2) allow visibility of the feet.
- n. Some inmates hang themselves under desks, benches, tables or stools/pull-out seats. Suicide-resistant remedies are: (1) Extending the bed slab for use as a seat; (2) Cylinder-shaped concrete seat anchored to floor, with rounded edges; (3) Triangular

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corner desk top
anchored to the two
walls; and (4)
Rectangular desk top,
with triangular end
plates, anchored to the
wall, thus preventing a
noose from being
attached.

0. All shelf tops and
exposed hinges should
have solid, triangular
end-plates, which
preclude a noose being
applied.

TRANSPARENCY 16-6

- p. It is preferred that
suicide cells have
security windows with
an outside view. The
ability to identify time
of day via sunlight helps
reestablish perception
and natural thinking
and minimizes dis-
orientation.
- q. The mattress should be
fire retardant and not
produce toxic smoke.
The seam should be
tear-resistant so that it
cannot be used as a cord
for hanging.
- r. Mirrors should be of
brushed, polished
metal, attached with

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tamper-proof screws,
not glass or plastic
(which can be melted
and broken).

- s. **A** computer logging system that records with a plastic key or credit-card type verifier at each door of suicide cells visited, should be implemented. The result is a paper printout of time and location of the supervision. This non-tamperable documentation is critical in the successful defense against a lawsuit.
- t. Padding of walls is not allowed in many states. If permitted, padded walls must be of fire-retardant materials' that are not combustible and do not produce toxic gasses.

3) **General Jail Population Sleeping Areas**

Many of the recommendations made for special management, administrative **segregation and holding** cell inmates also apply to general population inmates.

Correct construction of new facilities to make the sleeping areas suicide-resistant in the first place - no

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TRANSPARENCY 16-7

bars, properly-spaced air grille openings, ball-in-socket clothes latches, tamper-proof lights, un-exposed water sprinklers and solid concrete or molded plastic beds - would be no more costly than constructing the same facility in the old, non-suicide-resistant way, and is, in fact, less expensive than having to *change* new jails initially built the wrong way. (Many jails have learned this the hard way, especially following a lawsuit.) Since some of the suicides in general inmate populations can be prevented by taking away easy access to fixtures in which nooses can be affixed, some jails have made physical modifications in general inmate population housing areas. General inmate population cells/rooms can have porcelain sinks and toilets with concealed piping.

4) **New Construction: Special
Management Units, Administrative
Segregation and Holding Areas**

In addition to physical environment modifications **for** existing structures, outlined earlier, the following **guide** should be considered for cells and rooms.

- a. New facilities should meet the ACA's ***Standards for Adult Local Detention Facilities.***
- b. Doors should be a sliding metal type to reduce the opportunity of barricading and

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PRESENTATION GUIDE**TRANSPARENCY 16-8**

slamming the door into the officer's face. The upper half should have a polycarbonate viewing panel that provides a clear, unobstructed view of the room or cell. An alternative is to use detention screening which allows circulation and also allows officers to better hear in-cell noises.

- c. Ceiling height should be 10 feet to minimize the accessibility of the individual to the light fixture.
- d. The floor surface should be non-slip, treated concrete. No tile, or any surface that can be removed, should be used.
- e. A secure floor drain should be placed at a low slope in the floor to facilitate regular cleaning and hosing. Floor drains should have small holes no more than 3/16 inch diameter.
- f. Corners of walls in floor and ceiling of cells

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- should have rounded edges for sanitary and safety reasons.
- g. Joints at the ceiling should be sealed with neoprene rubber to prevent gouging plaster between walls for the purpose of anchoring a hook through the wall and attempting a hanging.

17. CONTROVERSIAL ISSUES IN SUICIDE PREVENTION

Chapter 17-I

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TRANSPARENCY 17-1

Professionals in the field have mixed feelings about different suicide prevention approaches which agencies are following. Some of these various approaches are:

A. CONTRACTS NOT TO COMMIT SUICIDE, WITH THE PROMISE THAT TREATMENT WILL BE PROVIDED

Some correctional and mental health agencies develop contracts with potentially suicidal inmates promising them that counseling services will be provided. Contractors report good success with the concept, but a danger is that some workers, wittingly or unwittingly, may not always keep their promises of timely service delivery. “Kept promises” is of vital importance to the potentially suicidal inmate.

Another danger is that the potentially suicidal inmate may misinterpret the intent of contract language. An example of one Contract: “I agree not to commit suicide during the period of time that counseling services are being provided.” Some experts feel that this leaves an impression with the inmate that the **agency’s primary** concern centers on the service delivery period only, and committing suicide thereafter is an acceptable option.

In addition, once an inmate becomes acutely suicidal, their written or verbal assurances are no longer sufficient to counter suicidal impulses.

Many mental health agencies encourage therapists to make a “no-suicide contract” and to document the contract in a treatment record. This is thought by many to

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provide a safeguard against liability in the event of a death. In truth, however, both plaintiff and defense counsel agree that a no-suicide contract does not provide the therapist with sufficient legal protection.

In sum, there is no harm in utilizing contracts as a therapeutic measure as long as the contractor does not succumb to the illusion that the contract is likely to prevent a suicide.

B . STRIPPING POTENTIAL SUICIDAL INMATES NAKED

Some jails strip potentially suicidal victims of all their clothes and isolate them. (Various jail and mental health personnel stress that placing a suicidal inmate in conditions of confinement worse than experienced by the general inmate population can result in the inmate not discussing his/her suicidal intentions and falsely showing an appearance of “getting well fast” in order to escape the degrading conditions of isolation and stripping of clothes.) Experts uniformly agree that this practice is very degrading and worsens feelings of depression. Although paper gowns and/or blankets are often provided to inmates stripped of their clothing, these measures are still insufficient without proper observation. More appropriate measures would be to provide constant or close supervision, place inmates in a “suicide-resistant” room with supervision, or place them with two or more trusted inmates (with staff supervision).

TRANSPARENCY 17-2

Further, *“less attention should be paid to physically restricting him from suicide by removal of all potential suicide implements and more attention should be paid to*

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providing essential human interaction with staff or other inmates, to hopefully provide alternative solutions and services.”³¹

C. USING CLOSED CIRCUIT TELEVISION (CCTV) AS THE MAJOR MONITORING INSTRUMENT AND “PUTTING THE SUICIDAL INMATE ON CAMERA VIOLATES HIS RIGHT TO PRIVACY”

Experience has clearly shown that CCTV should be used Only as a supplement to staff supervision.

One jail inmate died as the camera was photographing him for 85 minutes. Other, less dramatic suicide deaths have occurred while officers were watching but not really “seeing” what was on camera. Various officers report suffering from “monitor hypnosis” or burnout. Some jails limit the number of hours that any one officer can watch the monitor and rotate staff during a single shift. From many jail surveys, it is learned that CCTV reception is often fuzzy, equipment breakdowns are common, and numerous other officer duties cause distractions and, consequently, only intermittent monitoring.

If CCTV is utilized, it is highly recommended that an officer and/or dispatcher not be assigned to watch the monitor for more than one hour without being relieved by another staff member.

³¹K. Scott Denoon, B.C. Corrections, *A Study of Suicides, 1970-1980*, British Columbia, Canada: Ministry of Attorney General, Corrections Branch, 1983, p. xxiv.

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Various jails report that they do not use any CCTV for monitoring suicidal inmates, as they assume that it is illegal, or carries liability. This is a common misconception. As long as there is a written policy regarding its use and duration, CCTV is permitted in specific situations (e.g., suicide prevention). The jail's duty of care regarding life safety takes priority over the inmate's right to privacy. In addition, two-way audio monitoring systems are recommended by most national correctional standards and are often more effective than CCTV in detecting suicide attempts.

REMEMBER: CCTV and audio monitoring do not *prevent* jail suicides, they only **identify** a suicide attempt in progress. In fact, the mere presence of CCTV may encourage suicidal or other acting-out behavior, particularly with manipulative inmates.

D. RATING SCALES

Various facilities use a numerical scale to rate signs and symptoms of potentially suicidal inmates. When the number of points indicates that an inmate might be a potential suicide risk, he/she is assigned to the correct risk level of monitoring or supervision.

TRANSPARENCY 17-3

Some experts are suspicious of this approach, stressing that no one is skillful enough to precisely determine levels of potential lethality.. Further, this approach violates the principle that all threats of suicide must be taken seriously. Does one rate the ninth “wolf-cry” the same as the first? Various lawsuits existed because the so-called “manipulation” was not taken seriously.

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If is recommended that jails allow their officers wide discretion in referring all potentially suicidal inmates (and not just those meeting rating scale criteria) for assistance/surveillance (see Appendix D).

E. SUICIDE PROFILES: THE “TYPICAL” SUICIDE - DOES IT EXIST?

Jail administrators and other personnel must exercise caution when making decisions on suicide detection based on the “paper profile.” What is said and done by the inmate at arrest and while being transported is of prime importance. Equally important is the behavior and mood the inmate exhibits at booking and during confinement.

Further, properly trained booking officers, because of their *awareness* training in signs and symptoms of suicide, can combine their assessment process with the more common paper profile elements. Officers and mental health clinician& can thus rely upon their own local/regional profile of suicide characteristics that seem to fit into a pattern.

From our own experience, few cases exhibit *all* signs and symptoms. While all cases exhibit various signs and symptoms, there is no “typical” case. Hence, to be sure, each case must be considered unique in its combination of factors.

NCIA’s suicide victim profile and subsequent national research was not meant to be a death certificate of all inmates that commit suicide in our nation’s jails. The profile’s intent is meant to *sensitize* jail personnel to those

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characteristics appearing most often in jail suicide victims. When utilized in *conjunction* with staff training/awareness and intake screening, a victim profile can be a valuable *supplementary* tool in jail suicide prevention.

TRANSPARENCY 17-4 F. POLICY ON “NEVER ENTER A CELL WITHOUT BACKUP”

The policy at many jails is that an officer is never to enter a cell or room without backup support. Many suicide prevention experts support a more flexible policy, which various jail administrators have set down, that allows the officers to use their judgment. “Is the inmate faking and planning an escape?” -If hanging with his/her feet off the floor, there should be no doubt that this is a suicide attempt. If, however, the inmate is sitting or kneeling on the bottom bunk, it could be a different situation. He/she could be faking an attempt. However, don’t be misled into believing that hanging attempts only occur when the body and/or feet are off the floor. Numerous suicides occur in the sitting and/or kneeling position.

What happens in the majority of jails where only one dispatcher-jailer is on duty? Does the individual wait for five to ten minutes for backup support, e.g., a deputy sheriff or patrol officer to arrive from the streets? If so, it can mean that the court will find the officer and/or jail administrator liable for the death of the inmate in a suicide. In one-jailer facilities with the inmate hanging on the front cell bars, an officer can check the victim’s vital signs and at least begin life-saving measures (e.g., loosening/removing the noose) from outside the cell before arrival of back-up staff.

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Some jails authorize officers to act quickly, lock down all of the inmates except one or two who may help to either hold up the body or remove the noose.

Even before going into the cell or room, the officer can push a body sensor to alert another source that there is an emergency. If a wrong judgment on the situation is made, chances are that backup support will still arrive in time to provide assistance.

G. PROTECTING THE SCENE OF THE CRIME

Various jails still have policies which require that “the crime scene be preserved.” This has meant that some inmates continued to hang and die while orders were given not to touch anything until after photographs were taken. Needless to say, preserving life comes first, and agencies which place “preserving-the-scene-of-the-crime” policies first can be expected to lose in court. In fact, the failure to cut down a hanging victim upon the belief that the “crime scene” was being preserved may persuade a fact-finder that the officer was indifferent or lacked training.

H. WHEN NO VITAL SIGNS EXIST, PRESUME THAT DEATH HAS OCCURRED

There have been a number of cases in which, without vital signs, cardiopulmonary resuscitation (CPR) was never started. Apparently, those officers did not know that the purpose of CPR is to reestablish vital signs -to “get life started again.” Many persons once presumed to be “dead bodies” are alive today because CPR was started on them immediately.

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There are other instances in which CPR is not started because staff fear the victim might also suffer from an infectious disease, including AIDS. (This issue is addressed in Chapter 14 and includes the recommendation that all housing units should be equipped with CPR pocket masks, latex gloves, and other appropriate infectious disease equipment.)

TRANSPARENCY 17-5

REMEMBER: Only a physician or other professional as designated by state law can pronounce an individual dead. Until such time, standard first aid (including CPR) should be initiated and continued until staff are relieved by qualified medical personnel.

I. “DON’T TALK WITH INMATES”

Various jails have long-outmoded policies which discourage talking with inmates, or “fraternization.” They are told, in effect, to “just do your job - guard.” While such policies may have some positives, it is primarily a negative philosophy which cannot possibly help prevent suicides and, in fact, could be a contributing factor in a suicide. Further, some jails with this philosophy utilize an informant or “snitch” system which breeds paranoia among inmates and discontent between staff and inmates.

Good communication between officers and **inmates** is considered one of the most important factors **in suicide** prevention. In facilities where the inmate code of silence is not present, the inmate population often alerts staff to suicide attempts.

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PRESENTATION GUIDE**J. USING CITIZEN VOLUNTEERS AND INMATES FOR SUICIDE WATCH****1) Volunteers**

Various jails, both large and small, use *trained* volunteers for suicide watches and laud these efforts. One small town police chief said that his Neighborhood Crime Watch group, “Concerned Citizens,” provided a 24-hour suicide watch whenever needed. Yet, for a variety of stated reasons, most jails still refuse to use volunteers. Some of the stated reasons are:

- a. They are hard to recruit;
- b. You cannot always count on them; and
- c. “We’re afraid of the liability issue.”

However, experience has shown that, whenever a jail volunteer program is supported by *top administration*, it rarely ever fails. One-fourth of county jails use volunteers on one level or another. They are relatively easy to recruit when respected citizen *groups* in the community are approached. These groups do the volunteer screening, help with training, and assist in monitoring volunteer activities and progress.

From a liability standpoint, various jurisdictions define volunteers as unpaid staff and include them in insurance coverage.

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TRANSPARENCY 17-6

2) Inmate Watchers

Properly selected and trained inmates are serving as suicide watchers in various large and small jails, including New York city's Riker's Island jails, Alaska facilities, and various prisons within the Federal Bureau of Prisons (FBOP) system. However, various other FBOP facilities, as well as most jurisdictions, do *not* utilize inmate companions, citing philosophical or ethical problems, liability concerns, or security considerations. Other jail administrators cite problems of reliability and relaxation of staff responsibilities for inmate safety.

In those facilities that utilize the concept, inmate watchers generally number two or more. They are not usually stationed in the same cell or room with the suicidal inmate, but out in front, across the hall, or next door; viewing the suicidal inmate through a large polycarbonate panel. Ideally, inmate watchers do *not* exercise any kind of control over the potentially suicidal inmate. Rather, on a prearranged basis, they notify staff of any unusual circumstances. Officials utilizing the system report no harassment of the inmate watcher or companions, and the traditional inmate code of silence is not present. One large jail reported that use of inmate watchers eliminated the need for stripping, isolation, and restraints.³²

Realistically, inmates in dormitory settings have probably been the single greatest jail suicide prevention

³²See *Jail Suicide Update*, Fall 1990, 3(2):3

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factor for decades, although unknown to many of us. The presence of another person has always been a deterrent to suicide, as it is a very private matter. Since two-thirds of jail suicides occur in isolation, *the potentially suicidal inmate should probably not be removed from the general inmate population in the first place*, except under circumstances or conditions outlined earlier in this manual.

NOTE: Contact your city/county attorney regarding advice on liability issues surrounding use of either citizen volunteers and inmate watchers/companions. See also, for example, *Natriello v. Nynn* in Appendix E. Remember, national correctional standards do not specifically address the issue of utilizing non-staff resources for the supervision of suicide watch inmates. If utilized, written policies and procedures should be developed for the use of both citizen volunteers and/or inmate watchers/companions. Their selection and training should be incorporated into the total operation of a facility.

18. JAIL SUICIDE LITIGATION

Chapter 18-1

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TRANSPARENCY 18-1 A. OVERVIEW

Suicide prevention in our nation's jails takes many forms. Ironically, chief among them is litigation. As the number of jail suicides increase, so do the number of lawsuits. Twenty years ago, it was unusual for a jail to be sued for negligence and/or deliberate indifference following a suicide. Today, it is unusual if a suit is not filed. And while at the same time both state and federal courts are making it increasingly difficult to hold public officials, jail administrators and personnel liable for jail suicide, these same courts are requiring a higher standard to operate a constitutional jail. Further, as with most litigation, the vast majority of jail suicide cases culminate in out-of-court settlements, in sums ranging from \$24,000 to \$2.4 million. Such cases also usually result in improved jail conditions. Litigation has, therefore, played a significant role in jail suicide prevention.

Further, even when a jurisdiction is found **not** to be liable for a jail suicide, improved suicide prevention measures often result. For example, the defendants in ***Tittle v. Jefferson County*** [10 F. 3rd 1535 (11th Cir. 1994)] were ultimately found not liable for allowing exposed window pipes to continue to exist **in** their facility, resulting in numerous suicide incidents, yet eventually covered up the pipes in question, as well as updated intake screening and staff training policies.

Simply stated, a correctional officer has a duty to protect an inmate from any harm which the prisoner may inflict upon him/herself when such harm is reasonably

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foreseeable. This duty includes preventing the inmate from committing suicide. Breach of this fundamental principle of American common law will subject the negligent party for damages in a *Tort Action*, absent some state law barring such liability.

TRANSPARENCY 18-2

In a *Civil Rights Action*, a correctional officer who is “deliberately indifferent” to the mental health and protection needs of an inmate whom the officer knows (or should know) to be suicidal violates the constitutional rights of that inmate. Breach of this constitutional duty may expose the officer to damages under Title 42, United States Code, Section 1983, **as** well as to remedial court injunctions issued under the same statute.

In jail suicide litigation, it is far easier to state a claim of negligence to a tort action than a claim of deliberate indifference to a civil rights action. Plaintiffs have been successful in some Tort Actions filed in state courts on negligence grounds. However, in Civil Rights Actions in federal courts, there is no longer a controversy over whether negligence on the part of jailers which causes the death of an inmate states a cause of action under Section 1983.

Courts have recently ruled that mere negligence is an insufficient claim under Section 1983 and have required a showing of gross negligence or “*deliberate indifference*” to the need for precautions against suicide. The deliberate indifference standard, first utilized in *Estelle v. Gamble* 429 U.S. 97 (1976) is applicable to

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plaintiff claims of denial of medical care and other failures to protect inmates' health and safety. Courts are ruling that the deliberate indifference standard is met only if there is a **strong** likelihood, rather than a mere possibility, that failure to provide care would result in harm to the prisoner. **As** previously stated in Chapter 1, both jail officials and staff can be found liable under Section 1983 when:

- 1) The inmate had threatened or attempted suicide;
- 2) The threat/attempt was known to staff; and
- 3) Sufficient efforts were not made to protect the inmate.

Addressing the deliberate indifference standard, recent U.S. Supreme Court decisions in non-jail suicide cases have stated that there is no liability under Section 1983 for negligent acts by officials which result in unintended injuries to life, liberty or property. It seems implicit from these decisions that mere negligence, or inadvertent failure to protect a detainee's health and safety, does not rise to the level of a constitutional violation, and that a heightened standard of culpability is required in civil rights litigation in general, and jail suicide cases in particular.

Farmer v. Brennan (114 S.Ct. 1970 (1994)) is the Supreme Court's most recent decision regarding deliberate indifference. Issued in June 1994, the Court stated that:

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"We hold that a prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."

Other federal courts have also ruled that a claim of deliberate indifference can also prevail by revealing a *pattern of failure*. Plaintiffs will attempt to establish that the alleged violation(s) were not the result of a single event, but represented a continuing pattern of misconduct. Often, non-compliance with state *or* national standards and/or prior suicides will be utilized in the plaintiff's argument. In regard to standards, one court ruled that: "Although failure to comply with non-enforceable, recommended standards may not be a *prima facie* basis for liability, evidence of the existence of such standards is admissible to show a knowledge of existence or risk and a measure of actions of a reasonable man, or of custom." - *Falkenstein v. City of Bismarck* [268 N.W. 2d 787 (N.D. 1978)].

With regard to a pattern of prior suicides, another court, in reviewing the incidence of 20 suicides in one jail system over a six-year period, stated that: "If a city

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cannot be held liable when its policy makers had notice of a problem and failed to act, then it is difficult to posit a set of facts on which a city could be held liable to have *been* deliberately indifferent.” - *Simmons v. City of Philadelphia* [947 F. 2d 1042 (3rd Cir. 1991)].

TRANSPARENCY 18-3

In addition, claims of gross negligence or deliberate indifference have also been associated with a “policy or custom” in jail suicide litigation. Policies may be formally adopted by state, county or city policy-making officials who have a responsibility for jails. Where formal policies do not exist, the legal system relies upon custom and practice, in the form of actions and inactions of policy-making personnel. After establishing the existence of a policy or custom based on failure to correct unconstitutional conditions (e.g., lack of health screening, grossly inadequate monitoring and lack of training of officers insuicide prevention), the plaintiff must then prove that the violation of rights (e.g., inadequate care and treatment) was a reasonably *foreseeable* consequence of the inaction and that the failure to act was the proximate cause of the suicide.

In jail suicide litigation, plaintiffs will argue, with mixed results, that maintaining inadequate training and supervision, deficient jail conditions, overcrowding, insufficient staff, and a lack of written rules and procedures to screen and monitor potentially suicidal detainees fall within the purview of “policy or custom.”

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B. JAIL SUICIDE LITIGATION: CASE LAW REVIEW

Please refer to Appendix E for summaries of 13 selected court cases pertaining to jail suicide litigation.

TRANSPARENCY 18-4 **C. PRO-ACTIVE ADMINISTRATION**

The capable, pro-active jail administrator provides leadership in avoiding liability when staff: follow their job descriptions; carry out established policies and procedures; utilize their professional training; and reasonably control negative attitudes, biases, and prejudices so that their duty of care can be properly administered. It has long been generally accepted that no agency or organization will be any better than the capability of its leader. In the field of corrections, most experts agree that litigation can be successfully thwarted by the pro-active attitude and actions of the administrator. As one sheriff bluntly stated following several suicides in his facility: "Inmates are human beings and we were taught an important lesson through those deaths. *We simply will not tolerate it anymore.*"

19. CONCLUSION

Chapter 19-1

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TRANSPARENCY 19-1

Experience has clearly demonstrated that almost all jail suicides can be prevented if recognized standards and practices are followed.

The key suicide prevention factor in custodial facilities is capable, properly trained correctional, mental health, and medical staff. However, such a system cannot exist without capable, pro-active administration and effective supervisors.

Recognized national and state correctional standards, practices, and court decisions require that written policies and defined procedures - *a written plan* - be in place for jail suicide detection and prevention, including:

- 1) *Staff training* - provisions for staff training on the procedures for recognition, supervision, documentation, and handling of. potentially suicidal inmates, as well as all elements of the suicide prevention plan.
- 2) *Identification/Screening* - procedures for intake screening to identify potentially suicidal inmates and procedures for referrals to available mental health officials.
- 3) *Staff Communication* - procedures for communication of information relating to potentially suicidal inmates between staff members.

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- 4) ***Housing*** - procedures for the assignment of potentially suicidal inmates to appropriate housing.
- 5) ***Supervision*** - provisions for adequate supervision of potentially suicidal inmates and procedures for documenting supervision.
- 6) ***Intervention*** - procedures for staff intervention prior to the occurrence of a suicide and during the progress of a suicide.
- 7) ***Reporting*** - procedures for reporting of potential, attempted, and completed suicides to appropriate outside authorities and victim family members.
- 8) ***Follow-up/Review*** - procedures for follow-up and review by the administrator (sheriff or police chief) or designee with jail staff and mental health/medical officials of all potential, attempted, and completed suicides.

TRANSPARENCY 19-2

A common rule that jail administrators should heed is that “one suicide demands measures to prevent the next one.” The wise, pro-active administrator, however, goes further: Suicide attempts demand measures to prevent the first actual suicide.

The Success Formula - When recognized standards and practices are pursued and followed, it can be expected

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that “Almost ALL Suicides in Jails and Lockups Can Be Prevented If. . .” -with one of the most important “ifs” in suicide prevention being *human interaction*. This should be initiated by jail officers who have received “awareness” training in suicide prevention and follow the Golden Rule - “treat others as you would want to be treated.”

In closing, Edwin Shneidman, an eminent psychologist and founder of the American Association of Suicidology, put the issue into proper perspective when he stated - “Suicide is not some bizarre and incomprehensible act of self-destruction. Rather, suicidal people use a particular logic, a style of thinking that brings them to the conclusion that death is the only solution to their problems. This style can be readily seen, and there are steps we can take to prevent suicide, if we know where to look.”

The most effective tools we have to help us “know where to look” in preventing jail suicides are *human interaction* and *training*.

³³Edwin Shneidman, “At the Point of No Return,” *Psychology Today*, March 1987, 56

APPENDICES

- A. Sample Arrestee Medical Clearance
F o r m
- B. Sample Receiving Screening Health
Form for Arrestees Held in Jails
and Lockups
- C. NCIA's Sample Intake Screening
Form
- D. Suicide Prevention Screening
Guidelines
- E. Jail Suicide Litigation: Case Law
Review
- F. Bibliography
- G. Transparencies (Optional
Enclosure)

APPENDIX A

APPENDIX A

SAMPLE ARRESTEE MEDICAL CLEARANCE FORM*

NAME OF ARRESTEE: _____

BROUGHT INTO JAIL BY: _____

DATE: _____ TIME: _____

We have declined to accept the above-named arrestee into the jail, pending medical clearance, for the following reason(s):

_____/_____/_____
Signature of Jailer Date Time

NAME OF EXAMINING PHYSICIAN: _____

DISPOSITION (Check appropriate space):

- ☐ I have examined the arrestee and find him/her acceptable for admission to the jail. I have no specific suggestions regarding care of this arrestee for the condition for which I have examined him/her.
- ☐ I have examined the arrestee and find him/her acceptable for admission into the jail. I suggest treatment for the arrestee's condition as described below.
- ☐ I have examined the arrestee and find him/her acceptable for admission into the jail providing the following conditions are met.
- ☐ I have examined the arrestee and find him/her medically unacceptable for admission into the jail.

PHYSICIAN'S REMARKS:

_____/_____/_____
Signature of Physician Date Time Telephone Number

APPENDIX B

APPENDIX B

SAMPLE RECEIVING SCREENING HEALTH FORM FOR ARRESTEES HELD IN JAILS AND LOCKUPS*

Arrestee: Name/Number: _____

Jailer/Examiner's Name: _____

ARRESTING/TRANSPORTING OFFICER INFORMATION:

(CHECK)
YES NO

1. Did officer detect any suicidal signs/symptoms (if yes, check to right and specify under REMARKS) ☐ ☐
2. Were any other health problems noted? ☐ ☐

EXAMINER'S VISUAL OPINION:

- | | | |
|--|--------------------------|--------------------------|
| 3. Does arrestee have obvious pain or injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is there obvious sign of infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Appears to be under the influence of alcohol or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are there visible signs of alcohol and/or drug withdrawal? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does arrestee appear to be suicidal, e.g., despondent, depressed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Appears to be irrational, mentally ill, "crazy?" | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Behavior suggests risk of assault? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Appears to be mentally retarded? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Is arrestee small, frail, seemingly weak? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Appears to be gay, effeminate? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Appears to be naive, unsophisticated? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Is carrying medication or reports being on medication? | <input type="checkbox"/> | <input type="checkbox"/> |

ARRESTEE QUESTIONNAIRE:

YES NO REFUSED

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 15. Presently taking any medication? If yes, for what? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Use alcohol? If yes, how often? _____ How much? _____
When drunk last? _____ When last drink? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Use any street drugs? If yes, what type(s)? _____ How often? _____
When was last high? _____ When last drugs taken? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Is this the first time you have ever been jailed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever thought about or attempted to commit suicide?
(If yes, check to right and specify under REMARKS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have any serious medical or mental problems now?
(If yes, check to right and specify under REMARKS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you had any previous mental or emotional problems? If yes, were you ever hospitalized for those problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. If <u>female</u> , are you pregnant? If yes, months? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Are you on any special diet? (If yes, indicate under REMARKS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Is there anything special that we should know about you for your welfare or protection? (If yes, check to right and indicate below) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

REMARKS: _____

DISPOSITION OR REFERRAL TO: (Please check applicable response(s).*

- ☐ Emergency care (where?): _____
- ☐ General population
- ☐ Close supervision, e.g., potential same-sex rape victim
- ☐ Sick call
- ☐ Placed in one-person cell (____) (for communicable disease cases)
- ☐ Placed in suicide-resistant observation room under *constant* supervision (high risk suicide case)
- ☐ Placed in two- or more-person cell or dormitory (____) under special/close observation (suicidal inmate)

NOTE: All "YES" answers require documented action: See "Guidelines for Disposition"

*Each department/facility should modify the disposition checklist in accordance with its own resources and procedures. The above depicts a model approach under recognized practices.

Original form developed by American Medical Association Jail Project (1977); later revised by American Health Care Consultants (1982) and National Commission on Correctional Health Care, all of Chicago; form was further revised by Juvenile and Criminal Justice International (1988), Roseville, Minnesota.

SAMPLE RECEIVING SCREENING GUIDELINES FOR DISPOSITION

1. SIGNS AND SYMPTOMS OF SUICIDAL BEHAVIOR (Observed by Arresting/Transporting Officer)

- Symptoms:
- | | |
|-------------------|----------------------------------|
| a. Depression | f. Bizarre Behavior/Paranoia |
| b. Crying/Tearful | g. Noticeable Scars |
| c. Intoxicated | h. Talks About/Threatens Suicide |
| d. Scared | i. Hopelessness/Helplessness |
| e. Embarrassed | j. Previous Suicidal History |

Disposition: Depending upon severity, take to hospital/mental health provider for assessment; alert jail staff upon arrival at facility.

2. OTHER HEALTH PROBLEMS (Observed by Arresting/Transporting Officer)

Symptoms: See # 3,4,6,20 and 22.

Disposition: Take to hospital, obtain medical clearance.

3. OBVIOUS PAIN/INJURY (Trauma/Serious Illness)

- Symptoms:
- | | |
|--------------------------|--|
| a. Obvious pain | d. Profuse sweating |
| b. Significant bleeding | e. Extreme breathing difficulty |
| c. Untreated fracture(s) | f. Significant vomiting and/or visible signs of trauma/serious illness |

Disposition: Take to hospital (unless just minor vomiting or sweating associated with drug or alcohol use).

4. OBVIOUS SIGNS OF INFECTION (Possible Communicable Disease/Extreme Skin Condition)

- Symptoms:
- | | |
|-------------------------|---|
| a. Obvious fever | f. Uncontrolled vomiting |
| b. Swollen lymph nodes | g. Diarrhea/cramps |
| c. Jaundice/yellow skin | h. Extreme weakness |
| d. Chronic cough/phlegm | i. Evidence of infection which might spread to others and/or skin in extremely poor condition, e.g., rash, sores, spots, scabs. |
| e. Respiratory distress | |

Disposition:

a. Isolate
b. Take to hospital/clinic

5. UNDER INFLUENCE - ALCOHOL/DRUGS

Symptoms: Appears to be under the influence of alcohol, barbiturates, heroin or any other drugs:

- | | |
|-------------------------|------------------------------------|
| a. Slurred speech | d. Dilated pupils |
| b. Unsteady walk | e. Vomiting, sleepy or hyperactive |
| c. Confused/disoriented | f. Eyes "blood shot"/red |

Disposition:

a. Preferably, do not admit	c. If subject must be admitted, seek medical clearance first
b. Refer to detoxification	d. Keep under observation

NOTE: Vomiting is not uncommon for persons under the influence of alcohol/drugs and does not necessarily require a referral to hospital as for other conditions.

6. WITHDRAWAL

Symptoms: Visible signs of alcohol and/or drug withdrawal

- | | |
|--------------------|---|
| a. Sweating | e. Delirium |
| b. Severe shaking | f. Hallucinations |
| c. Nausea/vomiting | g. Serious breathing difficulties or decreased level of consciousness |
| d. Pinpoint pupils | |

Disposition: Take to hospital or detox center

7. DESPONDENT/DEPRESSED (Potential Suicide)

Symptoms:

- a. Appears to be despondent/depressed
- b. Intensely guilty or shame ridden/remorseful/self condemning
- c. Bereaved
- d. Withdrawn/silent
- e. Loss or increase of weight and/or appetite
- f. Sleep problems
- g. Mood variations
- h. Lethargy

Disposition:

- a. Constant staff supervision (for high risk)
- b. If totally suicide-resistant observation room is unavailable, house with selected, trained inmates
- c. Refer for mental health services

8. IRRATIONAL BEHAVIOR/MENTAL ILLNESS

Symptoms: Appears to be out of touch with reality:

- a. Hearing voices
- b. Hallucinating
- c. Withdrawn/non-communicative
- d. Displays some form of erratic behavior

Disposition: Follow Departmental/ Agency General Order: "Handling Persons in Need of Mental Treatment"

9. ASSAULT POTENTIAL

Symptoms:

- a. Behavior during arrest and/or booking
- b. Assaultive history
- c. Threats regarding): assault

Disposition:

- a. Use caution while processing):
- b. Consider in housing assignment
- c. Consider as symptom of potential suicide

10. MENTALLY RETARDED

Symptoms:

- a. Difficulty understanding questions/comments
- b. Slowness in reacting/understanding
- c. Short attention span
- d. Weak/shortened memory
- e. Language problems
- f. Poor academic history

Disposition:

- a. Follow Departmental/ Agency General Order: "Handling Mentally Retarded"
- b. Refer to appropriate agency
- c. Exercise close supervision to ensure non-victimization

11-33. POTENTIAL SAME-SEX RAPE VICTIM

Symptoms:

a. Small	d. Naive/gay/effeminate
b. Frail	e. Non-urban/non-ghetto
c. Appears weak	

Disposition: a. Orient to jail culture
 b. Provide close supervision

14-15. MEDICATIONS

Disposition: Follow Departmental Agency General Order; "Medications Administration"

16-17. UNDER INFLUENCE OF ALCOHOL/DRUGS (See # 5)

18. FIRST INCARCERATION

Disposition: A first arrestee, under the influence of alcohol/drug should be considered a strong suicide risk when incarcerated, particularly if any of the symptoms outlined in #7 of the Screening Form are present. For disposition, follow guideline in #7.

19. POTENTIAL SUICIDE

Disposition: Follow # 7: "Despondent/Depressed (Potential Suicide)"

20. SERIOUS MEDICAL OR MENTAL PROBLEMS (For Mental Problems, see # 8))

A) HEART CONDITION/ATTACK

Symptoms: Chest pain, pain radiating to arms/shoulders/neck/jaw, shortness of breath, nausea/indigestion, sweating, cold/clammy skin, very pale.

Disposition: Take to hospital

B ABDOMINAL PAIN

Symptoms: Severe pain/cramps, nausea/vomiting, difficult breathing, pale, sweating, blood in vomitus

Disposition: Take to hospital

21. PREVIOUS MENTAL/EMOTIONAL PROBLEMS/HOSPITALIZATION

- a. See # 8 and make disposition on basis of current conditions
b. If previous despondency/depression/despair are reported, follow # 7

22. PREGNANT

Disposition: a. Refuse admittance if near delivery date; or
b. Monitor closely, i.e., subject being within sight or sound at all times, with frequent visual checks

23. SPECIAL DIET

Disposition: Alert health care personnel for follow-up

24. SPECIAL WELFARE/PROTECTION PROBLEM

Symptoms:

- a. Subject may express opinion that s/he is gay or transsexual
- b. A young, first arrestee who is small and apparently weak may be a target for same-sex attacks (see #11-13)

Disposition: a. Special housing and/or close supervision should be considered
 b. Thorough orientation in risk avoidance upon admission

APPENDIX C

APPENDIX C NCIA'S SAMPLE INTAKE SCREENING FORM*

Inmate's Name	Date of Birth	Sex	Date	Time
Most Serious Charge	I.D. Number	Screening Officer		

Was inmate a medical, mental health or suicide risk during any prior contact or confinement with department?

☐ Yes ☐ No If Yes, when: _____

Does the arresting or transporting officer believe that inmate is a medical, mental health or suicide risk now?

☐ Yes ☐ No

OFFICERS' OBSERVATIONS

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Assaultive/Violent Behavior	<input type="checkbox"/>	<input type="checkbox"/>	Crying/Tearful
<input type="checkbox"/>	<input type="checkbox"/>	Loud/Obnoxious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	Confused
<input type="checkbox"/>	<input type="checkbox"/>	Any Noticeable Marks/Scars	<input type="checkbox"/>	<input type="checkbox"/>	Uncooperative
<input type="checkbox"/>	<input type="checkbox"/>	Bizarre Behavior	<input type="checkbox"/>	<input type="checkbox"/>	Passive
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	Intoxicated
<input type="checkbox"/>	<input type="checkbox"/>	Unusual Suspiciousness	<input type="checkbox"/>	<input type="checkbox"/>	Scared
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Voices/Seeing Visions	<input type="checkbox"/>	<input type="checkbox"/>	Incoherent
<input type="checkbox"/>	<input type="checkbox"/>	Observable Pain/Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Embarrassed
<input type="checkbox"/>	<input type="checkbox"/>	Other Observable Signs of Depression	<input type="checkbox"/>	<input type="checkbox"/>	Cooperative
Explain: _____					

MEDICAL HISTORY

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Are you injured? If Yes, explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently under a physician's care? If Yes, explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	If female, are you pregnant? _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently taking any medication? If Yes, list type(s), dosage(s), and frequency: _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain(s)
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain(s)	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Blackouts/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Other Medical Problems and/or Diseases	<input type="checkbox"/>	<input type="checkbox"/>	AIDS (Optional)

Explain: _____

SUICIDE ASSESSMENT

YES NO

- ☐ ☐ Have you ever attempted suicide? If yes, When? _____
Why? _____ How? _____
- ☐ ☐ Have you ever considered suicide? If Yes,
When? _____ Why? _____
- ☐ ☐ Are you now or have you ever been treated for mental health or emotional problems? If Yes,
When? _____ Inpatient: _____ Outpatient: _____ Both: _____
- ☐ ☐ Have you recently experienced a significant loss (job, relationship, death of family member/close friend, etc.)? If
Yes, explain: _____
- ☐ ☐ Has a family member/close friend ever attempted or committed suicide? If Yes, explain: _____
- ☐ ☐ Do you feel that there is nothing to look forward to in the immediate future (expressing helplessness and/or
hopelessness)? If Yes, explain: _____
- ☐ ☐ Are you thinking of killing yourself? If Yes, explain: _____

Additional Remarks: _____

DISPOSITION

- ☐ General Population
- ☐ Special Watch
- 1) Supervision Levels: Close (5-15 minutes) _____ Constant _____
- 2) Housing Assignment: Cell # _____ Cell # _____ Other _____
- 3) Other precautions taken (removal of clothing, bedding, etc., if appropriate) _____

- ☐ Medical Hospital. If inmate is later returned to facility, list any special watch recommendations.

- ☐ Mental Health Service. If inmate is later returned to facility, list any special watch recommendations.

- ☐ Other disposition/referral/transfer _____

FAILURE TO ANSWER/REFUSAL OF TREATMENT

Inmate refused to answer (circle) or unable to answer (circle and state why) the verbal response sections of this screening form.

_____ (print name), refuse any type of medical treatment.

SIGNATURES:

Screening
Officer: _____

Inmate: _____

Supervisor: _____

APPENDIX D

SUICIDE PREVENTION SCREENING GUIDELINES

Office of Mental Health

DETAINEE'S NAME	SEX	DATE OF BIRTH	MOST SERIOUS CHARGE(S)	DATE	TIME
NAME OF FACILITY		NAME OF SCREENING OFFICER		Detainee showed serious psychiatric problems during prior incarceration Yes _____ No _____	

Check appropriate column for each question

	Column A YES	Column B NO	General Comments/Observations
OBSERVATIONS OF TRANSPORTING OFFICER			
1. Arresting or transporting officer believes that detainee may be a suicide risk. <i>If YES, notify Shift Commander.</i>	YES	NO	
PERSONAL DATA			
2. Detainee lacks close family or friends in the community.	No Family/Friends		
3. Detainee has experienced a significant loss within the last six months (e.g., loss of job, loss of relationship, death of close family member).			
4. Detainee is very worried about major problems other than legal situation (e.g., serious financial or family problems, a medical condition or fear of losing job).			
5. Detainee's family or significant other (spouse, parent, close friend, lover) has attempted or committed suicide.			
6. Detainee has psychiatric history. (Note current psychotropic medications and name of most recent treatment agency.)			
7. Detainee has history of drug or alcohol abuse.			
8. Detainee holds position of respect in community (e.g., professional, public official) and/or alleged crime is shocking in nature. <i>If YES, notify Shift Commander.</i>	YES	NO	
9. Detainee is thinking about killing himself. <i>If YES, notify Shift Commander.</i>	YES	NO	
10. Detainee has previous suicide attempt. (Check wrists and note method.)			
11. Detainee feels that there is nothing to look forward to in the future. (expresses feelings of helplessness or hopelessness). <i>If YES, to 10 and 11, notify Shift Commander.</i>	Nothing to Look Forward to		
BEHAVIOR/APPEARANCE			
12. Detainee shows signs of depression (e.g., crying, emotional flatness).			
13. Detainee appears overly anxious, afraid or angry.			
14. Detainee appears to feel unusually embarrassed or ashamed.			
15. Detainee is acting and/or talking in a strange manner (e.g., cannot focus attention, hearing or seeing things which are not there).			
16. A. Detainee is apparently under the influence of alcohol or drugs.			
B. If YES, is detainee incoherent, or showing signs of withdrawal or mental illness? <i>If YES to both A & B, notify Shift Commander.</i>	YES		
CRIMINAL HISTORY			
17. This is detainee's first arrest.			

TOTAL Column A _____

ACTION

If total checks in Column A are 8 or more, notify Shift Commander.

Shift Commander notified: Yes _____ No _____

Supervision Instituted: Routine _____ Active _____ Constant _____

Detainee Referred to Medical/Mental Health: Yes _____ No _____	If Yes:	<u>EMERGENCY</u> medical _____ mental health _____	<u>NON-EMERGENCY</u> medical _____ mental health _____
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Medical/Mental Health Personnel Actions: (To be completed by medical/MH staff)

INSTRUCTIONS FOR COMPLETING SUICIDE PREVENTION SCREENING GUIDELINES—FORM 330 ADM

GENERAL INFORMATION

This form is to be completed in triplicate for all detainees prior to cell assignment.

Insert top copy in detainee's file. If detainee is referred, give second copy to medical or mental health personnel. The third copy is available for use according to our facility's procedures.

Comment Column: Use to note:
1. information about the detainee that officer feels is relevant and important.
2. information requested in questions 6 and 10, and
3. information regarding detainee's refusal or inability to answer questions (See Below - General Instructions)

Detainee's Name: Enter detainee's first and last name and middle initial.

Sex: Enter male (m) or female (f).

Date of Birth: Enter day, month and year.

Most Serious Charge(s): Enter the most serious charge or charges [no more than two (2)] from this arrest.

Date: Enter day, month and year that form was completed.

Time: Enter the time of day the form was completed.

Name of Facility: Enter name of jail or lock-up.

Name of Screening Officer: Enter name of officer completing form.

Psychiatric Problems During Prior Incarceration: Check YES if facility files show that during prior detention detainee attempted suicide and/or was referred for mental health services. If "unknown", write unknown across space.

INSTRUCTIONS FOR ITEMS 1 - 17

General Instructions

Check the appropriate YES or NO box for items 1 -17.

If information required to complete these questions is unknown to screening officer, such information should be obtained by asking detainee to answer questions. However, detainee has a right to refuse to answer.

If detainee refuses to answer questions 2-11, enter RTA (refused to answer) in the Comment Column next to each question. In addition complete the YES or NO boxes only if information is known to you.

If during an otherwise cooperative interview, detainee refuses to answer one or two questions: Check YES in the box(es) next to the unanswered question(s) and enter RTA in the comment box next to each unanswered question.

If detainee is unable to answer all question 2-11, enter UTA (unable to answer) in the Comment Column next to each question. Also enter reason (e.g., intoxicated, not English speaking) for not answering these questions in the Comment Column next to question 2. In addition complete the YES or NO boxes only if information is known to you.

Observation of Transporting Officer

ITEM (1) Suicide risk: Check YES or NO box based upon the verbal report of the arresting/transporting officer or upon the screening form completed by the police agency. If YES, notify shift commander.

Personal Data Questions

ITEM (2) Family/friends: Check NO box if someone other than a lawyer or bondsman would (1) be willing to post detainee's bail, (2) visit detainee while he/she is incarcerated, or (3) accept a collect call from detainee.

ITEM (3) Significant loss: Ask all three components to this question—loss of job, loss of relationship and death of close friend or family member.

ITEM (4) Worried about problems: Ask about such problems as financial, medical condition or fear of losing job. Check YES if detainee answers YES to any of these.

ITEM (5) Family/significant other attempted suicide: Significant other is defined as someone who has an important emotional relationship with the detainee.

ITEM (6) Psychiatric History: Check YES box if detainee (1) has ever had psychiatric hospitalization, (2) is currently on psychotropic medication, or (3) has been an outpatient psychotherapy during the past six months. Note current psychotropic medication and name of the most recent treatment agency in the Comment Column.

ITEM (7) Drug or Alcohol History: Check YES box if detainee has had prior treatment for alcohol/drug abuse or if prior arrests were alcohol/drug related.

ITEM (8) Respect and shocking crime: Check YES if detainee is very respected for work, community activities, etc. and/or the crime is shocking in nature, e.g. child molestation.

ITEM (9) Suicidal: Check YES box if detainee makes a suicidal statement or if he responds YES to direct question, "Are you thinking about killing yourself?" If YES, notify shift commander.

ITEM (10) Previous attempt: Check YES box if detainee states he has attempted suicide. If YES, note the method used in the Comment Column. If either YES or NO, check detainee's wrists and note any scars in Comment Column.

ITEM (11) Hopeless: Check YES box if detainee states feeling hopeless, that he has given up, that he feels helpless to make his life better. If YES to both items 10 and 11, notify shift commander.

Behavior Appearance Observations

YES or NO must always be checked for each of these items. They are observations made by the screening officer. They are not questions.

ITEM (12) Depression includes behavior such as: crying, emotional flatness, apathy, lethargy, extreme sadness, unusually slow reactions.

ITEM (13) Overly anxious, afraid or angry includes such behaviors as: handwringing, pacing, excessive fidgeting, profuse sweating, cursing, physical violence, threatening, etc.

ITEM (14) Unusually embarrassed or ashamed: Check YES box if detainee makes non-elicited statements indicating worry about how family/friends/community will respond to his detention.

ITEM (15) Acting in strange manner: Check YES box if you observe any unusual behavior or speech, such as hallucinations, severe mood swings, disorientation, withdrawal, etc.

ITEM (16A) Detainee under the influence: Check YES if someone is apparently intoxicated on drugs or alcohol.

ITEM (16B) Incoherence, withdrawal, or mental illness: Withdrawal means physical withdrawal from substance. If YES to both A & B, notify shift commander.

Criminal History

ITEM (17) No prior arrests: Check YES box if this is detainee's first arrest.

SCORING

Be sure to count all checks in column A and enter total in the space provided. Notify shift commander 1) total is 6 or more, or 2) any shaded boxes are checked, or 3) if you feel notification is appropriate.

DISPOSITION

Officer Actions

Shift commander notified: Check YES or NO. Shift Commander should be notified about detainee prior to cell assignment.

Supervision instituted: Check appropriate supervision disposition. This section is to be completed by shift commander. For definition of active, constant and routine see N.Y.S. Commission of Correction Minimum Standards for Local Correctional Facilities.

Detainee referred to medical and mental health personnel: Check YES or NO. If YES, check emergency/nonemergency, medical/mental health. This section is to be completed by shift commander.

Medical/Mental Health Actions

This section should be completed by medical/mental health staff and should include recommendations and/or actions taken.

APPENDIX E

APPENDIX E

JAIL SUICIDE LITIGATION: CASE LAW REVIEW

Listed below are case summaries of recent jail suicide litigation. This listing is not intended to be all inclusive.

- 1) ***Hare v. City of Corinth*** [22 F. 3rd 612 (5th Cir. 1994)]. The decedent was arrested for petty larceny and forgery and incarcerated in the city jail. During interrogation by police, it was learned that she was addicted to dilaudid, displayed signs of withdrawal, and appeared depressed over her arrest and fitness as a mother. The investigating officer was aware of her emotional state and acknowledged that the decedent told him if he put her back in the cell area she would kill herself. He did not take her threat seriously, but instructed a police dispatcher to keep an eye on her. In turn, an inmate trustee was told to check the decedent every 45 minutes. The trustee later found the decedent hanging from the bars in her cell by a noose fashioned from strips of a blanket. Not having access to the cell, the trustee notified the dispatcher who, in accordance with jail procedures, could not leave his host. The dispatcher, in turn, called the investigating officer at home and was instructed to leave the decedent hanging until the state investigator arrived.

The defendants filed a motion for summary judgment based upon grounds of qualified immunity. The appeals court denied the motion, citing that the record contained genuine issues of material fact that precluded summary judgment - "In the case at bar there is both the placing of Tina Hare in an isolated cell in her allegedly unstable and agitated condition and the failure to respond immediately when she was discovered hanging. If the facts alleged by Hare are proven, a jury is entitled to find that the actions taken by defendants, both commission and omission, equal or exceed deliberate indifference to serious medical needs and violate the decedent's due process rights."

- 2) ***Tittle v. Jefferson County Commission*** [10 F. 3rd 1535 (11th Cir. 1994)]. Between October 1987 and December 1989, 57 suicide attempts occurred in the county jail, including four successful suicides within the 12-month period of September 1988 and 1989. The majority of these incidents involved hangings from various window bars or pipes in the facility. Each pipe, measuring six inches in diameter and filled with concrete, was located

approximately four feet above the bed and bolted to concrete blocks in front of the window in each cell. In its first opinion [(966 E2d 606 (11th Cir. 1992))], the appeals court stated that “*it is true that prison officials are not required to build a suicide-proof cell. By the same token, however, they cannot equip each cell with a noose.*” It falls to the plaintiff on remand to establish that defendants were deliberately indifferent to the probability that inmates would attempt to commit suicide by hanging themselves from the bar.”

In the second opinion, after an *en banc* review of the first decision, the court overturned the verdict by stating that the prior history of suicides did not show that “all prisoners of the Jefferson County Jail are substantially likely to attempt suicide.” In the midst of this prolonged litigation, the defendants covered up the pipes in question, as well as updated its intake screening and staff training policies.

- 3) *Natriello v. Flynn* (837 F. Supp. 17 (D. Mass. 1993), 26 ATLA L. Rep. 368 (Dec. 1993)]. The decedent was incarcerated in the county jail in January 1989. During the intake assessment, he reported a prior history of IV drug use, a suicide attempt, family history of both suicidal behavior and substance abuse, and the recent death of his grandfather; The decedent was currently suffering from hepatitis. During seven months of confinement, he engaged in aggressive, combative and self-destructive behavior resulting in both disciplinary confinement and observation under suicide watch. On August 18, 1989, the decedent engaged in self-destructive behavior, was transported to the local hospital for treatment of injuries, and was subsequently returned to the jail and placed on suicide watch. Less than two days later, he was found hanging from a ceiling grate in his cell by a bed sheet. -The medical examiner later determined that the decedent had been dead for approximately 5 to 7 hours prior to being found.

The decedent’s family filed suit against the sheriff and his staff alleging various acts of deliberate indifference. During the jury trial, the plaintiff offered evidence that the sheriff provided inadequate training to the two officers assigned to the unit which housed the decedent, and did not require officers to visibly observe inmates while conducting regular hourly cell checks. Evidence was also offered that the two officers were either laying down and/or sleeping in the control booth with the lights out for the majority of their shift, and were not supervising the activities of an “inmate watcher” who was assigned to monitor the decedant as well as a second suicidal inmate in an adjacent cell. It was also alleged that

the jail's suicide prevention policies were grossly inadequate and the cells were inappropriate for housing suicidal inmates. The jury returned a verdict for the plaintiff and awarded the decedent's estate \$10,000 for his conscious pain, \$450,000 for his wrongful death, and a total of \$40,000 in punitive damages. The defendants filed a motion for judgment notwithstanding the verdict stating that the plaintiff failed to introduce evidence that 1) the sheriff was deliberately indifferent; 2) the two officers acted in a wanton, malicious or oppressive manner; or 3) any of the defendants were negligent. The trial judge denied the motion stating that "there was sufficient evidence for a reasonable jury to have found for the plaintiff on all three of those claims." However, in accordance with the damages limitation contained in the state tort claims act, the court reduced the wrongful death award to \$100,000. In lieu of further appeals, both parties subsequently agreed to a negotiated settlement of approximately \$230,000.

- 4) *Barber v. City of Salem* [953 F.2d 232 (6th Cir. 1992)]. The decedent and his fiancée were stopped by police with the decedent subsequently arrested for drunk driving. At the police station, the decedent became upset after being told by officers that he might receive 6 to 12 months in jail for the offense. He expressed concern for his fiancée, job, and ability to obtain custody of his young son if given a long jail sentence. The decedent was placed in an isolation cell and last observed to be sleeping at 3:05 am by a police officer. The officer subsequently left the building, leaving only a dispatcher who did not go back into the cell block area. The decedent was found hanging from the bars of his cell by a sheet when the next shift came on duty at 8:00 am. The plaintiff filed suit but the district court subsequently granted the defendant's motion for summary judgment.

In evaluating the case, the appeals court stated that "the proper inquiry concerning liability of a city and its employees in both their official and individual capacities under Section 1983 for a jail detainee's suicide is: whether the decedent showed a strong likelihood that he would attempt to take his own life in such a manner that failure to take adequate precautions amounted to deliberate indifference to the decedent's serious medical needs." In affirming the lower court ruling, the court held that the "decedent did express concern over his job, engagement, and his ability to obtain custody of his young son due to his arrest. However, such a reaction to an arrest for driving under the influence of alcohol could not be considered abnormal and would not alert the jail authorities to a strong likelihood that Kenneth

Robert Barber would commit suicide. His death is indeed a sad and unfortunate occurrence. However, the failure to take special precautions does not amount to a constitutional violation of deliberate indifference to Kenneth Robert Barber's serious medical needs."

- 5) *Hall v. Ryan* (957 E2d 402 (7th Cir. 1992)]. Decedent was arrested for driving with revoked license in May 1986. He did not act unusual *or* intoxicated during transport to police department lockup, but his behavior changed markedly upon arrival. He became agitated and belligerent, took off his shoes and threw them across the booking room floor, and later urinated on the floor of his cell. He repeatedly flushed the toilet, requiring the shift commander to turn off the water into his cell. The decedent was found hanging by his underwear approximately 30 minutes following arrival at the facility. He survived, but remain in a permanent comatose state.

In affirming the district court's denial of the defendant's motion for summary judgment, the appeals court ruled that the decedent's behavior on the night in question, standing by itself, was not "so bizarre as to put the defendants on notice that he would probably commit suicide. Instead, Hall has raised a genuine issue of material fact whether the defendants actually knew that the decedent was a serious suicide risk, based not only on behavior that but also on his past encounter's with the Decatur Police Department.!' The department had arrested and confined the decedent numerous times prior to May 1986. The decedent had been involved in a well publicized suicide threat during his arrest in August 1985, a little over nine months prior to the incident in question. The arrest report contained a notation that the decedent had attempted suicide several times in the past. The court concluded that - "At trial the defendants may be able to adduce various defenses, but they may not now avoid suit under the qualified immunity doctrine on the record that now exists."

- 6) *Heflin v. Stewart County* [958 F.2d 709 (6th Cir. 1992)J. A deputy went to the decedent's cell on September 3, 1987 and saw a sheet tied to the cell bars. The deputy immediately went to the dispatcher's office, told the dispatcher to call the sheriff and ambulance service, picked up the cell block keys, and returned to open the cell. When the deputy entered the cell, he observed the decedent "hanging by the neck on the far side of the shower stall."

The decedent's hands and feet were tied together, a rag was stuffed in his mouth, and his feet were touching the floor. With the body still hanging, the deputy checked for a pulse and signs of respiration, but found none though the body was still warm. He also opened the decedent's eyes and found the pupils were dilated. From these observations the deputy concluded that the decedent was dead. While the deputy was still alone in the cell with the hanging body, a jail trusty arrived with a knife he had picked up in the kitchen. Rather than utilize the knife to cut the decedent down, the deputy ordered the trusty out of the area. The sheriff arrived shortly thereafter and directed the deputy to take pictures of the decedent before he was taken down.

At trial, the plaintiffs introduced evidence that the defendant maintained a policy of leaving victims as discovered, despite the medical procedures available to resuscitate victims. They ultimately prevailed and a jury awarded damages to the decedent's family based upon proof that the defendants' acted with deliberate indifference after discovering the decedent hanging. The defendants appealed by arguing that the decedent was already dead and their action or inaction could not have been the proximate cause of his death. The appeals court ruled that "there clearly was evidence from which the jury could find that Heflin died as the proximate result of the failure of Sheriff Hicks and Deputy Crutcher to take steps to save his life. They left Heflin hanging for 20 minutes or more after discovering him even though the body was warm and his feet were touching the floor...The unlawfulness of doing nothing to attempt to save Heflin's life would have been apparent to a reasonable official in Crutcher or Hick's position in 'light of pre-existing law'..." The court also affirmed the award of damages in the amount of \$154,000 as well as approximately \$133,999.50 in attorney fees.

Bell v. Steigers [937 F.2d 1340 (8th Cir. 1991)]. The 18-year-old decedent was arrested for drunk driving and transported to jail where he was processed and booked. He answered "no" to several intake screening questions regarding previous mental health and medical problems. He also denied ever being incarcerated in the past. When the decedent voiced despair over his arrest and stated to booking officers that "I think I'll shoot myself," he was told that a gun wasn't available. He was not considered a suicide risk. Officers placed the decedent in a cell but neglected to remove his belt which was apparently hidden from view. He was checked periodically by officers. Approximately 30 minutes after the last

cell check, the decedent was found hanging from the cells bars by his belt. He survived but sustained permanent brain damage.

The plaintiff filed suit asserting that, among other issues, the decedent threatened suicide and fit a profile depicting inmates most likely to commit suicide. The appeals court subsequently ruled that “a single off-hand comment about shooting oneself when no gun is available cannot reasonably constitute a serious suicide threat.” It also stated that while information contained in suicide victim profiles may assist jailers in recognizing potentially suicidal inmates, without more evidence to suggest a strong likelihood of suicide, the defendant could not be held liable.

- 8) *Simmons v. City of Philadelphia* [947 F.2d 1042 (3rd Cir. 1991)]. The decedent was arrested for public intoxication and transported to a police precinct lockup for “protective custody.” He was initially described by the arresting officer as being heavily intoxicated; agitated, and crying. During the first few hours of incarceration, the booking officer periodically observed the decedent as having “glassy eyes...in a stupor” with behavior ranging from confusion to hysteria. The booking officer subsequently discovered the decedent hanging from the cell bars by his trousers. He was cut down and paramedics were called, but the booking officer did not initiate any life-saving measures. The plaintiff filed suit alleging that the city violated the decedent’s constitutional right to due process “through a policy or custom of inattention amounting to deliberate indifference to the serious medical needs of intoxicated and potentially suicidal detainees.” At trial, the plaintiff offered evidence which showed that from 1980 through 1985, the city’s police department experienced 20 suicides in its lockups, did not provide suicide prevention training to its officers nor intake screening for suicide risk to its inmates, or any other suicide prevention measures.

In affirming the jury verdict, the appeals court stated that “the evidence of 20 jail suicides in the Philadelphia prison system between 1980-85, of whom 15 were intoxicated, *the City’s possession of knowledge before 1982 that intoxicated detainees presented a high risk of suicide, its awareness of published standards for suicide prevention, and its failure to implement recommendations of experts, including its own director of mental health services for the prison system, was sufficient basis for the jury to have found the unnamed officials with responsibility over the City’s prisons acted recklessly or with deliberate indifference, thereby contributing to the deprivation of constitutional rights of*

plaintiff's decedent. If a city cannot be held liable when its policy makers had notice of a problem and failed to act, then it is difficult to posit a set of facts on which a city could be held liable to have been deliberately indifferent." The ruling also affirmed the lower court award of over \$1.1 million in wrongful death, survival damages, and delayed damages to the plaintiff.

- 9) *Buffington v. Baltimore County* [913 F.2d 113 (4th Cir. 1990)]. The decedent, with a long history of depression and substance abuse, was arrested and placed under protective custody after police received a telephone call from the family stating that he had departed the home with several rifles and handguns. A suicide note was left and subsequently given to police. At booking, an officer asked the decedent what he was going to do with all those guns, to which he replied - "I was going to shoot myself." As per departmental policy, the decedent was handcuffed to the bar at the booking desk for processing. An "unwritten" policy, of which not all officers were aware, was that suicidal inmates were not to be placed in the cell block. As the arresting officers were completing paperwork on an emergency commitment of the decedent to a psychiatric hospital, a cell block officer placed him in a cell block isolation cell. Within one hour, the decedent was found hanging from the cell bars by his trousers. He was immediately cut down and CPR was initiated, but the decedent later died at the hospital.

The plaintiff filed suit against several individual officers, police chief, and the police department alleging deliberate indifference to the obvious suicide risk of the decedent. The suit also contended that the department's police lockups "posed risks of grave physical harm and death to suicidal, intoxicated, or emotionally disturbed" inmates; police officers failed to adequately monitor inmates; and were inadequately trained to identify and assist inmates at risk of suicide. The first trial resulted in a mistrial, but a second trial ended with two officers, police chief, and the county being found liable. The appeals court later reversed the judgments against the police chief and department, but affirmed the jury verdict against the two officers. The court stated that it "may well be, as the Buffingtons contend, that better suicide prevention training, closer adherence to national standards on jail suicide prevention, written regulations, or some combination of these would have served to avoid what occurred here. But Canton has made it clear that municipal liability under Section 1983 may not rest on such proof...This particular injury would have been avoided by the individual desk officers

taking the minimal preventive step of following the precinct's official policy and customary practice of keeping Buffington handcuffed to the rail..." The court also affirmed the award of \$185,000 in damages and approximately \$430,000 in attorney fees.

- 10) *Lewis v. Parish of Terrebone* [894 F.2d 142 (5th Cir. 1990)]. The decedent was taken by jail staff to a local hospital to have his stomach pumped of pills following a suicide attempt. From the emergency room, he was taken to a mental hospital for evaluation. The psychiatrist wrote a letter to the jail, indicating the decedent was suicidal and that special precautions should be taken. The letter was given to the transport deputy for delivery to the warden. The letter was left unopened on the jail booking desk. Shortly thereafter, the decedent hit an officer and was placed in isolation by the warden who, although having not read the psychiatrist's letter, knew about the earlier suicide attempt. The decedent subsequently committed suicide. The appeals court upheld the jury verdict of deliberate indifference by stating that "one need not find a 'goose case' to imbue a warden at a jail with a constitutional duty to protect a prisoner prone to suicide from self-destruction." A punitive damage award of only \$6,279 (to cover funeral costs) was also affirmed.
- 11) *Cabrales v. County of Los Angeles* [886 F.2d 235 (9th Cir. 1989)]. The decedent had a well documented mental health history and was being held in a "behavior observation module" of the jail. While on this unit, two officers caught him as he was trying to leap from the top of the cell bars with a blanket tied around his neck. The decedent was subsequently examined by a psychiatrist who determined that the suicide attempt was simply a "gesture" undertaken to get transferred out of the module and back into general population. Two days later the psychiatrist concluded that the decedent was not a suicide risk and placed him back into general population. The decedent was involved in a fight the following week and placed in the "disciplinary isolation module." Several days later he was found hanging from a towel rack by an ace bandage. The plaintiff filed suit alleging that understaffing deprived the decedent of adequate mental health services because psychiatrists had too little time to analyze and treat inmates' psychological problems. A jury subsequently found the jail commander and county to be liable.

The appeals court affirmed the jury verdict and ruled that evidence at trial "adequately demonstrated that the medical understaffing

at the jail directly contributed to the decedent's death. The psychiatric staff could only spend a few minutes per month with disturbed inmates. The district court could conclude that lack of time and resources meant, in the decedent's case, that any psychological illness he had would go undiagnosed and untreated. The omission by the County and its policy makers in providing adequate medical care at the Men's Central Jail was the policy or custom that was the 'moving force' behind deprivation of the decedent's constitutional rights." An award of \$157,500 in damages and over \$152,000 in attorney fees was also upheld.

CONSENT JUDGMENTS MANDATING JAIL SUICIDE PREVENTION PROGRAMS

Courts will, on occasion, order that a jurisdiction implement a comprehensive prevention program to thwart future jail suicides. Summarized below are two such consent judgments.

- 1) Crosby v. *Jones County* [C.A. H92-0235 (S.D. MS. 1994)]. In March 1994, officials in Jones County, Mississippi entered into a consent decree with the U.S. Justice Department that required them to dramatically upgrade conditions of confinement in its jail. The facility was one of 18 city and county jails in Mississippi investigated by the Justice Department in 1993 for grossly substandard living conditions and inadequate jail suicide prevention procedures. Similar to the other Mississippi facilities investigated by the Justice Department, Jones County agreed to implement the following jail suicide prevention protocols:
 - A) The Defendants shall construct and maintain two (2) suicide prevention cells, known as special needs cells, which shall be used for persons identified as special needs inmates. The special needs cells shall be inspected by a suicide prevention expert. All reasonable changes recommended by the expert shall be completed within ninety (90) days after the expert issues his or her report.
 - B) The Defendants shall screen all inmates for suicide risk and other special needs prior to their admission to the Jail. Such screening shall thoroughly assess a potential inmate's mental health and shall comport with current mental health professional and correctional standards.
 - C) All Jail officers and other Jones County Sheriff's Department officers who come into contact with inmates

shall be trained by a jail suicide prevention expert or licensed mental health professional. Such training shall include, but not be limited to, the proper response to a suicide or suicide attempt, including how to cut down a hanging victim and other first-aid measures, the identification and screening of special needs inmates and training about the high-risk groups and periods for suicides and suicide attempts.

D) The Defendants shall develop and implement written policies and procedures on suicide prevention and the treatment of special needs inmates, which shall include, but not be limited to, the following:

1. the placement of all special needs inmates in a special needs cell;
2. the establishment of two levels of supervision of special needs inmates - "active" and "constant." Special needs inmates who are not currently suicidal shall be assigned to active supervision and visually monitored by Jail staff at irregular intervals no less frequent than fifteen minutes; special needs inmates who are currently suicidal shall be assigned to constant supervision and monitored at all times by a Jail officer. All monitoring shall be logged in a separate suicide watch book;
3. the communication of information relating-to special needs inmates between and among all Jail staff members, between arresting and transporting officers and Jail staff, between Jail staff and Jail administration and between Jail staff and the special needs inmates;
4. the notification by Jail staff to local or state mental health authorities that a special needs inmate (except intoxicated) has been admitted to the jail;
5. the notification to the special needs inmate's family that he or she has been admitted to the Jail;

6. the assessment of all special needs inmates (except intoxicated) as soon as reasonably possible by a qualified mental health professional to assess the inmate's level of suicide risk;
 7. the establishment of a mechanism by which Jail staff will communicate with health care providers regarding the status of potentially suicidal inmates or inmates who have recently attempted suicide;
 8. the establishment of a mechanism by which Jail staff will refer potentially suicidal inmates and inmates who have recently attempted suicide to mental health care providers or facilities for placement;
 9. the documentation of all attempted and completed suicides and notification to Jail administrators, outside authorities and family members of all attempted and completed suicides;
 10. the establishment of follow-up and administrative review procedures for all attempted and completed suicides, including the determination of what changes, if any, are needed in the Suicide Prevention Program.
- 2) *Garcia v. Board of County Commissioners of the County of El Paso* [C.A. 83-Z-222 (D. CO. 1985)]. On March 26, 1982, Vincent Garcia was arrested for several motor vehicle violations, including suspicion of drunk driving, and transported to the El Paso County Jail in Colorado Springs, Colorado. He expressed fear of being housed in the general population and was placed in a second floor isolation cell. Approximately six hours later the inmate was found hanging by a blanket. It marked the third suicide at the facility in less than 12 months. A lawsuit filed on behalf of the victim's family culminated in a consent judgment in January 1985. In addition to a \$10,000 settlement to the victim's estate and payment of attorney fees, the county agreed to:
- A) Provide intensive supervision of all recently admitted inmates during the first twenty-four hours of

incarceration. Intensive supervision is to be provided in the following manner:

1. Not less than one deputy will be assigned to supervise not more than three adjacent wards encompassing the wards designated for recently admitted inmates and inmates requiring mental health care on a 24-hour basis.
- B) Replace the doors on all of the existing holding cells in the booking area with “Lexan” glass doors, or similar material, thereby removing the currently existing solid steel doors with the view hole.
- C) Modify the existing light fixtures, ventilator covers and other protrusions in all holding cells as recommended by an expert in jail architecture to be designated and hired by the El Paso County Sheriff. Said expert shall furnish a written report of the recommended changes to the El Paso County Sheriff which report shall permanently be retained in the files of that office.
- D) Create and maintain a special ward for mental health purposes in which anyone who is in need of special observation as identified by a doctor, psychologist, licensed mental health professional or jail personnel shall be confined.
- E) Provide intensive and recurring suicide prevention training to all booking, intake and emergency medical technicians employed by the jail to be provided by the National Institute of Corrections (NIC) or by an expert approved by the NIC or by a licensed mental health professional on at least an annual basis. Additionally, all deputies who are assigned to the jail division shall receive recurring supplementary training in suicide prevention, crisis intervention and general mental health recognition from an accredited source. All training shall be comparable in length, quality and content with the training then available from or recommended by the NIC. Such training must either be approved by the NIC or the designated instructor must certify in writing to the sheriff of El Paso County that the training comports in length, content and quality with the training then available from NIC and that the trainer’s qualifications are equivalent to those of NIC instructors.

- F) Provide intensive screening of all inmates at the time of booking for risk of suicide. This screening will encompass an in-depth questionnaire which comports with current mental health and corrections standards, to be filled out at booking for all newly admitted inmates. Any individual who is identified as having special needs, i.e., those who are intoxicated, in a crisis situation, a suicide risk, or exhibiting any aberrant or unusual behavior will be placed under intensive supervision and a licensed mental health professional notified. Intensive supervision of inmates with an identified risk of suicide shall be no less than that described in paragraph 1 and shall be reasonable under the circumstances. No person who has been identified as presenting risk of suicide shall be placed in isolation without continuous visual observation, which term shall be defined as meaning not less than every 15 minutes.
- G) Contract services of an appropriately licensed mental health professional to be on call 24 hours a day to assist jail personnel involved in the booking/screening/classifying roles to identify individuals which special need of intensive supervision and for any other mental health need.
- H) Close Cell 212, an isolation cell on the second floor of the El Paso County Jail, in a manner which will prevent any use of that cell for confinement of inmates. Close Cell 312, an isolation cell on the third floor of the El Paso County Jail, in a manner which will prevent any-use of that cell for confinement of inmates.
- I) At the time of this agreement, it is contemplated that a new jail will be constructed in El Paso County. Said new jail shall be constructed pursuant to the American Correctional Association's (ACA) standards. The facility, once constructed, will make reasonable good-faith efforts to seek ACA accreditation. The provisions of paragraph 1 through 8, inclusive shall apply to any county jail facility in El Paso County which acts as the receiving facility for newly admitted inmates.
- J) Defendants agree that a copy of this Consent Decree will be furnished to all employees of the El Paso County Jail.

APPENDIX F

APPENDIX F

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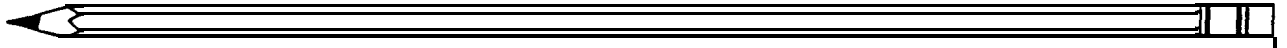
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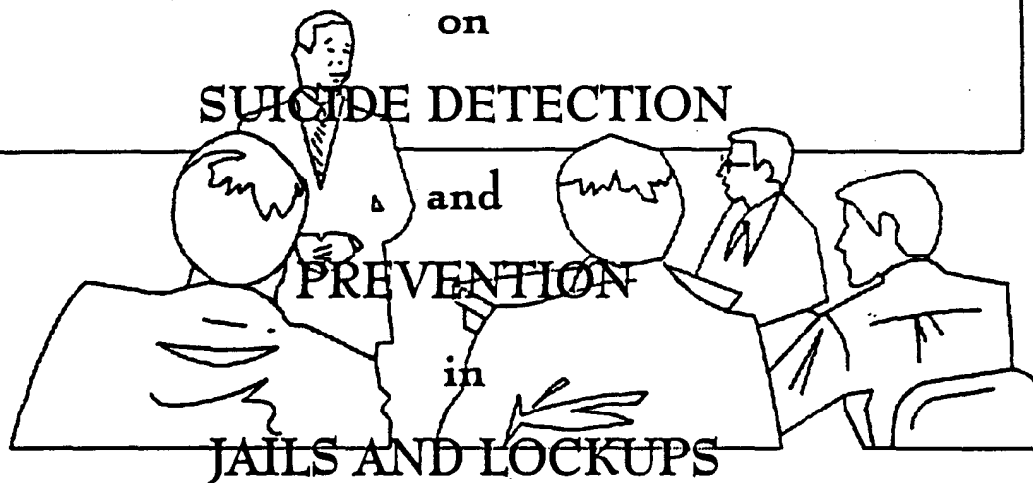


NOTES



APPENDIX G

TRANSPARENCIES FOR for TRAINING CURRICULUM



Second Edition

March 1995

APPENDIX G
TRANSPARENCIES
for
TRAINING CURRICULUM
ON SUICIDE DETECTION AND PREVENTION
IN JAILS AND LOCKUPS

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SUICIDE DETECTION AND PREVENTION IN JAILS AND LOCKUPS

1. INTRODUCTION

A. SUICIDE -A LEADING CAUSE OF DEATH IN JAILS

- IN SOME URBAN JAILS, AIDS-RELATED DEATHS OUTNUMBER SUICIDES
- RATE OF SUICIDE IN COUNTY JAILS IS NINE TIMES GREATER THAN IN COMMUNITY
- NCIA's NATIONAL SURVEYS-JAIL SUICIDES:

-	1979	419
-	1985	453
-	1986	401
- NUMBERS STABLE BUT LAWSUITS MOUNTING

B. OBSTACLES TO PREVENTION CAN BE OVERCOME

- NEGATIVE ATTITUDES IMPEDE PREVENTION EFFORTS
 - EXIST LOCALLY AND NATIONALLY
 - EMPTY EXCUSE: JAIL SUICIDES CAN'T BE PREVENTED
- LOCAL OBSTACLES
 - "WE DID EVERYTHING WE COULD TO PREVENT THIS DEATH, BUT HE SHOWED NO SUICIDE SIGNS OF SUICIDAL BEHAVIOR"

- “THERE’S NO WAY YOU CAN PREVENT SUICIDES UNLESS YOU HAVE SOMEONE SITTING WATCHING THE PRISONER ALL THE TIME, AND NO ONE CAN AFFORD TO BE A BABY-SITTER;”
- “WE DIDN’T CONSIDER HIM SUICIDAL, ,HE WAS SIMPLY BEING MANIPULATIVE AND I GUESS IT JUST WENT TOO FAR;”
- “WE AREN’T MIND READERS NOR TRAINED TO BE PSYCHIATRISTS;”
- IF SOMEONE REALLY WANTS TO KILL THEMSELVES, THERE’S GENERALLY NOTHING YOU CAN DO ABOUT IT;” AND
- SUICIDE PREVENTION IS A MEDICAL PROBLEM. . . IT’S A MENTAL HEALTH PROBLEM . . . IT’S NOT OUR PROBLEM.”

- UNIVERSAL OBSTACLES

- “STATISTICALLY SPEAKING, SUICIDE IN CUSTODY IS A RARE PHENOMENON, AND RARE PHENOMENA ARE NOTORIOUSLY DIFFICULT TO FORECAST DUE TO THEIR LOW BASE RATE. WE CANNOT PREDICT SUICIDE BECAUSE SOCIAL SCIENTISTS ARE NOT FULLY AWARE OF THE CASUAL VARIABLES INVOLVING SUICIDE;”
- “DEMOGRAPHIC PROFILES OF CUSTODIAL SUICIDE VICTIMS ARE OF LITTLE VALUE FOR PREDICTION BECAUSE THEY OFTEN MIRROR THE CHARACTERISTICS OF TYPICAL JAIL INMATES;”
- “EVEN THOSE SKILLED MENTAL HEALTH PROFESSIONALS, WHO HAVE THE TIME FOR EXTENSIVE PERSONAL INTERACTION WITH TROUBLED INDIVIDUALS, EITHER CANNOT FORECAST SUICIDE OR ARE UNABLE TO PREVENT PATIENT SUICIDE EVEN IF IT HAD BEEN SOMEWHAT ANTICIPATED;” AND
- “JAIL SUICIDES ARE EXTREMELY DIFFICULT TO PREDICT DUE TO THEIR SPONTANEOUS NATURE.”

C. PRO-ACTIVE STANCE NEUTRALIZES LIABILITY AND PREVENTS ALMOST ALL SUICIDES

- WRITTEN POLICIES/PROCEDURES
- CAPABLE/PROPERLY TRAINED STAFF
- SCREENING AT BOOKING'
- CLASSIFICATION SYSTEM
- INCREASED MONITORING
- COMPLIANCE - STATE AND NATIONAL STANDARDS
- "STATE-OF-THE-ART" KNOWLEDGE
- "OLD SCHOOL," DO-NOTHING APPROACH BREEDS LAWSUITS
- U.S. SUPREME COURT: CANTON V. HARRIS
 - INADEQUATE TRAINING CAN AMOUNT TO "DELIBERATE INDIFFERENCE" THE HIGHEST LIABILITY
 - SPECIFIC TRAINING NOT PROVIDED REASONABLY COULD HAVE PREVENTED SUICIDE
 - RISK REDUCTION STEMMING FROM TRAINING IS OBVIOUS AND SIGNIFICANT
- TRAINING MANUAL USERS
 - LAW ENFORCEMENT AND JAIL PERSONNEL
 - CONTRACTED HEALTH CARE PERSONNEL
 - STANDARDS AND REGULATORY AGENCIES
 - TRAINING ACADEMIES AND INSTITUTIONS
 - INDIVIDUAL TRAINERS
 - FINANCING BODIES
 - COLLEGES AND UNIVERSITIES

2. FACTS AND FICTION OF JAIL SUICIDE

TRUE OR FALSE?

A. MYTH: PEOPLE WHO MAKE SUICIDAL STATEMENTS OR THREATEN SUICIDE DON'T COMMIT SUICIDE

FACT: MOST PEOPLE WHO COMMIT SUICIDE HAVE MADE EITHER DIRECT OR INDIRECT STATEMENTS INDICATING THEIR SUICIDAL INTENTIONS

B. MYTH: SUICIDE HAPPENS SUDDENLY AND WITHOUT WARNING

FACT: MOST SUICIDAL ACTS REPRESENT A CAREFULLY THOUGHT OUT STRATEGY FOR COPING WITH VARIOUS PERSONAL PROBLEMS

C. MYTH: PEOPLE WHO ATTEMPT SUICIDE HAVE GOTTEN IT OUT OF THEIR SYSTEMS AND WILL NOT ATTEMPT IT AGAIN

FACT: ANY INDIVIDUAL WITH A HISTORY OF ONE OR MORE PRIOR SUICIDE ATTEMPTS IS AT MUCH GREATER RISK THAN THOSE WHO HAVE NEVER MADE AN ATTEMPT.

D. MYTH: SUICIDAL PEOPLE ARE INTENT ON DYING

FACT: MOST SUICIDAL PEOPLE HAVE MIXED FEELINGS ABOUT KILLING THEMSELVES. THEY ARE AMBIVALENT ABOUT LIVING, NOT INTENT ON DYING, AND MOST SUICIDAL PEOPLE WANT TO BE SAVED

E. MYTH: ASKING ABOUT AND PROBING INMATES ABOUT SUICIDAL THOUGHTS OR ACTIONS WILL CAUSE THEM TO KILL THEMSELVES

FACT: YOU CANNOT MAKE SOMEONE SUICIDAL WHEN YOU SHOW YOUR INTEREST IN THEIR WELFARE BY DISCUSSING THE POSSIBILITY OF SUICIDE

F. MYTH: ALL SUICIDAL INDIVIDUALS ARE MENTALLY ILL

FACT: ALTHOUGH THE SUICIDAL PERSON IS EXTREMELY UNHAPPY, HE IS NOT NECESSARILY MENTALLY ILL;

G. MYTH: THE RATE OF SUICIDE IS LOWER IN A JAIL SETTING

FACT: THE RATE OF JAIL SUICIDE IS SEVERAL TIMES GREATER THAN IN THE GENERAL POPULATION

H. MYTH: INMATES WHO ARE REALLY SUICIDAL CAN BE EASILY DISTINGUISHED FROM THOSE WHO HURT THEMSELVES BUT ARE JUST BEING MANIPULATIVE

FACT: MANIPULATIVE GOALS AS A MOTIVE FOR SELF-INJURY ARE NOT USEFUL IN DISTINGUISHING MORE LETHAL ATTEMPTS FROM LESS LETHAL ATTEMPTS

I. MYTH: IF SOMEONE REALLY WANTS TO KILL HIM/HERSELF, THERE'S GENERALLY NOTHING WE CAN DO ABOUT IT

FACT: AS WILL BE SHOWN THROUGHOUT THIS TRAINING SESSION, ALMOST ALL JAIL SUICIDES CAN BE PREVENTED

3. NATIONAL JAIL SUICIDE RESEARCH

A. AND DARKNESS CLOSE IN...A NATIONAL STUDY OF JAIL SUICIDES

1) FIRST NATIONAL STUDY OF PROBLEM

- BY NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES (NCIA)
- FOR NATIONAL INSTITUTE OF CORRECTIONS (U.S. JUSTICE DEPARTMENT)
- COMPLETED IN 1981 ON SUICIDES OCCURRING IN JAILS AND POLICE LOCKUPS IN 1979
- DEMOGRAPHIC DATA COLLECTED ON 344 OF 419 SUICIDES

2) PROFILE: VICTIM WOULD MOST LIKELY:

- HAVE BEEN 22 YEARS OLD, WHITE, SINGLE
- HAVE BEEN ARRESTED FOR PUBLIC INTOXICATION/UNDER INFLUENCE UPON INCARCERATION
- HAD INSIGNIFICANT OR NO ARREST HISTORY
- HAVE BEEN TAKEN TO URBAN COUNTY JAIL AND ISOLATED FOR OWN PROTECTION
- BE DEAD WITHIN THREE HOURS FROM HANGING WITH BEDDING

3) DETAILED PROFILE DATA:

- 73% OF VICTIMS CHARGES WITH NON-VIOLENT CRIMES
- 60% WERE UNDER INFLUENCE AT INCARCERATION
- 68% WHO COMMITTED SUICIDE HELD IN ISOLATION
- OVER 50% OF VICTIMS WERE DEAD WITHIN 24 HOURS - 27% WITHIN THREE HOURS

B) CAUTIONS ABOUT QUICK-FIXES AND PANACEAS

1) BE CAUTIOUS REGARDING QUICK-FIX SUICIDE PREVENTION SOLUTIONS:

- TELEVISION MONITORS
- TEARAWAY BLANKETS AND GOWNS

2) MORE ENERGIES NEED TO BE DEVOTED TO:

- STAFF AWARENESS TRAINING
- RECEIVING SCREENING
- CLASSIFICATION
- COUNSELING/REFERRAL
- SUPERVISION/MONITORING

- 3) PROFILES IMPORTANT BUT NOT END-ALLS:
 - SIGNS AND SYMPTOMS PICKED UP AT ARREST VERY IMPORTANT
 - BEHAVIOR AT BOOKING ALSO VERY SIGNIFICANT
 - VICTIM PROFILE IMPORTANT AS SUPPORTIVE INSTRUMENT/ ASSESSMENT AID
- 4) PROFILES INTENDED TO SENSITIZE JAIL PERSONNEL TO MOST COMMON VICTIM CHARACTERISTICS AND -SUPPLEMENT EXISTING WARNING SIGNS AND BEHAVIOR
- 5) WHILE SOME VARIABLES MIRROR TYPICAL JAIL INMATE “AGE, SEX, MARITAL STATUS -SIGNIFICANT DIFFERENCES EXIST:
 - WHITE INMATES COMPRISE 40% OF JAIL POPULATION; THEY ACCOUNT FOR 67% OF THE SUICIDES
 - 51% OF INMATES ARE DETAINEES; YET 91% OF SUICIDE VICTIMS ARE DETAINEES
 - 31% OF INMATES ARE INTOXICATED AT ARREST; ALMOST 60% OF SUICIDE VICTIMS ARE INTOXICATED
 - AVERAGE LENGTH OF STAY IN JAIL IS APPROXIMATELY 6 TO 11 DAYS; YET OVER 50% OF ALL SUICIDE VICTIMS AREA DEAD WITHIN FIRST 24 HOURS OF INCARCERATION, WITH 27% DEAD IN FIRST THREE HOURS
- 6) LOCAL/REGIONAL PROFILES ‘ENCOURAGED; THEY MAY BE MORE ACCURATE TOOL THAN THE NATIONAL PROFILE FOR YOUR FACILITY

C. NATIONAL STUDY SEVEN YEARS LATER - 1986 DATA

- 1) DEMOGRAPHIC DATA COLLECTED ON 339 OF 401 SUICIDES
- 2) FINDINGS STRIKINGLY SIMILAR TO 1979 DATA

D. HIGHLIGHTS OF 1986 SURVEY:

- 72% OF VICTIMS WERE WHITE
- 94% OF VICTIMS WERE MALE
- THE AVERAGE AGE WAS 30
- 52% OF VICTIMS WERE SINGLE
- 75% OF VICTIMS WERE DETAINED ON NON-VIOLENT CHARGES
- 46% OF HOLDING FACILITY VICTIMS HELD ON ALCOHOL/DRUG RELATED CHARGES
- 89% OF VICTIMS WERE CONFINED AS DETAINEES
- 78% OF VICTIMS HAD PRIOR CHARGES, YET ONLY 10% WERE HELD ON VIOLENT/ PERSONAL CHARGES
- 60% OF VICTIMS WERE UNDER THE INFLUENCE OF ALCOHOL AND/OR DRUGS AT INCARCERATION
- 82% OF HOLDING FACILITY VICTIMS WERE INTOXICATED AT TIME OF INCARCERATION

- 30% OF SUICIDES OCCURRED DURING SIX HOUR PERIOD OF MIDNIGHT AND 6:00 A.M.
- 94% OF SUICIDES WERE BY HANGING; 48% USED BEDDING
- TWO OUT OF THREE VICTIMS WERE IN ISOLATION
- 51% OF SUICIDES OCCURRED WITHIN THE FIRST 24 HOURS OF INCARCERATION; 29% OCCURRED WITHIN THE FIRST THREE HOURS
- 64% OF HOLDING FACILITY VICTIMS DIED WITHIN FIRST THREE HOURS
- 69% OF SUICIDES WERE IN COUNTY-RUN FACILITIES; 66% OCCURRED IN URBAN JAILS
- 89% OF VICTIMS WERE NOT SCREENED FOR POTENTIALLY SUICIDAL BEHAVIOR AT BOOKING

E. LOCALIZED STUDIES

- EACH JAIL SHOULD ANALYZE DATA FROM ITS OWN PRIOR SUICIDES FOR VALID NATIONAL COMPARISON

4. WHY JAIL ENVIRONMENTS ARE CONDUCTIVE TO SUICIDAL BEHAVIOR

- A. AUTHORITARIAN ENVIRONMENT - REGIMENTATION
- B. 'NO APPARENT CONTROL OVER FUTURE, INCLUDING FEAR AND UNCERTAINTY OVER LEGAL PROCESS
- C. ISOLATION FROM FAMILY, FRIENDS AND COMMUNITY
- D. THE SHAME OF INCARCERATION
- E. DEHUMANIZING ASPECTS OF INCARCERATION -VIEWED FROM INMATE'S PERSPECTIVE
- F. FEARS - BASED ON TV AND MEDIA STEREOTYPES
- G. OFFICER INSENSITIVITY TO ARREST AND INCARCERATION PHENOMENON; "VICTIM OF ENVIRONMENT"
 - UNLESS ARRESTED AND INCARCERATED, DIFFICULT TO EMPATHIZE
 - CAUTION: LONGER THE JAIL OFFICER'S CAREER, OFTEN THE GREATER INSENSITIVITY
 - JAIL PERSONNEL -VICTIMS OF OWN ENVIRONMENT
 - TRAUMA OF ARREST OFTEN INVERSELY PROPORTIONATE TO OFFENSE: THREE-QUARTERS OF SUICIDE VICTIMS CHARGED WITH NON-VIOLENT CRIMES
 - TEXT-BOOK KNOWLEDGE OF JAIL OPERATIONS INSUFFICIENT FOR FULL UNDERSTANDING OF EMOTIONAL ENVIRONMENT: ON-JOB CROSS-TRAINING NEEDED BY MENTAL HEALTH PERSONNEL

- HEALTH CARE PERSONNEL FROM COMMUNITY AGENCIES SHOULD SPEND AT LEAST ONE DAY IN ORIENTATION TO JAIL CULTURE AND ENVIRONMENT
- GOOD WORKING KNOWLEDGE OF JAIL ESSENTIAL FOR SUICIDE HOUSING AND MANAGEMENT RECOMMENDATIONS BY COMMUNITY HEALTH CARE PERSONNEL

5. PRE-DISPOSING FACTORS OF SUICIDAL BEHAVIOR

- A. RECENT, EXCESSIVE DRINKING AND/OR USE OF DRUGS
- B. RECENT LOSS OF STABILIZING RESOURCES:
 - WIFE/LOVED ONE; FOR JUVENILE COULD BE A PEER
 - JOB; OR EXPULSION FROM SCHOOL
 - HOME; OR FARM
 - FINANCES
- C. SEVERE GUILT OR SHAME OVER THE OFFENSE
- D. SAME-SEX RAPE OR THREATS OF IT
- E. CURRENT MENTAL ILLNESS
- F. POOR HEALTH OR TERMINAL ILLNESS
- G. APPROACHING AN EMOTIONAL BREAKING POINT

6. HIGH RISK SUICIDE PERIODS

- A. FIRST 24 HOURS OF CONFINEMENT
- B. INTOXICATION AND WHEN SOBERING UP
- C. WAITING FOR TRIAL
- D. SENTENCING
- E. IMPENDING RELEASE
- F. HOLIDAYS
- G. DARKNESS
- H. DECREASED STAFF SUPERVISION
 - WEEKENDS
 - NIGHTS
 - SHIFT CHANGES
 - HOLIDAYS
- I. BAD NEWS OF ANY KIND

7. SIGNS AND SYMPTOMS OF SUICIDAL BEHAVIOR

- KEY TIMES TO OBSERVE SIGNS AND SYMPTOMS:
 - AT ARREST
 - DURING TRANSPORTATION
 - AT BOOKING
 - DURING CONFINEMENT
- WARNING SIGNS AND SYMPTOMS:
 - A. CURRENT DEPRESSION OR PARANOIA
 - B. EXPRESSES OR EVIDENCES STRONG GUILT AND/OR SHAME OVER OFFENSE
 - c. TALKS ABOUT OR THREATENS SUICIDE
 - D. UNDER INFLUENCE OF ALCOHOL OR DRUGS
 - E. PREVIOUS SUICIDE ATTEMPTS AND/OR HISTORY OF MENTAL ILLNESS
 - RECENT PRIOR HISTORY IS CRITICAL SIGN OF RISK
 - F. SEVERE AGITATION OR AGGRESSIVENESS
 - G. PROJECTS HOPELESSNESS/HELPLESSNESS - NO SENSE OF FUTURE
 - H. EXPRESSES UNUSUAL OR GREAT CONCERN OVER WHAT WILL HAPPEN TO HIM/HER
 - I. NOTICEABLE MOOD AND/OR BEHAVIOR CHANGES

- J. MAY ACT VERY CALM ONCE DECISION IS MADE TO KILL SELF
- K. SPEAKS UNREALISTICALLY ABOUT GETTING OUT OF JAIL
- L. HAS INCREASING DIFFICULTY RELATING TO OTHERS
- M. DOES NOT EFFECTIVELY DEAL WITH PRESENT - PRE-OCCUPIED WITH PAST
- N. *BEGINS PACKING BELONGINGS
- O. STARTS GIVING AWAY POSSESSIONS
- P. MAY TRY TO HURT SELF: "ATTENTION-SEEKING" GESTURES
 - EACH GESTURE MUST BE CONSIDERED AS FIRST REAL ATTEMPT
- Q. PARANOID DELUSIONS OR HALLUCINATIONS
 - MAY BE COMMAND TO KILL SELF
 - IN SERIOUS TONE, ASK WHAT ARE VOICES SAYING?
- DEPRESSION -THE SINGLE BEST SUICIDE INDICATOR
 - A. FEELINGS OF INABILITY TO GO ON - HOPELESSNESS OR HELPLESSNESS
 - B. EXTREME SADNESS AND CRYING

- C. WITHDRAWAL OR SILENCE
- D. LOSS OR INCREASE OF APPETITE AND/OR WEIGHT
- E. PESSIMISTIC ATTITUDES ABOUT FUTURE.
- F. INSOMNIA OR AWAKENING EARLY; EXCESSIVE SLEEPING
- G. MOOD AND/OR BEHAVIOR VARIATIONS
- H. TENSENESS
- I. LETHARGY - SLOWING OF MOVEMENTS OR NON-REACTIVE
- J. LOSS OF SELF-ESTEEM
- K. LOSS OF INTEREST IN PEOPLE, APPEARANCE OR ACTIVITIES
- L. EXCESSIVE SELF-BLAMING
- RI. STRONG GUILT FEELINGS
- N. DIFFICULTY CONCENTRATING OR THINKING

- AGITATION FREQUENTLY PRECEDES SUICIDE - ITS SYMPTOMS ARE:

- A. HIGH LEVEL OF TENSION
- B. EXTREME ANXIETY

C. STRONG EMOTIONS:

- GUILT
- RAGE
- WISH FOR REVENGE

- SUICIDE MAY FOLLOW AGITATION AS MEANS OF RELIEVING TENSION OR PRESSURE

- PSYCHOTIC CONDITIONS INFLUENCE SUICIDES:

- DELUSIONS: PERSECUTION, BEING CONTROLLED, GRANDEUR
- HALLUCINATIONS: AUDIO AND/OR VISUAL

8. SITUATIONAL RISK FACTORS OF SUICIDAL BEHAVIOR

- A. MINOR OR INSIGNIFICANT ARREST HISTORY
- B. JUVENILE (ANYONE UNDER 18, WHETHER OR NOT WAIVED TO ADULT COURT)
- C. PERSONS WITH HIGH STATUS IN COMMUNITY
- D. PRIOR SUICIDE BY CLOSE FAMILY MEMBER OR LOVED ONE
- E. PREVIOUSLY IMPRISONED/FACING NEW, SERIOUS CHARGES AND LONG PRISON TERM
 - PRIOR SAME-SEX RAPE VICTIM HIGH SUICIDE RISK
- F. PRIOR JAIL SUICIDE OR RECENT ATTEMPT -A "COPYCAT"
- G. HARSH, CONDEMNING, REJECTING ATTITUDES OF OFFICERS
- H. PRIOR EXPERIENCE WITH PAIN/SUFFERING OF ALCOHOL/DRUG WITHDRAWAL

9. CURRENT AND RECENT STRESS SITUATIONS

- EACH OF US HAS “BREAKING POINT”
- AN HOUR, DAY, WEEK, MONTH LATER, WITHOUT ONE OR MORE STRESS SITUATIONS, MANY SUICIDES WOULD NEVER OCCUR:
 - A. LOSS OR THREAT OF LOSS OF LOVED ONE
 - B. RECENT JOB LOSS OR FAILURE
 - c. RECENT OR PENDING DIVORCE, SEPARATION OR BREAK-UP
 - D. REJECTION BY PEERS- ESPECIALLY TRUE OF JUVENILES
 - E. SERIOUS BUSINESS OR FINANCIAL LOSS
 - F. DISCOVERY OF MAJOR HEALTH PROBLEM
 - G. VICTIM OF SAME-SEX RAPE OR SERIOUSLY THREATENED
 - H. COMMITTED HEINOUS CRIME (OR ONE OF PASSION) OR A REVOLTING SEX CRIME

10. ARRESTING AND INVESTIGATIVE OFFICERS AND SUICIDE PREVENTION

- LAW ENFORCEMENT IS PROFESSIONAL SERVICE WITH PRIMARY GOALS:
 - PROTECT LIVES
 - PROTECT RIGHTS
- ARRESTING OFFICER FIRST OFFICIAL TO OBSERVE SUICIDE SIGNS AND SYMPTOMS
 - SUICIDE SIGNS AND SYMPTOMS
 - AVAILABLE CRISIS INTERVENTION SERVICES
- MANY OFFICERS HELP PREVENT JAIL SUICIDES
 - SOME NAMED IN LAWSUIT FOR FAILING IN “DUTY OF CARE”
- TRAINING APPROACHES:
 - ENTRANCE TRAINING AT ACADEMIES
 - IN-SERVICE RETRAINING EVERY TWO YEARS
- MOTIVATION FOR TRAINING
 - A. TO HELP PREVENT SUICIDES IN OWN LOCKUPS AND COUNTY JAILS
 - B. TO PREVENT LAWSUITS AGAINST THEIR AGENCIES AND THEMSELVES
 - C. BENEFITS OFFICER AND DEPARTMENT IN COMMUNITY-SUICIDE WORK

11. ASSESSING SUICIDAL RISK: SPECIAL ASPECTS OF HEALTH CLEARANCE AND RECEIVING SCREENING

- PROPERLY-TRAINED CORRECTIONAL OFFICERS/JAILERS CAN EFFECTIVELY ASSESS MOST POTENTIALLY SUICIDAL INMATES AT BOOKING
- MANY OTHERS DETECTED WHILE OFFICERS SUPERVISE INMATES IN GENERAL POPULATION
- 89% OF SUICIDE VICTIMS WERE NOT SCREENED FOR POTENTIALLY SUICIDAL BEHAVIOR AT BOOKING
- MANY JAILS REPORT REDUCTIONS IN SUICIDES FOLLOWING AWARENESS TRAINING OF OFFICERS IN SUICIDE SYMPTOMS AND IMPLEMENTATION OF SOUND PRACTICES
- A. REFUSAL AT ADMISSION OR REQUIRING WRITTEN HEALTH CLEARANCE FOR SUSPECTED CASES OF MENTAL ILLNESS, INCLUDING SUICIDE, SHOULD BE PURSUED
 - PRISONERS WHO SEEM VERY CONFUSED OR DISORIENTED
 - CAUTION SHOULD BE EXERCISED WITH KNOWN CASES OF DEPRESSION, PARANOID SCHIZOPHRENIA OR “PERSECUTION COMPLEX” AND MANIC DEPRESSIVE ILLNESS, WHO MAY BE HIGH RISK SUICIDE CANDIDATES
- INMATES WITH UNATTENDED MEDICAL PROBLEMS ARE GREATER SUICIDE RISKS
 - APPROPRIATE MEDICAL ATTENTION REDUCES ANXIETIES
 - IS A SUICIDE PREVENTION FACTOR

- VARIOUS CONDITIONS REQUIRING MEDICAL CLEARANCE:
 - 1) PRISONERS WHO ARE UNCONSCIOUS OR SEMI-CONSCIOUS
 - 2) PRISONERS WITH ANY SIGNIFICANT EXTERNAL BLEEDING
 - 3) PRISONERS WITH ANY OBVIOUS FRACTURES (BROKEN BONES)
 - 4) PRISONERS WITH ANY SIGNS OF HEAD INJURY
 - 5) PRISONERS WHO MAY HAVE NECK OR SPINE INJURY
 - 6) PRISONERS WITH ANY OTHER SORT OF SEVERE INJURY
 - 7) PRISONERS WHO CANNOT WALK UNDER THEIR OWN POWER
 - 8) PRISONERS DISPLAYING ANY SIGNS OR SYMPTOMS OF POSSIBLE INTERNAL BLEEDING
 - 9) PRISONERS WITH SEVERE ABDOMINAL PAIN
 - 10) PRISONERS DISPLAYING SIGNS OF SIGNIFICANT DRUG OR ALCOHOL ABUSE, E.G., A BLOOD ALCOHOL LEVEL OF .275 AND MORE
- STANDARD 72.5.6, COMMISSION ON ACCREDITATION FOR LAW ENFORCEMENT AGENCIES:
 - HOLDING FACILITY NOT EQUIPPED TO HANDLE INTOXICATED ARRESTEES
 - IF DETAINED, MUST BE OBSERVED CLOSELY

- REASONS FOR NOT DETAINING INTOXICATED PERSONS:
 - INMATE CHOKES ON OWN VOMIT
 - ASPIRATION PNEUMONIA HAS APPROXIMATELY ONE-THIRD CASUALTY RATE
 - INJURIES TO INTOXICATED PRISONERS AND VICTIMIZATION ARE CONSTANT PROBLEMS
 - HIGH RISK CANDIDATES FOR SUICIDE

11) PREGNANT WOMEN IN LABOR

12) PREGNANT WOMEN WITH OTHER SERIOUS PROBLEMS

13) PRISONERS WHO CLAIM THAT THEY NEED CERTAIN TYPES OF MEDICATION BUT WHO DO NOT HAVE MEDICATION WITH THEM

B. ADMISSION RECEIVING SCREENING: WHAT? WHEN? BY WHOM?

- RECEIVING SCREENING MOST IMPORTANT ASPECT OF HEALTH CARE
 - MOST SUICIDAL INMATES CAN BE DETECTED AT INTAKE
 - 1) WHAT IS RECEIVING SCREENING?
 - a. OBSERVATION OF SIGNS AND SYMPTOMS BY ARRESTING/TRANSPORTATION OR BOOKING/INTAKE PERSONNEL
 - APPENDIX B IS A FORM FOR BASIC MEDICAL, MENTAL HEALTH AND SUICIDE PREVENTION SCREENING

- APPENDIX C IS A FORM FOR MEDICAL AND MENTAL HEALTH SCREENING AND EXPANDED INQUIRY OF SUICIDE RISK
- APPENDIX D IS A FORM EXCLUSIVELY UTILIZED FOR SUICIDE PREVENTION SCREENING
 - IT SHOULD BE INCORPORATED INTO OR ACCOMPANIED BY A MEDICAL SCREENING FORM
 - WHY? UNDIAGNOSED, UNATTENDED MEDICAL PROBLEMS CAN CAUSE ANXIETIES AND BE A FACTOR IN SUICIDE ATTEMPTS
- b. JAILER-EXAMINER QUESTIONNAIRE CONTAINS A VARIETY OF MEDICAL, MENTAL HEALTH AND SUICIDE PREVENTION SCREENING QUESTIONS ASKED BY EXAMINER
- c. DISPOSITION AND REFERRAL GUIDELINES
 - DOCUMENTATION OF OBSERVATIONS CRUCIAL FOR:
 - EFFECTIVE FOLLOW-UP SERVICES
 - LAWSUIT PROTECTION
- 2) WHEN DONE? IMMEDIATELY UPON ARRIVAL AT JAIL:
 - OTHERWISE, DEATHS AND LAWSUITS CAN OCCUR
 - COMMUNICABLE DISEASES SPREAD

3) BY WHOM?

- HEALTH-TRAINED BOOKING OFFICERS
- NURSES
- EMERGENCY MEDICAL TECHNICIANS

C. VALUES AND BENEFITS OF RECEIVING SCREENING:

- 1) POTENTIALLY SUICIDAL INMATES ARE IDENTIFIED
- 2) TRAUMAS, POSSIBLE ILLNESSES AND INFECTIOUS DISEASES DETECTED
- 3) POSSIBLE DRUG AND ALCOHOL ABUSE AND WITHDRAWAL ASSESSED
- 4) EARLY EVALUATION AND TREATMENT OF CHRONIC AND ACUTE MENTAL ILLNESSES EFFECTED
- 5) MEDICATION USE DETERMINED
- 6) LEGAL LIABILITY PROTECTION
- 7) PREVENTS SUICIDES WHEN CARE, CONCERN AND “NON-ROBOT”STYLE INTERVIEWING OCCUR

D. HOW RECEIVING SCREENING OPERATES

- 1) OBSERVATION BY OFFICER WHILE CONDUCTING THE BOOKING:

- a. NOTES BEHAVIOR, SPEECH, ACTIONS, ATTITUDES AND STATE OF MIND
- b. SCARS FROM PREVIOUS SUICIDE ATTEMPTS
- c. TRAUMAS OR BRUISES, COLOR AND CONDITION OF SKIN
- d. VISIBLE SIGNS OF DRUG OR ALCOHOL USE AND WITHDRAWAL
- e. MEDICATION USE DETERMINED

2) QUESTIONNAIRE SERVES AS A BEGINNING: FOLLOW-UP QUESTIONS ENCOURAGED

- EFFECTIVE INTERVIEW CAN PRODUCE OVER 90% HONEST ANSWERS
 - a. EXPLAIN RATIONALE FOR PROCESS: THIS REDUCES PARANOIA AND FEELINGS OF BEING “PICKED ON”
 - b. ASKING QUESTIONS IN COMMON-SENSE MANNER, AS PRIVATELY AS POSSIBLE
 - c. SPEAKING IN NORMAL, QUIET, MATTER-OF-FACT TONE
 - d. USING LANGUAGE INMATE CAN UNDERSTAND
 - e. NOT BEING PUSHY, ABRUPT OR SARCASTIC
 - f. IF NOT UNDERSTOOD, REPEAT QUESTION SLOWLY AND CLEARLY
- EFFECTIVE INTERVIEW IMPRESSES INMATE THAT “SOMEBODY CARES”

- SETTLES INMATE
- RELIEVES TENSION AND ANXIETIES
- OBSERVATION AND QUESTIONNAIRE SECTIONS SHOULD BE DONE ON INTOXICATED ARRESTEES TO EXTENT POSSIBLE. SOME ARE MORE OPEN AND HONEST WHEN INTOXICATED THAN SOBER

E. SUICIDAL ASPECT OF RECEIVING SCREENING

1) MODIFIED AMERICAN MEDICAL ASSOCIATION FORM:

- APPEARS TO BE UNDER THE INFLUENCE OF ALCOHOL OR DRUGS?
- ARE THERE VISIBLE SIGNS OF ALCOHOL AND/OR DRUG WITHDRAWAL
- DOES ARRESTEE APPEAR TO BE DESPONDENT/DEPRESSED?
- APPEARS TO BE IRRATIONAL/MENTALLY ILL?
- BEHAVIOR SUGGESTS RISK OF ASSAULT?
- IS THIS THE FIRST TIME . . . ARRESTED OR DETAINED?
- HAD ANY PREVIOUS MENTAL OR EMOTIONAL PROBLEMS FOR WHICH YOU WERE TREATED?
- EVER HOSPITALIZED FOR ANY MENTAL OR EMOTIONAL PROBLEMS?
- HAVE YOU EVER THOUGHT ABOUT OR ATTEMPTED SUICIDE?

IS THERE ANYTHING SPECIAL THAT WE SHOULD KNOW ABOUT YOU FOR YOUR WELFARE OR PROTECTION?

2) NCIA'S INTAKE SCREENING FORM

- WAS INMATE MEDICAL, MENTAL HEALTH OR SUICIDE RISK DURING PRIOR CONFINEMENT?
- DOES ARRESTING, TRANSPORTING OFFICER BELIEVE, INMATE IS MEDICAL, MENTAL HEALTH OR SUICIDE RISK?
- EVER ATTEMPTED SUICIDE?
- EVER CONSIDERED SUICIDE?
- EVER TREATED FOR MENTAL/EMOTIONAL PROBLEMS?
- ANY RECENT SIGNIFICANT LOSS (LOVED ONE, JOB, ETC.)?
- SUICIDE HISTORY AMONG FAMILY/CLOSE FRIEND?
- FEEL NOTHING TO LOOK FORWARD TO IN IMMEDIATE FUTURE (HELPLESSNESS/HOPELESSNESS)?
- NOW THINKING OF KILLING YOURSELF?

3) NEW YORK STATE FORM -SUICIDE PREVENTION SCREENING

- ARRESTING OR TRANSPORTING OFFICER BELIEVES THAT DETAINEE MAY BE A SUICIDE RISK

- DETAINEE LACKS CLOSE FAMILY OR FRIENDS IN THE COMMUNITY
- DETAINEE HAS EXPERIENCED A SIGNIFICANT LOSS WITHIN THE LAST SIX MONTHS
- DETAINEE IS VERY WORRIED ABOUT MAJOR PROBLEMS OTHER THAN LEGAL SITUATION
- DETAINEE'S FAMILY OR SIGNIFICANT OTHER; HAS ATTEMPTED OR COMMITTED SUICIDE
- DETAINEE HAS PSYCHIATRIC HISTORY
- DETAINEE HAS HISTORY OF DRUG OR ALCOHOL ABUSE
- DETAINEE HOLDS POSITION OF RESPECT IN COMMUNITY AND/OR ALLEGED CRIME IS SHOCKING IN NATURE
- DETAINEE IS THINKING ABOUT KILLING HIMSELF
- DETAINEE HAS MADE PREVIOUS SUICIDE ATTEMPT
- DETAINEE FEELS THATTHERE IS NOTHING TO LOOK FORWARD TO IN THE FUTURE
- DETAINEE SHOWS SIGNS OF DEPRESSION
- DETAINEE APPEARS OVERLY ANXIOUS, AFRAID OR ANGRY
- DETAINEE APPEARS TO FEEL UNUSUALLY EMBARRASSED OR ASHAMED

- DETAINEE IS ACTING AND/OR TALKING IN A STRANGE MANNER - INTOXICATION, INCOHERENT, ETC.
- NO PRIOR ARRESTS
- DISPOSITION
 - ANY CLEAR “YES” ANSWERS DEMAND ATTENTION: POTENTIAL SUICIDE!

F. ASSESSMENT FACTORS AND PRINCIPLES IN RECEIVING SCREENING

DURING ARREST, TRANSPORTATION, BOOKING AND SUPERVISION OF INMATES, OFFICERS NEED TO ASSESS SUICIDAL RISK:

- 1) SEARCH RECORDS FOR SUICIDE RISK DURING PRIOR CONFINEMENT
- 2) ALL SUICIDE THREATS MUST BE TAKEN SERIOUSLY; “MANIPULATION” IS FIRST REAL THREAT
- 3) GAUGE INTENSITY OF STRESS AND DEPRESSION
- 4) DETERMINE IMPULSIVENESS; THE YOUNGER -THE INMATE, THE GREATER THE IMPULSIVITY
- 5) EXPLORE SITUATION AS FAR AS POSSIBLE:
 - ASK DIRECT QUESTIONS
 - EXPLORE PLAN FOR DEGREE OF RISK
 - THE MORE SPECIFIC THE PLAN, THE GREATER THE RISK

- 6) DETERMINE MEANS AVAILABLE TO CARRY OUT SUICIDAL ACT
 - IF ACCESS TO IMPLEMENTING PLAN, RISK IS HIGH
- 7) ASSESS MENTAL HEALTH RESOURCES AVAILABLE TO HELP PREVENT THE ACT, ESPECIALLY IN HIGH-RISK CASES

12. HOUSING AND SUPERVISING SUICIDAL INMATES

- JAILS TEND TO ISOLATE AND RESTRAIN SUICIDAL INMATES
- THIS PRACTICE IS DETRIMENTAL TO SUICIDAL INMATES
- 67% OF SUICIDE DEATHS OCCUR IN ISOLATION - INCREASES SENSORY DEPRIVATION AND FEELINGS OF ALIENATION
- MAIN DANGER: REMOVAL FROM PROPER SUPERVISION
- TO EXTENT POSSIBLE, HOUSE IN GENERAL POPULATION

A. LOW RISK SUICIDAL INMATES

- NOT ACTIVELY SUICIDAL
- HAVE EXPRESSED SUICIDAL THOUGHTS, OR
- HAVE HISTORY OF SELF-DESTRUCTIVE BEHAVIOR
- SHOULD BE PLACED UNDER CLOSE WATCH
 - PHYSICALLY OBSERVE IN GENERAL POPULATION AT STAGGERED INTERVALS NOT TO EXCEED EVERY 15 MINUTES

B. HIGH RISK SUICIDAL INMATES

- ACTIVELY SUICIDAL BY THREATENING AND/OR ENGAGING IN ACT OF SUICIDE OR SELF-DESTRUCTIVE BEHAVIOR; OR FROM VERY RECENT ATTEMPT

- CONSTANT PHYSICAL WATCH SHOULD OCCUR
- MUST BE OBSERVED BY STAFF CONTINUOUSLY WITHOUT INTERRUPTION

C. OTHER ISSUES

- 1) SUICIDAL INMATES SHOULD BE HOUSED IN SUICIDE-RESISTANT, PROTRUSION-FREE CELLS, DESCRIBED IN CHAPTER 16
 - PREFERRED CELLS SHOULD BE LOCATED IN VISIBLE, HIGH TRAFFIC AREAS:
 - BOOKING AREA
 - RECEIVING/DISCHARGE UNIT(S)
 - NEAR OFFICER'S/NURSE'S STATION
 - INFIRMARY
- 2) BELTS, TIES, SUSPENDERS, SHOELACES, CHAINS AND STRAPS SHOULD BE REMOVED
 - ORDINARY CLOTHING SHOULD BE RETAINED UNLESS BEHAVIOR CLEARLY DICTATES OTHERWISE
 - IN EXCEPTIONAL CASES WHERE CLOTHING IS REMOVED, PAPER GOWN SHOULD BE ISSUED
- 3) CONSTANT WATCH SHOULD PRECLUDE CLOTHING REMOVAL AND RESTRAINT USE
- 4) AUDIO AND CCTV MONITORING SHOULD ONLY BE A SUPPLEMENT TO STAFF OBSERVATION

- 5) RESTRAINT USE AND CLOTHING REMOVAL SHOULD EXIST ONLY AS LAST RESORT DURING TIME OF ACTUAL SELF-DESTRUCTIVE BEHAVIOR

D. DECELERATION AND REMOVAL OF INMATES FROM SUICIDE WATCH

- 1) CONTINUING SUICIDE ASSESSMENT SHOULD BE DONE FREQUENTLY
 - CONSTANT WATCH INMATES - EVERY 24 HOURS
 - EVERY 24 HOURS IF MEDICAL/MENTAL HEALTH STAFF ARE AVAILABLE
 - AT LEAST EVERY 7 DAYS IF FULL-TIME COVERAGE NOT AVAILABLE
 - ALL KEY STAFF SHOULD BE CONSULTED: CORRECTIONAL AND HEALTH CARE
- 2) CONSTANT WATCH INMATES SHOULD BE DECELERATED TO CLOSE WATCH AFTER ASSESSMENT
- 3) WHEN REMOVED FROM CLOSE WATCH, INMATES SHOULD BE PLACED IN GENERAL POPULATION (UNLESS SAFETY OR SECURITY DICTATES OTHERWISE)
- 4) NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE'S STANDARDS FOR HEALTH SERVICES IN JAILS STRESSES:
 - MENTAL STATUS OF INMATE CAN CHANGE ANYTIME
 - IMPERATIVE FOR STAFF TO HAVE GOOD OBSERVATIONAL SKILLS AND KNOWLEDGE OF SUICIDE SIGNS/SYMPTOMS
 - WHEN STAFF FEEL GREATER PRECAUTIONS ARE NEEDED, HEALTH CARE STAFF SHOULD BE NOTIFIED

13. MANAGING POTENTIALLY SUICIDAL INMATES

A. GENERAL PRINCIPLES

- HUMAN INTERACTION BY OFFICERS WHO FOLLOW GOLDEN RULE IS BEST SUICIDE PREVENTION
- SUICIDE PREVENTION GREATLY INFLUENCED BY STAFF ATTITUDES:
 - BE RESPECTFUL; BE CONSIDERATE; BE DIRECT

B. CHARACTERISTICS OF PROFESSIONAL CORRECTIONAL STAFF:

- 1) EXHIBITS FAIRNESS - NUMBER ONE AMONG ALL OFFICER TRAITS
- 2) SHOWS NO FAVORITISM - BECAUSE IT IS NOT FAIR
- 3) KEEPS PROMISES - BROKEN PROMISES ARE LIES TO INMATES
- 4) USES AUTHORITY AND POWER CONSTRUCTIVELY - OFFICERS WITH SELF-RESPECT HAVE NO WISH FOR "POWER"
- 5) ADMITS MISTAKES - IN ADMITTING MISTAKES, WE ELEVATE OURSELVES
- 6) NO PUT-DOWNS, OR IS NOT CONDESCENDING - SELF-CONFIDENT, SELF-RESPECTING OFFICERS DON'T PUT PEOPLE DOWN
- 7) NO WASHING OF DIRTY LINEN - NO OPEN CRITICISM OF STAFF- DEVASTATING, NON-TEAM PRACTICE

- 8) ANSWERS QUESTIONS - A REASONABLE ANSWER PROMOTES COMMUNICATION AND RESPECT FOR OTHERS
- 9) ASKS, NOT ALWAYS ORDERS TO DO SOMETHING -ASKING BRINGS BETTER RESULTS. YOU CAN ALWAYS ORDER LATER
- 10) CONSISTENCY - USED REASONING - EVERYONE RESPECTS CONSISTENCY
- 11) TALKS WITH US - GETTING AN INMATE TO TALK, A KEY FACTOR IN SUICIDE PREVENTION, REQUIRES OFFICER INVOLVEMENT AND SHOWS RESPECT
- 12) WE LOOK UP TO THEM - OFFICERS WHO ARE POSITIVE ROLE MODELS ARE MORE LIKELY TO DETER SUICIDES
- 13) ARE TEAM WORKERS - "TEAM EFFORTS ACCOMPLISH MORE"
- 14) SELF-CONFIDENT, NOT ARROGANT - SELF-RESPECT PRODUCES SELF-CONFIDENCE
- 15) DEMONSTRATES SINCERITY AND HONESTY -THESE TWO ARE FOUNDATION OF OTHER POSITIVE TRAITS
- 16) GIVES CREDIT WHEN CREDIT IS DUE - EMPHASIS ON POSITIVES PRODUCES MORE POSITIVES - DIRELY NEEDED IN OUR FIELD
- 17) ACCEPTS CONSTRUCTIVE CRITICISM, IS NOT DEFENSIVE - THE BETTER WORKER GROWS BY ACCEPTING/BENEFITING FROM HONEST CRITICISM
- 18) THEY HAVE OPEN MINDS - WITHOUT IT, LEARNING STOPS
- 19) DOESN'T KEEP THREATENING - OR YOU WILL NEVER EARN RESPECT

- 20) LEAVES PERSONAL PROBLEMS AT HOME
- 21) NO YELLING OR SWEARING - POSITIVE ROLE MODEL OFFICERS DON'T DO IT
- 22) THEY DO MORE THAN IS EXPECTED OF THEM - THE 2% EXTRA EFFORT CAN MAKE 100% DIFFERENCE
- 23) THEY ARE PATIENT - PATIENCE REFLECTS SELF-CONFIDENCE AND RESPECT FOR OTHERS
- 24) DOESN'T GIVE UP EASILY - WHEN WE GIVE UP, THEIR LAST HOPE IN LIFE MAY FADE
- 25) DOESN'T PREACH - POSITIVE EXAMPLE ACCOMPLISHES MORE THAN PREACHING
- 26) THEY CARE- CARING OFFICERS WHO SHOW IT CAN SAVE LIVES

c. COMMUNICATING AND INTERACTING WITH SUICIDAL INMATES

- FEW SUICIDES ACTUALLY PREVENTED BY HEALTH CARE STAFF
- JAIL/CORRECTIONAL OFFICERS, WHO WORK IN HOUSING UNITS (WHERE MOST SUICIDES OCCUR) ARE THE BACKBONE OF ACTUAL PREVENTION
- THESE STAFF RESPONSES FORM EFFECTIVE BRIDGES TO COMMUNICATION WITH SUICIDAL INMATES:
 - 1) LISTEN PATIENTLY
 - ENCOURAGE INMATE TO TALK
 - ENCOURAGE VERBALIZATION OF SUICIDE PLAN

2) TRUST OWN JUDGMENT

- IF YOU BELIEVE INMATE IS SUICIDAL, ACT ON YOUR BELIEFS
- DON'T LET ANYONE MISLEAD YOU INTO IGNORING SUICIDAL SIGNALS
- IMPLEMENT SUICIDE PRECAUTIONS PER ESTABLISHED PROCEDURES

3) MAINTAIN CONTACT

- LISTENING AND CONVERSATION
- EYE CONTACT/BODY LANGUAGE
- EXPRESS YOUR CONCERNS ABOUT INMATE

4) TRY TO KEEP INMATE'S SENSE OF FUTURE POSITIVE

- UPDATE INMATE ON POSITIVE FAMILY CONCERNS
- ANSWER OR MAKE REFERRAL CONCERNING "FEAR OF THE UNKNOWN"
QUESTIONS REGARDING JUSTICE SYSTEM THAT POLICY ALLOWS

5) STAY WITH THE INMATE

- STAY WITH INMATE UNTIL ASSISTANCE ARRIVES

6) TAKE ALL THREATS SERIOUSLY AND MAKE IMMEDIATE REFERRAL

- NUMEROUS SUICIDE DEATHS OCCUR BECAUSE STAFF ASSESS GESTURES AS BEING ONLY MANIPULATIVE
- IMMEDIATE REFERRAL IS CRUCIAL

THE FOLLOWING STAFF RESPONSES ARE BARRIERSTO EFFECTIVE COMMUNICATION. YOU SHOULD NOT :

1) OFFER SOLUTIONS OR GIVE ADVICE

- YOUR JOB IS NOT TO DIAGNOSE BUT TO REPORT SIGNS/SYMPTOMS

2) BECOME ANGRY, JUDGMENTAL OR THREATENING

3) ACT SARCASTIC OR MAKE JOKES

4) MAKE PROMISES WHICH CAN'T BE KEPT

5) CHALLENGE INMATE TO MAKE GOOD ON THREAT (REVERSE PSYCHOLOGY IS DANGEROUS)

6) IGNORE SUICIDAL RISK OR THREAT

D. DEALING WITH MANIPULATIVE INMATES

- MANIPULATION FOR SECONDARY GAINS IS COMMON IN JAIL SUICIDE ATTEMPTS/ GESTURES

- FEIGNED SUICIDE ATTEMPTS OFTEN END UP AS DEATHS

- RECOMMENDED GUIDELINES FOR MANAGEMENT OF MANIPULATIVE INMATES ARE:

- 1) USE PREVENTIVE STEPS (E.G., INCREASED SUPERVISION) TO DETER BEHAVIOR

- 2) AVOID ISOLATION AS IT CAN ESCALATE BEHAVIOR TO MORE SERIOUS GESTURES

- 3) YOUR JOB IS NOT TO ASSESS MANIPULATION; SIMPLY OBSERVE AND DOCUMENT
- 4) REFER INMATE TO HEALTH CARE PERSONNEL FOR ASSESSMENT
- 5) AVOID USING TERM “MANIPULATION” ‘IN DOCUMENTATION
 - OTHER STAFF WILL FOLLOW SUIT
 - WORSENS LIABILITY RISK

E. SUICIDE ASSESSMENT AND MENTAL HEALTH REFERRAL

- WHEN SIGNS/SYMPTOMS APPEAR, REFER TO MENTAL HEALTH
- WHERE UNAVOIDABLE, TRAINED OFFICERS CAN EFFECTIVELY ASSESS AND MANAGE SUICIDE RISKS
- THE TRAINED OFFICER IS THE BACKBONE OF SUICIDE DETECTION AND PREVENTION
- IN SMALL JAILS, OFFICERS TAKE PROACTIVE ROLE IN INVOLVING FAMILY MEMBERS IN PREVENTION EFFORTS
- TRUE TEAM APPROACH IS KEY TO SUCCESSFUL SUICIDE PREVENTION
 - MUTUAL RESPECT OF BOTH JAIL STAFF AND MENTAL HEALTH PERSONNEL IS ESSENTIAL
 - COMMITMENT NEEDED THAT WORKING IN UNISON IS ESSENTIAL FOR SUICIDE PREVENTION
 - NEITHER THE OFFICER NOR MENTAL HEALTH STAFF WORKING ALONE CAN ENSURE THE SAFETY AND EMOTIONAL WELL-BEING OF THE INMATE

14. INTERVENTION: STANDARD FIRST AID FOR HANGING ATTEMPTS

- JAIL POLICY ON INTERVENTION FOR SUICIDE ATTEMPTS SHOULD REQUIRE:
 - ALL DIRECT SERVICE STAFF ARE TRAINED IN STANDARD FIRST AID, INCLUDING CARDIOPULMONARY RESUSCITATION (CPR)
 - CPR REFRESHER TRAINING SHOULD BE DONE AT LEAST EVERY TWO YEARS
 - STAFF DISCOVERING ATTEMPTED SUICIDE SHOULD:
 - 1) RESPOND IMMEDIATELY
 - 2) SURVEY SCENE TO ASSURE NO SECURITY BREACH
 - 3) HAVE SOMEONE CALL AMBULANCE NOW
 - 4) ADMINISTER BASIC FIRST AID
 - NEVER ASSUME AN INMATE IS DEAD; ONLY A PHYSICIAN/OTHER QUALIFIED PERSON, CAN DECLARE DEATH
 - 1) FIRST AID MUST BE INITIATED
 - 2) CONTINUED UNTIL RELIEVED BY ARRIVING MEDICAL PERSONNEL
 - STAFF CAN BE LIABLE FOR NOT ACTING PROMPTLY AND EFFECTIVELY
 - 1) NEVER LET VICTIM HANG TO PROTECT “SCENE OF THE CRIME”

2) WHEN NO VITAL SIGNS EXIST, THAT IS THE DUTY OF CARE SIGNAL TO PURSUE CPR QUICKLY

- HANGINGS MAKE UP 94% OF JAIL SUICIDES

1) STRUCTURES IN THE NECK MAY BE AFFECTED

2) MAY INCLUDE AIRWAY, SPINAL CORD, MAJOR BLOOD VESSELS SUPPLYING BRAIN

A. DISPOSITION FOLLOWING HANGING ATTEMPT

1) CUT DOWN VICTIM IMMEDIATELY, PROTECTING HEAD AND NECK

2) FAILURE TO HAVE READY ACCESS TO RECOGNIZED CUTTING TOOL INFLUENCES SOME DEATHS

- SEAT BELT CUTTERS USED BY RESCUE SQUADS ARE CARRIED IN CASE ON BELT IN SOME JAILS

- THE "911 RESCUE TOOL" SHOULD AT LEAST BE READILY AVAILABLE AT EACH OFFICER'S POST

B. RESCUE BREATHING AND CPR

THE AMERICAN RED CROSS RECOMMENDS THESE PROCEDURES:

1) RESCUE BREATHING (IF VICTIM NOT BREATHING)

a. ROLL PERSON ONTO BACK, PULLING SLOWLY TOWARD YOU

b. OPEN AIRWAY

- IF NO HEAD/NECK INJURY IS EVIDENCED, USE “HEAD LIFT-CHIN LIFT” MANEUVER
- IF HEAD OR NECK INJURY SUSPECTED, USE “MODIFIED JAW-THRUST” MANEUVER WITHOUT HEAD TILT
 - PLACE FINGERS BEHIND ANGLES OF LOWER JAW
 - FORCEFULLY BRING JAW FORWARD
 - USE THUMB TO PULL LOWER LIP DOWN TO ALLOW MOUTH AND NOSE BREATHING
- SAFEST INITIAL APPROACH TO OPEN AIRWAY IS THE MODIFIED JAW THRUST WITHOUT TILTED HEAD. IF UNSUCCESSFUL, TILT HEAD BACKWARD SLIGHTLY

c. CHECK BREATHING FOR 3-5 SECONDS

d. TWO FULL BREATHS, FOLLOWING STANDARD APPROACH

e. CHECK FOR NECK PULSE FOR 5-10 SECONDS

f. BEGIN RESCUE BREATHING, ONE BREATH EVERY FIVE SECONDS

- CHECK BREATHING BETWEEN BREATHS

g. RECHECK PULSE EVERY MINUTE FOR 5-10 SECONDS

- IF PULSE EXISTS BUT NO BREATHING, CONTINUE RESCUE BREATHING
- IF ALSO NO PULSE, BEGIN CPR

2) CPR ADMINISTRATION

- a. FOLLOW “a” ABOVE FOR RESCUE BREATHING
- b. FOLLOW “b” AND “c” ABOVE
- c. FOLLOW “d” ABOVE
- d. FOLLOW “e” ABOVE
- e. FIND HAND POSITION
 - ‘PLACE HEEL OF ONE HAND IMMEDIATELY ABOVE NOTCH IN BREASTBONE.
 - PLACE SECOND HAND ATOP OTHER HAND
- f. GIVE 15 COMPRESSIONS
 - POSITION SHOULDERS OVER HANDS
 - COMPRESS BREASTBONE UP TO TWO INCHES
 - DO ONE COMPRESSION PER SECOND
- g. GIVE TWO FULL BREATHS

h. REPEAT COMPRESSION/BREATHING CYCLE

- DO FOUR CYCLES OF 15 COMPRESSIONS AND TWO BREATHS
- CHECK FOR PULSE AFTER ONE MINUTE
- IF NO PULSE, GIVE TWO FULL BREATHS AND CONTINUE CPR

C. EMERGENCY RESCUE EQUIPMENT

- EACH JAIL, AT A MINIMUM, SHOULD HAVE FOLLOWING ITEMS IN EACH HOUSING UNIT:
 - FIRST AID KIT
 - EMERGENCY RESCUE CUTTING TOOL
 - CPR FACE MASK/RESCUE BREATHER
 - LATEX GLOVES

D. CAUTION

- ONLY A PHYSICIAN OR OTHER PROFESSIONAL AS DESIGNATED BY STATE LAW, CAN DECLARE DEATH
- UNTIL THEN, FIRST AID/CPR MUST BE ~~INITIATED~~ AND ~~CONTINUED~~ UNTIL RELIEVED BY QUALIFIED MEDICAL PERSONNEL

15. FOLLOW-UP: ADMINISTRATIVE REVIEW, PSYCHOLOGICAL AUTOPSY,
AND SUPPORT FOR STAFF

- EACH COMPLETED SUICIDE AND ATTEMPT REQUIRING HOSPITALIZATION SHOULD RESULT IN ADMINISTRATIVE REVIEW AND/OR PSYCHOLOGICAL AUTOPSY
 - WITH GOAL TO REDUCE LIKELIHOOD OF FUTURE INCIDENTS
 - ALL STAFF INVOLVED SHOULD PARTICIPATE
 - IDEALLY, OUTSIDE AGENCY SHOULD COORDINATE REVIEW

A. ADMINISTRATIVE REVIEW

- SHOULD BE SEPARATE AND APART FROM OFFICIAL INVESTIGATION
 1. CRITICAL REVIEW OF CIRCUMSTANCES SURROUNDING INCIDENT
 2. CRITICAL REVIEW OF RELEVANT JAIL PROCEDURES
 3. SYNOPSIS OF RELEVANT TRAINING RECEIVED BY INVOLVED STAFF
 4. PERTINENT HEALTH CARE REPORTS
 5. RECOMMENDATIONS FOR CHANGES
 - P O L I C Y
 - TRAINING
 - PHYSICAL PLANT

- HEALTH SERVICES
- OPERATIONAL PROCEDURES

B. PSYCHOLOGICAL AUTOPSY

- CLINICAL EXAMINATION OF THE INMATE SUICIDE IS RECOMMENDED
 - SHOULD NOT BE A FINGER POINTING PROCESS
 - PROVIDES OPPORTUNITY TO LEARN
 - PROVIDES EMOTIONAL SUPPORT FOR STAFF
 - INVOLVES INTERVIEWS WITH:
 - 1) JAIL STAFF INVOLVED IN SUICIDE
 - 2) INMATES WHO HAD CONTACT WITH VICTIM
 - 3) FAMILY MEMBERS
 - 4) FRIENDS OF DECEASED
- PROCESS INVOLVES DATA COLLECTION
 1. NAME, AGE, MARITAL STATUS, ETHNICITY, ETC.
 2. DETAILS OF DEATH
 - METHOD
 - DATE
 - TIME
 - HOW DISCOVERED
 - BY WHOM

3. DECEASED'S HISTORY

- SOCIAL.
- LEGAL
- INCARCERATION ADJUSTMENT
- FAMILY/PEER RELATIONSHIPS
- PSYCHIATRIC HISTORY
- MEDICAL HISTORY

4. PRE-DISPOSING FACTORS

- DEMOGRAPHIC
- PSYCHIATRIC TREATMENT
- PERSONALITY STYLE
- ROLE OF ALCOHOL/DRUGS IN LIFESTYLE AND DEATH
- DEATH TRENDS IN FAMILY

5. PRECIPITANTS (RECENT CHANGES AND LOSSES)

6. CLUES TO SUICIDE BEFORE DEATH

- BEHAVIORAL
- AFFECTIVE
- DIRECT/INDIRECT COMMUNICATIONS
- FANTASIES, DREAMS, PREOCCUPATIONS

7. REACTIONS OF STAFF TO INMATE'S DEATH

8. RECOMMENDATIONS FOR CHANGES:

- IMPROVING SCREENING
- REFERRALS
- TREATMENT SERVICES
- TRAINING
- T R A I N I N G
- PROCEDURES

c. SUPPORT FOR STAFF

AN INMATE SUICIDE CAN BE EXTREMELY STRESSFUL

- FEELINGS OF ALIENATION
 - BEING OSTRACIZED BY PEERS/ADMINISTRATION
 - MISPLACED GUILT
 - “WHAT IF I HAD . . .”
- STAFF NEED ASSURANCE FROM ADMINISTRATION THAT THEY NEED NOT BEAR RESPONSIBILITY FOR AN INMATE’S DECISION TO TAKE HIS/HER LIFE
 - STAFF EXPECTED TO DO REASONABLE JOB IN PROTECTING INMATE FROM TAKING HIS/HER LIFE
 - ADMINISTRATION, WITH SUPPORT FROM MENTAL HEALTH STAFF, SHOULD DISCUSS FEELINGS WITH CONCERNED STAFF
 - PROFESSIONAL COUNSELING SERVICES MAY BE NEEDED FOR STAFF AND ANY INMATES AFFECTED
 - CRITICAL INCIDENT STRESS DEBRIEFING (CISD) PROCESS IS USED IN SOME JAILS, CONSISTING OF TRAINED TEAM:

- LAW ENFORCEMENT
 - PARAMEDICS
 - FIREFIGHTERS
 - MENTAL HEALTH PROFESSIONALS
 - CLERGY
- CISD OCCURS WITHIN 24-72 HOURS, FOR 2-4 HOURS IN LENGTH
 - THOUGHTS/FEELINGS PROCESSED
 - CRITICAL STRESS SYMPTOMS DISCUSSED
 - WAYS OF DEALING WITH SYMPTOMS ARE DEVELOPED
 - ALL METHODS USED MUST ASSURE CONFIDENTIALITY
 - KEPT SEPARATE AND APART FROM INVESTIGATIVE PROCESS AND LIABILITY ISSUES
 - DESPITE BEST EFFORTS, SUICIDES OCCUR
 - STAFF OFTEN BLAME THEMSELVES FOR “NOT HAVING DONE BETTER”
 - THESE FEELINGS NEED TO BE RECOGNIZED AND DEALT WITH OPENLY
 - KEY IS IMMEDIATE ENCOURAGEMENT AND SUPPORT FROM ADMINISTRATION OFFICIALS

16. THE IMPACT OF JAIL DESIGN ON INMATE MANAGEMENT AND SUICIDE PREVENTION - PROTRUSION-FREE ARCHITECTURE AND ENVIRONMENT

A. JAIL DESIGN

- POOR JAIL DESIGN AND LAYOUT INFLUENCE MANY SUICIDES
 - GREATLY AFFECT MONITORING AND SUPERVISION
- ACA STANDARD 3-ALDF-3A-03
 - OFFICERS MUST BE STATIONED IN OR IMMEDIATELY ADJACENT TO HOUSING AREAS
- ACA STANDARD 3-ALDF-4E-24
 - OFFICER MUST RESPOND TO SCENE WITHIN FOUR MINUTES TO EMERGENCIES
- ACA STANDARD 3-ALDF-2C-01/3-ALDF-2C-12
 - ALL GENERAL POPULATION AND SEGREGATION CELLS PROVIDE A MINIMUM OF 80 SQUARE FEET, OF WHICH 35 SQUARE FEET IS UNENCUMBERED SPACE
- CELLS LAID OUT ON LINEAR BASIS DOWN LONG HALLWAY MUCH MORE DIFFICULT TO MONITOR THAN IN POD OR MODULE:
 - WITH OFFICER INSIDE

- BETTER INTERACTION AND COMMUNICATION
- BEHAVIOR CHANGES PICKED UP QUICKER
- SUICIDE PREVENTION MORE LIKELY
- DIRECT SUPERVISION JAIL CONCEPT CLEARLY SUPPORTS NOT ONLY BETTER SUICIDE PREVENTION BUT ALLEVIATES MANY OTHER JAIL PROBLEMS
- PROPER JAIL DESIGN IS GOOD INSURANCE FOR ALLEVIATING LIABILITY, ESPECIALLY WITH ALL TOO OFTEN INADEQUATE JAIL STAFFING AND OVERCROWDING

1). PROTRUSION-FREE ARCHITECTURE AND ENVIRONMENT

- 'PROTRUSIONS WHICH GIVE EASY ACCESS FOR ANCHORING DEVICES IN JAIL CELLS/ ROOMS CAN BE VIRTUALLY ELIMINATED:
 - BARS
 - AIR GRILLES
 - CLOTHING HOOKS
 - TOWEL RACKS
 - BEDS
 - SPRINKLERS
 - SHELVES
 - DOOR HINGES, HANDLES AND KNOBS
 - WATER FAUCET LIP PROJECTION
 - TOILET PAPER HOLDERS. AND SOAP TRAYS
- CAUTION: SUICIDES STILL OCCUR IN PROTRUSION-FREE CELLS THROUGH IMAGINATIVE MEANS

- COMPLACENCY MUST BE GUARDED AGAINST
 - 1) AVOID ISOLATION
 - 2) SPECIAL MANAGEMENT UNITS, CELLS OR ROOMS (FOR POTENTIALLY SUICIDAL AND MENTALLY ILL INMATES), ADMINISTRATIVE SEGREGATION AND HOLDING CELLS
 - a. WALLS/DOORS OF STEEL BARS COVERED INSIDE FROM FLOOR TO CEILING WITH:
 - (1) ONE-FOURTH-INCH SCRATCH-RESISTANT POLYCARBONATE GLAZING, OR
 - (2) SECURITY SCREEN OR THIN STEEL PLATE, WITH HOLES NO MORE THAN 3/16 INCHES WIDE, OR 16 MESH PER SQUARE INCH
 - b. SOLID WALL CELL FRONTS AND DOORS (AND THOSE WITH PEEPHOLES) SHOULD BE CHANGED TO LARGE-VISION PANELS OF LOW ABRASION POLYCARBONATE
 - c. MODIFY VENTS, DUCTS, GRILLES, LIGHT FIXTURES, OTHER PROTRUSIONS WITH SECURITY SCREEN
 - d. BALL-IN-SOCKET TYPE CLOTHING LATCHES TO REPLACE TRADITIONAL, PULL-DOWN LATCH WITH SIDE SUPPORTS
 - NO U-SHAPED TOWEL RACKS
 - e. STAINLESS STEEL COMBO TOILET-SINK, WITHOUT CURVED PROJECTION OVER WATER SPOUT, REMOVE TOOTHBRUSH HOLDER

- f. BEDS OF SOLID CONCRETE WITH ROUNDED EDGES OR HEAVY MOLDED PLASTIC, TOTALLY ENCLOSED UNDERNEATH
 - TYPICAL STEEL BEDS WITH HOLES IN THE BOTTOM, NOT BUILT FLUSH TO THE WALL OPEN UNDERNEATH, OFTEN USED TO ATTACH ANCHORING DEVICES
- g. NO ELECTRICAL OUTLETS IN THE CELL OR ROOM
- h. LIGHT FIXTURES RECESSED IN CEILING AND TAMPER-PROOF
 - SOME FIXTURES CAN BE SECURELY ANCHORED IN CEILING OR WALL CORNERS
 - AMPLE LIGHT FOR READING, AT LEAST 20 FOOTCANDLES AT DESK LEVEL
 - LOW-WATTAGE NIGHT LIGHT BULBS
 - IN SPECIAL, HIGH-RISK SUICIDE UNITS, SUFFICIENT LIGHTING 24 HOURS PER DAY PROVIDED TO ALLOW CCTV CAMERA TO PICK UP ALL MOVEMENTS AND FORMS
- i. CELLS AND ROOMS PAINTED IN PASTEL COLORS
- j. ROOMS SHOULD HAVE SMOKE DETECTOR MOUNTED FLUSH IN THE CEILING WITH AN AUDIBLE ALARM AT THE CONTROL DESK
 - WATER SPRINKLERS IN JAIL CELLS SHOULD NOT BE EXPOSED

- FLUSH WITH CEILING
 - PROTECTIVE CONE
- k. ROOMS WITH AUDIO MONITORING INTERCOM FOR LISTENING TO CALLS OF DISTRESS
- SHOULD BE TURNED UP HIGH AS HANGING VICTIMS OFTEN CAN BE HEARD GURGLING, GASPING FOR AIR AND HITTING BODY ON WALL OR BARS
- i. SUICIDAL OBSERVATION ROOM OR HOUSING UNIT LOCATED NEAR CONTROL OR NURSING STATION
- m. MODESTY SHIELDS OR SCREENS: TRIANGULAR, ROUNDED OR SLOPING TOPS: FEET VISIBILITY
- n. INMATES HANG THEMSELVES UNDER DESKS, BENCHES, STOOLS, PULL-OUT SEATS: THE CAN BE MADE SUICIDE-RESISTANT:
- EXTEND BED SLAB FOR SEAT
 - ANCHORED CUBE OR CYLINDER-SHAPED SEAT, ROUNDED EDGES
 - TRIANGULAR DESK TOP ANCHORED FLUSH TO WALL IN CORNER
 - RECTANGULAR DESK TOP ANCHORED TO WALL, WITH TRIANGULAR STEEL OR WOODEN END PLATES ON TOP
- o. SHELF TOPS AND EXPOSED HINGES SHOULD HAVE SOLID, TRIANGULAR END PLATES, WHICH PRECLUDE A NOOSE BEING APPLIED

- p. SUICIDE CELLS SHOULD HAVE SECURITY WINDOWS WITH AN OUTSIDE VIEW
- q. MATTRESS SHOULD BE FIRE RETARDANT AND NOT PRODUCE TOXIC SMOKE
 - SEAM SHOULD BE TEAR-RESISTANT
- r. MIRRORS SHOULD BE OF BRUSHED, POLISHED METAL, NOT GLASS OR PLASTIC, ATTACHED WITH TAMPER-PROOF SCREWS
- s. COMPUTER LOGGING SYSTEM THAT RECORDS WITH PLASTIC KEY OR CREDIT-CARD TYPE VERIFIER AT EACH DOOR OF SUICIDE CELLS VISITED SHOULD BE IMPLEMENTED
 - TAMPER-PROOF SYSTEM SUCH AS THIS NEEDED IN SUCCESSFUL DEFENSE OF LAWSUITS
- t. PADDING OF WALLS NOT ALLOWED IN MANY STATES
 - IF PERMITTED, MUST BE FIRE-RETARDANT MATERIALS, NOT COMBUSTIBLE OR PRODUCING NO TOXIC GASES

3) GENERAL JAIL POPULATION SLEEPING AREAS

- MANY RECOMMENDATIONS MADE FOR SPECIAL MANAGEMENT, ADMINISTRATIVE SEGREGATION AND HOLDING CELL INMATES APPLY TO GENERAL POPULATION
- NEW FACILITIES' SLEEPING AREAS CAN BE BUILT SUICIDE-RESISTANT AT NO COST

- CAN SAVE EXPENSES OF LATER REMODELING, AS VARIOUS JAILS HAVE DONE FOLLOWING LAWSUITS OVER SUICIDES
 - SUICIDES DO OCCUR AMONG GENERAL INMATE POPULATIONS
 - SOME JAILS HAVE REMOVED EASY-ACCESS FIXTURES BY REMODELING OLD FACILITIES AFTER SUICIDES
- 4) NEW CONSTRUCTION: SPECIAL MANAGEMENT UNITS, ADMINISTRATIVE SEGREGATION AND HOLDING AREAS
- IN ADDITION TO PHYSICAL ENVIRONMENT MODIFICATIONS FOR EXISTING STRUCTURES, OUTLINED EARLIER, THE FOLLOWING GUIDE SHOULD BE CONSIDERED FOR SLEEPING AREAS:
 - a. NEW FACILITIES SHOULD MEET AMERICAN CORRECTIONAL ASSOCIATION'S STANDARDS FOR ADULT LOCAL DETENTION FACILITIES
 - b. DOORS SHOULD BE SLIDING METAL TYPE TO REDUCE OPPORTUNITY OF BARRICADING AND SLAMMING DOOR INTO OFFICER'S FACE
 - UPPER HALF SHOULD HAVE POLYCARBONATE VIEWING PANEL THAT PROVIDES CLEAR, UNOBSTRUCTED VIEW OF ROOM OR CELL
 - ALTERNATIVE IS TO USE DETENTION SCREENING WHICH ALLOWS CIRCULATION AND BETTER HEARING
 - c. CEILING HEIGHT SHOULD BE 10 FEET
 - d. THE FLOOR SURFACE SHOULD BE NON-SLIP, TREATED CONCRETE

- NO TILE
- NOTHING THAT CAN BE REMOVED
- e. SECURE FLOOR DRAIN PLACED AT A LOW SLOPE IN FLOOR
- f. CORNERS OF WALLS 'IN FLOOR AND CEILING OF CELLS SHOULD HAVE ROUNDED EDGES FOR SANITARY AND SAFETY REASONS
- g. JOINTS AT CEILING SEALED WITH NEOPRENE RUBBER

17. CONTROVERSIAL ISSUES IN SUICIDE PREVENTION

- A. CONTRACTS NOT TO COMMIT SUICIDE, WITH PROMISE THAT TREATMENT WILL BE PROVIDED
- CONTRACTORS REPORT-GOOD SUCCESS WITH CONCEPT
 - DANGER IS NOT ALL PROMISES FOR SERVICE DELIVERY ARE KEPT, OR
 - INMATE MISINTERPRETS INTENT OF CONTRACT, NAMELY WHEN TREATMENT ENDS, SO DOES COMMITMENT
- B. STRIPPING POTENTIAL SUICIDAL INMATES NAKED
- PRACTICE IS DEGRADING AND CAN WORSEN DEPRESSION
 - PLACING INMATE UNDER CONDITIONS WORSE THAN IN GENERAL POPULATION CAN RESULT IN FAILURE TO DISCLOSE INTENTIONS AND FALSELY “GETTING WELL FAST” TO ESCAPE SUBSTANDARD CONDITIONS
 - MORE SUITABLE MEASURES RECOMMENDED ARE:
 - CONSTANT OR CLOSE SUPERVISION BY STAFF
 - SUICIDE-RESISTANT CELL
 - PLACE WITH TWO OR MORE SELECTED AND TRAINED INMATES WHO CAN ALERT STAFF TO CRISES, YET HAVE NO CONTROL OVER SUICIDAL INMATE

- GREATER EMPHASIS SHOULD BE GIVEN TO PROVIDING ESSENTIAL HUMAN INTERACTION AND ALTERNATIVE SOLUTIONS AND SERVICES
- c. USING CLOSED CIRCUIT TELEVISION (CCTV) AS MAJOR MONITORING INSTRUMENT AND “PUTTING SUICIDAL INMATE ON CAMERA VIOLATES RIGHT TO PRIVACY”
 - CCTV A SUPPLEMENT TO OFFICER’S PHYSICAL OBSERVATIONS
 - VARIOUS INMATES COMMIT SUICIDE “ON CAMERA”
 - “MONITOR HYPNOSIS” CLAIMED BY OFFICERS
 - ONE OFFICER WATCHED FOR 85 MINUTES BUT DIDN’T SEE HANGING
 - VARIOUS JAILS ROTATE OFFICERS ON MONITOR WATCH PERIODICALLY
 - CAUTION: NO MORE THAN ONE HOUR WITHOUT A BREAK
 - CCTV OFTEN BROKEN DOWN OR FUZZY
 - DISPATCHING AND OTHER DISTRACTIONS IMPAIR USE
 - 24-HOUR MONITORING OF SUICIDAL INMATE ON CCTV NOT VIOLATION OF PRIVACY RIGHTS; LIFE SAFETY COMES FIRST
 - PRESENCE OF CCTV MAY ENCOURAGE ACTING-OUT, MANIPULATIVE BEHAVIOR

D. RATING SCALES

- VARIOUS SUICIDE EXPERTS DISAGREE WITH USE OF RATING SCALE ON DEGREE OF LETHALITY
 - “NO ONE CAN BE THAT EXACT OR SKILLFUL”
- “ALL THREATS MUST BE TAKEN SERIOUSLY” DISAVOWS RATINGS
 - NINTH “WOLF CRY” MUST BE HANDLED AS FIRST SUICIDE THREAT
 - THERE IS NO “MANIPULATION” IN JAIL SUICIDE
- ALLOW WIDE DISCRETION IN REFERRAL TO MENTAL HEALTH

E. SUICIDE PROFILES: THE “TYPICAL” SUICIDE - DOES IT EXIST?

- PROFILES MEANT TO “SENSITIZE” JAIL PERSONNEL TO COMMON CHARACTERISTICS
- CAUTION NECESSARY ON USE OF PAPER PROFILES
- WHAT HAPPENS AT ARREST, TRANSPORTATION, BOOKING AND DURING CONFINEMENT IS MOST IMPORTANT
- LOCAL/REGIONAL JAIL SUICIDE PROFILES MORE APPROPRIATE
 - AWARENESS TRAINING IN SIGNS/SYMPTOMS ENCOURAGES USE OF PROFILE FACTORS IN SUICIDE ASSESSMENT

- NO TYPICAL SUICIDE CASE
 - EACH IS UNIQUE COMBINATION OF FACTORS

F. POLICY ON “NEVER ENTER A CELL WITHOUT BACKUP”

- FLEXIBLE POLICY ADVOCATED
 - OFFICER MUST BE ALLOWED TO MAKE JUDGMENT DECISIONS
- MAJORITY OF JAILS HAVE ONE DISPATCHER-JAILER ON DUTY
 - DEATHS OCCUR DUE TO “NEVER ENTER” POLICY
- WORKABLE APPROACHES:
 - ASSESS: “IS HE REALLY HANGING?”
 - PUSH BODY WARNING SENSOR AND LOCK DOWN INMATE POPULATION
 - USE ONE OR TWO SELECTED INMATES TO ASSIST

G. PROTECTING THE SCENE OF THE CRIME

- SOME JAILS FOUND LIABLE WHEN OFFICERS STAND BY AND LET INMATE HANG --To PROTECT SCENE
- PRESERVING LIFE CLEARLY OVERRIDES “PROTECTING SCENE”

H. WHEN NO VITAL SIGNS EXIST, PRESUME DEATH HAS OCCURRED

- JAILS FOUND LIABLE FOR NOT STARTING CPR WHEN NO VITAL SIGNS
- “DEAD” PEOPLE ALIVE TODAY DUE TO CPR
- REMEMBER: ONLY A PHYSICIAN OR OTHER PROFESSIONAL DESIGNATED BY LAW CAN DECLARE DEATH; OFFICERS CANNOT MAKE DECISION

I. “DON’T TALK WITH INMATES”

- “DON’T TALK” POLICY PROHIBITS GOOD COMMUNICATION WITH INMATES -A KEY FACTOR IN SUICIDE PREVENTION

J. USING CITIZEN VOLUNTEERS AND INMATES FOR SUICIDE WATCH:

- TRAINED VOLUNTEERS LAUDED BY SOME JAIL ADMINISTRATORS
- NEIGHBORHOOD CRIME WATCH GROUP PROVIDES SUICIDE WATCHERS
- EXCUSES FOR NOT USING:
 - 1) THEY ARE HARD TO RECRUIT
 - 2) YOU CAN’T ALWAYS COUNT ON THEM
 - 3) “WE’RE AFRAID OF THE LIABILITY ISSUE”
- ABOVE EXCUSES DISAPPEAR WHEN CAPABLE ADMINISTRATION SUPPORTS VOLUNTEERS
- RESPECTED CITIZEN GROUPS KEY RECRUITMENT VEHICLE

- ENACT POLICY: “VOLUNTEERS ARE TO BE TREATED LIKE STAFF FROM ALL ASPECTS EXCEPT PAY, THIS INCLUDES LIABILITY MATTERS”
- INMATE WATCHERS:
 - PROPERLY SELECTED/TRAINED INMATES SERVING AS SUICIDE WATCHERS IN SOME FEDERAL BUREAU OF PRISONS FACILITIES AND VARIOUS LARGE AND SMALL JAILS
 - MOST JURISDICTIONS DO NOT UTILIZE INMATE’ WATCHERS, CITING PHILOSOPHICAL OR ETHICAL PROBLEMS, LIABILITY CONCERNS OR SECURITY CONSIDERATIONS. OTHER PROBLEMS: RELIABILITY AND STAFF RELAXATION
 - TWO OR MORE INMATES ASSIST STAFF: HAVE NO CONTROL OVER SUICIDAL INMATES
 - WATCHERS STATIONED IN FRONT, ACROSS, OR NEXT TO CELL
 - ONE LARGE JAIL REPORTED CONCEPT ELIMINATED NEED FOR STRIPPING ISOLATION AND RESTRAINTS
 - DORMITORY SETTING SAFE ENVIRONMENT FOR SUICIDAL INMATE
 - DON’T PLACE IN ISOLATION EXCEPT UNDER SPECIAL CIRCUMSTANCES
 - NOTE: CONTACT LEGAL COUNSEL REGARDING ADVICE ON IMPLEMENTING INMATE WATCHER CONCEPT
 - REMEMBER, NATIONAL CORRECTIONAL STANDARDS DO NOT ADDRESS THIS ISSUE. IF UTILIZED, WRITTEN POLICIES/PROCEDURES SHOULD BE DEVELOPED, INMATE SELECTION, TRAINING AND SUPERVISION NEED TO BE OUTLINED

18. JAIL SUICIDE LITIGATION

A. OVERVIEW

- LITIGATION CAN BE A KEY FACTOR IN JAIL SUICIDE PREVENTION
 - JAIL SUICIDE LAWSUITS WERE UNUSUAL 20 YEARS AGO
 - NOW IT IS UNUSUAL FOR A LAWSUIT NOT T BE FILED
 - COURTS MAKING IT MORE DIFFICULT TO HOLD DEFENDANTS LIABLE
 - EVEN WHEN NOT LIABLE, SYSTEMIC IMPROVEMENTS OCCUR
 - YET COURTS NOW REQUIRE A HIGHER STANDARD TO OPERATE A CONSTITUTIONAL JAIL
 - CORRECTIONAL OFFICER HAS DUTY TO PROTECT INMATE FROM HARM, INCLUDING SUICIDE, WHICH MUST BE REASONABLY FORESEEABLE
- NEGLIGENCE, OR “SIMPLE NEGLIGENCE” IS REQUIRED IN MANY STATE COURTS FOR LIABILITY IN DEATH BY SUICIDE (REFERRED TO AS TORT ACTION)
 - A REASONABLE PROBABILITY THAT WHAT YOU DO OR DON'T DO WILL CAUSE HARM TO THE INMATE

- IN CIVIL RIGHTS ACTION, FEDERAL COURTS REQUIRE “GROSS NEGLIGENCE”, RECKLESSNESS OR “DELIBERATE INDIFFERENCE” FOR LIABILITY UNDER TITLE 42, UNITED STATES CODE, SECTION 1983 WHEN:
 - 1) INMATE THREATENS OR ATTEMPTS SUICIDE
 - 2) IT IS KNOWN TO STAFF, AND
 - 3) SUFFICIENT EFFORTS NOT MADE TO PREVENT IT
 - 4) A STRONG PROBABILITY THAT WHAT YOU DO OR DON'T DO WILL CAUSE SERIOUS HARM
 - 5) ACTIONS WHICH ARE “SHOCKING TO THE CONSCIENCE”
 - 6) WHERE THERE IS A PATTERN OF NEGLIGENCE OR SIMPLE NEGLIGENCE
- PRIOR SUICIDES AND FAILURE TO MEET STATE AND NATIONAL STANDARDS ARE USED BY PLAINTIFFS TO SHOW A PATTERN OF MISCONDUCT
- GROSS NEGLIGENCE AND DELIBERATE INDIFFERENCE ARE ALSO BASED ON FORMAL POLICY OR CUSTOM AND PRACTICE
- PLAINTIFFS MUST SHOW EXISTENCE OF A POLICY OR CUSTOM AND PRACTICE IN PROVING FAILURE TO CORRECT UNCONSTITUTIONAL CONDITIONS, E.G.:

- NO SCREENING FOR POSSIBLE SUICIDAL BEHAVIOR
- GROSSLY INADEQUATE MONITORING OF SUICIDAL INMATE
- NO TRAINING OF OFFICERS IN SIGNS/SYMPTOMS OF SUICIDE
- PLAINTIFFS MUST ALSO PROVE THAT THE SUICIDE WAS A REASONABLY FORESEEABLE CONSEQUENCE OF THE INACTION OR ACTION OF PERSONNEL INVOLVED
- JAIL SUICIDE LITIGATION CENTERS PRIMARILY AROUND:
 - INSUFFICIENT STAFF
 - INADEQUATE TRAINING AND SUPERVISION
 - DEFICIENT JAIL CONDITIONS
 - LACK OF POLICIES AND PROCEDURES FOR SCREENING AND MONITORING POTENTIALLY SUICIDAL INMATES
 - OVERCROWDING

B. JAIL SUICIDE LITIGATION: CASE LAW REVIEW

- REFER TO APPENDIX E FOR 13 SELECTED COURT CASES

C. PRO-ACTIVE ADMINISTRATION

- SUICIDE PREVENTION PROGRAMS ONLY AS GOOD AS THE ADMINISTRATOR WHO SUPPORTS THEM
 - PROVIDES LEADERSHIP IN AVOIDING LIABILITY WHEN STAFF:
 - 1) FOLLOW JOB DESCRIPTIONS
 - 2) CARRY OUT POLICIES/PROCEDURES
 - 3) USE THEIR PROFESSIONAL TRAINING
 - 4) REASONABLY CONTROL NEGATIVE ATTITUDES, BIASES AND PREJUDICES
 - 5) MAINTAINING AN ATTITUDE OF "WE SIMPLY WILL NOT TOLERATE" SUICIDES IN THE FACILITY

19. CONCLUSION

- ALMOST ALL SUICIDES IN JAILS COULD HAVE BEEN PREVENTED HAD RECOGNIZED STANDARDS AND PRACTICES BEEN FOLLOWED
- KEY SUICIDE PREVENTION FACTOR IS CAPABLE, PROPERLY TRAINED DETENTION-CORRECTIONAL-MENTAL HEALTH AND MEDICAL STAFF
- ALSO IMPORTANT: CAPABLE PRO-ACTIVE ADMINISTRATORS AND EFFECTIVE SUPERVISORS
- STANDARDS, PRACTICES, COURTS REQUIRE WRITTEN SUICIDE PREVENTION PLAN:
 - 1) TRAINING OF PERSONNEL
 - 2) INTAKE SCREENING/IDENTIFICATION AND REFERRAL TO HEALTH CARE PERSONNEL
 - 3) STAFF COMMUNICATION: REQUIREMENTS AND PROCEDURES FOR SHARING NEED-TO-KNOW INFORMATION
 - 4) POLICY ON HOUSING POTENTIALLY SUICIDAL INMATES
 - 5) POLICY ON SUPERVISING/MONITORING INMATES ASSESSED AS SUICIDAL
 - 6) INTERVENTION TECHNIQUES AND PROCEDURES
 - 7) REPORTING INCIDENTS TO OUTSIDE AUTHORITIES AND VICTIM FAMILY MEMBERS
 - 8) FOLLOW-UP/REVIEW: PROCEDURES FOR ALL ASPECTS OF SUICIDE DETECTION AND PREVENTION

- “ONE SUICIDE DEMANDS MEASURES TO PREVENT THE NEXT ONE” - SUICIDE ATTEMPTS
DEMAND MEASURES TO PREVENT FIRST ACTUAL SUICIDE
- THE SUCCESS FORMULA:
 - FOLLOWING RECOGNIZED STANDARDS AND PRACTICES
 - EFFECTING HUMAN INTERACTION BY GOOD OFFICERS, WITH AWARENESS TRAINING
 - PRACTICING THE GOLDEN RULE
- IN CLOSING, EDWIN SHNEIDMAN, AN EMINENT PSYCHOLOGIST AND FOUNDER OF THE AMERICAN ASSOCIATION OF SUICIDOLOGY, PUT THE ISSUE INTO PROPER PERSPECTIVE WHEN HE STATED - “SUICIDE IS NOT SOME BIZARRE AND INCOMPREHENSIBLE ACT OF SELF-DESTRUCTION. RATHER, SUICIDAL PEOPLE USE A PARTICULAR LOGIC, A STYLE OF THINKING THAT BRINGS THEM TO THE CONCLUSION THAT DEATH IS THE ONLY SOLUTION TO THEIR PROBLEMS. THIS STYLE CAN BE READILY SEEN, AND THERE ARE STEPS WE CAN TAKE TO PREVENT SUICIDE, IF WE KNOW WHERE TO LOOK.”

THE MOST EFFECTIVE TOOLS WE HAVE TO HELP US “KNOW WHERE TO LOOK” IN PREVENTING JAIL SUICIDES ARE *HUMAN INTERACTION* AND *TRAINING*.