Preventing Jailhouse Suicides

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Psychiatric consultants to city and county jails are confronted with the challenge of preventing jailhouse suicides, a problem of national scope. Suicide prevention programs in jails must emphasize screening and identification, psychological support, observation, disarmament, clarity and consistency, and diagnosis, treatment, and/or hospitalization. Exactly how these principles are formulated and implemented will depend on the unique circumstances of each jail. Finally information is presented as evidence that a program that embodies these principles can effectively reduce the number of suicides in a jail where the average daily census has increased from fewer than 400 to greater than 900 in the past six years.

Jailhouse suicide is a national, albeit understated, problem. The first comprehensive survey of jailhouse suicides, accomplished by the National Center on Institutions and Alternatives (NCIA) in 1979, identified 419 jailhouse suicides in the U.S.[1] A second survey by NCIA reported 453 suicides behind bars in 1985 and 401 in 1986. Texas led the nation in these grim figures, with 94 suicides in two years.[2] Because jail populations continue to rise,[3] the number of jailhouse suicides can be expected to mount, at least proportionately, unless effective countermeasures are taken. Results of another national survey indicate that jail suicide rates are not affected by suicide prevention standards for jails including staff training, preventive procedures, and intake screening.[4] Thus the need is critical for empirical evidence pertaining to the efficacy of suicide prevention programs.

Several factors seem to contribute to the risk of jailhouse suicides:

1. Jails can be extremely stressful places to be,[5-8] and, combined with the inmate's dreadful legal situation,[7,8] ominous possibilities of disruption of employment and family ties[7,8] and other ensuing, destabilizing stressors can precipitate a situational crisis with a hopeless outlook.
2. Before apprehension and jailing, the individual may already have been experiencing an overwhelming crisis, which led to the desperate criminal act and resultant arrest.
3. Mental illness alone can predispose inmates to take their lives,[7,8] more or less independent of situational stressors. Recent surveys indicate some 3 percent to 11 percent of those jailed suffer from serious mental illness.[9,10]

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In many cases deinstitutionalization of psychiatric facilities results in re-institutionalization of correctional facilities.[6-8, 11, 12]

4. Many who are jailed have character weaknesses marked by impulsivity and low tolerance for frustration. The possibility of an impulsive, desperate act can be exacerbated if one is intoxicated when jailed.[5, 7, 8, 13, 14]
5. The jail itself may have features disturbingly suitable for suicide:[5, 14] cells with crossbars, poor interior lighting, low staff-inmate ratio, limited access to health professionals, and a crowded, stressful atmosphere.

All these factors set the stage for an unacceptably high rate of jailhouse suicide.

In their review of the literature on suicide by psychiatric patients in the United States, Hirschfeld and Davidson[15] identified the following risk factors: status as psychiatric patient; male sex; white race; older age; certain mental disorders (depression, schizophrenia, substance abuse); history of suicide attempts; recent events that are stressful, humiliating, or involve the loss of a friend or relative, and certain time periods (during hospitalization or the first 6 to 12 months following discharge). Like psychiatric patients, those in the general population who kill themselves are typically white males in their 30s or 40s. Mental disorders including depression and alcoholism are associated with suicide. The unmarried and the unemployed are at greater risk. Robins observed that men commit suicide by shooting themselves or jumping from heights, whereas women slash their wrists or overdose.[16] Several authorities maintain that hospitalization is the best or even the only effective preventive measure when the patient is actively suicidal,[16-19] but immediate hospitalization is generally impractical for most jail inmates.

Of the attempts to establish a profile of individuals likely to commit suicide while in jail,[13] the profile compiled by the NCIA from its nationwide surveys is preferred. The typical jailhouse suicide victim is described as a young, single, white man who is jailed for a minor drug- or alcohol-related offense. The young man takes his life by hanging within the first 24 hours after entering the jail.

Lester and Danto reviewed profiles reported by over 15 investigators.[14] In some contrast to the NCIA findings, Danto, in a single study, found that jail suicide was typically committed by a black male inmate two to four weeks after entering jail.[20] Although other studies include much lower numbers of suicides than the NCIA studies, they raise the possibility of less common typologies. Of relevance to the work in the Galveston County Jail, Stone found, in a study of 107 suicides in Texas jails between 1986 and 1988,[21] that suicides were typically committed by white males 23 to 25 years of age, and the usual means was hanging, consistent with the predominant typology described by NCIA.

Demographic factors should not be relied upon too heavily in deciding who

is at greatest risk. Because many inmates are young men accused of drug-related offenses, these descriptors lack specificity. Women and members of other racial-ethnic groupings, including African-Americans,[6, 10, 20] have also taken their lives. The compiled vignette, then, is more useful in selecting preventive measures than predicting who will suicide. For most vulnerable detainees, the application of preventive measures is most critical soon after entry into the jail; and when the acutely suicidal inmate has been identified, above all, the means for hanging must be removed.

Attention must be given to implementing humane, effective, and clinically sound methods of preventing jailhouse suicides. Steadman observed, "There is no one best way to organize a jail mental health program,"[9] and this includes suicide prevention programs. The best approach will take into account the resources within and available to the jail; circumstances vary vastly from one jail to another. The staff of some small lockups should try to transfer suicidal inmates to a facility better equipped to handle them.

Therefore it is not the purpose of this article to present concrete measures, all of which must be implemented to establish a satisfactory level of practice. Ideally all jails of any size should have suicide prevention cells, and medical rounds should be made every day on inmates under psychiatric care. Today universal enforcement of such a standard is not practical; jails would go without medical coverage if physicians set their preconditions for involvement too high. The concrete measures mentioned here are intended to illustrate how principles of prevention can be implemented, not to suggest that these measures are essential in every jail. Such examples hopefully would not be used as tools in litigation concerning jailhouse suicide. The principles advocated here, however, are reasonable and important. One might well ask why they were not followed when these principles have been neglected.

Six principles are stressed, the implementation of which will depend on the circumstances of the jail: (1) *screen* all new inmates and *identify* those who are actively suicidal; (2) provide *psychological support* for the suicidal inmate; (3) *observe* the suicidal inmate closely; (4) *disarm* the inmate of suicidal instruments; (5) *establish and follow clear and consistent precautionary measures*; and, where appropriate, (6) *diagnose*, *treat*, and/or *transfer* the inmate to a hospital.

These principles were selected based on a knowledge of how and under what circumstances suicides are typically accomplished in jails, approaches to suicide prevention generally, and literature on preventing jailhouse suicides in particular. Then, as now, various authorities recommend some of the same preventive principles for suicidal patients generally[22] and for jail inmates. Yet not all principles proffered in the literature are emphasized here. A more comprehensive listing of preventive principles would, for example, include linkage with a mental health agency and special training for jail officers.[7] At the time the present program was begun, linkage to a

mental health agency, although in place, seemed too fundamental to list separately. Further, the final phase in identifying and assessing a suicidal inmate, and diagnosis,[23] treatment,[22] and hospital transfer[23] presuppose affiliation with a mental health agency. Although important, special training programs in the Galveston County Jail are still in the making; therefore, however desirable, it cannot be claimed that this was a cornerstone in the program begun seven years earlier.

Screen All New Inmates and Identify Those Who Are Acutely Suicidal

The best mental health team is virtually powerless to prevent suicides if all new inmates are not screened when booked into the jail. Without adequate screening the at-risk inmate will go unnoticed and will suicide before the next psychiatric clinic. Of course, any subject who appears to have a mental illness should first be taken to a hospital emergency room for professional evaluation. Many who are at risk, however, do not seem overtly disturbed, and therefore *all* new inmates must be asked a number of key questions upon entry.

Several instruments have been designed for the purpose of screening and identifying high-risk inmates.[13, 14, 23] At the very least, the booking officer must inquire about prior suicide attempts and present self-destructive thoughts. If the person appears very depressed, notation of this should be made as well. Those who have been suicidal in the same jail once before should be "flagged" for special review when they reenter the jail (Steadman recommends a central Rolodex file.[9] The Galveston County Jail uses a computer record for this purpose.) With the presence of any significant warning signs, the booking officer must contact a health provider or deputy trained in mental health assessment to interview the inmate and make an initial determination of potential for suicide. If the interviewer suspects that the person may be suicidal, the interviewer should immediately consult a mental health professional by telephone. Unless it is clear that the individual is not suicidal, precautions should be initiated. In questionable cases, the mental health professional should make an emergency visit to the jail and evaluate the inmate in person. In most cases, however, the suicidal inmate will be placed on full suicide precautions and evaluated more fully at the next psychiatric clinic, preferably within 24 hours.

Although most jail suicides occur within the first 24 to 48 hours of entering jail,[1, 2, 13, 14, 24] and early screening is therefore essential, some inmates will become suicidal at some point later in their incarceration.[20] The three days preceding and the three days following a scheduled court hearing can be a period of greater risk for some defendants.[6] Jail staff must be vigilant and report any significant changes in behavior and mental state, especially crying, agitation, or withdrawal. Any threats or preparatory behaviors should be registered immediately, and a risk-identification procedure similar to the screening should follow.

The mental health professional who assesses the high-risk inmate identified on initial screening, or later on, must obtain a history and evaluate the inmate's mental state with suicidal assessment a primary objective. An adequate history includes information about prior jailings, prior suicide attempts,[25,26] and prior psychiatric treatment(s).[6,14] Inquiry should be made about individual vulnerabilities to particular stressors, most recent and current stressors, and current thoughts of suicide including details and intention or plan,[26] lethality of method, and availability of method while the subject is jailed. Some seriously suicidal individuals deny intent when asked directly. Although one can easily deny a thought, it is difficult for a truly hopeless and desperate person to conjure up positive views of her or his future. The professional should obtain the inmate's view of his or her future and assess this for presence and degree of hope. Standardized scales for depression and hopelessness can serve as useful adjunctive measures in this initial assessment.

Beyond the determination of acute suicidality, the professional must address several related issues. If the inmate is suicidal, did this condition precede incarceration or develop only after the subject was jailed? Is the suicidal state a function of the stress of being in jail and likely to dissipate when the inmate is released? Or are the suicidal determinants likely to persist independent of whether the subject remains in jail? In the last case, reassessment and reconsideration of hospitalization will be needed before the inmate is released from custody. Is the subject likely to become suicidal around the time of trial or sentencing? If so, even if not presently suicidal, the inmate should be reassessed just before the stressful phase of criminal proceedings.

Provide Psychological Support

The mental health professional should establish and maintain personal contact in a manner that realistically serves to restore hope.[25] Personal contact and support of the inmate's sense of hope can be neglected in facilities where the staff-patient ratio is low. If the at-risk inmate is hostile and offensive, he may distance himself by driving others away. Nonetheless professionals must show the suicidal inmate genuine care, listen attentively, support the inmate emotionally,[27] show him or her respect, and help the inmate to embrace more adaptive methods of coping with stressors.[26] Desperate, hopeless individuals often adopt rigid, fatalistic views of their future. When inmates asks about their legal status, refer them to an attorney. The professional should assure the inmate he will be monitored closely and will be seen in follow-up. With the inmate's permission, a "contacting" telephone call to a friend or family member will often serve to restore hope and reaffirm the sense that others care. When it is necessary to take preventive measures, which the inmate may experience as depriving or restricting, the rationale for such measures should be explained to the inmate.

A "psychological contract," wherein

the inmate agrees not to suicide, should not be relied upon to make the determination that the inmate is not suicidal. Rather, the assessment of potential for suicidal should be conducted first, and the contract made only after it is clear the inmate has the capacity to resist self-destructive impulses. Only then should an agreement of nonsuicide be solicited from the inmate. The contract serves to strengthen the supportive bond with the professional and to reinforce those ego defenses that are pro-life and adaptive.

Observe the Suicidal Inmate Closely

Close observation is a critically important element of any suicide prevention program.[19] If one-to-one observation of suicidal inmates were possible, some of the more depriving preventive measures to achieve complete disarmament would be unnecessary. Hospitals can often provide this level of care, but jail staffing patterns typically do not permit constant monitoring.

Research on jailhouse suicides has shown repeatedly that many who suicide had been placed in isolation.[1,2,5,6,14] The isolation process may select those who are prone to suicide, remove social supports, add to the stress of loneliness and sensory deprivation, and diminish the opportunity for close observation. On the other hand, placement with other inmates makes effective implementation of some precautions more difficult, and inmates have taken their lives in the presence of other inmates (from 32% to 33% of inmates who committed suicide in the NCIA's surveys were *not* isolated[13]).

Although jails have used other inmates as inmate aides, suicide prevention aides, or staff extenders, this approach creates ambiguity in lines of accountability, which, for the important task of suicide prevention, should be clear and direct. Some authorities advise placing suicidal inmates in a cell with other inmates,[5,6,24] who can observe, offer support, and notify staff of disturbing behavior. Cellmates provide company, but they should not be relied upon to replace staff observation. As noted above inmates have killed themselves in the presence of other inmates.

Closed-circuit television has been used to provide the possibility of nearly constant observation where staffing is limited.[5,14] If used conscientiously to monitor suicidal inmates, television can help, but used alone it does not provide personal contact from a caring, responsible staff and therefore should not replace in-person checks by staff.[14]

When staffing is too limited for constant observation, 15-minute checks may have to suffice. Other preventive measures must be employed, because suicide can be accomplished in less than 15 minutes.[2] Checks must occur regularly and must be documented. The officer or nurse who makes these rounds should be encouraged to interact with the suicidal inmate, even if only to exchange pleasantries. Suicidal inmates should be placed close to the hub of staff activity, near the booking-in office in some jails or near the nurse's station in jails with an infirmary.

Disarm the Suicidal Inmate

When they enter the jail, all inmates should be routinely divested of offensive weapons such as knives and potentially dangerous substances such as medicines. Belts and leather shoestrings are routinely held as well. Unfortunately, suicidal inmates often take their lives with items which we all take for granted for comfortable living: bedding material and personal articles of clothing.[1, 2, 24] Even fragile toilet tissue can be twisted and braided into a strong enough ligature to support the head.

The degree of disarmament needed depends on the nature and intensity of the inmate's current self-destructive potential. For example, the inmate who is likely to inflict superficial cuts but has no suicidal intent should be restricted from access to instruments that can be fashioned into blades or picks. The acutely suicidal inmate should have no items which could be used for hanging, strangulation, suffocation, cutting, burning, poisoning, or overdosing.

For the acutely suicidal inmate, the extent of disarmament will also depend on the availability of certain human and structural resources within the jail. If one-to-one staff observation is possible, the inmate may be permitted some bedding and a set of clothes. If constant observation is not practical, but minimal-risk cells are available, tear-away gowns, 15-minute checks, and television monitoring may suffice. If all cells have cross-bars and constant staff observation is not possible, then virtually all cloth, paper, plastic, metal, and glass objects should be removed. At least 15-minute checks by staff are essential regardless of other circumstances. The inmate should be informed that his/her mental status will be evaluated frequently, and suicide precautions, however austere, will not be continued any longer than necessary.

Self-destructive inmates can conjure up an astonishing menu of self-injuring methods: submerging their heads in the commode, electrocution, swallowing sharp objects, self-burning, and jumping. Beyond basic precautions needed for any inmate who is acutely suicidal, extra measures may be required in individual cases to ensure safety, such as turning off water to the cell.

Even with full suicide precautions, some inmates bang their heads against the concrete floor or in other ways actively injure themselves. To preserve life and limb, application of leather restraints may be necessary. The jail should have a policy in place to ensure restraints are used according to proper clinical and legal standards. Jail staff who apply restraints should have initial and refresher training in correct technique.

If a single cell is the only way to achieve complete disarmament, frequent checks on the inmate and human contact by responsible staff are critical. It is courting disaster to isolate a suicidal inmate and then neglect him.

Clear and Consistent Procedure

Procedures for suicide prevention in jail must be as clear and as consistently applied as they would be in a hospital.[28] The jail policy should define the responsibilities of those involved in the preven-

tive efforts including the booking officer and jail nurse. Suicide precautions should be written on a "doctors' orders" form and each specific measure should be explicitly cited (e.g., "Restrict all sharp instruments") to avoid ambiguity. Full precautions are appropriate for every inmate who is acutely suicidal.

Eventually, often within only a day or two, the inmate's suicidal crisis dissipates. When the inmate is clearly no longer suicidal, all precautions can be withdrawn. Lingering doubt may persist in other cases, although the inmate is not so patently suicidal as before. Some adjustment in precautions may be indicated, such as allowing the inmate clothing and a mattress, but continuing the 15-minute checks and restricting other items that can easily be fashioned into self-destructive weapons (e.g., sheets for hanging). If hope and trust are to be fostered, precautions should not be overused and should be discontinued when no longer required.

Diagnose, Treat, and/or Hospitalize

Those inmates who experience a situational crisis but do not have major mental illness need support and protective intervention to see them through their "window of vulnerability." For others, who are mentally ill, their problems are not overcome without more intensive, therapeutic measures.[28] Adequate diagnostic assessment is the first step.

If indicated and arrangeable, psychiatric hospitalization should be provided, especially if the inmate is psychotically disturbed or the diagnosis remains unclear. Because inmates are defendants in criminal litigation, security measures must be taken to prevent escape. In a civil hospital the safety of other patients must be considered. The mentally disturbed can be transferred to a hospital within the criminal justice system to satisfy both clinical and security needs, but the authority for criminal commitment typically belongs to the criminal court.

Hospitalization, even when urgently needed, is not always easily and promptly accomplished. The escape risk from a non-security hospital must be considered. The risk of harm to other patients is said to be too great, particularly if the alleged offense is disturbingly serious and the apparent mental illness is not sufficiently severe. Such objections, made in both clinical and legal circles, can constitute impediments to hospitalization. The consulting psychiatrist may have no choice but to commence and continue treatment while the inmate is in jail. For clinically depressed and suicidal inmates, antidepressant medicine is indicated. Because of the risk of stockpiling and overdosing in jail, the liquid form of tricyclic is preferred,[6] or alternatively a safer selective serotonin reuptake inhibitor may be used.[14] When chemotherapy is begun, the inmate should be followed to titrate the dose, to monitor response of target symptoms, and to detect adverse reactions early.

Evidence for Efficacy

Can the application of these principles actually reduce the incidence of jailhouse suicides? Principles thought to be

preventive do not lend themselves to empirical research because of restraining legal and ethical considerations. Because every suicidal inmate deserves the best attempt at prevention within reason, withholding measures thought to be preventive cannot be morally justified and may lead to legal liability. Consequently there is no scientific evidence based on prospective, carefully controlled studies that assess the effectiveness of each preventive measure alone and in combination with others.

It can be reported retrospectively, however, that when preventive measures were developed from these principles and implemented in the Galveston County Jail, the already unacceptable rate of suicide was reduced to zero. From 1976 through August of 1986, seven suicides were reported in this facility. Measures based on the preventive principles advocated here were effected before the end of 1986, and since then (i.e., for over seven years) no suicides have occurred. This is not to deny the occurrence of a few near-suicides. Accurate figures do not exist on the number of inmates processed through the jail from 1976 to 1987, but the number has increased relentlessly. Now intolerably overcrowded, the jail population has more than doubled since 1986. The suicide rate has been reduced to zero, despite a sharp, inexorable rise in the jail population and the number of inmates processed.

The rate of jail suicides is far higher than that for the general population in the U.S., estimated to be 12.3 per 100,000 per year.[14] Winfree found the rate of jail suicides to be 187.5 and 131.5 in 1977 and 1982, respectively.[29] Hayes determined the rate of suicide in detention facilities to be about 107.[30] In the Galveston County Jail, the rate per 100,000 cannot be made for comparison because the total number of inmates is too low. Further limiting statistical applications is the lack of accurate admission and census data in this facility before 1988. However, since then accurate figures have been maintained on the average daily census for every month. The inexorable increase in the jail census is demonstrated in Figure 1. Again, the success of the facility's suicide prevention program is demonstrated by the lack of a successful suicide since August 1986, a period of over 7 years of unprecedented census growth and terrible overcrowding, whereas seven suicides occurred in the prior 10 years.

Appreciation of the value of preventive principles must be tempered with a few caveats. Admittedly an inmate could suicide any time despite having a program that adheres to these principles. Although principles of prevention have served the Galveston County Jail well, even the best policies and most conscientious staff are not omnipotently capable of preventing every suicide. Similarly, one cannot conclude that had measures based on these principles been fully in place before 1986, specific suicides would not have occurred. Neither can preventive weight be attributed to each preventive principle. It is hard to say, based on available data, which principles or specific measures are the most effective. Although this empirical report

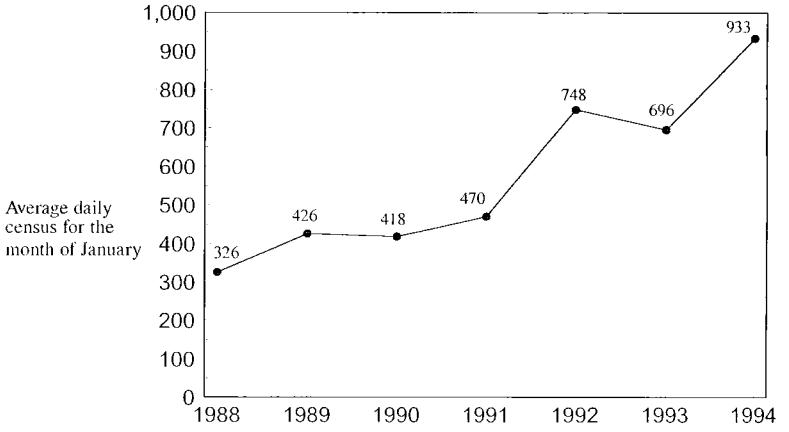

Figure 1. This graph illustrates the substantial and relentless increase in the average daily census in the Galveston County Jail in the month of January from 1988 to 1994. Despite the uncontrolled growth and difficult adjustment, the six-year period was without a suicide occurence.

of success does not follow a research design, it may constitute the best kind of evidence presently available to demonstrate that such measures can be effective.

According to a national survey by the National Alliance for the Mentally Ill and the Public Citizen Health Research Group,[12] more than 20 percent of jails in this country have no mental health services whatsoever, and therefore many jails may well lack any kind of suicide prevention program. Some jails, however, have developed suicide prevention programs and have reported favorable results, including a number of jails in the city and state of New York,[31] the Mobile County Jail in Alabama,[32] the Champaign County Correctional Center in Illinois,[33] and the El Paso County Jail in Texas.[33] The programs in these jails differ from one another and do not rely on the same set of preventive techniques. Nonetheless the principles emphasized here are recurrent themes in these successful programs, especially early screening, assessment, observation, and disarmament.

Conclusion and Summary

One of the most serious problems confronting correctional health care today is the distressingly high number of jail suicides. Six principles of prevention are outlined here, which can be adapted to jails with diverse needs and resources, as well as evidence for the efficacy of a program that has incorporated these principles. It is sad to note that perhaps the single greatest force for improvement in health care delivery to jails has been lawsuits. Empirical evidence that the application of preventive principles can be effective as well should serve clinicians and jail administrators as they strive to improve mental health services and reduce the incidence of suicide.

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