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U.S. Department of Justice
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National Study of Jail Suicide

20 Years Later

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U.S. Department of Justice
National Institute of Corrections
320 First Street, NW
Washington, DC 20534

Morris L. Thigpen
Director

Thomas J. Beauclair
Deputy Director

Virginia A. Hutchinson
Chief, Jails Division

Fran Zandi
Program Manager

National Institute of Corrections
www.nicic.gov

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National Study of Jail Suicide

20 Years Later

Lindsay M. Hayes, Project Director
National Center on Institutions and Alternatives

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Foreword

This report represents the third collaboration between the National Institute of Corrections and the National Center on Institutions and Alternatives (NCIA) regarding national studies of jail suicide. During the 1980s, two NCIA studies found high rates of suicide in county jails throughout the country. Although suicide continues to be a leading cause of death in jails, the rate of suicide continues to decrease, as demonstrated in this report, *National Study of Jail Suicide: 20 Years Later.* Yet this report does more than simply present a calculation of suicide rates. It presents the most comprehensive updated information on the extent and distribution of inmate suicides throughout the country, including data on the changing face of suicide victims. Most important, the study challenges both jail and health-care officials and their respective staffs to remain diligent in identifying and managing suicidal inmates. The National Institute of Corrections hopes that this report will encourage continued research, training, and development and revision of comprehensive prevention programs that are critical to the continued reduction of jail suicide throughout the country.

Morris L. Thigpen
Director
National Institute of Corrections

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I would like to acknowledge several individuals for their assistance in completing this national study of jail suicides. Catherine A. Gallagher, Ph.D., Associate Professor at George Mason University's Justice, Law and Crime Policy Program, was instrumental in the data analysis portion of the project. As she has done on many prior occasions, Alice Boring of the National Center on Institutions and Alternatives (NCIA) brought the report together to its final form.

The National Institute of Corrections (NIC) continues to be an advocate for suicide prevention in correctional facilities. NIC provided the funding to NCIA to carry out this study and other national studies on jail and prison suicide. NIC also previously funded NCIA's *Jail Suicide/Mental Health Update,* a quarterly newsletter distributed throughout the country at no charge to correctional and health-care administrators, their staff, and other interested persons for more than 20 years.

Special thanks are extended to Virginia Hutchinson, Chief of the NIC Jails Division, and Fran Zandi, Correctional Program Specialist in the NIC Jails Division and the program manager who oversaw this project. This project would not have come to fruition without the support of Ms. Hutchinson and Ms. Zandi, who were committed to finding the precious federal dollars necessary to fund the study. I applaud their commitment and appreciate their patience with me in completing this project.

Lindsay M. Hayes
Project Director
National Center on Institutions and Alternatives

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Executive Summary

Suicide continues to be a leading cause of death in jails across the country; the rate of suicide in county jails is estimated to be several times greater than that in the general population. In September 2006, the National Center on Institutions and Alternatives (NCIA) entered into a cooperative agreement with the National Institute of Corrections (NIC) to conduct a national study on jail suicide that would determine the extent and distribution of inmate suicides in local jails (i.e., city, county, and police department facilities) and also gather descriptive data on the demographic characteristics of each victim, characteristics of the incident, and characteristics of the jail facility that sustained the suicide. The study, a followup to a similar national survey that NCIA conducted in 1986, resulted in a report of the findings to be used as a resource tool for both jail personnel in expanding their knowledge base and correctional (as well as mental health and medical) administrators in creating and/or revising policies and training curricula on suicide prevention.

The study identified 696 jail suicides in 2005 and 2006, with 612 deaths occurring in detention facilities and 84 in holding facilities. Demographic data were subsequently analyzed on 464 of these suicides.

Following are some findings regarding characteristics of the suicide victims:

- Sixty-seven percent were white.
- Ninety-three percent were male.
- The average age was 35.
- Forty-two percent were single.
- Forty-three percent were held on a personal and/or violent charge.
- Forty-seven percent had a history of substance abuse.
- Twenty-eight percent had a history of medical problems.
- Thirty-eight percent had a history of mental illness.
- Twenty percent had a history of taking psychotropic medication.
- Thirty-four percent had a history of suicidal behavior.

Following are some findings regarding characteristics of the suicides:

- Deaths were evenly distributed throughout the year; certain seasons and/or holidays did not account for more suicides.
- Thirty-two percent occurred between 3:01 p.m. and 9 p.m.
- Twenty-three percent occurred within the first 24 hours, 27 percent between 2 and 14 days, and 20 percent between 1 and 4 months.

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- Twenty percent of the victims were intoxicated at the time of death.
- Ninety-three percent of the victims used hanging as the method.
- Sixty-six percent of the victims used bedding as the instrument.
- Thirty percent of the victims used a bed or bunk as the anchoring device.
- Thirty-one percent of the victims were found dead more than 1 hour after the last observation.
- Cardiopulmonary resuscitation (CPR) was administered in 63 percent of incidents.
- Thirty-eight percent of the victims were held in isolation.
- Eight percent of the victims were on suicide watch at the time of death.
- No-harm contracts were used in 13 percent of cases.
- Thirty-seven percent of the victims were assessed by qualified mental health professionals; 47 of the victims who committed suicide and were assessed saw a clinician within 3 days of death.
- Thirty-five percent occurred close to the date of a court hearing, with 80 percent occurring in less than 2 days.
- Twenty-two percent occurred close to the date of a telephone call or visit, with 67 percent occurring in less than 1 day.

Following are some findings regarding characteristics of the jail facilities:

- Eighty-four percent were administered by county, 13 percent by municipal, 2 percent by private, and less than 2 percent by state or regional agencies.
- Seventy-seven percent provided intake screening to identify suicide risk, but only 27 percent verified the victim's suicide risk during prior confinement and only 31 percent verified whether the arresting or transporting officer believed the victim was a suicide risk.
- Sixty-two percent provided suicide prevention training, but 63 percent either did not provide training or did not provide it on an annual basis.
- Sixty-nine percent of training provided was for 2 hours or less, and only 6 percent was for a duration of 8 hours.
- Eighty percent provided CPR certification.
- Ninety-three percent provided a protocol for suicide watch, but less than 2 percent had the option for constant observation; most (87 percent) used 15-minute observation periods.
- Fifty-one percent allowed only mental health personnel to downgrade and discharge inmates from suicide watch.
- Thirty-two percent maintained safe housing for suicidal inmates.
- Thirty-five percent maintained a mortality review process.
- Eighty-five percent maintained a written suicide prevention policy, but suicide prevention programming was not comprehensive.

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Twenty years after the survey that was conducted in 1986, this national study of jail suicides found substantial changes in the demographic characteristics of inmates who committed suicide. Some of these changes were stark. For example, suicide victims once characterized as being confined on "minor other" offenses were found in the 2005–06 data to be held on "personal and/or violent" charges. Intoxication was previously viewed as a leading precursor to inmate suicide, yet recent data indicate that it is now found in only a minority of cases. Whereas more than half of all jail suicide victims were dead within the first 24 hours of confinement according to 1986 data, current data suggest that less than a quarter of all victims commit suicide during this time period, with an equal number of deaths occurring between 2 and 14 days of confinement. In addition, inmates who committed suicide appeared to be far less likely to be housed in isolation than previously reported and, for unknown reasons, were less likely to be found within 15 minutes of the last observation by staff. Finally, more jail facilities that experienced inmate suicides had both written suicide prevention policies and an intake screening process to identify suicide risk than in years past, although the comprehensiveness of programming remains questionable.

In 2006, the suicide rate in detention facilities was 36 deaths per 100,000 inmates, which is approximately 3 times greater than that in the general population (Mumola and Noonan 2008). This rate, however, represents a dramatic decrease in the rate of suicide in detention facilities during the past 20 years. The nearly threefold decrease from a previously reported 107 suicides per 100,000 inmates in 1986 is extraordinary. Absent indepth scientific inquiry, there may be several explanations for the reduced suicide rate. During the past several years, national studies of jail suicide have given a face to this longstanding and often ignored public health issue in the nation's jails. Study findings have been widely distributed throughout the country and were eventually incorporated into suicide prevention training curricula. The increased awareness of inmate suicide is also reflected in national correctional standards that now require comprehensive suicide prevention programming, better training of jail staff, and more indepth inquiry of suicide risk factors during the intake process. Finally, litigation involving jail suicide has persuaded (or forced) jurisdictions and facility administrators to take corrective actions in reducing the opportunity for future deaths. Therefore, based on this dramatic decrease in the rate of suicides, the antiquated mindset that "inmate suicides cannot be prevented" should forever be put to rest.

In 2006, the suicide rate in detention facilities was 36 deaths per 100,000 inmates. This rate represents a dramatic decrease in the rate of suicide in detention facilities during the past 20 years.

This report offers recommendations in the areas of comprehensive suicide prevention programming, staff training, and future research efforts.

In conclusion, findings from this study create a formidable challenge for both correctional and healthcare officials as well as their respective staff. Although our knowledge base continues to increase, which has seemingly corresponded to a dramatic reduction in the rate of inmate suicide in detention facilities, much work lies ahead. The data indicate that inmate suicide is no longer centralized to the first 24 hours of confinement and can occur at any time during an inmate's confinement. As such, because roughly the same number of deaths occurred within the first several hours of custody as occurred during more than a few months of confinement, intake screening for the identification of suicide risk upon entry into a facility should be viewed as time limited. Because inmates can be at risk for suicide at any point during confinement, the biggest challenge for those who work in the corrections system is to view the issue as requiring a continuum of comprehensive suicide prevention services aimed at the collaborative identification, continued assessment, and safe management of inmates at risk for self-harm.

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Chapter 1. Introduction

Suicide continues to be a leading cause of death in jails across the country, where well over 400 inmates take their lives each year (Hayes 2005). Mumola and Noonan (2008) estimate the rate of suicide in county jails to be approximately three times greater than that in the general population. Prior research indicates that most jail suicide victims were young white males who were arrested for nonviolent offenses and were intoxicated upon arrest. Many were placed in isolation and were dead within 24 hours of incarceration (Davis and Muscat 1993; Hayes 1989), although more recent research (Frottier et al. 2002) found that jail inmates are at a higher risk for suicide at both 24 to 48 hours and after 60 days of confinement. The overwhelming majority of victims were found hanging by either bedding or clothing. Most victims were not adequately screened for potentially suicidal behavior upon entry into the jail (Hayes 1989). A disproportionate number of suicide attempts involved inmates with mental illness (Goss et al. 2002). Research specific to suicide in urban jail facilities provided some disparate findings. Most victims of suicide in large urban facilities were arrested for violent offenses and were dead within 1 to 4 months of incarceration (DuRand et al. 1995; Marcus and Alcabes 1993). Because of the extended length of confinement prior to suicide, intoxication was not always the salient factor in urban jails as it was in other types of jail facilities. Characteristics such as age, race, gender, method, and instrument used were generally consistent in both urban and nonurban jails.

The precipitating factors of suicidal behavior in jail are well established (Bonner 1992, 2000; Winkler 1992). Experts theorize that two primary causes for jail suicide exist: (1) jail environments are conducive to suicidal behavior and (2) the inmate is facing a crisis situation. From the inmate's perspective, certain features of the jail environment enhance suicidal behavior: fear of the unknown, distrust of an authoritarian environment, perceived lack of control over the future, isolation from family and significant others, shame of incarceration, and perceived dehumanizing aspects of incarceration. In addition, certain factors are prevalent among inmates facing a crisis situation that could predispose them to suicide: recent excessive drinking and/or drug use, recent loss of stabilizing resources, severe guilt or shame over the alleged offense, current mental illness, prior history of suicidal behavior, and approaching court date. In addition, some inmates simply are (or become) ill equipped to handle the common stresses of confinement. During initial confinement in a jail, this stress can be limited to fear of the unknown and isolation from family, but over time (including stays in prison) it may become exacerbated and include loss of outside relationships, conflicts within the institution, victimization, further legal frustration, physical and emotional breakdown, and problems coping in the institutional environment (Bonner 1992). As the inmate reaches an emotional breaking point, the result can be suicidal ideation (i.e., a wish to die without a specific threat or plan), attempt, or completion.

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Although suicide is well recognized as a critical problem in jails, the issue of prison suicide has not received comparable attention, primarily because the number of jail suicides far exceeds the number of prison suicides. Suicide ranks third (behind natural causes and AIDS) as the leading cause of death in prisons (Mumola 2005). Even though the rate of suicide in prisons is considerably lower than in jails, it still remains greater than the rate in the general population (Hayes 1995). Most research on prison suicide has found that the vast majority of victims are convicted of personal crimes, housed in single cells (often some type of administrative confinement), and have histories of prior suicide attempts and/or mental illness (Daniel and Fleming 2006; He et al. 2001; Patterson and Hughes 2008; Salive, Smith, and Brewer 1989; White and Schimmel 1995). Although normally serving long sentences, most victims commit suicide in the early stages of their prison confinement (New York State Department of Correctional Services 2002) as well as during earlier stages of disciplinary confinement (Way et al. 2007). Precipitating factors in prison suicide may include new legal problems, marital or relationship difficulties, and inmate-related conflicts (Kovasznay et al. 2004).

Suicide ranks third (behind natural causes and AIDS) as the leading cause of death in prisons.

Finally, an inmate's suicide is emotionally devastating to the victim's family and can be financially devastating to the correctional facility (and its personnel) sustaining the death. Many inmate suicides result in litigation against a state or local jurisdiction alleging that the cause of death was negligence and/or deliberate indifference on the part of facility personnel. Although the plaintiff's burden to demonstrate liability in these cases remains high (Cohen 2008), several recent federal court jury awards have well exceeded $1 million (*Sanville* v. *Scaburdine* 2002; *Woodward* v. *Myres* 2003).

Prior Jail Suicide Research

In February 1988, the National Institute of Corrections released the National Center on Institutions and Alternatives' (NCIA's) *National Study of Jail Suicides: Seven Years Later* (Hayes 1989), which replicated an earlier national survey *(And Darkness Closes In . . . A National Study of Jail Suicides)* that NCIA conducted in 1981 (Hayes 1983). The 1988 report was a compilation of data gathered on jail suicides that occurred in 1986. About 30 percent of the 1986 suicides took place in holding facilities (which normally detain persons for less than 48 hours) and about 70 percent took place in detention facilities (which normally detain persons or house committed and/or sentenced offenders for more than 48 hours but less than 2 years). Other findings are as follows:

- Seventy-two percent of victims were white.
- Ninety-four percent of victims were male.
- The average (mean) age of the victim was 30.
- Fifty-two percent of victims were single.
- Seventy-five percent of victims were detained on nonviolent charges, with 27 percent detained on alcohol and/or drug-related charges.
- Eighty-nine percent of victims were confined as detainees.

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- Seventy-eight percent of victims had prior charges, yet only 10 percent were previously held on personal and/or violent offenses.
- Sixty percent of victims were intoxicated at the time of incarceration.
- Thirty percent of suicides occurred during a 6-hour period between midnight and 6 a.m.
- Ninety-four percent of suicides were by hanging.
- Forty-eight percent of victims used their bedding as the instrument.
- Two out of three victims were in isolation.
- Fifty-one percent of suicides occurred within the first 24 hours of incarceration; 29 percent occurred within the first 3 hours.
- Eighty-nine percent of victims were not screened for potentially suicidal behavior at booking.
- Fifty-two percent of all victims charged with alcohol and/or drug-related offenses died within the first 3 hours of confinement.
- Seventy-eight percent of victims who were intoxicated died within the first 24 hours of incarceration; 48 percent died within the first 3 hours.
- The suicide rate in detention facilities was projected to be approximately nine times greater than that in the general population.

In addition, data from holding facilities include the following:

- Forty-six percent of victims were held on alcohol and/or drug-related charges.
- Eighty-two percent of victims were intoxicated at the time of their incarceration.
- Sixty-four percent of victims died within the first 3 hours.
- Ninety-seven percent of victims were not screened for potentially suicidal behavior at booking.

Jail facilities that experienced a suicide in 1986 provided suicide prevention programs in only 58 percent of detention facilities and 32 percent of holding facilities. The study did not analyze the quality of these programs. Despite minor variations, findings from the 1988 study were consistent with NCIA's 1981 national study of jail suicides (which used 1979 data). Allowing for slight differences in characteristics of jail suicides, most of the key indicators (offense, intoxication, method and/or instrument, isolation, and length of incarceration) showed the same value over time.

A Word About Suicide Victim Profiles

Efforts to prevent suicide in jails are sometimes geared toward quick-fix solutions. These types of approaches (e.g., use of closed-circuit television monitors, use of safety garments, and removal of blankets) are usually attempts to treat only the symptom. Although these tools can be an important part of jail suicide prevention, experts agree that they should never be used in lieu of staff training, intervention, and supervision.

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Suicide victim 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 seem to be contradictory. When used without an awareness of potentially suicidal behavior, they are misleading. NCIA constructed and released its first victim profile from 1979 jail suicide data; at that time it was equally praised and criticized. Although the profile appeared in many training manuals throughout the country, it was maligned because critics claimed it allowed jail personnel to believe that profiles can predict and thus prevent suicides. Further, critics charged that many of the characteristics appearing in the suicide profile fit those of a typical jail inmate and, therefore, such a profile was useless as a predictive tool. The primary objective of NCIA's report—to help jail personnel become sensitive to the characteristics or variables that appear 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.

Demographic victim profiles cannot predict suicide risk; jail officials have been warned that these profiles should only be used to help correctional personnel understand the general risk of suicide for those in custody (Hayes 1989; Winter 2003). As stated by Farmer and colleagues: "In predicting who will be at risk over time, factors such as mental disorders, prior psychiatric hospitalizations, prior suicidal and self-destructive acts, substance abuse, and ongoing stressors may eventually prove to be more useful danger signals than demographic variables such as age, race, and gender" (Farmer, Felthous, and Holzer 1996:246). That is, a demographic profile of suicide victims should not be viewed as a "death certificate" for all inmates in the nation's jails, nor should jail personnel ignore those inmates who exhibit suicidal tendencies but do not fit within certain demographic variables. The fundamental goal of a victim profile is to help correctional, medical, and mental health personnel become sensitive to the characteristics that appear most often in jail suicide victims, while at the same time acting as a supplement to the warning signs of potential suicidal behavior. In essence, ignoring obvious signs of potentially suicidal behavior because the individual does not fit the profile is not only foolish, but also negligent.

Death in Custody Reporting Act of 2000

Before 2000, state and local jurisdictions did not have uniform requirements for reporting the circumstances surrounding the deaths of inmates in their custody, and some had no system for requiring such reports. Therefore, the number of individuals who were dying in custody and the causes of death could not be determined. The two national studies of jail suicides that NCIA released in 1981 and 1988 provided the only data regarding the extent and scope of inmate suicides throughout the country.

Signed into law on October 13, 2000, the Death in Custody Reporting Act of 2000 (Public Law 106–297) requires each state that receives prison construction funding under the federal truth-in-sentencing incentive grant program to "report, on a quarterly basis, information regarding the death of any person who is in the process of arrest, is en route to be incarcerated, or is incarcerated at a municipal or county jail, state prison, or other local or state correctional facility (including any juvenile facility) that, at a minimum, includes (a) the name, gender, race, ethnicity, and age of

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the deceased; (b) the date, time, and location of death, and (c) a brief description of the circumstances surrounding the death." The Bureau of Justice Statistics (BJS) is responsible for collecting and analyzing the data, and implemented the Act over a 4-year period. Data collection on deaths in local jail facilities began in 2000, followed by collection from state prisons in 2001. In 2002, BJS began collecting records of deaths from all state juvenile correctional systems, and in 2003, it began collecting data on arrest-related deaths involving approximately 17,784 state and local law enforcement agencies throughout the country. BJS requests data quarterly and reports it annually.

According to the most recent BJS data, 277 inmate suicides occurred in more than 3,000 jail facilities in 2006 (Mumola and Noonan 2008).[1] The suicide rate in these jails was calculated to be 36 deaths per 100,000 inmates. During the period 2000–06, the BJS data found that 92 percent of jail suicide victims were male, 70 percent were white, and most were 25 to 44 years old. Earlier BJS data (Mumola 2005) found that white jail inmates were six times more likely than African-American inmates, and more than three times more likely than Hispanic inmates, to commit suicide. In addition, male inmates had higher rates of suicide than female inmates, and violent offenders had a much higher suicide rate than nonviolent offenders. Almost half of the jail suicides occurred during an inmate's first week in custody (Mumola 2005).

[1] For purposes of reporting on the number of deaths in custody, jail facilities excluded law enforcement and police department lockups, privately operated jails, and facilities operated by multiple jurisdictions (e.g., regional jails). In 2003, BJS began surveying law enforcement and police department lockups to obtain these data, which are not available to date.

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Chapter 2. National Study of Jail Suicides: 20 Years Later

Historically, jail suicides have created publicity, increased public awareness, and ultimately led to litigation against jail facilities, city governments, county commissioners, and others. The past 20 years have produced national studies on inmate suicide, training curricula on suicide prevention in correctional facilities, and revised suicide prevention provisions in national correctional standards that call for increased emphasis on suicide risk inquiry at intake. There is little argument that jail administrators are far more aware of the suicide risk in their facilities today than in years past. Most important are indications that the suicide rate in U.S. jails has fallen substantially. In 1988, the National Center on Institutions and Alternatives' (NCIA's) national study of jail suicides calculated that there were 107 county jail suicides per 100,000 inmates in 1986, a rate about 9 times greater than that in the general population.[2] As stated in chapter 1, the Bureau of Justice Statistics (BJS) recently calculated that in 2006 the suicide rate in these jails was 36 deaths per 100,000 inmates, which is about 3 times greater than that in the general population.

Because the last comprehensive national study on jail suicides was conducted more than 20 years ago and BJS data, although useful, are limited to basic demographic information (e.g., age, race, gender, most serious offense, length of confinement), the current study was born out of the belief that a new, comprehensive study regarding the total scope and extent of inmate suicides in jails and lockups throughout the country was long overdue.

In September 2006, NCIA entered into a cooperative agreement with the National Institute of Corrections (NIC) to conduct a national study on jail suicides that would determine the extent and distribution of inmate suicides in local jails (i.e., city, county, and police department facilities) and to collect data on the demographic characteristics of each victim, each incident, and the jail facility that sustained the suicide. A report of the findings would become a resource tool to help jail personnel expand their knowledge base and help correctional (as well as mental health and medical) administrators create and/or revise policies and training curricula on suicide prevention.

Methodology: Phase 1

This survey, the third national study that NCIA conducted for NIC (see Hayes 1983 and 1989), was divided into two phases. During phase 1, surveys were mailed to 15,978 facilities across the United States, including 3,173 county jails and 12,805 law enforcement agencies that administered short-term lockups. Each respondent was asked to complete a one-page survey if his/her facility sustained one or more suicides in 2005 and/or 2006 (see appendix A). A jail was defined

[2] According to Heron and colleagues (2009), the suicide rate in the general population is approximately 11 deaths per 100,000 citizens.

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as any facility operated by a local jurisdiction (e.g., county, municipality), private entity, or multi-jurisdictional authority whose purpose was to confine individuals primarily apprehended by law enforcement personnel. Per this definition, jails included temporary holding and pretrial detention facilities, lockup facilities that normally detained individuals for less than 72 hours, and facilities that normally detained individuals or housed committed and/or sentenced offenders for more than 72 hours. The definition also included facilities that housed inmates from other jurisdictions (e.g., a state or federal prison system), including privately operated jails and regional jails.

Phase 1 surveys were mailed to all jail facilities in July and August 2007. Return business reply envelopes were included in the mailing to ensure a higher rate of return. Further, to help verify data, survey forms were also sent (from September through December 2007) to state medical examiner offices, state and federal jail inspection and/or regulatory agencies, state police/bureau of investigation offices, and private health-care providers that had contracts with county and municipal jurisdictions. Finally, an Internet search engine was used to search newspaper articles on inmate suicides that were not identified through other sources.

Phase 1 data identified a total of 696 jail suicides in 2005 and 2006 (366 in 2005 and 330 in 2006). The suicides occurred in 47 states and the District of Columbia.[3] Table 1 shows that 383 (55 percent) of the deaths were identified through jail facilities' self-reports. Data from state inspection, investigation, and regulatory agencies showed an additional 177 (25.4 percent) suicides that were not identified through self-reports. Of the remaining deaths, 92 (13.2 percent) were identified through the Internet and newspaper articles, 28 (4.1 percent) through state medical examiner offices, 12 (1.7 percent) through private health-care providers, and 4 (0.6 percent) from other sources.[4]

Table 1. Sources for Identifying Inmate Suicides in U.S. Jails: 2005–06

SOURCE	NUMBER	PERCENT
Self-report	383	55.0
Inspection, investigation, and regulatory agencies	177	25.4
Internet and newspaper articles	92	13.2
Medical examiners	28	4.1
Private health-care providers	12	1.7
Other	4	0.6
Total	**696**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

[3] No suicides were reported in Alaska, Hawaii, and Vermont.

[4] Other sources were from the project director's expert witness consultation and/or technical assistance to facilities that sustained these deaths.

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It is important to note that "self-report" is the primary category for identifying jail suicide. For example, if a jail suicide was identified by multiple sources, including a self-report from the facility in which the suicide occurred, the source would be attributed to a self-report. Table 1 is intended to reflect a survey respondent's willingness to self-report an inmate suicide within his/her facility rather than the data collection efforts of state inspection and/or regulatory agencies, state medical examiners, or other organizations.

A total of 696 jail suicides were identified during phase 1—in 2005, 324 deaths occurred in detention facilities and 42 occurred in holding facilities and in 2006, 288 deaths occurred in detention facilities and 42 occurred in holding facilities (see table 2). The vast majority (89 percent) of suicides occurred in detention facilities (612 of 696 deaths).

Table 2. Total Number of Suicides Identified in U.S. Jails: 2005–06

YEAR	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
2005	42	50.0	324	52.9	366	52.6
2006	42	50.0	288	47.1	330	47.4
Total	**84**	**100.0**	**612**	**100.0**	**696**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Methodology: Phase 2

In phase 1, facilities that experienced one or more suicides in 2005 and/or 2006 were identified. In phase 2, the survey process was initiated, including dissemination of an eight-page survey instrument to facility administrators (see appendix B). The survey instrument was designed to collect the following data:

- Demographic characteristics of each victim, including but not limited to age, gender, race, living status, current offense(s), prior offense(s), legal status (detained or sentenced), length of confinement, alcohol and/or drug intoxication at confinement, history of isolation or segregation, room confinement, substance abuse history, medical and/or mental health history, psychotropic medication history, and history of suicidal behavior.
- Characteristics of each incident, including but not limited to date, time, and location of suicide; intoxication at time of incident; housing assignment (e.g., single or multiple occupancy, whether the victim was in isolation or segregation and/or on suicide watch); method and instrument used; time span between when the incident occurred and when the victim was found; whether cardiopulmonary resuscitation (CPR) and/or an automated external defibrillator were used in emergency response; whether a "no-harm" contract was used prior to the incident; whether the

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victim attended a court hearing, received a visit or telephone call, and/or was assessed by a qualified mental health professional close to the date of the incident; and any possible precipitating factors to the suicide.

- Facility characteristics, including but not limited to facility type; facility ownership (e.g., state, county, private); capacity and/or population when the suicide occurred; and the suicide-prevention measures in place at the time of the incident (e.g., written policy, intake screening, staff training in suicide prevention and CPR, observation levels, safe housing, and mortality review).

In January 2008, phase 2 survey instruments were initially mailed to facility administrators of the 696 facilities that sustained suicides; 422 surveys were completed and returned. Between March and August 2008, facility administrators who did not respond to the initial survey received a followup letter and a phone call; as a result, an additional 42 surveys were completed and returned. Survey respondents were given the following assurances verbally and in writing: "Data provided will be coded and held in the strictest confidence. Results of this study will be presented in summary fashion, therefore, victim and facility names will not appear in any project report." Nevertheless, some facility administrators did not cooperate with requests to complete the survey. In September 2008, data collection efforts were concluded with a final response rate of 67 percent (464 responses out of 696 surveys).[5]

[5] The response rate for this study was lower than the rates from the two earlier studies of jail suicide (82 percent for the 1981 study and 85 percent for the 1988 study). Facility administrators gave several reasons for not fully participating in the study, including ongoing litigation and advice from legal counsel, sensitivity of the subject matter, issues of confidentiality, and time and/or manpower constraints. Some respondents incorrectly stated that completing the survey would violate the Health Insurance Portability and Accountability Act Privacy Rule. In addition, some facility administrators may have decided not to participate in the process because of the time it would have taken to complete the comprehensive eight-page survey instrument.

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Chapter 3. Demographic Findings of Jail Suicide Data

As stated in chapter 2, project staff analyzed data on 464 of the 696 jail suicides identified between 2005 and 2006. Demographic findings in this section will be presented in relationship to the type of jail facility. For purposes of this analysis, two facility types were considered: (1) holding facilities (which normally detain individuals for less than 72 hours) and (2) detention facilities (which normally detain individuals or house committed and/or sentenced offenders for more than 72 hours but less than 2 years). Twelve percent (58) of the jail suicides took place in holding facilities and 88 percent (406) took place in detention facilities. Although the data presented in the following tables are categorized by facility type rather than by the jurisdictional agency that controls the facility, it is important to note that 84 percent of the suicides occurred in facilities operated by county governments, nearly 13 percent in facilities operated by municipal governments, less than 2 percent in facilities operated by private organizations, and less than 2 percent in facilities operated by multijurisdictional authorities.

African-American inmates, who account for nearly the same percentage of the total jail population as whites, constitute a much lower percentage of jail suicide victims.

Personal Characteristics of the Victims

Race

Table 3 shows that approximately two-thirds (67.2 percent) of suicide victims were white, 15.1 percent were African American, 12.7 percent were Hispanic, and 2.8 percent were American Indian. These percentages are consistent with both the National Center on Institutions and Alternatives' (NCIA's) 1988 study (Hayes 1989) and recent Bureau of Justice Statistics (BJS) data (Mumola and Noonan 2008). More white victims committed suicide in detention facilities than holding facilities and more Hispanic victims committed suicide in holding facilities than detention facilities.[6] Of note is that, although white inmates account for about 44 percent of the total jail population throughout the country, they represent the majority (67 percent) of inmates who committed suicide, whereas African-American inmates, who account for nearly the same percentage of the total jail population as whites (39 percent), constitute a much lower percentage of jail suicide victims (15 percent).[7] Other recent BJS data also found that white inmates had higher rates of suicide than African-American inmates (Mumola 2005). The cause of this disproportionate relationship is outside the purview of this survey.

[6] For purposes of this study, differences greater than 10 percent will be considered significant.

[7] For comparative data on jail inmates, see Minton and Sabol 2009.

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Table 3. Race of Suicide Victims in U.S. Jails: 2005–06

RACE	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
White	32	55.2	280	68.9	312	67.2
African American	11	19.0	59	14.5	70	15.1
Hispanic	14	24.1	45	11.1	59	12.7
American Indian	1	1.7	12	3.0	13	2.8
Other	0	0.0	10	2.5	10	2.2
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Gender

An overwhelming majority (93.1 percent) of the victims were male. The data presented in table 4 are consistent with both NCIA's 1988 study (Hayes 1989) and recent BJS data (Mumola and Noonan 2008). No significant gender differences were found between suicides that occurred in holding and detention facilities. These findings are not surprising because the vast majority of jail inmates throughout the country are male (Minton and Sabol 2009).

Table 4. Gender of Suicide Victims in U.S. Jails: 2005–06

GENDER	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Male	54	93.1	378	93.1	432	93.1
Female	4	6.9	28	6.9	32	6.9
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

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Age

Table 5 shows that more than one-third of all suicide victims (approximately 36 percent) were ages 33 to 42. Only four victims (0.9 percent) were 17 or younger, and the average age was 35. These percentages are slightly higher than those from both NCIA's 1988 study (Hayes 1989) and recent BJS data (Mumola and Noonan 2008). No significant age differences were found between suicides that occurred in holding and detention facilities.

Table 5. Age of Suicide Victims in U.S. Jails: 2005–06

AGE	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
≤17	1	1.7	3	0.7	4	0.9
18–22	5	8.6	55	13.5	60	12.9
23–27	7	12.1	58	14.3	65	14.0
28–32	8	13.8	48	11.8	56	12.1
33–37	12	20.7	72	17.8	84	18.0
38–42	13	22.5	70	17.3	83	17.9
43–47	6	10.3	57	14.0	63	13.6
48–53	5	8.6	21	5.2	26	5.6
≥53	1	1.7	22	5.4	23	5.0
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Marital Status

Forty-two percent of the victims were single, 21.4 percent were married or living in a common-law relationship, and 8.8 percent were divorced (see table 6). The remaining 4.7 percent were either separated or widowed. These percentages are consistent with the findings from NCIA's 1988 study (Hayes 1989). More single inmates committed suicide in detention facilities than holding facilities, and slightly more married inmates committed suicide in holding facilities than detention facilities. No information is available on the marital status of almost one-quarter of all suicide victims, a finding that might relate to the inadequacy of intake screening at facilities that sustained the suicides.

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Table 6. Marital Status of Suicide Victims in U.S. Jails: 2005–06

MARITAL STATUS	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Single	19	32.8	176	43.3	195	42.0
Married	15	25.9	74	18.2	89	19.2
Common law	4	6.9	6	1.5	10	2.2
Separated	2	3.4	13	3.2	15	3.2
Divorced	4	6.9	37	9.1	41	8.8
Widowed	1	1.7	6	1.5	7	1.5
Unknown	13	22.4	94	23.2	107	23.1
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Most Serious Charge

For purposes of this study, the most serious charge was broken down into four offense categories: personal and/or violent, serious property, alcohol and/or drug related, and minor other. Table 7 shows that 43.4 percent of the victims were charged with a personal and/or violent offense(s), followed by minor other (22.5 percent), alcohol and/or drug related (19.0), and serious property (15.1 percent). These data vary widely from the findings of NCIA's 1988 study (Hayes 1989), which showed that suicide victims were fairly evenly distributed across the four offense categories and that personal and/or violent charges accounted for only 24.7 percent of victims. These current data, however, are consistent with other recent BJS data that also found that inmates charged with violent offenses had higher rates of suicide than those charged with nonviolent offenses (Mumola 2005). More inmates charged with alcohol and/or drug-related offenses committed suicide in holding facilities than detention facilities and more inmates charged with serious property offenses committed suicide in detention facilities than holding facilities.

In almost 50 percent of jail suicides, the victims had been charged with one or more of the following offenses: sexual assault and/or murder of a child (32), possession of drugs (27), murder (24), burglary (21), driving while intoxicated (21), rape/sexual assault (20), assault (19), aggravated assault (17), domestic violence (17), and attempted murder (16). The single charge of sexual assault and/or murder of a child was associated with approximately 7 percent of all jail suicides.

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Table 7. Most Serious Charge of Suicide Victims in U.S. Jails: 2005–06

MOST SERIOUS CHARGE	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Personal and/or violent	23	39.7	178	43.8	201	43.4
Serious property	4	6.9	66	16.3	70	15.1
Alcohol and/or drug related	22	37.9	67	16.5	89	19.0
Minor other	9	15.5	95	23.4	104	22.5
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Notes: "Personal and/or violent" includes murder, negligent manslaughter, armed robbery, rape, sexual assault, indecent assault, child abuse, domestic violence, assault, battery, aggravated assault, kidnapping, and other offenses. "Serious property" includes burglary, grand larceny, auto theft, robbery (other), receiving stolen property, arson, breaking and entering, entering without breaking, vandalism, carrying a concealed weapon and/or firearm, and other offenses. "Alcohol and/or drug related" includes public intoxication, driving while intoxicated, disorderly conduct, resisting arrest, possession and/or distribution of controlled dangerous substances, narcotics (unspecified), and other offenses. "Minor other" includes shoplifting, petty larceny, prostitution, sex offenses (other), trespassing, unauthorized use of motor vehicle, traffic offenses (other), violation of probation, contempt of court, vagrancy, indecent exposure, status offenses, escape, forgery, embezzlement, and other offenses.

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Additional Charges and Jail Status

Almost 42 percent of inmates who committed suicide had a second current charge filed against them,[8] and the overwhelming majority (90.1 percent) of suicide victims were in detention facilities at the time of their death. These percentages are consistent with the findings from NCIA's 1988 study (Hayes 1989). However, these data are quite different from those of inmates who do not commit suicide. Current BJS data indicate that 62 percent of all inmates confined in U.S. jails in 2006 were on detention status (Minton and Sabol 2009). The fact that most inmates who committed suicide were on detention status at the time of their deaths may be related to the shorter length of confinement prior to the suicide (see table 16, page 22).

Most Serious Prior Charge

More than one-third (37.7 percent) of the inmates who committed suicide did not have a history of prior arrests (see table 8). The data also show that 19.6 percent of the victims were charged with a minor other offense, followed by alcohol and/or drug related (19.4 percent), personal and/or violent (16.0 percent), and serious property (7.3 percent). These percentages are somewhat consistent with the findings from NCIA's 1988 study, although that study indicated fewer (21.8 percent) victims with no history of prior arrests (Hayes 1989). No significant differences were found between suicides that occurred in holding and detention facilities in regard to the most serious prior charge.

[8] Data were recorded on only the two most serious charges filed against inmates who committed suicide; more than two charges were filed against only a small percentage of victims.

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Table 8. Most Serious Prior Charge of Suicide Victims in U.S. Jails: 2005–06

MOST SERIOUS PRIOR CHARGE	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Personal and/or violent	8	13.8	66	16.2	74	16.0
Serious property	1	1.7	33	8.1	34	7.3
Alcohol and/or drug related	13	22.4	77	19.0	90	19.4
Minor other	12	20.7	79	19.5	91	19.6
None	24	41.4	151	37.2	175	37.7
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

History of Substance Abuse

Nearly 47 percent of inmates who committed suicide were identified during the intake process as having a history of substance abuse (see table 9). Most victims used alcohol, marijuana, synthetic drugs (e.g., methamphetamine, PCP, OxyContin), or multiple illegal drugs. These data are consistent with available BJS data on substance abuse history among inmates in U.S. jails (Karberg and James 2005). No significant differences were found between suicides that occurred in holding and detention facilities in regard to substance abuse. No information is available on the substance abuse history of approximately 35 percent of all inmates who committed suicide, a finding that might relate to the inadequacy of intake screening in facilities that sustained the suicides.

Table 9. History of Substance Abuse Among Suicide Victims in U.S. Jails: 2005–06

SUBSTANCE ABUSE	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	29	50.0	188	46.3	217	46.8
No	11	19.0	72	17.7	83	17.9
Unknown	18	31.0	146	36.0	164	35.3
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

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History of Medical Problems

Only 27.6 percent of inmates who committed suicide indicated a history of medical problems (e.g., cardiac issues, seizures, diabetes, hypertension, asthma) during the intake process (see table 10). This is somewhat lower than available BJS data on medical problems among inmates in U.S. jails (Maruschak 2006). Significant differences were found between suicides that occurred in holding and detention facilities in regard to medical problems; holding facilities reported fewer medical problems. No information is available about medical concerns in approximately 30 percent of all inmates who committed suicide, a finding that might relate to the inadequacy of intake screening in facilities that sustained the suicides.

Table 10. History of Medical Problems Among Suicide Victims in U.S. Jails: 2005–06

MEDICAL PROBLEMS	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	5	8.6	123	30.3	128	27.6
No	32	55.2	166	40.9	198	42.7
Unknown	21	36.2	117	28.8	138	29.7
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

History of Mental Illness

The research literature on suicide in the general community shows a strong relationship between suicide and mental illness. Although the vast majority of individuals who suffer from mental illness do not commit suicide, it is estimated that more than 90 percent of suicides are associated with mental or addictive disorders and that approximately two-thirds of individuals who commit suicide are depressed at the time of their deaths (Moscicki 2001).

Only 38.1 percent of inmates who committed suicide were identified as having a history of mental illness during the intake process (see table 11). Most inmates with mental illness who later committed suicide suffered from depression or psychosis.[9] The percentage of victims with mental illness was also significantly lower than available BJS data on mental health problems among inmates in U.S. jails. For example, recent BJS data show that 64 percent of jail inmates reported a history of mental health problems and 61 percent reported symptoms of mental health disorders within the past 12 months (James and Glaze 2006). Significant differences were found between suicides that occurred in holding and detention facilities in regard to prior mental illness, with holding facilities reporting far fewer such issues. No information is available about the mental health of approximately 30 percent of all inmates who committed suicide. This finding, along with the relatively low

[9] Survey respondents did not list the victims' mental illness according to the *Diagnostic and Statistical Manual III* or *IV* criteria.

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reporting rate of mental illness in jail suicide victims (particularly in holding facilities), might relate to the inadequacy of intake screening in facilities that sustained the suicides.

History of Psychotropic Medication

Nearly 20 percent of inmates who committed suicide took psychotropic medication to treat their mental illness, and most were reported to have taken an antidepressant (see table 12). This is consistent with available BJS data on the use of psychotropic medication by inmates in U.S. jails (James and Glaze 2006). The findings also indicated that approximately 16 percent of all inmates who committed suicide were receiving psychotropic medication at the time of their death. Only slight differences were found between suicides that occurred in holding and detention facilities in regard to the use of psychotropic medication. No information is available about the use of psychotropic medication in approximately 40 percent of all inmates who committed suicide, a finding that might relate to the inadequacy of intake screening in facilities that sustained the suicides.

Table 11. History of Mental Illness Among Suicide Victims in U.S. Jails: 2005–06

MENTAL ILLNESS	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	14	24.1	163	40.1	177	38.1
No	23	39.7	123	30.3	146	31.5
Unknown	21	36.2	120	29.6	141	30.4
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Table 12. History of Psychotropic Medication Use Among Suicide Victims in U.S. Jails: 2005–06

PSYCHOTROPIC MEDICATION	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	7	12.0	85	20.9	92	19.8
No	19	32.8	169	41.7	188	40.5
Unknown	32	55.2	152	37.4	184	39.7
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

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History of Suicidal Behavior

The research literature on suicide in jails shows a strong relationship between suicide and a history of suicidal behavior. A history of suicide attempts has consistently been shown to be one of the strongest risk factors for completed suicides (Moscicki 2001). Although the vast majority of individuals who think about suicide and/or engage in suicidal behavior do not commit suicide, it is estimated that 20 to 50 percent of individuals who commit suicide made a previous attempt to do so (American Foundation for Suicide Prevention 2009).

Only 33.8 percent of inmates who committed suicide reported a history of suicidal behavior during the intake process (see table 13). The percentage of victims who had a history of suicidal behavior is significantly higher than available BJS data on prior suicidal behavior among inmates in U.S. jails (James and Glaze 2006). Recent BJS data indicate that only 13 percent of jail inmates reported one or more suicide attempts within the past 12 months (James and Glaze 2006). Significant differences were found between suicides that occurred in holding and detention facilities in regard to prior suicidal behavior, with holding facilities reporting far less behavior. No information is available on the prior suicidal behavior of approximately 24 percent of all inmates who committed suicide; this finding, along with the relatively low identification of prior suicidal behavior in jail suicide victims, might relate to the inadequacy of intake screening in facilities that sustained the suicides.

Table 13. History of Suicidal Behavior Among Suicide Victims in U.S. Jails: 2005–06

SUICIDAL BEHAVIOR	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	11	19.0	146	36.0	157	33.8
No	29	50.0	168	41.4	197	42.5
Unknown	18	31.0	92	22.6	110	23.7
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Characteristics of the Suicides

Date

Fifty-two percent (240) of the suicides occurred in 2005 and 48 percent (224) occurred in 2006. The suicides were fairly evenly distributed throughout the year, although more than 22 percent occurred in July and August (see table 14). This is similar to the findings from NCIA's 1988 study (Hayes 1989). Contrary to common belief, particular seasons and/or holidays did not account for a significantly higher number of suicides, a finding confirmed by other research on suicide in

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Table 14. Month in Which Suicide Occurred in U.S. Jails: 2005–06

MONTH	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
January	6	10.3	32	7.9	38	8.2
February	3	5.2	21	5.2	24	5.2
March	10	17.4	32	7.9	42	9.1
April	2	3.4	39	8.9	41	8.8
May	5	8.6	36	8.9	41	8.8
June	2	3.4	33	8.1	35	7.6
July	6	10.3	51	12.8	57	12.3
August	4	6.9	43	10.8	47	10.2
September	3	5.2	28	6.9	31	6.7
October	4	6.9	29	7.2	33	7.1
November	6	10.3	31	7.7	37	7.8
December	7	12.1	31	7.7	38	8.2
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

confinement (Fruehwald et al. 2004). No significant differences were found between suicides that occurred in holding and detention facilities in regard to month and day of the week in which the suicides took place.

Time of Day

Experts theorize that inmate suicides occur more often when jail staff perform less frequent supervision. NCIA's 1988 study generally supported this theory—project staff found that more than 30 percent of all suicides occurred during the 6 hours between midnight and 6 a.m. Results from the current study, however, show that almost one-third (31.9 percent) of all suicides occurred during the 6 hours between 3:01 and 9 p.m. (see table 15). This is consistent with other recent BJS data that also found that the frequency of suicides was fairly evenly distributed throughout the day (Mumola 2005). No significant differences were found between the time of day when suicides occurred in holding and detention facilities.

Length of Confinement Prior to Suicide

Less than one-quarter (23.4 percent) of all inmates who committed suicide were dead within the first 24 hours of confinement (see table 16). This is in stark contrast to NCIA's 1988 study (Hayes 1989), which found that more than 50 percent of victims were dead within the first 24 hours. This

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Table 15. Time of Day When Suicide Occurred in U.S. Jails: 2005–06

TIME OF SUICIDE	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
12:01–3 a.m.	8	13.8	55	13.5	63	13.6
3:01–6 a.m.	5	8.6	43	10.6	48	10.3
6:01–9 a.m.	1	1.7	40	9.9	41	8.8
9:01 a.m.–noon	10	17.2	46	11.3	56	12.1
12:01–3 p.m.	8	13.8	43	10.6	51	11.0
3:01–6 p.m.	10	17.2	65	16.0	75	16.2
6:01–9 p.m.	12	20.7	61	15.0	73	15.7
9:01 p.m.–midnight	4	7.0	53	13.1	57	12.3
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

current finding, however, is consistent with other recent BJS data regarding length of confinement prior to suicide (Mumola 2005). In addition, whereas NCIA's prior study found that 15 percent of suicides occurred between 2 and 14 days of confinement, the most recent data indicate that 26.6 percent of the deaths occurred during this same period. However, almost half (44.8 percent) of all inmates who committed suicide in holding facilities in 2005 and 2006 were dead within the first 6 hours of confinement. Although significant, this finding is much lower than NCIA's 1988 study, which found that 80 percent of suicides in holding facilities occurred within the first 6 hours (Hayes 1989).

The availability of better screening to identify suicide risk during the initial booking process is a possible explanation for the variations in time periods prior to suicide between this study and the earlier study. Another explanation may be increased staff awareness through training that emphasized the first few hours of confinement as the highest risk period for suicide. Overall, half (52.3 percent) of all inmates who committed suicide in detention and holding facilities were dead between 2 days and 4 months of confinement (in contrast to 34.5 percent in NCIA's 1988 study).

Intoxication

NCIA's 1988 study found a significant relationship between intoxication and inmate suicide—60 percent of inmates who committed suicide were under the influence of alcohol, drugs, or both at the time of their death. In contrast, the recent data show that only 19.6 percent of all inmates (including 15 percent of detention facility inmates) who committed suicide were intoxicated at the time of their deaths (see table 17). However, more than 50 percent of inmates who committed suicide in holding facilities were intoxicated at the time of death. This finding is consistent with the

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Table 16. Length of Confinement Prior to Suicide in U.S. Jails: 2005–06

LENGTH OF CONFINEMENT	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
0–3 hours	14	24.2	23	5.6	37	8.0
4–6 hours	12	20.7	18	4.4	30	6.5
7–9 hours	2	3.4	8	1.9	10	2.1
10–12 hours	1	1.7	11	2.7	12	2.6
13–18 hours	0	0.0	4	0.9	4	0.8
19–24 hours	3	5.2	13	3.2	16	3.4
25–48 hours	5	8.6	40	9.8	45	9.7
2–14 days	11	19.0	112	27.7	123	26.6
15–30 days	1	1.7	25	6.1	26	5.6
1–4 months	4	6.9	89	22.1	93	20.1
5–7 months	1	1.7	29	7.2	30	6.5
8–12 months	0	0.0	15	3.7	15	3.2
>1 year	3	5.2	13	3.2	16	3.4
Unknown	1	1.7	6	1.5	7	1.5
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

data in table 16, which indicate that fewer inmates committed suicide within the first 24 hours of confinement, the most likely time period in which they would have been intoxicated.

Although these findings seem to indicate that most of the inmates who committed suicide were not intoxicated at the time of their deaths, there remains a strong relationship between intoxication and suicide. Intoxication acts as a precipitant of suicidal behavior, and has been consistently linked to impulsive suicides in the general community (Moscicki 2001).

Method, Instrument, and Anchoring Device

The overwhelming majority (92.7 percent) of inmates who committed suicide chose asphyxiation by hanging as the method (see table 18). No significant differences in the method used were found between suicides that occurred in holding and detention facilities. This is consistent with findings from NCIA's 1988 study (Hayes 1989). Methods listed as "other" included self-strangulation and asphyxiation using a plastic bag.

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Table 17. Intoxication of Suicide Victims in U.S. Jails: 2005–06

INTOXICATION	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Alcohol	19	32.7	33	8.1	52	11.2
Drugs	8	13.8	25	6.2	33	7.1
Both alcohol and drugs	3	5.2	3	0.7	6	1.3
Neither alcohol nor drugs	21	36.2	307	75.6	328	70.7
Unknown	7	12.1	38	9.4	45	9.7
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

As shown in table 19, two-thirds (66.4 percent) of inmates who committed suicide used their bedding as the instrument. Clothing (other than shoelaces and belts) was used in 15.5 percent of suicides. These findings are in contrast to NCIA's 1988 study, which found that slightly less than half (47.9 percent) of the suicides involved bedding and 34 percent involved clothing (Hayes 1989). Significant differences in regard to the instrument used were found between suicides that occurred in holding and detention facilities. Clothing (other than shoelaces and belts) was used in 46.5 percent of suicides that occurred in holding facilities, but in only 11.1 percent of those that occurred in detention facilities. Bedding was used in 71.2 percent of suicides that occurred in detention facilities, but in only 32.8 percent of those that occurred in holding facilities. It is likely that these differences, which are consistent with findings from NCIA's 1988 study (Hayes 1989), occurred because holding facilities are less likely to confine individuals overnight and therefore make less use of bedding.

More than half of the inmates who committed suicide by hanging used either the bed/bunk (29.6 percent) or bars or cell door (27.0 percent) as the anchoring device (see table 20). Ventilation grates were used in 18.2 percent of the deaths; another study on prison suicide found that ventilation grates were used in more than 50 percent of deaths by hanging (He et al. 2001). A recently released national study on juvenile suicides in confinement found that door knobs and hinges (21 percent), air vent grates (20 percent), bunk frames and holes (20 percent), and window frames (15 percent) were the anchoring devices used in most suicides that occurred among youth (Hayes 2009). Telephones that have cords of varying length and that are located inside holding and booking cells also have been used in hanging attempts (Hayes 2003; Quinton and Dolinak 2003). Findings from this study indicate that multiple anchoring devices, however innocuous they may appear, are routinely available to inmates who attempt to commit suicide by hanging.

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Table 18. Method of Suicide in U.S. Jails: 2005–06

METHOD	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Hanging	56	96.6	374	92.1	430	92.7
Overdose	1	1.7	5	1.2	6	1.3
Cutting	0	0.0	6	1.5	6	1.3
Jumping	0	0.0	8	2.0	8	1.7
Ingestion of foreign object	0	0.0	2	0.5	2	0.4
Other	1	1.7	11	2.7	12	2.6
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Table 19. Instrument Used in Suicide in U.S. Jails: 2005–06

INSTRUMENT	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Bedding	19	32.8	289	71.2	308	66.4
Clothing	27	46.5	45	11.1	72	15.5
Shoelace	7	12.1	12	3.0	19	4.1
Belt	1	1.7	5	1.2	6	1.3
Towel	0	0.0	7	1.7	7	1.5
Razor/knife	0	0.0	5	1.2	5	1.1
Drugs	1	1.7	5	1.2	6	1.3
None	0	0.0	7	1.7	7	1.5
Unknown	3	5.2	31	7.7	34	7.3
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

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Time Span Between Last Observation and Finding Victim

Nearly 21 percent of suicide victims were found less than 15 minutes after the last observation, and 30.8 percent of victims were found more than 1 hour after the last observation (see table 21). No significant differences were found between suicides that occurred in holding and detention facilities in regard to time span. This is different from NCIA's 1988 study, which found that 42.3 percent of victims were found less than 15 minutes after the last observation and only 11.2 percent were found more than 1 hour after the last observation (Hayes 1989). There is no clear explanation for these differences in time span between the two studies.

Administration of Cardiopulmonary Resuscitation

Almost two-thirds (62.7 percent) of respondents stated that jail staff administered cardiopulmonary resuscitation (CPR) to the victim before medical personnel arrived (see table 22). Jail staff did not administer CPR in the remaining cases because they believed the victim was already dead, were waiting for medical staff to arrive, or did not have training in CPR. This finding is consistent with a recent study of prison suicides, which found that first responders (usually officers) failed to initiate life-saving measures in approximately one-third of cases involving suicide (Patterson and Hughes 2008). In addition, only 35.6 percent of respondents stated that jail or medical personnel used an automated external defibrillator (AED) on the victim. In the majority of cases, staff did not have access to an AED.

Table 20. Anchoring Device Used in Hanging in U.S. Jails: 2005–06

ANCHORING DEVICE	NUMBER	PERCENT
Bed or bunk	127	29.6
Bars or cell door	116	27.0
Ventilation grate	78	18.2
Shower hardware	16	3.7
Corded telephone	14	3.3
Conduit piping	12	2.8
Light fixture	9	2.1
Window	8	1.8
Shelf/clothing hook	8	1.8
Smoke detector	6	1.3
Other	24	5.6
Unknown	12	2.8
Total	**430**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

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Table 21. Time Span Between Last Observation and Finding Victim in U.S. Jails: 2005–06

TIME SPAN	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
<15 minutes	10	17.2	86	21.2	96	20.7
15–30 minutes	12	20.7	91	22.4	103	22.2
30–60 minutes	9	15.5	78	19.2	87	18.8
1–3 hours	15	25.9	89	21.9	104	22.4
>3 hours	9	15.5	30	7.4	39	8.4
Unknown	3	5.2	32	7.9	35	7.5
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Table 22. Administration of Cardiopulmonary Resuscitation (CPR) to Suicide Victims in U.S. Jails: 2005–06

CPR ADMINISTRATION	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	36	62.1	255	62.8	291	62.7
No	22	37.9	151	37.2	173	37.3
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Housing Assignment

At the time of death, approximately 60 percent of inmates who committed suicide were assigned to single-occupancy cells and 40 percent were housed in multiple-occupancy cells. Cellmates were absent from the cells in about two-thirds of the suicides that occurred in multiple-occupancy cells. No significant differences were found between suicides that occurred in holding and detention facilities in regard to housing assignment.

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Well over one-third (38.4 percent) of inmates who committed suicide were in isolation or segregation at the time of their deaths (see table 23), and 29.3 percent of inmates who committed suicide had a history of being placed in isolation or segregation prior to their deaths. Many more inmates who committed suicide in detention facilities were in isolation or segregation than inmates who died in holding facilities (41.1 percent versus 19.0 percent). In contrast, NCIA's 1988 study found that 67 percent of the victims were held in isolation at the time of their death (Hayes 1989). A possible explanation for the decreased use of isolation for inmates who later committed suicide is increased staff awareness through training that emphasized isolation as a contributing factor to inmate suicides.

Table 23. Isolation or Segregation at Time of Death for Suicide Victims in U.S. Jails: 2005–06

ISOLATION/ SEGREGATION	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	11	19.0	167	41.1	178	38.4
No	47	81.0	236	58.2	283	61.0
Unknown	0	0.0	3	0.7	3	0.6
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Suicide Precautions

Only 7.5 percent of the inmates who committed suicide were on suicide precautions at the time of their deaths (see table 24). No significant differences were found between suicides that occurred in holding and detention facilities in regard to suicide precautions. Of the 35 inmates who committed suicide while on suicide precautions, 6 were being observed at 30-minute intervals, 24 at 15-minute intervals, 1 at 10-minute intervals, and 4 were under constant observation (including closed-circuit television (CCTV) monitoring). Of the inmates who committed suicide, 29.5 percent had previously been placed on suicide precautions during their current or previous confinement, and some of them were removed from this status shortly before their death.

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Table 24. Suicide Precaution Status Among Suicide Victims in U.S. Jails: 2005–06

SUICIDE PRECAUTION STATUS	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	4	6.9	31	7.6	35	7.5
No	54	93.1	375	92.4	429	92.5
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

There may be several reasons why inmates are able to commit suicide while on suicide precautions: (1) jail staff do not observe the inmate at the required time interval, (2) the inmate is on an observation level that is not commensurate with the level of risk (e.g., an acutely suicidal inmate placed on a 15-minute observation level), (3) the inmate is on an observation level that is not consistent with national correctional standards (e.g., a 30-minute interval), (4) CCTV monitoring is not reliable, and (5) the inmate is placed in a cell that contains anchoring devices that can be used in a hanging attempt. In fact, because medical experts warn that brain damage from asphyxiation caused by a suicide attempt can occur within 4 minutes and death can occur within 5 to 6 minutes (American Heart Association 1992), observation at 10- or 15-minute intervals is only sufficient under the following conditions—surveillance must be conducted at staggered intervals (e.g., 5 minutes, 10 minutes, 7 minutes) and the cell housing the suicidal inmate must be free of protrusions (Hayes 2006).

No-Harm Contracts

Mental health clinicians often develop no-harm contracts with potentially suicidal inmates, seeking assurance that their clients will not engage in self-injurious behavior. Correctional facilities may also ask each incoming inmate to sign a no-harm letter as a protection against liability. In truth, however, most legal experts believe that a no-harm contract or letter does not afford legal protection to a correctional agency or mental health worker. Although no-harm contracts or letters may be positive in some cases, most clinicians agree that once an inmate becomes acutely suicidal, his or her written or verbal assurances cannot be taken seriously (Thienhaus and Piasecki 1997).

The survey questionnaire defined a no-harm contract as "a verbal and/or written agreement between the inmate and facility staff/clinician in which the inmate provides assurances they will not commit suicide or engage in self-injurious behavior." Table 25 shows that 12.7 percent of the inmates who committed suicide stated that they would not commit suicide or engage in self-injurious behavior, thus casting significant doubt as to the usefulness of such a contract.

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Table 25. No-Harm Contracts Used in U.S. Jails: 2005–06

NO HARM CONTRACTS	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	1	1.7	58	14.3	59	12.7
No	51	87.9	317	78.1	368	79.3
Unknown	6	10.4	31	7.6	37	8.0
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Assessment by a Qualified Mental Health Professional

The survey questionnaire defined a qualified mental health professional (QMHP) as "an individual by virtue of their education, credentials, and experience that is permitted by law to evaluate and care for the mental health needs of patients. May include, but is not limited to, a psychiatrist, psychologist, clinical social worker, and psychiatric nurse." Table 26 shows that 37.1 percent of inmates who committed suicide were assessed by a QMHP prior to their deaths. Because holding facilities do not usually have QMHP staff, significant differences were found between suicides that occurred in holding and detention facilities in regard to a QMHP assessment; a much higher percentage of suicide victims in detention facilities were seen by a QMHP prior to their deaths.

Table 26. Qualified Mental Health Professional (QMHP) Assessment of Suicide Victims in U.S. Jails: 2005–06

QMHP ASSESSMENT	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	10	17.2	162	39.9	172	37.1
No	46	79.4	217	53.4	263	56.6
Unknown	2	3.4	27	6.7	29	6.3
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

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Among inmates who committed suicide and received a QMHP assessment prior to their deaths, almost half (47 percent) had been assessed within 3 days before their death (see table 27). No significant differences were found between suicides that occurred in holding and detention facilities in regard to last contact with a QMHP.

Inmates on suicide precautions should be assessed daily for suicide risk (Hayes 2005; National Commission on Correctional Health Care 2008); however, of the 35 inmates on suicide precautions at the time of their deaths, only 20 percent had been seen by a QMHP within the previous 24 hours.

Table 27. Suicide Victims' Last Contact With a Qualified Mental Health Professional (QMHP) in U.S. Jails: 2005–06

LAST CONTACT WITH QMHP	NUMBER	PERCENT
<1 day	34	19.7
1–3 days	47	27.3
4–6 days	13	7.6
7–13 days	15	8.8
14–30 days	18	10.4
1–2 months	16	9.4
3–4 months	4	2.3
5–6 months	5	2.9
7–9 months	1	0.6
>1 year	1	0.6
Unknown	18	10.4
Total	**172**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Court Hearing, Telephone Call, and/or Visit Prior to Suicide

Although the possible relationship between an inmate suicide and a court hearing, telephone call, and/or visit has not received considerable attention in recent prior research efforts, one earlier study found that approximately 50 percent of suicides in a large urban jail system occurred within 3 days of a court hearing (Marcus and Alcabes 1993). Approximately one-third (34.5 percent) of the inmates who committed suicide attended (or were scheduled to attend) a court hearing close to the date of their deaths (see table 28).

The vast majority (80 percent) of the inmates who committed suicide attended (or were scheduled to attend) a court hearing within 2 days of when they committed suicide (see table 29). No

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Table 28. Suicides Occurring Close to Date of Court Hearing in U.S. Jails: 2005–06

SUICIDE AND COURT HEARING	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	15	25.8	145	35.8	160	34.5
No	39	67.3	207	50.9	246	53.0
Unknown	4	6.9	54	13.3	58	12.5
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Table 29. Suicides Occurring Close to a Scheduled Court Hearing in U.S. Jails: 2005–06

SCHEDULED COURT HEARING	NUMBER	PERCENT
<1 day	39	24.3
1–2 days	89	55.7
3–7 days	32	20.0
Total	**160**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

significant differences were found in regard to attendance at a court hearing between suicides that occurred in holding and detention facilities.

Only 21.8 percent of the inmates who committed suicide received a telephone call and/or visit close to the date of their deaths (see table 30). The vast majority (approximately 80 percent) of the events were telephone calls. This variable received nearly 46 percent of "unknown" responses.

Approximately two-thirds (67.3 percent) of the inmates who committed suicide and received a telephone call and/or visit died less than 24 hours after the event (see table 31). No significant differences were found between suicides that occurred in holding and detention facilities in regard to receiving a telephone call or visit.

A significant number of respondents answered "unknown" to survey questions regarding the proximity of the suicide to a court hearing, telephone call, and/or visit. Based on the author's experience in reviewing inmate suicide cases and mortality reviews, it is likely that these relationships would be proved stronger if jails kept appropriate records.

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Table 30. Suicides Occurring Close to a Telephone Call or Visit in U.S. Jails: 2005–06

TELEPHONE CALL OR VISIT	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	16	27.6	85	20.9	101	21.8
No	24	41.4	127	31.3	151	32.5
Unknown	18	31.0	194	47.8	212	45.7
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Table 31. Suicides Occurring Close to a Scheduled Telephone Call or Visit in U.S. Jails: 2005–06

RECEIPT OF TELEPHONE CALL OR VISIT	NUMBER	PERCENT
<1 day	68	67.3
1–2 days	10	9.9
3–7 days	3	3.0
Unknown (but within 7 days)	20	19.8
Total	**101**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Characteristics of the Jail Facilities

Type, Administration, Population, and Capacity

As stated previously, data were received from 406 detention facilities and 58 holding facilities. County governments administered the vast majority (83.9 percent) of facilities that experienced suicides, followed by municipal governments (12.8 percent), private agencies (1.8 percent), and state or regional governments (1.5 percent). The average population of most detention facilities that sustained suicides was about 550 inmates, whereas holding facilities averaged 5 inmates. Approximately 70 percent of the facilities that experienced suicides were at or under capacity at the time of the inmate suicide, suggesting that overcrowding was not a contributing factor to the deaths.

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Identification and/or Screening for Suicide Risk

A correctional facility's suicide prevention efforts must include the screening and assessment of inmates when they enter the facility (Hayes 2005; National Commission on Correctional Health Care 2008). Although mental health and medical communities agree that no single set of risk factors can predict suicide, there is little disagreement about the value of screening and assessment in preventing suicide (Cox and Morschauser 1997; Hughes 1995). Intake screening for all inmates and ongoing assessment of at-risk inmates are critical because research consistently reports that at least two-thirds of suicide victims communicate their intent some time before death, and that an individual with a history of one or more suicide attempts is at a much higher risk for suicide than one who has never made an attempt (Clark and Horton-Deutsch 1992; Maris 1992). Although ideation, prior attempt(s), and/or other forms of suicidal behavior indicate current risk, other factors such as a recent significant loss, limited prior incarceration, lack of social support system, and various stressors of confinement can also be strongly related to suicide (Bonner 1992). Intake screening should include not only questions about current suicidal ideation and prior suicidal behavior, but also questions about the inmate's suicide risk during any prior confinement in the facility and the arresting and/or transporting officer(s)' belief that the inmate is currently at risk (Hayes 2005; National Commission on Correctional Health Care 2008).

Table 32 shows that the vast majority (77.1 percent) of respondents reported that they maintained an intake screening process to identify inmates' suicide risk when they entered the facility; holding facilities screened for suicide risk to a lesser degree (63.7 percent) than detention facilities (79.1 percent). However, only 27.4 percent of respondents reported that the intake screening process included verification as to whether the newly arrived inmate was on suicide precautions during any prior confinement in the jail facility (see table 33).

Table 32. Intake Screening for Suicide Risk in U.S. Jails: 2005–06

INTAKE SCREENING FOR SUICIDE RISK	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	37	63.7	321	79.1	358	77.1
No	21	36.3	85	20.9	106	22.9
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

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In addition, only 30.6 percent of respondents reported that the intake screening process included verification as to whether the arresting and/or transporting officer(s) believed that the newly arrived inmate was at risk for suicide (see table 34).

Table 33. Verification of Suicide Risk During Prior Confinement in U.S. Jails: 2005–06

SUICIDE RISK DURING PRIOR CONFINEMENT	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	15	25.9	112	27.6	127	27.4
No	43	74.1	294	72.4	337	72.6
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Table 34. Arresting and/or Transporting Officer Opinion About Suicide Risk in U.S. Jails: 2005–06

ARRESTING AND/OR TRANSPORTING OFFICER OPINION ABOUT SUICIDE RISK	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	18	31.0	124	30.6	142	30.6
No	40	69.0	282	69.4	322	69.4
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Thus, although a high percentage of facilities that sustained inmate suicides had a screening process to identify potentially suicidal behavior at intake, the process was flawed in that most facilities did not verify whether the newly arrived inmate was on suicide precautions during any prior confinement in the jail facility, nor whether the arresting and/or transporting officer(s) believed that the inmate was at risk for suicide.

Suicide-Prevention Training

The essential component in any suicide prevention program is properly trained correctional staff, who form the backbone of any jail or prison facility. Very few suicides are actually prevented by

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mental health, medical, or other professional staff because suicides usually take place in inmate housing units, often during late evening hours or on weekends when inmates are generally outside the purview of program staff. Therefore, correctional staff who have been trained in suicide-prevention techniques and have developed an intuitive sense about the inmates under their care must prevent these incidents. In addition, correctional officers are often the only staff available 24 hours a day and thus form the front line of defense in preventing suicides. However, as with medical and mental health personnel, correctional staff cannot detect, assess, or prevent a suicide without training. Lives are lost and jurisdictions incur unnecessary liability from these deaths when administrators fail to create and maintain effective training programs (Cohen 2008; Hayes 2005).

Table 35 shows that the majority (61.8 percent) of respondents reported that they had provided suicide-prevention training to at least 90 percent of their correctional staff, although holding facilities provided far less training (48.3 percent) than detention facilities (63.7 percent).

Table 35. Suicide-Prevention Training in U.S. Jails: 2005–06

SUICIDE PREVENTION TRAINING	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	28	48.3	259	63.7	287	61.8
No	30	51.7	147	36.3	177	38.2
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Of the respondents who reported suicide-prevention training, 74.9 percent stated that the training took place yearly. The remainder (25.1 percent) reported that training took place either biennially or on a preservice basis. Holding facilities provided far less annual training (32.2 percent) than detention facilities (79.5 percent). Further, only 6 percent of all reported suicide-prevention training was 8 hours in length. The majority (69 percent) of training was 2 hours or less. No significant differences were found between suicides that occurred in holding and detention facilities in regard to the duration of suicide-prevention training.

The combined data in tables 35 and 36 indicate that almost two-thirds (63.3 percent) of all facilities that sustained a suicide either did not provide suicide-prevention training or did not provide the training annually.

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Table 36. Frequency of Suicide-Prevention Training in U.S. Jails: 2005–06

FREQUENCY OF SUICIDE PREVENTION TRAINING	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yearly	9	32.2	206	79.5	215	74.9
Other	19	67.8	53	20.5	72	25.1
Total	**28**	**100.0**	**259**	**100.0**	**287**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

CPR Certification

Following a suicide attempt, the victim's chances for survival depend on both the level and promptness of staff intervention. According to most national correctional standards and practices, a facility's emergency response policy should require all staff to be trained in CPR procedures. The vast majority (80.3 percent) of respondents reported providing CPR training to their correctional staff (see table 37); holding facilities provided slightly less training (70.7 percent) than detention facilities (81.7 percent). Almost two-thirds (62.7 percent) of respondents stated that their jail staff administered CPR to the victim before medical personnel arrived (see table 22, page 26).

Table 37. Certification in Cardiopulmonary Resuscitation (CPR) in U.S. Jails That Sustained a Suicide: 2005–06

CPR CERTIFICATION	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	41	70.7	332	81.7	373	80.3
No	17	29.3	74	18.3	91	19.7
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Suicide Watch and Levels of Observation

National correctional standards and practices recommend two levels of supervision for suicidal inmates: close observation and constant observation (Hayes 2005; National Commission on Correctional Health Care 2008). Close observation is appropriate for an inmate who is not actively suicidal, but who expresses suicidal ideation and/or has a recent prior history of self-harming behavior. Staff should observe these inmates at staggered intervals not to exceed every 10 minutes

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(e.g., 5 minutes, 10 minutes, 7 minutes). Constant observation is appropriate for an inmate who is actively suicidal (i.e., either threatening or engaging in suicidal behavior). Staff should observe these inmates on a continuous, uninterrupted basis. In some jurisdictions, staff use an intermediate level of observation that involves monitoring at staggered intervals that do not exceed 5 minutes. Other aids (e.g., CCTV, inmate companions, or observers) can be used as a supplement to, but never as a substitute for, these observation levels.

Table 38 shows that the overwhelming majority (92.7 percent) of respondents reported that they maintained a suicide watch[10] protocol (apart from CCTV or an inmate companion[11]) to provide staff observation of inmates identified as suicidal; holding facilities had such a process to a far lesser degree (69.0 percent) than detention facilities (96.1 percent). One reason why holding facilities reported a lower percentage for suicide watch protocol could be their traditional reliance on CCTV.

Table 38. Suicide Watch Protocol in U.S. Jails: 2005–06

SUICIDE WATCH PROTOCOL	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	40	69.0	390	96.1	430	92.7
No	18	31.0	16	3.9	34	7.3
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

In addition, although the vast majority of facilities had a suicide watch protocol, only 1.7 percent of respondents reported that constant observation was an option for supervising suicidal inmates. The vast majority (87.2 percent) of inmates on suicide watch were required to be closely observed at 15-minute intervals. No significant differences were found between suicides that occurred in holding and detention facilities in regard to the levels of observation provided to suicidal inmates.

Slightly more than half (51.2 percent) of the respondents reported that only mental health personnel were authorized to downgrade and discharge inmates from suicide watch (see table 39). In approximately one-quarter (25.4 percent) of the facilities, either medical or mental health personnel were authorized to downgrade and discharge inmates from suicide watch. In a small number (2.2 percent) of facilities, inmates could only be removed from suicide watch when they were released from custody. Significant differences were found between holding and detention

[10] For purposes of the survey, "suicide watch" was defined as "the level(s) of direct visual observation by staff that is given to an inmate identified as being at risk of suicide. Excludes closed circuit television, inmate companions/inmate observation aide, or any other non-staff monitoring."

[11] For purposes of the survey, "inmate companion" was defined as "a designation by which another inmate is entrusted with the responsibility of providing observation to an inmate on suicide watch."

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Table 39. Authorization To Discharge Inmates From Suicide Watch in U.S. Jails: 2005–06

AUTHORIZATION TO DISCHARGE FROM SUICIDE WATCH	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Correctional	40	68.9	3	0.7	43	9.3
Medical	6	10.3	25	6.1	31	6.7
Mental health	0	0.0	238	58.6	238	51.2
Medical or mental health	3	5.2	115	28.3	118	25.4
All	1	1.8	23	5.7	24	5.2
None	8	13.8	2	0.6	10	2.2
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

facilities—most holding facilities (68.9 percent) permitted correctional personnel to downgrade and discharge inmates from suicide watch, presumably because these facilities lacked medical and/or mental health personnel. Holding facilities were also more likely to remove inmates from suicide watch only when they were released from custody.

Safe Housing

Inmates placed on suicide precautions are frequently housed in unsafe cells containing protrusions (i.e., anchoring devices) that could be used to commit suicide by hanging (Hayes 2005; National Commission on Correctional Health Care 2008). It is well established that hanging is the method of choice in the overwhelming majority of inmate suicides (Hayes 1989). Although it is impossible to create a "suicide-proof" cell environment in any correctional facility, it is possible to ensure that any cell housing a potentially suicidal inmate is free of all obvious protrusions (Atlas 1989; Hayes 2006). Decisions about the location of cells designated to house suicidal inmates should be based on the ability to maximize staff interaction with those inmates. When possible, suicidal inmates should be housed in the general population unit, mental health unit, or medical infirmary, if available, but they should always be located close to staff. As a federal appeals court once stated, "It is true that prison officials are not required to build a suicide-proof jail. By the same token, however, they cannot equip each cell with a noose" (*Tittle* v. *Jefferson County Commission* 1992).

Two-thirds (67.9 percent) of respondents reported that they did not maintain a protocol by which suicidal inmates would be assigned to a safe, suicide-resistant, and protrusion-free cell (see table 40). No significant differences were found between holding and detention facilities in regard to the safe housing of suicidal inmates.

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Table 40. Safe Housing for Suicidal Inmates in U.S. Jails: 2005–06

SAFE HOUSING FOR SUICIDAL INMATES	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	16	27.6	133	32.8	149	32.1
No	42	72.4	273	67.2	315	67.9
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Mortality Review Process

Every completed suicide, as well as attempts that require hospitalization, should be examined through a morbidity-mortality review process (Hayes 2005, 2007; National Commission on Correctional Health Care 2008). If resources permit, a clinical review through a psychological autopsy is also recommended (Aufderheide 2000; Sanchez 2006). Ideally, an outside agency should coordinate the morbidity-mortality review to ensure impartiality. The review (separate from other formal investigations that may be required to determine the cause of death) should include a critical inquiry of the circumstances surrounding the incident, procedures relevant to the incident, all relevant training that involved staff received, pertinent medical and mental health services or reports involving the victim, precipitating factors that may have led to the suicide, and any recommendations for changes involving policy, training, the physical plant, medical or mental health services, and operational procedures.

Table 41 shows that the majority (62.9 percent) of respondents reported that they did not conduct a mortality review following the inmate suicide.[12] No significant differences were found between suicides that occurred in holding and detention facilities in regard to the mortality review process, although holding facilities were slightly less likely to conduct a review.

Survey respondents were also asked whether any possible precipitating factors (i.e., circumstances that may have caused the victim to commit suicide) were uncovered during the mortality review process. Although mortality reviews were not conducted in most cases, when they did occur, respondents either did not cite any precipitating factors or cited possible factors such as a recent conviction or sentence, fear of transfer to the state prison system, frustration or anger regarding release, death of a family member or friend, lack of family visitation, and ending of a relationship. In addition, several respondents reported poor communication among staff and/or inadequate observation by correctional officers as precipitating factors in the suicides.

[12] For purposes of the survey, a "mortality review" was defined as "an interdisciplinary committee process comprised of correctional, medical, and mental health personnel that examines the events surrounding the death to determine if the incident was preventable. The review process may include recommendations aimed at reducing the opportunity of future deaths."

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Table 41. Mortality Review Process in U.S. Jails: 2005–06

MORTALITY REVIEW PROCESS	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	16	27.6	148	36.5	164	35.3
No	42	72.4	250	61.6	292	62.9
Unknown	0	0.0	8	1.9	8	1.8
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

Finally, respondents were asked whether the mortality review process resulted in any recommendations for corrective action to reduce the likelihood of future suicides. For the cases in which the reviews occurred, respondents either did not cite any recommendations for corrective action or cited actions such as staff being reassigned or fired, increased staff training, revision of the suicide watch process, and revision of the intake screening process.

Written Suicide-Prevention Policy

The literature is replete with examples of how jail and prison systems have developed effective suicide-prevention programs (Cox and Morschauser 1997; Goss et al. 2002; Hayes 1995, 1998; White and Schimmel 1995). New York experienced a significant drop in the number of jail suicides following the implementation of a statewide comprehensive prevention program (Cox and Morschauser 1997). Texas saw a 50-percent decrease in the number of county jail suicides and nearly a sixfold decrease in the rate of these suicides from 1986 through 1996; much of it can be attributed to increased staff training and a state requirement for jails to maintain suicide-prevention policies (Hayes 1996). One researcher reported no suicides during a 7-year period in a large county jail after suicide-prevention policies were developed based on the following principles: screening; psychological support; close observation; removal of dangerous items from cells; clear and consistent procedures; and diagnosis, treatment, and transfer of suicidal inmates to the hospital as necessary (Felthous 1994).

The American Correctional Association (ACA), American Psychiatric Association (APA), and National Commission on Correctional Health Care (NCCHC) are advocates for comprehensive suicide prevention programs. These organizations have promulgated national correctional standards that are adaptable to individual jail, prison, and juvenile facilities. Although the ACA standards are the most widely recognized throughout the country, they provide limited guidance about suicide prevention and simply state that institutions should have a written prevention policy that is

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reviewed by medical or mental health staff. ACA's broad focus on the operation and administration of correctional facilities precludes these standards from containing needed specificity. Both the APA and NCCHC standards, however, are much more instructive and offer the following recommendations for a suicide prevention program: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, review, and critical incident debriefing (American Psychiatric Association 2000; National Commission on Correctional Health Care 2008).

Table 42 shows that the vast majority (84.9 percent) of survey respondents reported that their facilities maintained a written suicide-prevention policy at the time of the suicide, although holding facilities maintained policies to a lesser degree (70.7 percent).

Table 42. Written Suicide-Prevention Policy in U.S. Jails: 2005–06

WRITTEN SUICIDE PREVENTION POLICY	FACILITY TYPE					
	HOLDING (0–72 hours)		DETENTION (>72 hours)		COMBINED	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Yes	41	70.7	353	86.9	394	84.9
No	17	29.3	53	13.1	70	15.1
Total	**58**	**100.0**	**406**	**100.0**	**464**	**100.0**

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

However, as stated previously, the quality of the written policies for suicide prevention is questionable. For example, although many respondents reported that their facilities maintained an intake screening process to identify the suicide risk of inmates entering the facility, in most facilities the process did not include verification as to whether the arresting and/or transporting officer(s) believed that the newly arrived inmate was at risk for suicide, nor whether the inmate was at risk for suicide during prior confinement. In addition, although the majority of respondents reported that staff in their facilities received suicide-prevention training, most of the training was 2 hours or less in duration. Most surveyed facilities had a suicide watch protocol, but few provided constant observation. Further, only one-third of respondents reported the availability of protrusion-free housing for suicidal inmates, and most did not provide a mortality review following an inmate suicide. These findings are consistent with a national survey on juvenile suicide in confinement indicating that although the vast majority of facilities had a written suicide-prevention policy, only 20 percent had written policies encompassing all of the components of a suicide-prevention program (Hayes 2009).

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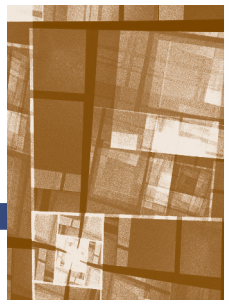
Chapter 4. Special Considerations



The Changing Face of Jail Suicide

The National Center on Institutions and Alternatives' (NCIA's) 1981 and 1988 national studies of jail suicide found that, despite a 7-year time interval, demographic data on inmate suicides did not change dramatically. Most of the key characteristics of jail suicide—offense, intoxication, method and instrument, isolation, and length of confinement—remained constant over time (Hayes 1989).

Twenty years later, this national study of jail suicides found substantial changes in the demographic characteristics of inmates who committed suicide during 2005–06. Table 43 shows that some of these changes are stark. For example, suicide victims once characterized as being confined on "minor other" offenses were most recently confined on "personal and/or violent" charges. Intoxication was previously viewed as a leading precipitant to inmate suicide, yet recent data indicate that it is now found in only a minority of cases. Previously, more than half of all jail suicide victims were dead within the first 24 hours of confinement; current data suggest that less than one-quarter of all victims commit suicide during this time period, with an equal number of deaths occurring between 2 and 14 days of confinement. In addition, it appears that inmates who committed suicide were far less likely to be housed in isolation than previously reported, yet for unknown reasons it was less likely that they would be found within 15 minutes of the last observation by staff. Finally, more jail facilities that experienced inmate suicides had both written suicide-prevention policies and an intake screening process to identify suicide risk than in previous years, although the comprehensiveness of programming remains questionable.

Previously, more than half of all jail suicide victims were dead within the first 24 hours of confinement; current data suggest that less than one-quarter of all victims commit suicide during this time period, with an equal number of deaths occurring between 2 and 14 days of confinement.

Jail Suicide Rates

Suicide continues to be a leading cause of death among inmates in the nation's jails. However, a simple question that is routinely asked—"Aside from the number of deaths, what is the jail suicide rate throughout the country?"—often evokes controversy (Lester and Yang 2008; Metzner 2002; O'Toole 2008). Suicide rates are calculated using either average daily population (ADP) or yearly admission data. Many jail administrators would argue that the suicide rate should be calculated based on the total number of inmates who pass through a facility each year, suggesting that each of them is at potential risk of suicide and should be counted. A suicide rate calculated according to yearly admissions would result in a much lower number. For example, few would argue that there would be cause for concern if a 2,000-bed jail experienced 3 inmate suicides during the course of 12 months. If yearly admissions were used to calculate the suicide rate of this jail, and approximately 17,000 inmates passed through the facility each year,[13] the rate would be 17.6 deaths per 100,000 inmates. If, however, the ADP was used to calculate the suicide rate, the rate would be 150 deaths per 100,000 inmates.

[13] Based on an actual example.

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Table 43. Changing Face of Suicide in U.S. Jails: 1985–86 to 2005–06

VARIABLE	1985–86	2005–06
Facility type	70% detention	88% detention
Race	72% white	67% white
Gender	94% male	93% male
Age	30	35
Marital status	52% single	42% single
Most serious charge	29% minor other	43% personal and/or violent
Jail status	89% detained	91% detained
Intoxication at death	60%	20%
Time of suicide	30% between midnight and 6 a.m.	32% between 3:01 and 9 p.m.
Length of confinement	51% within first 24 hours	23% within first 24 hours
Method	94% hanging	93% hanging
Instrument	48% bedding	66% bedding
Time span between last observation and finding victim	42% found within15 minutes	21% found within15 minutes
Isolation	67%	38%
Known history of suicidal behavior	16%	34%
Known history of mental illness	19%	38%
Intake screening for suicide risk	30%	77%
Written suicide-prevention policy	51%	85%

Source: National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

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Historically, suicide rates have been calculated using the ADP. Experts in methodology would argue that yearly admission data are often unreliable (Mumola 2005) and, because the vast majority of individuals spend considerably less time in jail during the year than in the community, it is more appropriate to use the ADP. As previously discussed, the Bureau of Justice Statistics (BJS) has been collecting and analyzing limited inmate suicide data pursuant to the Death in Custody Reporting Act of 2000. Although BJS calculations of suicide rates have previously been based on the ADP, BJS apparently was sensitive to the controversy when it recently wrote that "BJS has usually based jail mortality rates on the average daily population of inmates (an ADP of under 700,000). A more sensitive measure of jail mortality would reflect the far larger number of admissions into these facilities over the entire year (nearly 13 million). All of these persons admitted are at risk of dying while held in jail" (Mumola 2005:5). BJS began collecting annual admission data on the 50 largest jails "to calculate an at-risk measure of mortality" and found the ADP-based suicide rate for these jurisdictions (29 per 100,000) was 14 times the at-risk suicide rate (2 per 100,000) (Mumola 2005). However, BJS still uses ADP data to calculate the overall suicide rate of jails (excluding holding facilities) throughout the country. According to the most recent BJS data, the suicide rate in jails during 2006 was 36 deaths per 100,000 inmates. These data also suggest that the jail suicide rate has been in decline since the reporting program began in 2000 (Mumola and Noonan 2008).

It is important to compare jail suicide rates with the suicide rate in the general population. The Centers for Disease Control and Prevention (CDC) uses general population statistics (not data based on yearly admission or entry into the United States) to calculate the suicide rate in the community each year. Thus, to compare the rate of suicide in jail to that in the community, the ADP must be used. The most recent CDC data calculate the suicide rate in the community at 11 deaths per 100,000 citizens (Heron et al. 2009). Based on these data, the jail suicide rate (as calculated by BJS) is approximately three times greater than that in the general population in the community.

There are several reasons for the higher rate of suicide in jail. Jail environments are conducive to suicidal behavior and an individual entering a jail is at increased risk of facing a crisis situation. From an inmate's perspective, certain features of the jail environment may enhance suicidal behavior: fear of the unknown, distrust of an authoritarian environment, perceived lack of control over the future, isolation from family and significant others, the shame of being incarcerated, and the perceived dehumanizing aspects of incarceration. In addition, certain factors that are common among inmates facing a crisis situation could predispose them to suicide: recent excessive use of alcohol and/or drugs, recent loss of stabilizing resources, severe guilt or shame over the alleged offense, current mental illness, prior history of suicidal behavior, and approaching court date. Some inmates simply are (or become) ill equipped to handle the common stresses of confinement.

Some have argued that jail populations are biased in a number of ways that affect and, perhaps, distort suicide rates. One theorist stated that: "Two of the primary problems that make jails high suicide risk points are their unusual population and the high cyclic rate or the total number of people exposed to a jail in the course of a year" (Stone 1987:84), arguing that there are certain variables (including sex, age, marital status, occupational status, and alcoholism) that relate to suicide

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in the general population that are predominantly found in jails and, therefore, make such environments more suicide prone. In addition, the jail suicide rate "is affected by the 'cyclic rate'.... What is occurring in jails is that large numbers of a very suicide-prone population are submitted to short periods of stay. You might say that our jails are 'testing' the suicide potential of a suicide prone group" (Stone 1987:84).

Despite this possible distortion, the examination of suicide rate comparisons enhances our understanding of the jail suicide problem. The 1988 national study of jail suicides calculated 107 suicides per 100,000 inmates in detention facilities in 1986 (based on the ADP in those facilities); that rate was approximately 9 times greater than the rate in the general population (Hayes 1989).[14] NCIA's most recent national study of jail suicide identified 288 suicides that occurred in detention facilities in 2006. Based on these data, and using the BJS methodology indicating a national ADP of 755,896,[15] there were 38 suicides per 100,000 inmates in detention facilities in 2006, and that rate was approximately 3 times greater than the rate in the general population.

The increased awareness about the problem of suicide among jail inmates is also reflected in national correctional standards that now require comprehensive suicide-prevention programming, better training of jail staff, and more indepth inquiry of suicide risk factors during the intake process.

This calculation is consistent with previously reported BJS data and it confirms that there has been a dramatic decrease in the suicide rate in detention facilities during the past 20 years. The nearly threefold decrease from 107 suicides in 1986 to 38 suicides in 2006 is extraordinary. Absent indepth scientific inquiry, there may be several explanations for the reduced suicide rate. During the past several years, NCIA's prior national studies of jail suicide have given a face to this long-standing and often ignored public health issue in the nation's jails. Findings from the studies have been widely distributed throughout the country and were eventually incorporated into suicide-prevention training curricula. The increased awareness about the problem of suicide among jail inmates is also reflected in national correctional standards that now require comprehensive suicide-prevention programming, better training of jail staff, and more indepth inquiry of suicide risk factors during the intake process. Finally, litigation involving jail suicide has persuaded (or forced) counties and facility administrators to take corrective actions in reducing the opportunity for future deaths. Therefore, the antiquated mindset that "inmate suicides cannot be prevented" should forever be put to rest.

[14] Rates of suicide in holding facilities were not computed due to the unreliability of average daily population data.

[15] See Sabol, Minton, and Harrison 2007.

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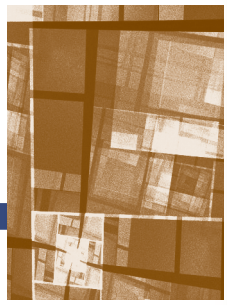
Chapter 5. Conclusion



The primary goal of this study was to provide updated data on the extent and distribution of inmate suicides throughout the country, as well as to gather recent descriptive data on the demographic characteristics of each victim, characteristics of the incident, and characteristics of the holding or detention facility that sustained the suicide. To that end, project staff compiled significant data on inmate suicides throughout the country, and it is hoped that these findings can be used as a resource tool for practitioners in expanding their knowledge base and for facility administrators in creating and/or revising sound policies and training curricula on suicide prevention.

Comprehensive Suicide-Prevention Programming

Although the vast majority of facilities that sustained a suicide had a written suicide-prevention policy, the comprehensiveness of the program was questionable.

The findings indicate that, although the vast majority of facilities that sustained a suicide had a written suicide-prevention policy, the comprehensiveness of the program was questionable. For example, even though many respondents reported that their facilities maintained an intake screening process to identify the suicide risk of inmates entering the facility, the process for most facilities did not include verification as to whether the arresting and/or transporting officer(s) believed that the newly arrived inmate was at risk for suicide, nor whether the inmate was at risk for suicide during prior confinement. In addition, although the majority of respondents reported that their facilities provided suicide-prevention training to staff, most of the training was 2 hours or less in duration. Most surveyed facilities had a suicide watch protocol, but few provided for constant observation. Further, only one-third of respondents reported the availability of protrusion-free housing for suicidal inmates and most did not provide a mortality review following an inmate suicide.

Consistent with national correctional standards, as well as practices in facilities that have effectively reduced the opportunity for inmate suicide, all holding and detention facilities (regardless of size and type) must have a detailed, written, suicide-prevention policy that addresses each of the critical components discussed in the following sections (Hayes 2005; Metzner and Hayes 2006; National Commission on Correctional Health Care 2008).

Training

All correctional, medical, and mental health personnel, as well as any staff who have regular contact with inmates, should receive 8 hours of initial suicide-prevention training and 2 hours of refresher training each year. The initial training should include instruction regarding administrator and staff attitudes about suicide and how negative attitudes impede suicide-prevention efforts, why correctional facilities' environments are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, how to identify suicidal inmates despite a denial of risk, components of the facility's suicide-prevention policy, and liability

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issues associated with inmate suicide. The 2-hour refresher training should review the topics discussed during the initial training and also describe any changes to the facility's suicide prevention plan. The annual training should also include a general discussion of any recent suicides and/or suicide attempts in the facility.

In addition, all staff who are in contact with inmates should be trained in standard first aid and cardiopulmonary resuscitation (CPR) procedures, and all staff should learn how to use the emergency equipment located in each housing unit. To ensure an efficient emergency response to suicide attempts, mock drills should be incorporated into both the initial and refresher training for all staff.

Identification, Referral, and Evaluation

Screening should not be a single event but a continuous process because inmates can become suicidal at any point during their confinement.

Intake screening and ongoing assessment of all inmates are critical to a correctional facility's suicide-prevention efforts. Screening should not be a single event but a continuous process because inmates can become suicidal at any point during their confinement, including during initial admission into the facility, after adjudication when the inmate is returned to the facility from court, after receiving bad news or after suffering any type of humiliation or rejection, during confinement in isolation or segregation, and following a prolonged stay in the facility.

Intake screening for suicide risk can be included on the medical screening form or it can be a separate form. The screening process should include questions about past suicidal ideation and/or attempts; current ideation, threat, or a plan to commit suicide; prior mental health treatment or hospitalization; any recent significant loss (e.g., job, relationship, death of family member or close friend); history of suicidal behavior by a family member or close friend; suicide risk during prior confinement; and the arresting and/or transporting officer(s)' belief that the inmate is currently at risk. Specifically, the suicide screening process should determine the following:

- Was the inmate a medical, mental health, or suicide risk during any prior contact and/or confinement in this facility?
- Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates the inmate is currently a medical, mental health, or suicide risk?
- Has the inmate ever attempted suicide?
- Has the inmate ever considered suicide?
- Is the inmate being treated for mental health or emotional problems, or has the inmate been treated in the past?
- Has the inmate recently experienced a significant loss (e.g., relationship, death of family member or close friend, job)?
- Has a family member or close friend ever attempted or committed suicide?
- Does the inmate feel there is nothing to look forward to in the immediate future (i.e., is the inmate expressing helplessness and/or hopelessness)?
- Is the inmate thinking of hurting and/or killing himself or herself?

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An inmate's verbal responses during the intake screening process are critically important when assessing the risk of suicide. However, staff should not rely exclusively on an inmate's statement that he or she is not suicidal and/or does not have a history of mental illness or suicidal behavior, particularly when the inmate's behavior, actions, or previous confinement in the facility suggest otherwise. The process should also include procedures for referring the inmate to mental health and/or medical personnel for a more thorough and complete assessment.

In addition, given the strong association between suicide and placement in isolation or a special housing unit (e.g., disciplinary and/or administrative segregation), any inmate assigned to such a special housing unit should receive a written assessment for suicide risk by medical or mental health staff upon admission to the placement.

Finally, findings from this study demonstrate that the majority of suicides do not occur within the first 24 hours of confinement. In addition, various high-risk periods are associated with potentially suicidal behavior, including whether the inmate has an upcoming date for a court hearing and following a telephone call or scheduled visit. Staff must be aware of these high-risk periods so they can effectively assess inmates' risk for suicide.

Various high-risk periods are associated with potentially suicidal behavior, including whether the inmate has an upcoming date for a court hearing and following a telephone call or scheduled visit.

Communication

The screening and assessment process is one of several tools that can be used to identify suicide risk in inmates. This process, coupled with staff training, will be successful only if an effective method of communication is in place at the facility.

The inmate may exhibit certain behaviors that indicate a risk of suicide. If these behaviors are detected and communicated to others, the likelihood of suicide can be reduced. In addition, most suicides can be prevented by correctional staff who establish trust and rapport with inmates, gather pertinent information, and take action. Three levels of communication are important in preventing inmate suicides:

- **Communication between the arresting and/or transporting officer and correctional staff.** In many ways, suicide prevention begins at the point of arrest. What an arrestee says and how he or she behaves during arrest, transport to the facility, and at intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the individual, and the arresting officer should pay close attention to the arrestee during this time. Suicidal behavior may occur because of the arrestee's feelings of anxiety or hopelessness, and previous suicidal behavior can be confirmed by family members and/or friends. The arresting or transporting officer must communicate any pertinent information about the arrestee's well-being to correctional staff. It is also critically important for correctional staff to maintain open lines of communication with family members, who often have pertinent information about the inmate's mental health.
- **Communication among facility staff (correctional, medical, and mental health personnel).** Effective management of suicidal inmates depends on communication between the facility's correctional personnel and other professional staff. Because inmates can become suicidal at any point during confinement, correctional staff must maintain awareness, share information, and make appropriate referrals to mental health and medical staff. At a minimum, the

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facility's shift supervisor should ensure that appropriate correctional staff are properly informed of the status of each inmate placed on suicide precautions. At the end of a shift, the shift supervisor should inform the incoming shift supervisor about the status of all inmates on suicide precautions. Multidisciplinary team meetings that include correctional, medical, and mental health personnel should occur on a regular basis to discuss the status of inmates on suicide precautions. Finally, the authorization for suicide precautions, any changes in suicide precautions, and observation of inmates placed on precautions should be documented on designated forms and distributed to appropriate staff.

- **Communication between facility staff and the suicidal inmate.** Facility staff must use various communication skills with the suicidal inmate, including active listening, staying with the inmate if immediate danger is suspected, and maintaining contact through conversation, eye contact, and body language. Correctional staff should trust their own judgment and observation of risk behavior and should not let other facility personnel (including mental health staff) convince them to ignore signs of suicidal behavior. Poor communication among correctional, medical, and mental health personnel, as well as with outside entities (e.g., arresting or referral agencies and family members) is a common factor in many custodial suicides. A lack of respect, personality conflicts, and boundary issues often lead to problems with communication. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides.

Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten depersonalizing aspects of confinement.

Housing

When determining the most appropriate housing location for a suicidal inmate, correctional facility officials (with concurrence from medical and/or mental health staff) often tend to physically isolate (or segregate) and sometimes restrain the individual. Although these responses may be convenient for facility staff, they are detrimental to the inmate because isolation escalates a sense of alienation and further removes the individual from proper staff supervision. Whenever possible, suicidal inmates should be housed in the general population unit, mental health unit, or medical infirmary, and should be located close to facility staff. Further, removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, handcuffs, and straitjackets) should be avoided whenever possible; these measures should only be used as a last resort when the inmate is physically engaging in self-harming behavior. Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten depersonalizing aspects of confinement.

All cells designated to house suicidal inmates should be as suicide resistant as possible, free of all obvious protrusions, and provide full visibility. These cells should contain tamperproof light fixtures along with smoke detectors and ceiling and/or wall air vents that are free of protrusions. In addition, the cells should not contain any live electrical switches or outlets, bunks with open bottoms, any type of clothing hook, towel racks on desks or sinks, radiator vents, or any other object that provides an easy anchoring device for hanging. Each cell door should contain a heavy-gauge Lexan (or equivalent grade) clear panel that is large enough to allow staff a full and unobstructed view of the cell interior. Finally, each housing unit in the facility should have an emergency response bag. The bag should contain emergency equipment, including a first aid kit, a pocket

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mask or face shield, a self-inflating resuscitator bag, and a rescue tool (to quickly cut through fibrous material). Correctional staff should ensure that such equipment is in working order on a daily basis.

Observation and Treatment Plan

Two levels of observation are generally recommended for suicidal inmates:

- Close observation is recommended for the inmate who is not actively suicidal but expresses suicidal ideation and/or has a recent history of self-harming behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other behavior (through actions, current circumstances, or recent history) that could indicate the potential for self-injury, should be placed under close observation. Staff should observe such an inmate in a protrusion-free cell at staggered intervals not to exceed every 10 minutes (e.g., at 5 minutes, 10 minutes, 7 minutes).
- Constant observation is recommended for the inmate who is actively suicidal (i.e., either threatening or engaging in suicidal behavior). Staff should observe such an inmate on a continuous, uninterrupted basis. Some jurisdictions also use an intermediate level of supervision, with observation at staggered intervals that do not exceed 5 minutes.

Other aids (e.g., closed-circuit television monitors, inmate companions, and cellmates) can be used as a supplement to, but never as a substitute for, these observation levels.

Mental health staff should assess and interact with (not just observe) the suicidal inmate daily. The daily assessment should focus on the inmate's current behavior as well as changes in thoughts and behavior during the past 24 hours. For example, mental health staff can ask the following questions: "What are your current feelings and thoughts?", "Have your feelings and thoughts changed over the past 24 hours?", and "What are some of the things you have done or can do to change these thoughts and feelings?"

An individualized treatment plan (including followup services) should be developed for each inmate on suicide precautions. Qualified mental health staff should develop the plan in conjunction with both the inmate and medical and correctional personnel. The treatment plan should describe signs, symptoms, and the circumstances under which the risk for suicide is likely to recur; how the inmate can avoid having suicidal thoughts; and actions the inmate and staff will take if suicidal ideation recurs.

Finally, because of the strong correlation between prior suicidal behavior and suicide, and to safeguard the continuity of care for suicidal inmates, all inmates who are discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled followup assessments by mental health personnel until they are released from custody. Although there is no nationally accepted schedule for followup, a suggested assessment schedule following discharge from suicide precautions might be: daily for 5 days, once a week for 2 weeks, and then once a month until release.

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Intervention

National correctional standards and practices generally acknowledge that a facility's policy regarding intervention should include three components. First, all staff who have contact with the inmate should be trained in standard first aid procedures and CPR. Second, a staff member who discovers an inmate engaging in self-harming behavior should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR if necessary. If facility policy prohibits an officer from entering a cell without backup support, the first responding officer should, at a minimum, make the proper notification for backup support and medical personnel, secure the area outside the cell, and retrieve the housing unit's emergency response bag. Third, correctional staff should never presume that the victim is dead, but rather should initiate and continue appropriate lifesaving measures until medical personnel arrive. Finally, although not all suicide attempts require emergency medical intervention, all such attempts do require immediate intervention and assessment by mental health staff.

Notification and Reporting

In the event of a serious suicide attempt (i.e., one that requires hospitalization for injuries) or a completed suicide, all appropriate officials should be notified through the chain of command. Following the incident, the victim's family and appropriate outside authorities should be notified immediately. All staff who had contact with the victim before the incident should be required to submit a statement that includes any information they may have about the inmate and/or the incident.

Critical Incident Stress Debriefing and Mortality-Morbidity Review

An inmate suicide is extremely stressful for both staff and other inmates. Staff members who recently had contact with the inmate may also feel ostracized by other personnel and administration officials. Following a suicide, a correctional officer may experience guilt because he or she might ask, "What if I had made my cell check earlier?" Staff and inmates who are affected by a traumatic event such as inmate suicide should be offered immediate assistance. One form of assistance is critical incident stress debriefing (CISD). A CISD team, composed of professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, firefighters, clergy, and mental health personnel), allows staff and inmates to process their feelings about the incident, develop an understanding of critical stress symptoms, and seek ways of dealing with those symptoms. For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident.

Every completed suicide, as well as every serious suicide attempt, should be examined through a mortality-morbidity review process. If resources permit, a clinical review through a psychological autopsy is also recommended. Ideally, an outside agency should coordinate the mortality-morbidity review to ensure impartiality. This review, which is separate and apart from other formal investigations that may be required to determine the cause of death, should include the following:

- A critical inquiry of the circumstances surrounding the incident.
- Facility procedures relevant to the incident.
- Relevant training that involved staff received.
- Pertinent medical and mental health services or reports involving the victim.

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- Possible precipitating factors that led to the suicide or serious suicide attempt.
- Recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.

Future Training Efforts

Although findings from this study show that most of the facilities that experienced a suicide provided some type of suicide-prevention training to staff, a sizable number (approximately 38 percent) did not offer any training. In addition, almost two-thirds (63.3 percent) of the facilities that experienced a suicide either did not provide suicide-prevention training to staff or did not provide the training on an annual basis. Only a handful of facilities provided a full day of suicide prevention training to staff.

In addition, as indicated by the report's findings, many of the demographic characteristics of suicide victims and characteristics of the incidents have changed dramatically since prior studies. For example, suicide victims previously confined on "minor other" offenses were more recently confined on "personal and/or violent" charges. Intoxication was previously viewed as a leading precipitant to inmate suicide, yet recent data indicate that this factor is now found in only a minority of cases. Whereas more than half of all jail suicide victims were previously dead within the first 24 hours of confinement, current data show that less than one-quarter of all victims commit suicide during this time period, with an equal number of deaths occurring between 2 and 14 days of confinement. In addition, inmates who committed suicide were far less likely to be housed in isolation than previously reported, yet for unknown reasons they were less likely to be found within 15 minutes of the last observation by staff.

Correctional administrators should ensure that suicide-prevention training curricula are developed and/or revised to reflect these new research findings and that all correctional, medical, and mental health personnel receive regular and comprehensive instruction in suicide-prevention methods.

For the reasons stated above, correctional administrators should ensure that suicide-prevention training curricula are developed and/or revised to reflect these new research findings and that all correctional, medical, and mental health personnel receive regular and comprehensive instruction in suicide-prevention methods. At a minimum, initial suicide-prevention training should include but not be limited to the following topics: administrator and staff attitudes about suicide and how negative attitudes impede suicide-prevention efforts, ways in which correctional facility environments are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, how to identify suicidal inmates even if they deny they are at risk, components of the facility's suicide-prevention policy, and liability issues associated with inmate suicide. Annual refresher training should include a review of administrator and staff attitudes about suicide and how negative attitudes impede suicide-prevention efforts, predisposing risk factors, warning signs and symptoms, how to identify suicidal inmates despite a denial of risk, and a review of any changes to the facility's suicide-prevention plan. The annual training should also include a general discussion of any recent suicides and/or suicide attempts in the facility.

Holding or detention facility staff will lack the means to both identify and manage suicidal inmates if they have received little or no training in suicide-prevention methods. Lives will continue to be lost and jurisdictions will incur unnecessary liability from these tragic deaths if administrators do not create and maintain effective training programs.

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Data Limitations and Further Research Needed

Project staff mailed survey requests to nearly 16,000 jail facilities in the United States as well as to hundreds of secondary sources (e.g., state medical examiner offices, state and federal jail inspection and/or regulatory agencies, state police and/or bureau of investigation offices, and private health-care providers that have contracts with county and municipal jurisdictions). This mailing, along with a review of newspaper articles retrieved from Internet search engines, yielded an accounting of jail suicides during 2005 and 2006 that is as accurate as is reasonably possible. However, because of underreporting and a reluctance to share data, it is not certain whether every death was identified. In addition, a sizable number of survey respondents were unable to supply some data and answered "unknown" to several key variables (e.g., substance abuse, medical and mental health, psychotropic medication, and history of suicidal behavior), thus reflecting either inadequate intake screening, inadequate recordkeeping, or a combination of both. Only about one-third of respondents conducted mortality reviews following the suicides; this factor also hindered data collection efforts.

In addition, although this study represented the National Institute of Corrections' third comprehensive national survey of inmate suicide, the current findings invite additional research. For example, future research could explore in more detail the reason(s) behind the occurrence of more suicides during the first 2 to 14 days of confinement rather than within the first 24 hours of confinement. This study revealed a possible relationship between suicide and an inmate's confinement for sexual assault and/or murder of a child (which accounted for approximately 7 percent of all suicides), but additional research is necessary to explain the reasons for this relationship. Further research is also necessary to explore the relationship between the occurrence of inmate suicides and recent court hearings, telephone calls, and visitation, as well as other possible precipitating factors that study respondents could not identify. The identification of precipitating factors to inmate suicide is critically important to the field's further understanding of the problem.

The Continuing Challenge of Prevention

In conclusion, findings from this study create a formidable challenge for both correctional and health-care officials as well as their respective staffs. Although the knowledge base continues to increase, which seemingly corresponds to a dramatic reduction in the rate of inmate suicide in detention facilities, much work lies ahead. The data indicate that inmate suicide no longer occurs mostly during the first 24 hours of confinement and can occur at any time during an inmate's confinement. Given that roughly the same number of deaths occurred within the first few hours of custody as occurred in more than several months of confinement, information gathered about current suicide risk during intake screening should be viewed as time limited. Because inmates can be at risk at any point during confinement, the greatest challenge for those who work in the correctional system is to view the issue as one that requires a continuum of comprehensive suicide-prevention services aimed at the collaborative identification, continued assessment, and safe management of inmates at risk for self-harm.

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Appendix A

NATIONAL STUDY OF JAIL SUICIDES

INFORMATION REQUESTED BY:

**THE NATIONAL CENTER ON
INSTITUTIONS AND ALTERNATIVES
ON BEHALF OF THE
NATIONAL INSTITUTE OF CORRECTIONS
U.S. DEPARTMENT OF JUSTICE**

Dear Sheriff, Police Chief, and/or Facility Commander:

The National Institute of Corrections, U.S. Department of Justice, has requested the National Center on Institutions and Alternatives (NCIA) to conduct a national study on jail suicides. You may recall that a similar comprehensive study was conducted by NCIA during the 1980s. With your assistance, the project will utilize collected on inmate suicides to generate programmatic recommendations to confront this issue. This information can then be employed by your agency and others in an effort to reduce the occurrence of future inmate suicides.

DATA PROVIDED BY INDIVIDUAL FACILITIES WILL BE CODED AND HELD IN THE STRICTEST CONFIDENCE. RESULTS OF THIS STUDY WILL BE PRESENTED IN SUMMARY FASHION, THUS PREVENTING THE DIRECT LINKAGE OF SPECIFIC DATA TO THE PARTICULAR FACILITY FROM WHICH THE INFORMATION ORIGINATED.

Data requested for this study (see over) should be limited to inmate suicides occurring between the two-year period of January 1, 2005 thru December 31, 2006.

In order to facilitate data compilation, we ask that you utilize the definitions provided on the back of this form. When this is not possible, please inform us of specific differences in your reporting.

For your convenience in submitting the completed form, we have enclosed a self-addressed, business reply envelope. We ask that the completed form be returned within thirty (30) days of its receipt. **We also ask that you return the completed form only if you had a suicide(s) during 2005 and/or 2006.**

If you have any questions regarding completion of this form or the study, please feel free to contact Mr. Lindsay M. Hayes of NCIA at (508) 337-8806 or lhayesta@msn.com. Thank you for your cooperation. Copies of the final report will be available upon request.

Sincerely,

Morris L. Thigpen, Director
National Institute of Corrections
U.S. Justice Department

Lindsay M. Hayes, Project Director
National Center on Institutions
and Alternatives

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DEFINITIONS

SUICIDE: Any death of an individual while in custody of any law enforcement agency resulting from or leading directly from any self-inflicted act perpetrated by that individual. Further, any incident in which the individual was left in a comatose and/or brain-dead state would be included within this definition. (NOTE: For purposes of this study, an individual who attempted suicide within the facility yet later died enroute to or at the hospital or other health care provider is classified as an inmate suicide and should be reported below.)

JAIL: Any facility operated by a local jurisdiction (e.g., county, municipality, etc.), private entity, or multi-jurisdictional authority whose purpose is the confinement of individuals primarily apprehended by law enforcement personnel. Jails, as defined here, would include temporary holding and pre-trial detention facilities, lockup facilities which normally detain persons for less than 72 hours, as well as facilities which normally detain individuals or have committed/sentenced offenders for more than 72 hours. The definition includes facilities which are housing inmates for another jurisdiction (e.g., state or federal prison system), including privately operated jails and regional jails.

QUESTIONS

In the spaces provided below, please indicate the TOTAL NUMBER OF INMATE SUICIDES occurring in your facility during the two-year period between JANUARY 1, 2005 THRU DECEMBER 31, 2006. Please only complete the form if your jail facility had a suicide(s) during this two-year period. If you have any questions regarding completion of this form or the study, please feel free to contact Mr. Lindsay M. Hayes of NCIA at (508) 337-8806 or lhayesta@msn.com.

1. Number of inmate suicides between: January 1, 2005 and December 31, 2005 _____

   January 1, 2005 and December 31, 2006 _____

2. Which of the following categories best describes your facility? (**Please only check one category**.)

   a) Facility for committed/sentenced offenders _____

   b) Temporary Holding or Pre-Trial Detention Facility (0 to 72 hours) _____

   c) Pre-Trial Detention Facility (over 72 hours) _____

   d) Other (Specify:_____) _____

THE FOLLOWING WILL BE UTILIZED FOR INTERNAL PURPOSES ONLY

Completed by (name/title): _____

Name of Facility: _____

Street Address: _____

City, State, Zip: _____

Telephone/E-Mail: ( ) _____ E-Mail:_____

Please return the completed survey within 30 days of receipt to:
NCIA
P.O. BOX 111
MANSFIELD, MA 02048

visited 8/6/2019

Appendix B

PHASE 2: NATIONAL STUDY OF JAIL SUICIDES

NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES
Acting as Collecting Agent for the
NATIONAL INSTITUTE OF CORRECTIONS
U.S. DEPARTMENT OF JUSTICE

Items contained in this questionnaire refer to a suicide that occurred in your facility between January 1, 2005 and December 31, 2006 as identified during Phase 1 of the National Study of Jail Suicides project. Please complete the following questionnaire by checking the appropriate boxes and/or filling in the blanks (and use additional sheets if necessary). Definitions for certain terms used in this questionnaire appear on page 8.

DATA PROVIDED WILL BE CODED AND HELD IN THE STRICTEST CONFIDENCE. RESULTS OF THIS STUDY WILL BE PRESENTED IN SUMMARY FASHION, THEREFORE, VICTIM AND FACILITY NAMES WILL NOT APPEAR IN ANY PROJECT REPORT.

We ask that you complete and return this questionnaire within 30 days. Should you have any questions or concerns regarding completion of this questionnaire, please contact Lindsay M. Hayes, Project Director, National Center on Institutions and Alternatives (NCIA), P.O. Box 111, Mansfield, Massachusetts 02048, 508/337-8806, e-mail: LHayesta@msn.com.

NAME OF FACILITY_____**STATE**_____

PART A: PERSONAL CHARACTERISTICS OF VICTIM

1) **Victim's Name** (or any other identifiable notation): _____
Last First M.I.

2) **Race/Ethnicity:**
(1)_____Caucasian (4)_____American Indian
(2)_____African-American (8)_____Other (Specify_____)
(3)_____Hispanic (9)_____Unknown

3) **Sex:** (1)_____Male (2)_____Female

4) **Date-of-Birth:** ___/___/___ or _____**Years-Old**

5) **Marital Status:**
(1)_____Single (5)_____Widowed
(2)_____Married (6)_____Common-Law Relationship
(3)_____Separated (8)_____Other (Specify_____)
(4)_____Divorced (9)_____Unknown

Please specify **Current Charge(s)** for which the victim was confined at time of suicide and whether victim was being **Detained** or had been **Sentenced** on those charge(s).

CHARGE(S)	DETAINED	SENTENCED
_____	(1)_____	(1)_____
_____	(2)_____	(2)_____
_____	(3)_____	(3)_____

7a) Did the victim have a record of **Prior Arrests**?
(1)_____Yes (2)_____No (9)_____Unknown

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7b) If the victim had a prior arrest record, specify the **Most Recent Prior Charges**.

Most Recent Prior Charge(s)	**Date**
_____	_____
_____	_____
_____	_____

8) What was the total **Length of Confinement** that the victim had been in your facility prior to their death? (If less than two days, indicate in hours.)

_____Hours _____Days _____Months _____Years

9a) Did the victim have a history of **Substance Abuse**?

(1)_____Yes (2)_____No (9)_____Unknown

9b) If the victim had a history of substance abuse, briefly **Describe Type of Substance Abuse**._____

_____

10a) Did the victim have a history of **Medical Problems**?

(1)_____Yes (2)_____No (9)_____Unknown

10b) If the victim had a history of medical problems, briefly **Describe Type of Medical Problems**._____

_____

11a) Did the victim have a history of **Mental Illness**?

(1)_____Yes (2)_____No (9)_____Unknown

11b) If the victim had a history of mental illness, briefly **Describe Type of Mental Illness**._____

_____

_____

12a) Did the victim have a history of taking **Psychotropic Medication**?

(1)_____Yes (2)_____No (9)_____Unknown

12b) If the victim had a history of taking psychotropic medication, briefly **Describe Type of Psychotropic Medication(s)**._____

_____

12c) Was the victim receiving **Psychotropic Medication** during the most recent confinement?

(1)_____Yes (2)_____No (9)_____Unknown

12d) If the victim was receiving psychotropic medication during the most recent confinement, briefly **Describe Type of Psychotropic Medication**._____

_____

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13a) Did the victim have a history of **Suicidal Behavior**?

(1)_____Yes (2)_____No (9)_____Unknown

13b) If the victim had a history of suicidal behavior, briefly **Describe Suicidal Behavior**._____

_____

_____

14a) Was the victim ever on **Suicide Watch** (see definition on page 8) in your facility either during this confinement or a prior confinement?

(1)_____Yes (2)_____No (9)_____Unknown

14b) If the victim had previously been on Suicide Watch at any time in your facility, what was the **Time Span between Discharge from Suicide Watch and the Suicide, and Briefly Describe the Circumstances that resulted in Discharge from Suicide Watch.**_____

_____

_____

_____

15a) Did the victim have a **history** of placement in **Isolation** or **Segregation** while in your facility?

(1)_____Yes (2)_____No (9)_____Unknown

15b) If the victim had a history of placement in isolation or segregation, briefly **Describe Type and Circumstances of Isolation or Segregation**._____

_____

_____

PART B: SUICIDE INCIDENT CHARACTERISTICS

16) What was the **Date** and **Time** of the victim's suicide?

Date:_____/_____/200_ **Time (found):** _____am _____pm

17) What was the **Method** of suicide and the **Instrument** used?

Method	**Instrument**	
(1)_____Hanging [from _____(bed, vent, etc.)]	(01)_____Clothing (specify type:_____)	
(2)_____Overdose	(02)_____Belt	(08)_____Knife
(3)_____Cutting	(03)_____Shoelace	(09)_____Glass
(4)_____Shooting	(04)_____Bedding	(10)_____Drugs
(5)_____Jumping	(05)_____Telephone Cord	Specify_____
(6)_____Ingestion of Foreign Object(s)	(06)_____Razor	
(8)_____Other	(07)_____Other (Specify_____)	

18) What was the **Time Span** between the suicide and finding the victim?

(1)_____Less Than 15 Minutes (4)_____Between 1 and 3 Hours
(2)_____Between 15 and 30 Minutes (5)_____Greater Than 3 Hours
(3)_____Between 30 and 60 Minutes (9)_____Unknown

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19a) At the time of the suicide, was the victim **Under the Influence** of:

(1)_____Drugs
(2)_____Alcohol
(3)_____Drugs and Alcohol
(4)_____Neither Drugs or Alcohol
(9)_____Unknown

19b) If the victim was under the influence of drugs at the time of the suicide, briefly **Describe the Type(s) of Drugs**:_____

_____

20a) At the time of the suicide, was the victim assigned to a **Single** or **Multiple Occupancy** cell?

(1)_____Single (2)_____Multiple (9)_____Unknown

20b) If the victim was assigned a multiple occupancy cell, **Were other Inmates in the Cell at the Time of the Suicide**?

(1)_____Yes (2)_____No (9)_____Unknown

21a) Did correctional staff initiate **Cardiopulmonary Resuscitation** on the victim prior to the arrival of medical personnel?

(1)_____Yes (2)_____No (9)_____Unknown

21b) If **Cardiopulmonary Resuscitation** was **not** provided on the victim prior to the arrival of medical personnel, briefly **Describe Reasons why it was not provided**._____

_____

_____

22) Did either correctional or medical staff utilize an **Automated External Defibrillator** on the victim?

(1)_____Yes (2)_____No (9)_____Unknown

23a) Was the victim under any type of **Isolation or Segregation at the Time of the Suicide**?

(1)_____Yes (2)_____No (9)_____Unknown

23b) If the victim was under **Isolation** or **Segregation** at the time of the suicide, what was **Time Span between placement in Isolation/Segregation and the Suicide, and Briefly Describe Type and Circumstances of Isolation or Segregation**._____

_____

_____

24a) Was the victim under **Suicide Watch** (see definitions on page 8) **at the Time of the Suicide**?

(1)_____Yes (2)_____No (9)_____Unknown

24b) If the victim was under suicide watch at the time of the suicide, what was the **Frequency of Direct Visual Observation by Staff** (excluding any closed circuit television monitoring and/or inmate companion/ inmate observation aide)?

(1)_____Continuous
(2)_____Every 5 Minutes
(3)_____Every 10 Minutes
(5)_____Every 30 Minutes
(6)_____Every 60 Minutes
(8)_____Other (Specify_____)

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(4)_____Every 15 Minutes

24c) If the victim was under suicide watch at the time of the suicide, was **Closed Circuit Television Monitoring** utilized as a method of observation?

(1)_____Yes (2)_____No (9)_____Unknown

24d) If the victim was under suicide watch at the time of the suicide, was an **Inmate Companion/ Inmate Observation Aide** (see definition on page 8) utilized as a method of observation?

(1)_____Yes (2)_____No (9)_____Unknown

25) Did facility staff utilize a **No-Harm or No-Suicide Contract** (see definition on page 8) at any time with the victim?

(1)_____Yes (2)_____No (9)_____Unknown

26a) Did the victim attend a **Court Hearing or other Legal Proceeding** in close proximity to the suicide?

(1)_____Yes (2)_____No (9)_____Unknown

26b) If the victim attended a court hearing or other legal proceeding in close proximity to the suicide, what was **Time Span between the Hearing/Legal Proceeding and the Suicide, and Briefly Describe the Circumstances of the Court Hearing/Legal Proceeding?**_____

_____

_____

27a) Did the victim have a **Visit or Telephone Call** in close proximity to the suicide?

(1)_____Yes (2)_____No (9)_____Unknown

27b) If the victim had a visit or telephone call in close proximity to the suicide, what was **Time Span between the Visit/Telephone Call and the Suicide, and Briefly Describe the Circumstances of the Visit/ Telephone Call?**_____

_____

_____

_____

28a) Was the victim ever **Assessed by a Qualified Mental Health Professional** (see definitions on page 8) prior to the suicide?

(1)_____Yes (2)_____No (9)_____Unknown

28b) If the victim was assessed, specify the **Last Contact by a Qualified Mental Health Professional** prior to the suicide? (If less than two days, indicate in hours.)

_____Hours _____Days _____Weeks _____Months

29a) Was a **Mortality Review** (see definitions on page 8) conducted following the suicide?

(1)_____Yes (2)_____No (9)_____Unknown

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29b) If a mortality review was conducted, did the process offer any **Possible Precipitating Factors** (i.e., circumstances which may have caused the victim to commit suicide)? If yes, briefly list: _____

_____
_____
_____
_____
_____

29c) If a mortality review was conducted, did the process offer any **Recommendations to Prevent Future Suicides**? If yes, briefly list: _____

_____
_____
_____
_____
_____

PART C: FACILITY CHARACTERISTICS

30) The **Facility** is best described as a:

(1)_____Facility for Pre-Trial Detainees and Sentenced Inmates
(2)_____Temporary Holding or Pre-Trial Detention Facility (0 to 72 hours)
(3)_____Pre-Trial Detention Facility (over 72 hours)
(4)_____Other (Specify:_____)

31) At the time of the suicide, what was the rated **Capacity** and **Population** of the facility?

(1)_____Capacity (2)_____Population

32) The facility is **Administered** by a:

(1)_____State (3)_____Municipality (8)_____Other (Specify_____)
(2)_____County (4)_____Private Organization

33) At the time of the suicide, did the facility have a **Written Suicide Prevention Policy**?

(1)_____Yes (2)_____No

34a) At the time of the suicide, did the facility have an **Intake Screening** process **to Identify Suicide Risk**?

(1)_____Yes (2)_____No

34b) At the time of the suicide, did the **Intake Screening** process include the ability to verify whether the victim had been on **Suicide Watch During a Prior Confinement?**

(1)_____Yes (2)_____No

34c) At the time of the suicide, did the **Intake Screening** process include the ability to verify whether the **Arresting/Transporting Officer Believed the Victim was at Risk for Suicide?**

(1)_____Yes (2)_____No

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35a) At the time of the suicide, had most (90% or more) correctional staff received **Suicide Prevention Training**?

(1)_____Yes (2)_____No

35b) If most correctional staff had received suicide prevention training, what was the **Frequency and Duration of the Suicide Prevention Training** at the time of the suicide?

Frequency	**Duration**
(1)_____Yearly	(01)_____Hours (Specify Number)
(8)_____Other (Specify_____)	(02)_____Minutes (Specify Number)

36) At the time of the suicide, had most (90% or more) correctional staff received **Certification in Cardiopulmonary Resuscitation**?

(1)_____Yes (2)_____No

37a) At the time of the suicide, did the facility have a **Suicide Watch** process (excluding any closed circuit television monitoring and/or inmate companion/inmate observation aide)?

(1)_____Yes (2)_____No

37b) If the facility had a suicide watch process at the time of the suicide, what was the **Frequency Level(s) of Direct Visual Observation by Staff**? (Check all that apply.)

(1)_____Continuous
(2)_____Every 5 Minutes
(3)_____Every 10 Minutes
(4)_____Every 15 Minutes
(5)_____Every 30 Minutes
(6)_____Every 60 Minutes
(8)_____Other (Specify_____)

37c) At the time of the suicide, which of the following **Best Describes Which Staff were Permitted to Downgrade and Discharge an Inmate from Suicide Watch**?

(1)_____Correctional
(2)_____Medical
(3)_____Mental Health
(4)_____Medical and/or Mental Health
(5)_____All of the above
(8)_____Other (Specify_____)

38) At the time of the suicide, did the facility have a **Housing** process by which a suicidal inmate would be assigned to a safe, suicide-resistant, and protrusion-free cell?

(1)_____Yes (2)_____No

DEFINITIONS

SUICIDE WATCH: The level(s) of direct visual observation by staff that is given to an inmate identified as being at risk of suicide. Excludes closed circuit television, inmate companion/inmate observation aide, or any other non-staff monitoring.

INMATE COMPANION/INMATE OBSERVATION AIDE: A designation by which another inmate is entrusted with the responsibility of providing observation to an inmate on suicide watch.

NO-HARM/NO-SUICIDE CONTRACT: A verbal and/or written agreement between the inmate and facility staff/clinician in which the inmate provides assurance they will not commit suicide or engage in self-injurious behavior.

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QUALIFIED MENTAL HEALTH PROFESSIONAL: An individual by virtue of their education, credentials, and experience that is permitted by law to evaluate and care for the mental health needs of patients. May include, but is not limited to, a psychiatrist, psychologist, clinical social worker, and psychiatric nurse.

MORTALITY REVIEW: An interdisciplinary committee process comprised of correctional, medical, and mental health personnel that examines the events surrounding the death to determine if the incident was preventable. The review process may include recommendations aimed at reducing the opportunity of future deaths.

THE FOLLOWING WILL BE USED FOR INTERNAL PURPOSES ONLY:

Completed by (name/title):_____
Facility/Agency:_____
Address (street):_____
City:_____ State:_____ Zip Code:_____
Telephone:_____
E-Mail Address:_____
Date Completed:_____

Would you like to be placed on the mailing list to receive the ***Jail Suicide/Mental Health Update*** (a free quarterly newsletter devoted to jail suicide prevention and produced by the National Center on Institutions and Alternatives under contract with the National Institute of Corrections, U.S. Justice Department) and receive notification of the findings from this National Study of Jail Suicides? _____Yes _____No

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THANK YOU FOR YOUR COOPERATION

Please return this completed questionnaire in the enclosed business reply envelope within 30 days to:

NCIA
P.O. Box 111
Mansfield, MA 02048

or fax to NCIA at:
508/337-3083

or e-mail to:
Lhayesta@msn.com

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National Institute of Corrections

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