Jail/Custody Suicide:

A Compendium of Suicide Prevention Standards and Resources

edited by

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Introduction

Suicide in custody represents a double tragedy. There is both the loss of a human life, as well as the failure by the criminal justice system to protect those whose behavior has brought them into the custody of the state. This is especially important given the large numbers of persons with mental illness who are currently incarcerated. To better understand the phenomenon of jail/custody suicide, an examination of its extent and impact is in order.

Because there is as yet no central repository of custody suicide data, the number of suicides in juvenile facilities, police lockups, county jails and state and federal prisons can only be approximated. Although the Death in Custody Reporting Act of 2000 may one day resolve this reporting problem, no data arising from this legislation are yet available for public consumption.

We simply do not know how many juveniles kill themselves while in custody. Hayes (2000) quotes two government studies reporting 17 suicides during 1988 and 14 during 1993. Parent et. al. (1994) reported that ten juveniles took their own lives in 1990. Memory (1989) argues that studies which find a lower suicide rate among incarcerated juveniles than free juveniles may be methodologically flawed and that proper calculation of suicide rates by person-day exposure would reveal a suicide rate 4-5 times higher among children in custody.

Hagan identified 419 suicides in adult county jails and local police lockups during 1979 (Hayes, 1983) and argued that the suicide rate in jails was 16 times greater than in the free community. In a follow up study the inmate rate was 9 times higher (Hayes and Rowan, 1988). This disparity between custodial suicide rates and free world rates is repeatedly cited throughout the literature (e.g. Bonner, 2000). However, O=Toole (1997) challenges such comparative

claims because he believes suicide rates should be based on number of admissions rather than on Average Daily Population. Putting aside methodological arguments for a moment, and without examining the problem of underreporting, the Bureau of Justice Statistics reports that 324 jail inmates died by their own hand in 1999 (Stephan, 2001). During 2000, 185 state prisoners and 13 federal prisoners took their own lives (Maruschak, 2002). In a more recent discussion of jail suicide, Hayes (2003) estimates there are close to 200 prison suicides per year and between 400 and 600 jail suicides per year.

The impact of jail/custody suicide on the prisoner=s family is often exacerbated by guilt feelings as well as a resentment toward the corrections officers involved with inmate care. Correctional officers themselves often develop a sense of guilt (Kennedy, 1994) and must sometimes face a grueling litigation process as family survivors demand accountability through the courts (Welch and Gunther, 1997; See also Raba, 1998). Naturally, in a free society such as ours, any death in police custody deserves scrutiny by appropriate authorities and the media. While various scholars and practitioners will continue to debate methodologies, few will debate the value of prevention. It was with prevention in mind that the Jail Suicide Task Force of the American Association of Suicidology endeavored to review various operational standards designed to prevent suicide in our nation=s detention and custody facilities. National professional associations whose members are charged with prisoner and juvenile care were selected for inclusion in this review.

This effort to identify guidelines and standards is in accord with important federal policy

objectives regarding suicide prevention in correctional settings. The National Strategy for Suicide Prevention, under Goal 8-Improve Access to and Community Linkages with Mental Health and Substance Abuse Services, lists the following objective:

> Objective 8.6 -*By 2005, for adult and juvenile incarcerated populations, define national guidelines for mental health screening, assessment, and treatment of suicidal individuals. Implement the guidelines in correctional institutions, jails and detention centers.*

The National Strategy also identifies as an AIdea for Action@ to work with professional correctional organizations to identify and promote model suicide assessment guidelines for jails during the acute period of incarceration. It is in pursuance of the goals of the National Strategy that the AAS Jail Suicide Task Force undertakes this effort.

It must be emphasized, however, that the standards included herein do not create constitutional requirements per Rhodes v. Chapman, 452 US 337 (1981), although they may be useful in evaluating reasonable conduct by corrections officials. Readers are urged to seek out the original materials from which the information being reported is drawn. Due to space considerations, we were forced to omit from this publication various discussions, recommendations and definitions which the reader may find helpful.

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American Correctional Association

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For more than 125 years, the American Correctional Association (ACA) has championed the cause of corrections and correctional effectiveness. Founded in 1870 as the National Prison Association, ACA is the oldest association developed specifically for practitioners in the correctional profession. At the 1954 Congress of Correction in Philadelphia, Pennsylvania, the name of the American Prison Association was changed to the American Correctional Association, reflecting the expanding philosophy of corrections and its increasingly important role within the community and society as a whole. Today, the ACA has more than 20,000 active members.

The ACA publishes its recommended standards in book form. These standards pertain to 20 different programs, services and facilities. Just five sets of standards were selected for this review, including Standards for Adult local Detention Facilities (1999), Standards for Small Jail Facilities (1989), Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions (2002), Standards for Juvenile Training Schools (1991), and Standards for Juvenile Detention Facilities (1991). Each standards book is updated periodically, most recently by the 2002 Standards Supplement (2002).

Listed below are the standards most pertinent to suicide prevention in each of five types of correctional facilities.

Adult Local Detention Facilities (Jails)

Training Requirements

3-ALDF ID-12 Revised January 1994. Written policy, procedure, and practice provide that all new correctional officers receive an added 120 hours of training during their first year of employment, and an added 40 hours of training each subsequent year of employment. At a minimum this training covers the following areas:

- $ security procedures
- $ supervision of offenders
- $ signs of suicide risks
- $ suicide precautions
- $ use-of-force regulations and tactics
- $ report writing

- $ offender rules and regulations
- $ rights and responsibilities of offenders
- $ fire and emergency procedures
- $ safety procedures
- $ key control
- $ interpersonal relations
- $ social/cultural lifestyles of the offender population
- $ communication skills
- $ first aid/CPR
- $ counseling techniques
- $ cultural diversity

Supervision

3-ALDF 3D-08 **(Ref. New)** Written policy, procedure, and practice require that all special management inmates are personally observed by a correctional officer at least every 30 minutes on an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; suicidal inmates are under continuous observation.

Reception and Orientation

3-ALDF 4A-01 **(Ref. 2-5346)** Written policies and procedures govern the admission of inmates new to the system. These procedures include at a minimum the following:

- $ determination that inmate is legally committed to the facility
- $ drug/alcohol use
- $ thorough search of the individual and possessions
- $ disposition of personal property
- $ shower and hair care, if necessary
- $ issue of clean, laundered clothing when appropriate
- $ photographing and fingerprinting, including notation or identifying marks or other unusual physical characteristics
- $ medical, dental, and mental health screening
- $ assignment to housing unit
- $ recording basic personal data and information to be used for mail and visiting list
- $ explanation of mail and visiting procedures
- $ assistance to inmates in notifying their next of kin and families of admission
- $ suicide screening
- $ assignment of registered number to the inmate
- $ giving written orientation materials to the inmate

- $ telephone calls by inmate
- $ assignment of a housing unit
- $ criminal history check

Special Management Inmates

3-ALDF 4B-03 (Ref. 2-5354) The facility provides for the separate management of the following categories of inmates:

- $ female and male inmates
- $ other classes of detainees (witnesses, civil inmates)
- $ community custody inmates (work releases, weekender, trustees)
- $ inmates with special problems (alcoholics, narcotics addicts, mentally disturbed persons, physically handicapped persons, persons with communicable diseases)
- $ inmates requiring disciplinary detention
- $ inmates requiring administrative segregation
- $ juveniles

Suicide Prevention and Intervention

3-ALDF 4E-34 **Revised August 1994 (MANDATORY).** There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with responsibility for inmate supervision are trained in the implementation of the program.

Small Jail Facilities (<50 Inmates)

Training and Staff Development

SJ-028 **Revised October 1997.** Written policy, procedure, and practice provide that all new correctional officers receive an added 120 hours of training during their first year of employment and an added 40 hours of training each subsequent year of employment. At a minimum, this training covers the following areas:

- $ security procedures
- $ supervision of offenders
- $ signs of suicide risk
- $ suicide precautions
- $ use-of-force regulations and tactics
- $ report writing

$ offender rules and regulations
$ rights and responsibilities of offenders
$ fire and emergency procedures
$ safety procedures
$ key control
$ interpersonal relations
$ social/cultural lifestyles of the offender population
$ communication skills
$ first aid/CPR
$ counseling techniques
$ cultural diversity

Physical Plant

SJ-051 **Revised October 1997.** Written policy, procedure, and practice provide that single-occupancy cells/rooms shall be available when indicated for the following:

$ inmates with severe medical disabilities
$ inmates suffering from serious mental illness
$ sexual predators
$ inmates likely to be exploited or victimized by others
$ inmates who have other special needs for single-occupancy housing

Security and Control

SJ-086 Written policy and procedure require that all high and medium security inmates are personally observed by a correctional officer at least every thirty minutes, but on an irregular schedule. More frequent observation is required for those inmates who are mentally disordered or who demonstrate unusual or bizarre behavior. Suicidal inmates are under continuous observation.

Health Care Services

SJ-147 Written policy and procedure require medical screening to be performed by health-trained staff on all inmates on arrival at the facility. The findings are recorded on a printed screening form approved by the health authority. The screening process includes at least the following procedures:

1. Inquiry into

   $ current illness and health problems, including dental problems, sexually transmitted diseases and other infectious disease

- $ medication taken and special health requirements
- $ use of alcohol and other drugs, which includes types of drugs used, mode of use, amounts used, frequency used, date or time of last use and history of problems that may have occurred after ceasing use (e.g., convulsions)
- $ past and present treatment or hospitalization for mental disturbance or suicide
- $ other health problems designated by the responsible physician
- $ mental illness

2. Observations of

- $ behavior, which includes state of consciousness, mental status, appearance, conduct, tremor and sweating
- $ body deformities, trauma markings, bruises, lesions, jaundice, ease of movement, etc.

3. Disposition to

- $ general population
- $ general population and referral to appropriate health care service
- $ referral to appropriate health care service on an emergency basis

(MANDATORY)

Classification

SJ-191 Written policy, procedure, and practice provide for inmate classification in terms of level of custody required, housing assignment, and participation in correctional programs. They are reviewed at least annually and updated if necessary. These include, at a minimum:

1. Criteria and procedures for determining and changing the status of an inmate, including custody, transfers, and major changes in programs

2 An appeals process for classification decisions

3. The separate management of the following categories of inmates:

- $ female and male inmates
- $ other classes of detainees (witnesses, civil prisoners)
- $ community custody inmates (work releases, weekenders, trusties)

- $ inmates with special problems (alcoholics, narcotics addicts, mentally disturbed, physically handicapped, those with communicable diseases)
- $ inmates requiring disciplinary detention
- $ inmates requiring administrative segregation
- $ juveniles

Adult Correctional Facilities (Prisons)

Mental Health Program

1-HC-1A-25 (Ref. 3-4336) **(MANDATORY)** There is a mental health program that includes at a minimum:

- $ screening for mental health problems on intake as approved by the mental health professional
- $ outpatient services for the detection, diagnosis, and treatment of mental illness
- $ crisis intervention and the management of acute psychiatric episodes
- $ stabilization of the mentally ill and the prevention of psychiatric deterioration in the correctional setting
- $ elective therapy services and preventive treatment where resources permit
- $ provision for referral and admission to licensed mental health facilities for offenders whose psychiatric needs exceed the treatment capability of the facility
- $ procedures for obtaining and documenting informed consent

Mental Health Screen

1-HC-1A-27 (Ref. New) **(MANDATORY)** All intersystem and intrasystem transfer offenders will receive an initial mental health screening at the time of admission to the facility by mental health trained or qualified mental health care personnel. The mental health screening includes, but is not limited to:

Inquiry into:

- $ whether the offender has a present suicide ideation
- $ whether the offender has a history of suicidal behavior
- $ whether the offender is presently prescribed psychotropic medication
- $ whether the offender has a current mental health complaint
- $ whether the offenders are being treated for mental health problems
- $ whether the offender has a history of inpatient and outpatient psychiatric treatment

- $ whether the offender has a history of treatment for substance abuse

Observation of:

- $ general appearance and behavior
- $ evidence of abuse and or trauma
- $ current symptoms of psychosis, depression, anxiety, and or aggression

Disposition of offender:

- $ to the general population
- $ to the general population with appropriate referral to mental health care service
- $ referral to appropriate mental health care service for emergency treatment

Mental Health Appraisal

1-HC-1A-28 **(MANDATORY)** All intersystem offender transfers will undergo a mental appraisal by a qualified health person within fourteen days of admission to a facility. If there is documented evidence of a mental health appraisal within the previous ninety days, a new mental health appraisal is not required, except as determined by the designated mental health authority. Mental health examinations include, but are not limited to:

(Ref. New)

- $ assessment of current mental status and condition
- $ assessment of current suicidal potential and person-specific circumstances that increase suicide potential
- $ assessment of violence potential and person-specific circumstances that increase violence potential
- $ review of available historical records of inpatient and outpatient psychiatric treatment
- $ review of history of treatment with psychotropic medication
- $ review of history of psychotherapy, psycho educational groups, and classes or support groups
- $ review of history of drug and alcohol treatment
- $ review of educational history
- $ review of history of sexual abuse-victimization and predatory behavior
- $ assessment of drug and alcohol abuse and/or addiction
- $ use of additional assessment tools, as indicated
- $ referral to treatment, as indicated
- $ development and implementation of a treatment plan, including

recommendations concerning housing, job assignment, and program participation

Suicide Prevention and Intervention

1-HC-1A-30 **(MANDATORY)** There is a written suicide prevention plan that is approved by
(Ref 3-4364) the health authority and reviewed by the facility or program administrator. The plan includes staff and offender critical incident debriefing that covers the management of suicidal incidents, suicide watch, and death of an offender or staff member. It ensures a review of critical incidents by administration, security, and health services. All staff with responsibility for offender supervision are trained on an annual basis in the implementation of the program. Training should include but not be limited to:

- $ identifying the warning signs and symptoms of impending suicidal behavior
- $ understanding the demographic and cultural parameters of suicidal behavior, including incidence and variations in precipitating factors responding to suicidal and depressed offenders
- $ communication between correctional and health care personnel referral procedures
- $ housing observation and suicide watch level procedures
- $ follow-up monitoring of offenders who make a suicide attempt

Emergency Response

1-HC-2A-14 **(MANDATORY)** Correctional and health care personnel are trained to respond
(Ref. 3-4351) to health related situations within a four-minute response time. The training program is conducted on an annual basis and is established by the responsible health authority in cooperation with the facility or program administrator and includes instruction on the following:

- $ recognition of signs and symptoms, and knowledge of action that is required in potential emergency situations
- $ administration of basic first aid
- $ certification in cardiopulmonary resuscitation (CPR) in accordance with the recommendations of the certifying health organization
- $ methods of obtaining assistance
- $ signs and symptoms of mental illness, violent behavior, and acute chemical intoxication and withdrawal
- $ procedures for patient transfers to appropriate medical facilities or health care providers
- $ suicide intervention

Offender Assistants

1-HC-2A-18 **(Ref. 34340)** Unless prohibited by state law, offenders (under staff supervision) may perform familial duties commensurate with their level of training. These duties may include the following:

- $ peer support and education
- $ hospice activities
- $ assisting impaired offenders on a one-on-one basis with activities of daily living
- $ serving as a suicide companion or buddy if qualified and trained through a formal program that is part of a suicide prevention plan

Offenders are not to be used for the following duties:

- $ performing direct patient care services
- $ scheduling health care appointments
- $ determining access of other offenders to health care services
- $ handling or having access to surgical instruments, syringes, needles, medications, or health records
- $ operating diagnostic or therapeutic equipment except under direct supervision (by specially trained staff) in a vocational training program

Internal Review and Quality Assurance

1-HC-4A-03 **(Ref. New)** **(MANDATORY)** A system of documented internal review will be developed and implemented by the health authority. The necessary elements of the system will include:

- $ participating in a multidisciplinary quality improvement committee
- $ collecting, trending, and analyzing data combined with planning, intervening, and reassessing
- $ evaluating defined data, which will result in more effective access, improved quality of care, and better utilization of resources
- $ on-site monitoring of health service outcomes on a regular basis through:

    a. chart reviews by the responsible physician or his or her designee, including investigation of complaints and quality of health records
    b. review of prescribing practices and administration of medication practices
    c. systematic investigation of complaints and grievances
    d. monitoring of corrective action plans

- $ reviewing all deaths in custody, suicides or suicide attempts, and illness outbreaks
- $ implementing measures to address and resolve important problems and concerns identified (corrective action plans)
- $ reevaluating problems or concerns to determine objectively whether the corrective measures have achieved and sustained the desired results
- $ incorporating findings of internal review activities into the organization=s educational and training activities
- $ maintaining appropriate records (for example, meeting minutes) of internal review activities
- $ issuing a quarterly report to be provided to the health services administrator and facility or program administrator of the findings of internal review activities
- $ requiring a provision that records of internal review activities comply with legal requirements on confidentiality of records

Clothing

1-HC-5A-04 **(Ref. New)** When standard issued clothing presents a security or medical risk (for example, suicide observation), provisions are made to supply the offender with a security garment that will promote offender safety in a way that is designed to prevent humiliation and degradation.

Juvenile Training Schools

Admissions and Review

3-JTS-3E-01 **(Ref. 2-9189)** Written policy, procedure, and practice provide special management for juveniles with serious behavior problems and for juveniles requiring protective care. An individual program plan will be developed.

3-JTS-3E-04 **(Ref. 2-9302)** Juveniles placed in confinement are checked visually by staff at least every 15 minutes and are visited at least once each day by personnel from administrative, clinical, social work, religious, or medical units. A log is kept recording who authorized the confinement, persons visiting the juvenile, the person authorizing release from confinement, and the time of release.

Mental Health Services

3-JTS-4C-16 Written policy, procedure, and practice specify the provision of mental health

(Ref. New) services for juveniles. These services include but are not limited to those provided by qualified mental health professionals who meet the educational license/certification criteria specified by their respective professional discipline (e.g., psychiatric nursing, psychiatry, psychology, and social work).

Health Screenings and Examinations

3-JTS-4C-22 Written policy, procedure, and practice require medical, dental and mental
(Ref. 2-9245) health screening to be performed by health-trained or qualified health care
Mandatory personnel on all juveniles, excluding intrasystem transfers on juveniles' arrival at the facility. All findings are recorded on a form approved by the health authority. The screening form includes at least the following:

Inquiry into:

- $ current illness and health problems, including venereal diseases and other infectious diseases
- $ dental problems
- $ mental health problems
- $ use of alcohol and other drugs, which includes types of drugs used, mode of use, amounts used, frequency used, date or time of last use, and a history of problems that may have occurred after ceasing use (e.g., convulsions)
- $ past and present treatment or hospitalization for mental disturbance or suicide
- $ other health problems designated by the responsible physician

Observation of:

- $ behavior, which includes state of consciousness, mental status, appearance, conduct, tremor, and sweating
- $ body deformities, ease of movement, etc.
- $ condition of skin, including trauma markings, bruises, lesions, jaundice, rashes and infestations, and needle marks or other indications of drug abuse.

Medical disposition of juvenile:

- $ general population OR
- $ general population with appropriate referral to health care service OR
- $ referral to appropriate health care service for emergency treatment

Comprehensive Education Program

3-JTS-5D-02 The facility provides or makes available to all juveniles the following program
(Ref.2-9334) and services, at a minimum:

- $ reception and orientation
- $ evaluation and classification
- $ educational programs that will include opportunity for vocational/job training
- $ religious services and/or counseling
- $ social services
- $ psychological and psychiatric services, if needed
- $ library services
- $ medical and dental health care
- $ athletic, recreational, and leisure-time activities
- $ juvenile involvement with community groups
- $ mail and visiting privileges
- $ access to media, legal material, attorneys, and courts
- $ prerelease orientation and planning

Juvenile Detention Facilities

3-JDF-ID-09 **Revised January 1994.** Written policy, procedure, and practice provide that all new juvenile care workers receive an added 120 hours of training during their first year of employment and an added 40 hours of training each subsequent year of employment. At a minimum this training covers the following areas:

- $ security procedures
- $ supervision of juveniles
- $ signs of suicide risks
- $ suicide precautions
- $ use-of-force regulations and tactics
- $ report writing
- $ juvenile rules and regulations
- $ rights and responsibilities of juveniles
- $ fire and emergency procedures
- $ safety procedures
- $ key control
- $ interpersonal relations
- $ social/cultural lifestyles of the juvenile population
- $ communication skills
- $ first aid/CPR
- $ counseling techniques
- $ cultural diversity

Specialist Employees

3-JDF-lD-10 Written policy, procedure, and practice provide that all professional specialist

(Ref. 2-8092) employees who have juvenile contact receive an additional 120 hours of training during their first year of employment and an additional 40 hours of training each subsequent year of employment. At a minimum this training covers the following areas:

- $ security procedures
- $ supervision of juveniles
- $ signs of suicide risks
- $ suicide precautions
- $ use-of-force regulations and tactics
- $ report writing
- $ juvenile rules and regulations
- $ rights and responsibilities of juveniles
- $ fire and emergency procedures
- $ key control
- $ interpersonal relations
- $ social/cultural lifestyles of the juvenile population
- $ communication skills
- $ first aid
- $ counseling techniques

Protection From Harm

3-JDF-3D-06 Written Policy, procedure, and practice protect juveniles from personal
(Ref. 2-8301) abuse, corporal punishment, personal injury, disease, property damage, and harassment.

Admission and Review

3-JDF-3E-04 Juveniles placed in confinement are checked visually by staff at least every 15
(Ref. 2-8321) minutes and are visited at least once each day by personnel from administrative, clinical, social work, religious, or medical units. A log is kept recording who authorized the confinement, persons visiting the juvenile, the person authorizing release from confinement, and the time of release.

Health Screenings and Examinations

3-JDF-4C-21 Written policy, procedure and practice require medical, dental, and mental
(Ref. 2-8264) health screening to be performed by health-trained or qualified health care
Mandatory personnel on all juveniles, excluding intrasystem transfers, on arrival at the facility. All findings are recorded on a form approved by the health authority. The screening form includes at least the following:

Inquiry into:

- $ current illness and health problems, including venereal diseases and other infectious diseases
- $ dental problems
- $ mental health problems
- $ use of alcohol and other drugs, which includes types of drugs used, mode of use, amounts used, frequency of use, date or time of last use, and a history of problems that may have occurred after ceasing use (e.g., convulsions)
- $ past and present treatment or hospitalization for mental disturbance or suicide
- $ other health problems designated by the responsible physician

Observation of:

- $ behavior, which includes state of consciousness, mental status, appearance, conduct, tremor, and sweating
- $ body deformities, ease of movement, etc.
- $ condition of skin, including trauma markings, bruises, lesions, jaundice, rashes and infestations, and needle marks or other indications of drug abuse

Medical disposition of juvenile:

- $ general population OR
- $ general population with appropriate referral to health care service OR
- $ referral to appropriate health care service for emergency treatment

First Aid

3-JDF-4C-27 **(Ref. 2-8273)** **Mandatory** Written policy, procedure, and practice provide that juvenile care worker staff and other personnel are trained to respond to health-related situations within a four-minute response time. A training program is established by the responsible health authority in cooperation with the facility administrator that includes the following:

- $ recognition of signs and symptoms and knowledge of action required in potential emergency situations
- $ administration of first aid and cardiopulmonary resuscitation (CPR)
- $ methods of obtaining assistance
- $ signs and symptoms of mental illness, retardation, and chemical dependency
- $ procedures for patient transfers to appropriate medical facilities or health care providers

Suicide Prevention and Intervention

3-JDF 4C-35 Revised August 1994 (Mandatory) There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with responsibility for juvenile supervision are trained in the implementation of the program.

Intake

3-JDF-5A-02 (Ref. 2-8349, 2-8350) Written procedures for admission of juveniles new to the system include but are not limited to the following:

- $ determination that the juvenile is legally committed to the facility
- $ complete search of the juvenile and possessions
- $ disposition of personal property
- $ shower and hair care, if necessary
- $ issue of clean, laundered clothing, as needed issue of personal hygiene articles
- $ medical, dental, and mental health screening
- $ assignment to a housing unit
- $ recording of basic personal data and information to be used for mail and visiting lists
- $ assistance to juveniles in notifying their families of their admission and procedures for mail and visiting
- $ assignment of a registered number to the juvenile
- $ provision of written orientation materials to the juvenile

National Commission on Correctional Health Care

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The National Commission on Correctional Health Care (NCCHC) origins date to the early 1970's, when an American Medical Association study of jails found inadequate, disorganized health services and a lack of national standards to guide correctional institutions. In collaboration with other organizations, the AMA established a program that in the early 1980's became the National Commission on Correctional Health Care, an independent, not-for-profit 501(c)(3) organization. NCCHC's early mission was to evaluate formulate policy and develop programs for an area clearly in need of assistance. Today, NCCHC's leadership in setting standards for health services and improving health care in correctional facilities is widely recognized.

Standards for Health Services in Jail

J-A-08 Communication on Special Needs Patients
essential

Standard

Communication occurs between the facility administration and treating clinicians regarding inmates' significant health needs that must be considered in classification decisions in order to preserve the health and safety of that inmate, other inmates, or staff.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. Correctional staff are advised of inmates' special needs that may affect housing, work, and program assignments; disciplinary measures; and admissions to and transfers from institutions. Such communication is documented.

3 . Health and custody staff communicate about inmates who are:

   a. chronically ill
   b. *on dialysis;*
   c. adolescents in adult facilities;

d. infected with *serious communicable diseases;*
e. *physically disabled;*
f. *pregnant;*
g. *frail or elderly;*
h. *terminally ill;*
i. mentally ill or suicidal; or
j. *developmentally disabled.*

J-C-04 Training for Correctional Officers
essential

Standard

A training program, established or approved by the responsible health authority in cooperation with the facility administrator, guides the health-related training of all correctional officers who work with inmates.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. Correctional officers who work with inmates receive health-related training at least every 2 years, which includes at a minimum:

   a. administration of first aid;
   b. recognizing the need for emergency care and intervention in life-threatening situations (e.g., heart attack);
   c. recognizing acute manifestations of certain chronic illnesses (e.g., asthma, seizures), intoxication and withdrawal, and adverse reactions to medications;
   d. recognizing signs and symptoms of mental illness;
   e. procedures for suicide prevention;
   f. procedures for appropriate referral of inmates with health complaints to health staff;
   g. precautions and procedures with respect to infectious and communicable diseases; and
   h. cardiopulmonary resuscitation.

3. The appropriateness of the health-related training is verified by an outline of the course content and the length of the course.

4. A certificate or other evidence of attendance is kept on site for each employee.

5. While it is expected that 100% of the correctional staff who work with inmates are trained in all of these areas, compliance with the standard requires that at least 75% of the staff present on each shift are current in their health-related training.

J-E-02 Receiving Screening
essential

Standard

Receiving screening is performed on all inmates immediately upon arrival at the intake facility.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. Qualified health care professionals or health-trained personnel perform the receiving screening.

3. The receiving screening takes place immediately for all inmates.

4. Persons who are unconscious, semiconscious, bleeding, mentally unstable, or otherwise urgently in need of medical attention are referred immediately for care. If inmates are referred to a community hospital and are returned, their admission to the facility is predicated upon written medical clearance.

5. Reception personnel, using a health-authority-approved form, inquire about:

   a. current and past illnesses, health conditions, or special health requirements (e.g., dietary needs);
   b. past serious infectious disease;
   c. recent communicable illness symptoms (e.g., chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, night sweats);
   d. past or current mental illness, including hospitalizations;
   e. history of or current suicidal ideation;
   f. dental problems;
   g. allergies;
   h. legal and illegal drug use (including the time of last use);
   i drug withdrawal symptoms;
   j. current or recent pregnancy; and
   k. other health problems as designated by the responsible physician.

6. Reception personnel record, on the receiving screening form, an observation of the inmate's:
   a. appearance (e.g., sweating, tremors, anxious, disheveled);
   b. behavior (e.g., disorderly, appropriate, insensible);
   c. state of consciousness (e.g., alert, responsive, lethargic);
   d. ease of movement (e.g., body deformities, gait);
   e. breathing (e.g., persistent cough, hyperventilation); and
   f. skin (including lesions, jaundice, rashes, infestations, bruises, scars, tattoos, and needle marks or other indications of drug abuse).

7. When clinically indicated, there is an immediate referral to an appropriate health care service. The referral is noted on the receiving screening form.

8. The disposition of the inmate (e.g., immediate referral to an appropriate health care service, placed in general inmate population) is indicated on the receiving screening form.

9. Receiving screening forms are dated and timed immediately upon completion and include the signature and title of the person completing the receiving screening form.

10. Immediate health needs are identified and addressed, and potentially infectious inmates are isolated.

J-E-05 Mental Health Screening and Evaluation
essential

Standard

All inmates receive mental health screening; inmates with positive screens receive a mental health evaluation.

Compliance Indicators

1. There is a written policy and defined procedures addressing the postadmission mental health screening and evaluation process.

2. Within 14 days of admission to the correctional system, qualified mental health professionals or *mental health staff* conduct initial mental health screening.

3. The initial mental health screening includes a structured interview with inquiries into:

a. a history of:

1. psychiatric hospitalization and outpatient treatment,
2. suicidal behavior,
3. *violent behavior,*
4. *victimization,*
5. special education placement,
6. cerebral trauma or seizures, and
7. sex offenses;

b. the current status of:

1. psychotropic medications,
2. suicidal ideation,
3. drug or alcohol use, and
4. orientation to person, place, and time;

c. emotional response to incarceration; and
d. a screening for *intellectual functioning* (i.e., mental retardation, developmental disability, learning disability).

4. The patient's health record contains results of the initial screening.

5. Inmates with positive screening for mental health problems are referred to *qualified mental health professionals* for further evaluation.

6. The health record contains results of the evaluation with documentation of referral or initiation of treatment when indicated.

7. Patients who require acute mental health services beyond those available at the facility are transferred to an appropriate facility.

J-G-01 Special Needs Treatment Plans
essential

Standard

A proactive program exists that provides care for *special needs patients who* require close medical supervision or multidisciplinary care.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. Individual *treatment plans* are developed by a physician or other qualified clinician at the time the condition is identified, and updated when warranted.

3. The treatment plan includes, at a minimum:

   a. the frequency of follow-up for medical evaluation and adjustment of treatment modality;
   b. the type and frequency of diagnostic testing and therapeutic regimens; and
   c. when appropriate, instructions about diet, exercise, adaptation to the correctional environment, and medication.

4. Special needs are listed on the master problem list.

5. The facility maintains a list of special needs patients.

J-G-04 Mental Health Services
essential

Standard

Mental health services are available for all inmates who require them.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. Treatment services minimally include on or off-site crisis intervention including short-term individual and/or group therapy follow-up, as needed, and psychotropic medication management.

3. Mental health, medical, and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, health needs are met, and the impact of any of these conditions on each other is adequately addressed.

J-G-05 Suicide Prevention Program
essential

Standard

The facility has a program that identifies and responds to suicidal inmates.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. The suicide prevention program includes the following:

    a. *training,*
    b. *identification,*
    c. *referral,*
    d. *evaluation,*
    e. *housing,*
    f. *monitoring,*
    g. *communication,*
    h. *intervention,*
    i. *notification,*
    j. *reporting,*
    k. *review,* and
    l. *critical incident debriefing*.

3. When a facility employs other inmates in any way in the suicide prevention program (e.g., companions, suicide-prevention aides), the inmate's role is supplemental to and does not take the place of staff supervision.

Discussion

While juveniles may become suicidal at any point during their stay, high-risk periods include the time immediately upon admission to the facility; after adjudication, when the juvenile is returned to a facility from court; following the receipt of bad news regarding self or family (e.g., serious illness, the loss of a loved one); prolonged stays in juvenile detention facilities; and after suffering some type of humiliation or rejection (e.g., sexual assault). Juveniles entering and/or unable to cope with segregation or other specialized single-cell housing assignments are also at increased risk of suicide. In addition, juveniles who are in the early stages of recovery from severe depression may be at risk as well.

Key components of a suicide prevention program include the following:

1. *Training.* All staff who work with juveniles should be trained to recognize verbal and behavioral cues and to watch for signs of vulnerability that indicate potential suicide, and how to respond appropriately. The plan should include initial and subsequent training.

2. *Identification.* The receiving screening form should include observation and interview items related to each juvenile's potential suicide risk (see the sample screening forms in Appendix B).

3. *Monitoring.* The plan should specify the facility's procedures for monitoring a juvenile who has been identified as potentially suicidal. Regular, documented supervision should be maintained. Other supervision aids (e.g., closed circuit television, juvenile companions/watchers) can be utilized as a supplement to, but never as a substitute for, staff supervision. (See Appendix F for sample protocols on suicide precaution levels.)

4. *Referral.* The plan should specify the procedures for referring potentially suicidal juveniles and attempted suicides to mental health care providers or facilities. The plan also should specify a time frame for response to the referral.

5. *Evaluation.* This should be conducted by a qualified mental health professional, who designates the juvenile's level of suicide risk (see Appendix F). The purpose of the evaluation is to determine the juvenile's suicide risk, the need for hospitalization, or the need for transfer to an inpatient health facility. Patients should be reassessed periodically to identify any change in condition.

6. *Housing.* An actively suicidal juvenile always should be observed on a continuous, uninterrupted basis, or transferred to an appropriate facility. A potentially suicidal juvenile should not be housed or left alone unless constant supervision can be maintained. If a sufficiently large staff is not available so that constant supervision can be provided when needed, the juvenile should not be isolated. Rather, she/he should be housed with another resident and checked every 10 15 minutes. The room should be as suicide-resistant as possible (i.e., without protrusions of any kind that would enable the juvenile to hang him/herself). It is inappropriate to place a suicidal youth in a maximum security isolation unit.

7. *Communication*. Procedures for communication between health services staff and child care workers regarding the status of the juvenile should exist to provide clear and current information. These procedures also should include communication between transferring authorities (e.g., court personnel, medical/psychiatric facility) and child care workers.

8. *Intervention.* The plan should address how to handle a suicide in progress, including appropriate first-aid measures.

9. *Notification.* Procedures should be in place stating when facility administrators, outside authorities, and legal guardians should be notified of potential, attempted, and completed suicides.

10. *Reporting*. Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide. The facility administrators and the health authority should receive reports about attempted and completed suicides.

11. *Review.* The plan should specify a medical and administrative review process if a suicide or serious attempt does occur.
12. *Critical incident stress debriefing* (CISD). Responding to and/or observing a suicide in progress can be extremely stressful for staff and juveniles. The plan should specify the procedures for offering CISD to all affected personnel and juveniles.

Standards for Health Services in Prisons

P-A-08 Communication on Special Needs Patients
essential

Standard

Communication occurs between the facility administration and treating clinicians regarding inmates' significant health needs that must be considered in classification decisions in order to preserve the health and safety of that inmate, other inmates, or staff.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. Correctional staff are advised of inmates' special needs that may affect housing, work, and program assignments; disciplinary measures; and admissions to and transfers from institutions. Such communication is documented.

3 . Health and custody staff communicate about inmates who are:

   a. chronically ill;
   b. on dialysis;
   c. adolescents in adult facilities;

d. infected with *serious communicable diseases;*
e. physically disabled;
f. pregnant;
g. frail or elderly;
h. terminally ill;
i. mentally ill or suicidal; or
j. developmentally disabled.

P-C-04 Training for Correctional Officers
essential

Standard

A training program, established or approved by the responsible health authority in cooperation with the facility administrator, guides the health-related training of all correctional officers who work with inmates.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. Correctional officers who work with inmates receive health-related training at least every 2 years, which includes at a minimum:

   a. administration of first aid;
   b. recognizing the need for emergency care and intervention in life-threatening situations (e.g., heart attack);
   c. recognizing acute manifestations of certain chronic illnesses (e.g., asthma, seizures), intoxication and withdrawal, and adverse reactions to medications;
   d. recognizing signs and symptoms of mental illness;
   e. procedures for suicide prevention;
   f. procedures for appropriate referral of inmates with health complaints to health staff;
   g. precautions and procedures with respect to infectious and communicable diseases; and
   h. cardiopulmonary resuscitation.

3. The appropriateness of the health-related training is verified by an outline of the course content and the length of the course.

4. A certificate or other evidence of attendance is kept on site for each employee.

5. While it is expected that 100% of the correctional staff who work with inmates are trained in all of these areas, compliance with the standard requires that at least 75% of the staff present on each shift are current in their health-related training.

P-E-02 Receiving Screening
essential

Standard

Receiving screening is performed on all inmates immediately upon arrival at the intake facility.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. Qualified health care professionals perform the receiving screening. In facilities with fewer than 500 inmates, health-trained correctional personnel may perform this function.

3. The receiving screening takes place immediately for all inmates.

4. Persons who are unconscious, semiconscious, bleeding, mentally unstable, or otherwise urgently in need of medical attention are referred immediately for care. If inmates are referred to a community hospital and are returned, their admission to the facility is predicated upon written medical clearance.

5. Reception personnel, using a health-authority-approved form, inquire about:

    a. current and past illnesses, health conditions, or special health requirements (e.g., dietary needs);
    b. past serious infectious disease;

c. recent communicable illness symptoms (e.g., chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, night sweats);
d. past or current mental illness, including hospitalizations;
e. history of or current suicidal ideation;
f. dental problems;
g. allergies;
h. legal and illegal drug use (including the time of last use);
i drug withdrawal symptoms;
j. current or recent pregnancy; and
k. other health problems as designated by the responsible physician.

6. Reception personnel record, on the receiving screening form, an observation of the inmate's:

   a. appearance (e.g., sweating, tremors, anxious, disheveled);
   b. behavior (e.g., disorderly, appropriate, insensible);
   c. state of consciousness (e.g., alert, responsive, lethargic);
   d. ease of movement (e.g., body deformities, gait);
   e. breathing (e.g., persistent cough, hyperventilation); and
   f. skin (including lesions, jaundice, rashes, infestations, bruises, scars, tattoos, and needle marks or other indications of drug abuse).

7. When clinically indicated, there is an immediate referral to an appropriate health care service. The referral is noted on the receiving screening form.

8. The disposition of the inmate (e.g., immediate referral to an appropriate health care service, placed in general inmate population) is indicated on the receiving screening form.

9. Receiving screening forms are dated and timed immediately upon completion and include the signature and title of the person completing the receiving screening form.

10. Immediate health needs are identified and addressed, and potentially infectious inmates are isolated.

11. A screening test for tuberculosis is completed (see P-B-01 Infection Control Program).

P-E-05 Mental Health Screening and Evaluation
essential

Standard

All inmates receive mental health screening; inmates with positive screens receive a mental health evaluation.

Compliance Indicators

1. There is a written policy and defined procedures addressing the postadmission mental health screening and evaluation process.

2. Within 14 days of admission to the correctional system, qualified mental health professionals or *mental health staff* conduct initial mental health screening.

3. The initial mental health screening includes a structured interview with inquiries into:

    a. a history of:
        1. psychiatric hospitalization and outpatient treatment,
        2. suicidal behavior,
        3. *violent behavior,*
        4. *victimization,*
        5. special education placement,
        6. cerebral trauma or seizures, and
        7. sex offenses;

    b. the current status of:

        1. psychotropic medications,
        2. suicidal ideation,
        3. drug or alcohol use, and
        4. orientation to person, place, and time;

    c. emotional response to incarceration; and
    d. a screening for *intellectual functioning* (i.e., mental retardation, developmental disability, learning disability).

4. The patient's health record contains results of the initial screening.

5. Inmates with positive screening for mental health problems are referred to *qualified mental health professionals* for further evaluation.

6. The health record contains results of the evaluation with documentation of referral or initiation of treatment when indicated.

7. Patients who require acute mental health services beyond those available at the facility are transferred to an appropriate facility.

P-G-01 Special Needs Treatment Plans
essential

Standard

A proactive program exists that provides care for *special needs patients who* require close medical supervision or multidisciplinary care.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. Individual *treatment plans* are developed by a physician or other qualified clinician at the time the condition is identified, and updated when warranted.
3. The treatment plan includes, at a minimum:

    a. the frequency of follow-up for medical evaluation and adjustment of treatment modality;
    b. the type and frequency of diagnostic testing and therapeutic regimens; and
    c. when appropriate, instructions about diet, exercise, adaptation to the correctional environment, and medication.

4. Special needs are listed on the master problem list.

5. The facility maintains a list of special needs patients.

P-G-04 Mental Health Services
essential

Standard

Mental health services are available for all inmates who require them.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. Treatment services minimally include on or off-site crisis intervention including short-term individual and/or group therapy follow-up, as needed, and psychotropic medication management.

3. Mental health, medical, and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, health needs are met, and the impact of any of these conditions on each other is adequately addressed.

P-G-05 Suicide Prevention Program
essential

Standard

The facility has a program that identifies and responds to suicidal inmates.

Compliance Indicators

1. All aspects of the standard are addressed by written policy and defined procedures.

2. The suicide prevention program includes the following:
   a. training,
   b. identification,
   c. referral,
   d. evaluation,
   e. housing,
   f. monitoring,
   g. communication,
   h. intervention,
   i. notification,
   j. reporting,
   k. review, and
   l. critical incident debriefing.

3. When a facility employs other inmates in any way in the suicide prevention program (e.g., companions, suicide-prevention aides), the inmate's role is supplemental to and does not take the place of staff supervision.

(See J-G-05 for further discussion and key components)

Standards for Health Services in Juvenile Detention and Confinement Facilities

Y-08 Communication on Special Needs Patients *(essential)*

Written policy requires consultation between the facility administrator and the responsible physician or their designees prior to the following actions being taken regarding patients who are diagnosed as having significant medical or psychiatric illnesses: housing assignments; program assignments; disciplinary measures; and admissions to and transfers from facilities.

Y-21 Training for Child Care Workers (essential)

Written policy and defined procedures require, and actual practice evidences, a training program established or approved by the responsible health authority in cooperation with the facility administrator to ensure that all child care workers who have direct responsibility for juveniles are trained in the following:

- $ types of action required for potential emergency situations;
- $ signs and symptoms of an emergency;
- $ administration of first aid, with training to have occurred within the past three years;
- $ methods of obtaining emergency care;
- $ procedures for transferring patients to appropriate medical facilities or health care providers;
- $ signs and symptoms of mental illness, retardation, emotional disturbance, potential suicide, and chemical dependency; and
- $ signs and symptoms of suspected child abuse (including sexual abuse).

Further, all child care workers who have direct responsibility for juveniles are currently certified in cardiopulmonary resuscitation (CPR) and trained to recognize symptoms of the illnesses most common to juveniles.

Y-34 Receiving Screening and Medical Clearance ***(essential)***

Written policy and defined procedures require, and actual practice evidences, that *receiving screening* is performed by health-trained or qualified health care professionals on all juveniles immediately upon their arrival at the facility. Persons who are unconscious, semiconscious, bleeding, mentally unstable, or otherwise urgently in need of medical attention are referred immediately for care. If they are referred to a community hospital, their admission or return to the facility is predicated upon written medical clearance. The receiving screening findings are recorded on a printed form approved by the health authority. At a minimum, the screening process includes the following:

1. Inquiry into current and past illnesses, health problems, and conditions including:

   $ medical, mental, dental, and communicable diseases;
   $ medications taken and special health requirements;
   $ allergies;
   $ use of alcohol and other drugs, including types, methods, amounts, frequency, date or time of last use, and a history of problems that may have occurred after ceasing use (e.g., convulsions);
   $ other health problems, as designated by the responsible physician, such as a history of violence as determined by a *violence risk assessment; and*
   $ where appropriate, a history of gynecological problems and pregnancies.

2. Observation of the following:

   $ behavior, which includes state of consciousness, mental status (including suicidal ideation), appearance, conduct, tremors, and sweating;
   $ physical deformities and ease of movement; and
   $ condition of skin, including trauma markings, bruises, lesions, jaundice, rashes, infestations, needle marks, or other indications of drug use.

3. Notation of the disposition of the patient, such as:

   $ referral to an appropriate health care service on an emergency basis;
   $ placement in the general juvenile population and later referral to an appropriate health care service; or
   $ placement in the general juvenile population.

4. Documentation of the date and time the receiving screening is completed.

5. Signature and title of the person completing the screening.

Y-36 Mental Health Assessment *(essential)*

Written policies and defined procedures require, and actual practice evidences, post-admission assessment of all juveniles by *mental health staff within* 14 calendar days of admission. Results of the assessment become a part of the juvenile's health record. Juveniles thought to be suffering from serious mental illness or developmental disability are referred immediately for evaluation by a *qualified mental health professional.* Those who require acute mental health services beyond those available at the facility, or whose adaptation to the correctional environment is significantly impaired, are transferred to an appropriate program as soon as the need for such

treatment is determined by a qualified mental health professional. A written list of referral sources exists.

The post-admission mental health assessment includes:

1. A structured interview by *mental health staff* in which inquiries into the items list below are made:

   $ history of psychiatric hospitalization and outpatient treatment;
   $ family history;
   $ current psychotropic medications;
   $ suicidal ideation and history of suicidal behavior;
   $ drug usage;
   $ alcohol usage;
   $ history of sex offenses;
   $ history of *expressively violent* behavior;
   $ history of victimization or abuse;
   $ special education placement;
   $ history of cerebral trauma or seizures; and
   $ emotional response to incarceration.

2. Testing of intelligence to screen for mental retardation. It is recommended that juveniles identified as possibly retarded on group tests of intelligence or brief intelligence screening instruments be evaluated further by a comprehensive, individually administered instrument such as the Wechsler Intelligence Scale for Children (WISC).

Y-51 **Special Needs Treatment Plans** (essential)

Written policy and defined procedures guide the care of juveniles with *special needs* requiring close medical supervision and/or multidisciplinary care. Included among special needs patients are the following:

$ *the chronically ill,*
$ juveniles with *serious communicable diseases,*
$ *the physically disabled,*
$ *pregnant juveniles,*
$ *the terminally ill,*
$ juveniles with *serious mental health needs, and*
$ *the developmentally disabled.*

For each of these special needs patients, there is a written individualized *treatment plan,* developed by a physician or other qualified health practitioner where permitted

by law. The plan includes instructions about diet, exercise, adaptation to the correctional environment, medication, the type and frequency of diagnostic testing, and the frequency of follow-up for medical evaluation and adjustment of treatment modality. The plan also includes directions to healthcare and other personnel regarding their roles in the care and supervision of these patients.

Y-53 **Suicide Prevention** (essential)

Written policy and defined procedures require, and actual practice demonstrates, that the facility has a program for identifying and responding to suicidal juveniles. The program components include training, identification, monitoring, referral, evaluation, housing, communication, intervention, notification, reporting, review, and *critical incident stress debriefing.*

(See J-G-05 for further discussion and key components)

Commission on Accreditation for Law Enforcement Agencies

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The Commission on Accreditation for Law Enforcement (CALEA), was established as an independent accrediting authority in 1979 by the four major law enforcement membership associations: International Association of Chiefs of Police (IACP); National Organization of Black Law Enforcement Executives (NOBLE); National Sheriff=s Association (NSA); and Police Executive Research Forum (PERF). The Executive Directors of these four associations appoint members to the Commission annually; an endorsement requires a majority vote for each appointment. CALEA maintains a small, professional staff managed by an Executive Director. The staff conducts all administrative and operational duties as directed by the Commission. Commission staff is available to assist applicants and accredited agencies through a toll-free telephone number. CALEA produces a newsletter and offers workshops to explain the accreditation process and standards during the Commission Conference held three times annually.

CALEA=s most recent standards manual, Standards for Law Enforcement Agencies (1999), contains Chapter 72, AHolding Facility,@ which is most relevant to suicide prevention. Five standards pertaining to suicide prevention are presented here below.

72.5 Detainee Processing

72.5.5* A *written directive prescribes methods for handling, detaining, and segregating persons under the influence of alcohol or other drugs or who are violent or self-destructive.*

Commentary: The holding facility is not normally equipped to provide treatment to persons under the influence of drugs or alcohol. Such persons should be detained in other facilities, when available. When these facilities are not available, special consideration should be given to ensuring that the potential for detainees to injure themselves or others is minimized. Such detainees should remain under close observation by facility staff.

72.6 Medical and Health Care Services

72.6.1* A *written directive, approved by a licensed physician, identifies the policies and procedures to be followed when a detainee is in need of medical assistance.*

Commentary: Arrangements for detainee emergency health care should be made with a local medical facility. If possible, a licensed health care professional should be identified as the emergency health care contact person. At least one on-duty person should be certified in first aid. The intent of this standard is to ensure that staff recognize, take immediate action on, and report all detainee medical emergencies.

72.6.3 A *written directive requires that detainee Areceiving screening" information be obtained and recorded when detainees are admitted to the facility and before transfer to another facility. Receiving screening must include an inquiry into:*

a. current health of the detainee;
b. medications taken by detainee;
c. behavior, including state of consciousness and mental status; and
d. body deformities, trauma markings, bruises, lesions, jaundice, ease of movement, etc.

Commentary: The purpose of the screening is to determine whether medical attention is required. Female detainee screening should take into account the special needs of women.
Receiving screening may be performed by allied health personnel or by trained correctional officers at the time of booking. The information obtained may be recorded on a separate form designed for this purpose or recorded with other information obtained during the booking process (see 72.5.3). In addition, a record should be kept of all treatment and medication administered to a detainee, including circumstances or events necessitating such treatment.

72.6.4* *Procedures for gaining access to medical services are posted in areas used by detainees, in the language(s) prevalent to the area.*

Commentary: It is important that detainees know that emergency health care services are available to them. The procedures for requesting emergency health care should be posted in conspicuous places in English and in any other languages that may be prevalent in the area. Access procedures should be explained orally to detainees unable to read. Signs should be permanently mounted and legible.
Compliance may be OBSERVED.

72.8 Supervision of Detainees

72.8.1 A *written directive requires 24-hour supervision of detainees by agency staff, including a count of the detainee population at least once every eight hours, and establishes procedures to ensure that the detainee is visually observed by agency staff at least every thirty minutes.*

Commentary: Twenty-four hour supervision is essential for maintaining security and ensuring the safety and welfare of detainees. Supervision, as used in this standard, assumes agency staff are present in the same building that houses the holding facility and not at a remote location. One intent of this standard is to prohibit delegating supervision to a trustee. In addition to a count of the detainee population at least once every eight hours, other counts may be necessary prior to and following certain activities, such as night lockup, recreation, and meals.
Care should be taken during physical checks that the detainee does not anticipate the appearance of agency staff. Detainees who are security risks should be under closer surveillance and require more frequent observation. This classification includes not only detainees who are violent but also those who are suicidal or mentally ill or demonstrate unusual or bizarre behavior.

Commission Interpretation (March 22, 1996) term "Visually Observed": Agencies are encouraged, but not required, to introduce direct physical checks whenever possible, but detainees may be observed through audio/visual means.

American Jail Association

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The American Jail Association (AJA) was formed in 1981 as a result of a merger between the National Jail Association and the National Jail Managers' Association. AJA is a national, nonprofit organization that exists to support those who work in and operate our nation's jails and is the only national association that focuses exclusively on issues specific to the operations of local correctional facilities.

AJA endorses the NCCHC standards for health services in jails and publishes no jail health standards of its own. However, the AJA does publish a pamphlet series known as AJail Managers Bulletins@ and AJail Operations Bulletins@ which include several titles directly relevant to suicide prevention. The following may be obtained directly from the AJA or abstracts may be found on the AJA website:

Jail Managers Bulletins

Vol. 2	No. 11	Jail Standards
Vol. 3	No. 4	Special Problems in Inmate Management

Jail Operations Bulletins

Vol. 1	No. 8	Inmates with Special Needs
Vol. 2	Nol. 5	Administrative Segregation
Vol. 2	No. 12	Preventing Suicides in Jails and Police Lockups
Vol. 3	No. 1	Dealing with Inmates at Risk for Suicide
Vol. 6	No. 2	Inmates with Special Needs
Vol. 6	No. 10	Inmates, Jails, and Mental Illness

International Association of Chiefs of Police

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The International Association of Chiefs of Police (IACP) is the world's oldest and largest nonprofit membership organization of police executives, with over 19,000 members in over 100 different countries. IACP's leadership consists of the operating chief executives of international, federal, state and local agencies of all sizes. Founded in 1893, the association's goals are to advance the science and art of police services; to develop and disseminate improved administrative, technical and operational practices and promote their use in police work; to foster police cooperation and the exchange of information and experience among police administrators throughout the world; to bring about recruitment and training in the police profession of qualified persons; and to encourage adherence of all police officers to high professional standards of performance and conduct.

The IACP does not formally promulgate standards pertaining to the care of prisoners and suicide prevention. It does, however, publish ATraining Keys@ and Model Polices=@ each of which is accompanied by a AConcepts and Issues Paper.@ Both the ATraining Keys@ series and the AModel Policies@ series contain selections which are pertinent to suicide prevention in a lockup setting.

Model Policies

Dealing with the Mentally Ill	(4/97)
Juvenile Enforcement and Custody	(10/92)
Lockups and Holding Facilities	(4/95)

Training Keys

Vol. 3	No. 59	Severe Mental Illness
Vol. 3	No. 68	Suicide Prevention
Vol. 8	No. 180	Handling the Alcoholic
Vol. 9	No. 195	Suicide Investigation, Part I
Vol. 9	No. 196	Suicide Investigation, Part II
Vol. 11	No. 249	Taking Prisoners into Custody
Vol. 12	No. 273	Suicide Intervention
Vol. 12	No. 274	Abnormal Behavior
Vol. 14	No. 327	Detention of the Mentally Disabled
Vol. 15	No. 338	The Mentally Retarded Offender

Vol. 16	No. 377	Identifying the Suicide Risk in Police Lockups
Vol. 16	No. 378	Managing the Suicide Risk in Police Lockups
Vol. 20	No. 429	Custody Death Syndrome
Vol. 25	No. 487	Dealing with the Mentally Ill
Vol. 29	No. 535	Officer Assisted Suicide, Part 1
Vol. 29	No. 536	Officer Assisted Suicide, Part 2

National Sheriff=s Association

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(703) 836-782
www.sheriffs.org

The National Sheriff=s Association (NSA), now in its sixty-second year of serving the law enforcement/criminal justice professionals of the nation, is a nonprofit organization dedicated to raising the level of professionalism among those in the criminal justice field. Through the years, NSA has been involved in numerous programs to enable sheriffs, their deputies, chiefs of police, and others in the field of criminal justice to perform their jobs in the best possible manner and to better serve the people of their cities/counties or jurisdictions.

The NSA generally supports jail health care standards promulgated by the ACA, NCCHC and also refers inquiries to CALEA. The NSA=s major contribution in this area seems to be a publication entitled Jail Officers=s Training Manual (1980), which includes Chapter 25, Suicide Prevention. Other training manuals of varying titles are available through the organization.

American Public Health Association
800 I Street, NW
Washington, DC 20001
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www.apha.org

The American Public Health Association (APHA) has been influencing policies and setting priorities in public health for over 125 years. Throughout its history, it has been in the forefront of numerous efforts to prevent disease and promote health. The APHA is the oldest and largest organization of public health professionals in the world, representing more than 50,000 members from over 50 public health occupations.

The APHA has been involved in correctional healthcare issues since the early 1970's. In 1976, APHA published the first edition of Standards for Health Services in Correctional Institutions. A second edition was published in 1986. The following standards are taken from the 2003 edition.

V. B. E. Suicide Prevention

Principle: Jails and prisons must have a suicide prevention program that has written protocols and procedures and includes a staff training component. Jail programs must have specific procedures for early assessments.

Public Health Rationale: Suicide is a leading cause of death among persons confined to correctional facilities even though it is largely preventable through a well functioning mental health program. Prisoners are especially at risk for suicide when first admitted to a jail. For example, 50% of jail suicides occur in the first 24 hours and 27% occur during the first 3 hours after admission. Health and custody staff must be trained to recognize warning signs of suicidal intent and devise appropriate plans to safeguard life. Whereas correctional authorities have responsibility for safe custody, health staff possess the training and expertise to recognize signs of depression and aberrant behavior such as suicidal intent.

Satisfactory compliance: Elements of an effective suicide prevention program must include the following:

r. Jail and prison health staff with appropriate training must screen prisoners for suicidal intent or ideation as part of the admission medical evaluation;

2. Jail and prison health staff must also screen prisoners for suicidal intent upon transfer to another facility;

3. When an at risk prisoner is identified by medical staff, the prisoner must be referred to onsite mental health staff (or offsite staff, if mental health staff is not available within the institution) for immediate psychiatric evaluation. Upon mental health evaluation, any prisoner considered to be an imminent suicide risk must be hospitalized on an emergency basis. All other at risk prisoners must be placed in a mental observation area or treatment unit with a suicide watch (the details of which are dictated by the mental health provider) pending further evaluation by a psychiatrist (within 24 hours);

4. Isolation may increase the chance that a prisoner will commit suicide and must not be used as a substitute for continuity of contact with staff and appropriate supervision. (The practice of placing suicidal prisoners in "safety cells" instead of talking to them and maintaining continuing observation is inappropriate.); and

5. Custody staff must be trained to recognize signs and symptoms of suicidality and there must be written protocols requiring that prisoners be taken immediately to mental health or health care staff (when there is no mental health staff in the facility) whenever (at time of admission or during the course of incarceration) such behaviors is observed.

Legal References

Freedman v City of Allentown, 853 F2d 1111, 1115 (3rd Cir 1988).
Estate of Cills vs Kaftan, 105 F Supp 2d 391 (D NJ 2000).
Feliciano v Gonzalez, 13 F Supp 2d 151 (DPR 1998).
Viero v Bufano, 925 F Supp 1374 (ND Ill 1996).
Coleman v Wilson, 912, F Supp 1282 (ED Ca 1995).

American Psychiatric Association

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www.psych.org

The American Psychiatric Association (APA) is a medical specialty society recognized world wide. Its 37,000 U.S. and international member physicians work together to ensure humane care and effective treatment for all persons with a mental disorder, including mental retardation and substance related disorders. It is the voice and conscience of modern psychiatry. Its vision is a society that has available, accessible quality psychiatric diagnosis and treatment

In September of 1987, the APA first published guidelines designed to inform the provision of psychiatric services in jails and prisons. More recently, an APA task force revised these guidelines and published in 2000 a book entitled Psychiatric Services in Jails and Prisons (2nd edition). The APA believes inmates with mental disorders are likely to stay incarcerated four or five times longer than similarly charged people without disorders, and thus require more focused mental health attention. Suicide prevention is addressed separately in Part I of the book.

Suicide Prevention

An adequate suicide prevention program must include the following components:

- $ Training of all staff who interact directly with inmates in how to recognize danger signs and what to do when they believe that an inmate may be suicidal;
- $ Identification, through admission screening and referral of inmates at heightened risk of suicide;
- $ Policies to ensure adequate monitoring of suicidal inmates to prevent the loss of life;
- $ Effective and well-understood referral system that allows staff and inmates to bring a suicidal inmate to the prompt attention of mental health staff;
- $ Timely evaluation by mental health clinicians to determine the level of risk posed by an inmate who has been referred by screening or correctional staff;
- $ Housing options that allow for adequate monitoring of suicidal inmates by staff;
- $ Communication between mental health, correctional, medical, and other staff of the specific needs and risks presented by a suicidal inmate;
- $ Timely provision of mental health services, including medication, verbal therapies, and crisis intervention for chronically or acutely suicidal inmates;
- $ Accurate and behaviorally specific reports documenting behaviors or statements that indicate suicide risk;
- $ Review of incidents of suicide attempts or completed suicides to improve institutional practices and to prevent unnecessary future occurrences; and

- Critical incident debriefing in the event of a completed suicide to assist staff and inmates in dealing with predictable feeling of guilt, fear, grief, and anger.

American Association for Correctional Psychology

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American Association for Correctional Psychology (AACP) members typically hold advanced degrees in behavioral sciences and engage in administration, practice, teaching or research relating to incarcerated populations and those under community supervision. As the need for mental health services in correctional settings became more clear in the mid 1970s, the idea of providing correctional psychologists with practice standards emerged at AACP business meetings during the late l970s. Pursuant to the AACP's goal of improving the quality of mental health care for criminal offenders, the AACP formulated standards for the delivery of mental health services in correctional facilities. Consequently, the standards were first published in the March l980 issue of Criminal Justice and Behavior.

The l980 Standards remained the only comprehensive set of practice guidelines for correctional psychologists as well as correctional organizations within which psychological services were provided. However, the original task force recognized that these standards would need periodic updating. This recognition was realized in the second edition of these standards entitled A Standard for Psychological Services in Jails, Prisons, Correctional Facilities and Agencies, which was published in the journal Criminal Justice and Behavior in August of 2000.

Mental Health Services/ Programs

Standard Operating Policies/Procedures

24. Current written standard operating policies and procedures approved by the chief or supervisor psychologist are maintained and are implemented for all activities carried out by all psychological services personnel.

25. At least one staff member per shift within sight or sound of all inmates has training sufficient to recognize symptoms of mental disturbance most common to the facility and knows how to rapidly contact psychological services staff.

Access to Psychological Services/Programs

Reception

26. At the time of admission to the facility, inmates receive a written communication explaining the procedures for gaining access to psychological and mental health services, possible limits of confidentiality, and information regarding informed consent to treatment.

27. There is a written and implemented policy approved by the chief psychologist regarding offender access to psychological services for (a) post admission inmates with emergency problems and (b) daily referrals of non-emergency problems covering both scheduled and unscheduled psychological care.

Screening/Evaluation

Reception Screening/Evaluation

29. Reception screening is performed on all inmates upon admission to a facility before being placed in the general population or housing area. The findings are recorded on a printed screening form. This form is placed in the inmates psychological services file. Inmates identified by the intake screening as having mental health problems are referred for a more comprehensive psychological evaluation. The screening will include inquiry into (a) past and present mental health difficulties including suicidal ideation, suicide attempts, psychiatric hospitalizations, and psychotropic medications and (b) current mental status including behavioral observations, stressors, measures of daily functioning (e.g., appetite, sleeping, and activity level), and psychotropic medications.

31. The individual assessment of all inmates referred for a special comprehensive psychological evaluation is completed within fourteen days after the date of the referral unless otherwise required.

    As applied in a jail or to offenders diagnosed with a major mental illness and/or placed in a mental health treatment program, this standard includes:

    A. reviewing earlier screening information;
    B. contacting prior psychotherapists or the individual/family physician regarding any history of mental symptomatology;
    C. conducting an extensive diagnostic interview;
    D. writing and filing a brief report;
    F. if evidence of mental disturbance is found, placing the individual in a separate area where closer supervision is possible; and either
    G. referring the individual to an appropriate mental health resource or to his or her family physician (if indicated and when release is imminent); or
    H. beginning appropriate care in the jail by staff members of the psychological and/or psychiatric services.

This standard as applied in a prison setting includes:

A. reviewing earlier screening information and psychological evaluations data;
B. collecting and reviewing any additional data to complete the individual mental health history;
C. collecting behavioral data from observations by correctional staff;
D. administering tests that assess levels of cognitive and emotional functioning and the adequacy of psychological coping mechanisms;
E. writing a report describing the results of the assessment procedures, including an outline of a recommended plan and treatment that mentions any indication by the inmate for a desire for help; and
F. communicating results to the referral source; and
G. writing and filing a report of findings and recommendations.

Inmate Treatment and Management

33. Diagnostic and treatment mental health services are provided to inmates of the facility as part of the facility=s total program.

34. If mental disturbance is identified in pretrial and/or presentenced detainees, the court and/or the inmate=s attorney are notified according to a written policy or procedure approved by the facility=s and/or organization=s chief executive. Such notification will be documented and placed in the inmate=s psychological services file.

35. Inmates held for emergency evaluation and/or treatment are housed in a specially designated area with close staff or trained volunteer supervision and sufficient security to protect these individuals.

Treatment Plans

39. Inmates requiring acute, chronic and/or convalescent mental health care receive these services either at the facility or a more appropriate mental health care facility to which they are referred.

40. Prison systems will have their own resources for managing and providing mental health care and services for severely psychologically disturbed inmates, either in specifically designated on-site special management units or a separate facility. If

a transfer to a separate mental health facility is necessary, such transfer will be carried out expeditiously.

41. Correctional facilities must ensure that security staff who are assigned to special management units are screened and trained to interact with mentally ill offenders.

43. There are written and implemented policies and procedures that require the responsible psychologist be consulted prior to taking the following actions with respect to emotional disturbed inmates: housing assignment changes (including cell status), program assignment changes, disciplinary sanctions, and transfer in and out of the facility.

44. Inmates in segregation must be accorded crisis, psychological/psychiatric assessment, diagnosis, and treatment opportunities, irrespective of their segregation status.

In-Service Training

52. Written standard operating procedures are implemented that provide for and require psychological services staff to participate in training facility and community staff (e.g., probation and parole agents) with respect to the following: (a) types of potential psychological emergency situations, signs, and (b) symptoms of various mental disturbances and procedures for making referrals to psychological services and program area (e.g., drug treatment and counseling).

National Mental Health Association

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The National Mental Health Association (NMHA) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With more than 340 affiliates nationwide, NMHA works to improve the mental health of all Americans, especially the 54 million individuals with mental disorders, through advocacy, education, research and services. NMHA was established in 1909 by former psychiatric patient Clifford W. Beers. During his stays in public and private institutions, Beers witnessed and was subjected to horrible abuse. From these experiences, Beers set into motion a reform movement that took shape as the National Mental Health Association.

NMHA's work has resulted in positive change. Millions of people have been educated about mental illnesses and reduced barriers to treatment and services. As a result of these efforts, many Americans with mental disorders have sought care and now enjoy fulfilling, productive lives in their communities.

Treatment During Confinement (based on a statement approved by the NMHA Board of Directors, June 6, 1998)

When children with mental and emotional disorders must be confined in correctional settings, certain principles pertinent to suicide prevention should be observed:

- All youths should be screened upon admission by trained personnel for mental health and substance abuse problems. When the screening detects possible mental health problems, children should be referred for further evaluation, assessment and treatment by mental health professionals. Children and their families who are already receiving treatment before they enter should be assisted in continuing treatment. All juveniles who are not released within one week should have behavioral, mental health and/or substance abuse evaluations done by qualified mental health staff with expertise in children and adolescents.
- Juveniles who suffer from acute mental disorders or who are actively suicidal should be placed in or transferred to an appropriate medical or mental health facility and returned to confinement only with medical clearance. Correctional facilities should have written arrangements with local medical or mental health facilities for providing emergency medical and mental health care.

- Facilities should take extra precautions to assure against suicide by emotionally disturbed children who are confined. Facilities should have a

suicide prevention plan that includes appropriate admission screening, staff training and certification, assessment by qualified mental health professionals, adequate monitoring, referral to appropriate mental health providers or facilities, and procedures for notification of the child=s parents or guardian. Suicidal youth should never be isolated.

National Juvenile Detention Association

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www.njda.com

The National Juvenile Detention Association (NJDA) is based at Eastern Kentucky University and at Michigan State University. NJDA exists exclusively to advance the science, processes, and art of juvenile detention services through the overall improvement of the juvenile justice profession. While NJDA is primarily focused on juvenile detention issues, the Association is committed to several facets of juvenile justice through grants and contracts from state and federal agencies. NJDA has strong collaborative relations with juvenile justice agencies.

Although the NJDA has no formally promulgated national consensus standards, it has issued position statements pertaining to the use of detention facilities to lodge mentally disturbed youth and pertaining to minimum direct care staff ratios. The NJDA also publishes the ADetention Careworker Curriculum@ which is in its third edition. This training program contains an 8 hour suicide prevention instructional module designed for juvenile facility professionals. Other modules of interest deal with health care and admissions screening and managing mentally ill youth.

Council of Juvenile Correctional Administrators

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The Council of Juvenile Correctional Administrators (CJCA) is a national non-profit organization dedicated to the improvement of youth correctional services and practices. Incorporated in July 1994, CJCA has served to unite the nation=s youth correctional chief executive offices to promote and aid advancements within juvenile justice. CJCA initiates and facilitates the exchange of ideas and philosophies among administrators from all jurisdictions at three annual meetings as well as through regular communications such as the quarterly newsletter and its website. CJCA serves as the clearinghouse of information for members seeking referrals for practices and services, the lawmakers needing juvenile justice perspective or position, and public inquiries for youth correction information.

The CJCA is working to improve conditions of confinement in youth correction and detention facilities by developing and implementing performance-based standards (PbS). The project is funded by the Office of Juvenile Justice and Delinquency Prevention in the Office of Justice Programs, United States Department of Justice. The performance-based standards promulgated by CJCA are distributed over seven broad goals: security, order, safety, health and mental health, programming, justice and reintegration. Two goals are particularly pertinent to suicide prevention.

Safety Goal

Safety Standard

1. Protect staff and youths from intentional and accidental injuries.

   Expected Practices

   $ Youth are classified and assigned to housing based on a classification system.

- $ Facility administrators and medical authorities use summary data to make the facility safer for youths.
- $ Within one hour of presentation for admission, all youths are screened for risk of suicide.
- $ Qualified mental health professionals train staff in the suicide prevention plan.
- $ Youth filing requests for medical attention are seen promptly by health care personnel or qualified counselor or mental health provider.
- $ All youth care staff are trained in each area of the training curricula

Health and Mental Health Goal

Health and Mental Health Standard

1. Identify youths at time of admission who have acute health problems or crisis mental health situations and following evaluation, ensure delivery of appropriate health or mental health services.

   Expected Practices

   - $ All youth presented for admission receive a complete health, mental health and suicide intake screening.
   - $ All staff assigned to do mental health intake screenings are trained by qualified mental health professionals.
   - $ All staff assigned to do suicide prevention screenings are trained by qualified mental health professionals.
   - $ Health, mental health and suicide intake screenings are completed for all youth within one hour of their presentation for admission to the facility.
   - $ Youths whose health, mental health and suicide intake screenings are not done within 1 hour after admission are under constant supervision until the screenings take place.
   - $ All youths receive complete health, mental health, and suicide intake screenings before they are assigned to housing units.
   - $ Youth whose health, mental health, and suicide intake screenings indicate non-acute illnesses, injuries, or other problems receive appropriate treatment, placement or supervision.
   - $ Youths whose health, mental health, and suicide intake screenings indicate intoxication, mental illness, suicidal behavior, or acute injury are referred to proper medical, mental health, or substance abuse facilities.

- $ Youth referred to a medical, mental health or detoxification facility and who are later admitted to the confinement facility receive a medical clearance before admission to the facility.

2. Provide health appraisals for all youths not released quickly, as well as behavior, mental health and substance abuse evaluations where indicated.

   Expected Practices

   - $ All youths are given a mental health assessment, within seven days, or sooner as required by law.
   - $ Trained and qualified staff apply the mental health assessment and interpret findings.
   - $ Youths whose health or mental health intake screening or behavior during the course of confinement reveals a need for a substance abuse assessment are referred for and receive testing.
   - $ Trained and qualified staff apply the substance abuse assessment and interpret findings.
   - $ An individual treatment plan is created for each youth.
   - $ Health, mental health and substance abuse treatment staff sign off on the written individual treatment plans.
   - $ Written individual treatment plans are based on the results of the health, mental health, substance abuse assessments.
   - $ Copies of the individual treatment plans are distributed to the staff responsible for implementing them.
   - $ Written agreements exist guaranteeing the provision of medical, mental health and detoxification services by outside providers.

Summary and Conclusions

While these standards reflect diverse professional affiliations, some correctional, some medical, several clear themes emerge. Common issues addressed include training requirements, supervision of inmates, screening procedures, procedures for mental health referral, intervention and treatment, and the existence of written suicide prevention and intervention programs. Communication between correctional and health staff, procedures for review and critical incident debriefing are also given emphasis. The similarity between the recommendations made by these organizations, and the National Strategy for Suicide Prevention=s Objective 8.6 for adult and juvenile incarcerated populations Ato define national guidelines for mental health screening, assessment and treatment of suicidal individuals@is quite striking and represents an important first step towards fulfillment of the National Strategy=s objective to A implement the guidelines in correctional institutions, jails and detention centers.@

We are hopeful that this compendium can prove to be a useful resource in facilitating a dialog in pursuance of these important objectives.

Annotated Bibliography

Provided courtesy of
The Centre for Suicide Prevention,
Calgary, Alberta, Canada

SIEC No: 1990-1659

Title:
Psychosocial Vulnerability, Life Stress, and Suicide Ideation in a Jail Population: a Cross-validation Study
Authors:
Bonner R L, Rich A R
Abstract:
Administered measures of psychosocial vulnerability to 146 male inmates at a county jail. 51% of the variation in suicide ideation was accounted for by the linear combination of low reasons for living, irrational beliefs, jail stress and loneliness. Interactions between select psychosocial vulnerability factors and situational stress best explained suicide intent. A stress-psychosocial vulnerability model may be useful in explaining why so many jail inmates are at risk for suicide. (37 refs.)
Source: Suicide and Life-Threatening Behavior, v.20, no.3, (Fall 1990), p.213-224

SIEC No: 1990-1267

Title:
Jail Suicide and Legal Redress
Authors:
Olivero J M, Roberts J B
Abstract:
Suicide is the leading cause of death in jails. Especially at risk are pretrial detainees. This paper provides clinicians who serve as consultants to jails with an overview of legal precedent concerning liability for jail suicide on the federal appellate and district and state levels. Liability on the federal level is based upon actions involving deliberate indifference or gross negligence. A table provides appellate-level decisions. The paper concludes with several liability-generating scenarios.
Source: Suicide and Life-Threatening Behavior, v.20, n.2, (Summer 1990), p.138-147

SIEC No: 1990-057

Title:
Suicide? Accident? Predictable? Avoidable? The Psychological Autopsy in Jail Suicides
Authors:
Spellman A, Heyne B

Abstract:

The authors of this article state that staff in jails often interpret psychological autopsies after an inmate suicide as an investigation into their job performance. They suggest that the staff should instead view autopsies as a form of "peer review," conducted in a nonthreatening way to provide staff with closure and more effective safeguards. They discuss the evolution of the psychological autopsy, its application to inmate suicides, and provide a model for jails. (VM)

Source: Psychiatric Quarterly, v.60, no.2, (Summer 1989), p.173-183

SIEC No: 1990-0576

Title:

Reducing the Opportunity for Inmate Suicide: A Design Guide

Authors:

Atlas R

Abstract:

Poor correctional design and layout have contributed to many jail suicides, and the ability to supervise inmates adequately is greatly affected by institutional design and the circulation patterns of staff and inmates. Due to difficulties in officer supervision, the promotion of isolation, and safety concerns, the linear style of many older jails may make it more difficult to reduce environmental factors that encourage suicidal actions. Recommendations for the design of jail environments are presented.

Source: Psychiatric Quarterly, v.60, no.2, (Summer 1989), p.161-171

SIEC No: 1990-0308

Title:

Juvenile Suicides in Secure Detention Facilities: Correction of Published Rates

Authors:

Memory J M

Abstract:

Reanalyze suicide rates for 1978 among incarcerated juveniles as reported by the Community Research Center. Previously reported rates were found to be considerably lower than than recalculated estimates. Statistical data are included and implications are discussed. 6 refs.

Source: Death Studies, v.13, no.5, (1989), p.455-463

SIEC No: 1990-0203

Title:

Race and Suicide in Jails and Prisons

Authors:

Haycock J

Abstract:

Discusses the findings of Toch and Johnson that black prisoners are less likely and white and Hispanic prisoners more likely to hurt or kill themselves. Overrepresentation of whites and Hispanics and underrepresentation of blacks does not warrant the authors conclusions. Interpretation that black free-world life prepares blacks better for prison, whereas white and Hispanics experiences render them more crisis-prone, ignores institutional and interpersonal factors that may affect inmate behavior. (32 ref)

Source: Journal of the National Medical Association, v.81, no.4, (April 1989), p.405-411

SIEC No: 1991-0532

Title:

Predicting Custodial Suicides: Problems With the Use of Profiles

Authors:

Kennedy D B, Homant R J

Abstract:

In this study, jail and lockup suicide data from Michigan for 1980-1985 were examined to discover if published profiles of jail suicide are reliable. The authors found only 7 of 80 suicides fit a national profile completely, while 9 suicides would have been totally unexpected. The authors conclude that, because of differences between jail environments and inmate populations, it is unlikely that any profile would be accurate for all jails. (VM)

Source: Justice Quarterly, v.5, no.3, (September 1988), p.441-456

SIEC No: 1987-2040

Title:

Jail Suicides by Hanging: An Epidemiological Review and Recommendations for Prevention

Authors:

Jordan F B, Strope M

Abstract:

Source: American Journal of Forensic Medicine and Pathology, v.8, no.1, (March 1987), p.27-31

SIEC No: 2001-0812

Title:

Suicidality and the State-Trait Debate on Problem Solving Deficits: a Re-Examination With Incarcerated Young Offenders

Authors:

Biggam F H, Power K G

Abstract:

This research examines the relationships between means-end problem-solving and suicidality in a group of incarcerated Scottish young offenders (n=61). The paper examines the issue concerning whether trait or state problem-solving deficits are more inextricably linked to suicidality. Results suggest a more complex interaction between problem-solving deficits, affective state, and suicidality than previously suggested. This study suggests that although problem-solving is not a trait phenomenon, it may be a state corollary of suicidality. It also provides evidence to suggest psychological distress is both a trait and state indicator of parasuicidal behaviour, in particular concerning depression, which was more pronounced among inmates with a parasuicidal history than found in the comparison group. (40 refs.)

Source: Archives of Suicide Research, v.5, no.1, (1999), p.27-42

SIEC No: 2003-0159

Title:

Causes of Death Among People in Custody in Ontario, 1990-1999

Authors:

Wobeser W L, Datema J, et al

Abstract:

The authors examined causes of death (violent and natural) among people in custody in Ontario. They also compared the causes of death in 3 custodial systems (federal penitentiaries, provincial prisons, and police cells). Of the 238 deaths involving men, over half resulted from violent causes. Suicide by strangulation accounted for 90 deaths. Compared with the Canadian male population, male inmates were found to have a higher overall rate of death and a much higher rate of death from violent causes. (31 refs)

Source: Canadian Medical Association Journal, v.167, no.10, (12 November 2002), p.1109-1113

SIEC No: 2002-0772

Title:

Class Action Litigation in Correctional Psychiatry

Authors:

Metzner J L

Abstract:

Class action litigation has been instrumental in jail and prison reform during the past twenty years. Forensic psychiatrists have been crucial in the litigation process and the subsequent evolution of correctional mental health care systems. This article summarizes information regarding basic demographics of correctional populations and costs of correctional health care and provides a brief history of such litigation. The role of

psychiatric experts, with particular reference to standards of care, is described. Specifically discussed are issues relevant to suicide prevention, the prevalence of mentally ill inmates in supermax prisons, and discharge planning. (77 refs.)

Source: Journal of the American Academy of Psychiatry and the Law, v.30, no.1, (2002), p.19-29

SIEC No: 2002-0552

Title:

The use of "Safe Cells" in the Management of Suicidal and Violent Prisoners

Authors:

Corcos C D, Lewin R D

Abstract:

Surveyed psychiatrists' practice in the use of prison safe cells. The experiences, views and working protocols of Australia and New Zealand forensic psychiatrists in relation to authorization of placement of prison inmates in safe cells were sought via a postal questionnaire. Despite a low response rate, most psychiatrists with clinical involvement in the area replied. There was a wide diversity of clinical practice, ethical standpoint, knowledge of and reference to practices in other parts of the world, and sense of priorities. There appears to be considerable ambivalence and some discomfort in the role that psychiatrists in Australia and New Zealand are asked to play in the placement of prisoners in safe cells. (5 refs)

Source: Australasian Psychiatry, v.9, no.1, (March 2001), p.47-50

SIEC No: 2001-0672

Title:

Bullying and Suicidal Behavior in Jails

Authors:

Blaauw E, Winkel F W, Kerkhof A J F M

Abstract:

Relationships between bullying features and suicidal behavior of inmates were examined. The files of 95 suicide victims in jails and prisons in the Netherlands were examined for reports of bullying. In addition, 221 nonsuicidal inmates and 53 suicidal jail inmates were interviewed. The files of 34% of the suicide victims noted the victim had felt bullied. Bullying, especially serious bullying, was relatively often reported by suicidal inmates and by vulnerable inmates. Different types of bullies were associated with different forms of bullying and different degrees of suicide risk. Results suggest that bullying and suicide risk are related and that a distinction should be made between mild and serious features of bullying. (48 refs.)

Source: Criminal Justice and Behavior, v.28, no.3, (June 2001), p.279-299

SIEC No: 2001-0830

Title:
Correctional Suicide Prevention in the Year 2000 and Beyond
Authors:
Bonner R L
Abstract:
Although the problem of suicide in jail and prison historically has been ignored, significant insight has been gained over the past several decades due primarily to increasing litigation. This article provides a brief overview of the progress in research, programming, and policy. The new millenium offers exciting opportunities for continued growth in correctional suicide prevention. The key areas of process research, risk assessment, and public and penological policy changes are reviewed and considered vital for the field's advancement. (36 refs.)
Source: Suicide and Life-Threatening Behavior, v.30, no.4, (Winter 2000), p.370-376

SIEC No: 2001-0829

Title:
Prison Suicides in Austria, 1975-1997
Authors:
Fruehwald S, Frottier P, et al
Abstract:
A study was conducted evaluating all suicides that occurred in Austrian prisons between 1975-1997 (n=220). In addition to examining the number of male versus female suicides, methods were studied as well as suicide risk in different custodial circumstances. Suicide rates of distinguishable, important subgroups of prisoners were calculated. The suicide rate for prisoners on remand was 236.0/100,000 and for offenders classified as mentally ill, it was 205.4/100,000, about 8 times higher than the suicide rate in Austria's general population. The authors recommend psychologists or psychiatrists concentrate on suicide prevention among high-risk offenders after screening the newly admitted offenders for their propensity to suicide. (37 refs.)
Source: Suicide and Life-Threatening Behavior, v.30, no.4, (Winter 2000), p.360-369

SIEC No: 2001-0671

Title:
Suicide Assessment in a Prison Environment: a Proposed Protocol
Authors:
Correia K M
Abstract:

This article discusses various aspects of the successful coordination of an effective suicide prevention program in corrections. It reviews some of the major warning signs that should be examined by mental health providers evaluating inmates referred as having significant suicidal risk. A method of organizing the suicide assessment and categorizing referrals as inappropriate, malingering, or at true risk is discussed, along with methods of distinguishing among the 3 types. Some of the primary differences between suicide attempts and suicide gestures are reviewed as are other special considerations which should taken into account when formulating recommendations following suicide risk assessments. Various recommendations that can be used as a result of the assessments are presented. (45 refs.)

Source: Criminal Justice and Behavior, v.27, no.5, (October 2000), p.581-599

SIEC No: 2000-0455

Title:

Fifty Years of Prison Suicide in Austria: Does Legislation Have an Impact?

Authors:

Fruehwald S, Frottier P, et al

Abstract:

The absolute and relative frequency of suicides in jails and prisons in Austria from 1947-96 is described. Important legislation changes regarding the criminal justice system are discussed with regard to possible consequences for the incidence of inmate suicide. Within the 5 decades a significant increase in the absolute numbers of jail suicides was evident in spite of the considerable decrease in the total inmate population. Possible reasons for this are discussed in relation to changes in the law.

Source: Suicide and Life-Threatening Behavior, v.30, no.3, (Fall 2000), p.272-281

SIEC No: 2000-0425

Title:

Self-Harm in Prison: Manipulators can Also be Suicide Attempters

Authors:

Dear G E, Thomson D M, Hills A M

Abstract:

Source: Criminal Justice and Behavior, v.27, no.2, (April 2000), p.160-175

SIEC No: 2000-0216

Title:

Correctional Suicide Prevention in the Year 2000 and Beyond

Authors:

Bonner R L

Abstract:

Source: Jail Suicide/Mental Health Update, v.9, no.3, (Spring 2000), p.1-5

SIEC No: 1999-0760

Title:
The Management of Suicide and Self-Harm in Prisons: Recommendations for Good Practice
Authors:
Howells K, Hall G, Day A
Abstract:
Suicide and self-harm in prisons are serious problems in Australia and many other jurisdictions. Psychologists frequently have a role in advising on, and assisting in, the prevention of such behaviors. Few guidelines and formal statements of good professional practice exist for such work. This paper reviews the published literature and current prevention practices with a view to devising recommendations for good practices in management and prevention. (75 refs.)
Source: Australian Psychologist, v.34, no.3, (November 1999), p.157-165

SIEC No: 1999-0756

Title:
Ethical Issues in the Prevention of Suicide in Prison
Authors:
Bell D
Abstract:
Literature relevant to the abuse of psychiatric power is reviewed. The means for immediate containment of highly suicidal patients in certain prison contexts is described and the paucity of relevant empirical research literature relating to this is identified. A framework is proposed to assist clinicians in making an ethical evaluation of coercive interventions that is applicable not only in the prevention of prisoner suicide, but also in the practice of psychiatry as a whole. (33 refs.)
Source: Australian and New Zealand Journal of Psychiatry, v.33, (1999), p.723-728

SIEC No: 1999-0049

Title:
Prison Suicide
Authors:
Dabrowski J
Abstract:
Dabrowski highlights key issues relevant to the forensic psychologist who must assess suicide risk in prison inmates. This population's resistance to authority figures, their impulsiveness, the limited number of observation cells, and the need for the psychologist

to gain inmates' trust and respect are some of the reasons why suicide risk assessment is so difficult. Ultimately, a psychologist must still trust what a client tells them.

Source: Psymposium, v.9, no.1, (May 15, 1999), p.6-7

SIEC No: 1998-0510

Title:

The Psychophysiology of Self-Mutilation: Evidence of Tension Reduction

Authors:

Brain K L, Haines J, Williams C L

Abstract:

The psychophysiological reactions of self-mutilators were studied. Previous research in self-mutilative prisoners found a physiological reduction in arousal during the actual act of imagery and the final "consequence" stage, but this differed with subjective reports which expressed reduction in the final stage only. The responses of the participants over 4 stages - setting the scene, approach, incident and consequence - are given. Controls and past and current mutilators are compared. (39 refs.)

Source: Archives of Suicide Research, v.4, no.3, (1998), p.227-242

SIEC No: 1998-0496

Title:

Prison Suicide and the Nature of Imprisonment in Deaths of Offenders: the Hidden Side of Justice, edited by A Liebling)

Authors:

Liebling A

Abstract:

This chapter attempts to discover what high prison suicide rates tells one about the nature of the prison experience. The psychological effect of prison experiences such as confinement and bullying and how they contribute to feelings of suicide is mentioned. Suicide risk factors, and their inherent prevalence amongst prisoners, is mentioned. Prisoners' personal vulnerabilities and the subjectivity of the prison experience is discussed with regards to their effect on suicide.

Source: Westminster, UK: Waterside Press, 1998. p.64-74

SIEC No: 2001-0962

Title:

Prison Suicide in Finland, 1969-1992

Authors:

Joukamaa M

Abstract:

All 184 prisoner suicides in Finland during 1969-1992 were studied. Suicide accounted for 47% of all prisoner deaths. More than half of those committing suicide had a psychiatric disturbance and one half had visited the prison health services because of a psychiatric problem not more than 1 week before the suicide. Almost one-third of suicides were committed in isolation room. In contrast to findings from other studies, there was no concentration of suicides at weekends, on religious holidays, in different seasons nor at the beginning of the confinement. (16 refs.)

Source: Forensic Science International, v.89, no.3, (October 6, 1997), p.167-174

SIEC No: 1998-0763

Title:

Does "Isolation" Cause Jail Suicides?

Authors:

Felthous A R

Abstract:

This article examines whether or not placing suicidal inmates in isolation to restrict access to harmful materials and instruments causes suicide. The hypothesis that isolation causes jail suicides is reviewed, and an argument of why isolation per se does not promote suicide is put forth. Alternative explanations for the apparent association between isolation and jail suicides are also offered. Ways in which isolation can be used as a prevention strategy and alternatives to isolation are described.

Source: Journal of the American Academy of Psychiatry and the Law, v.25, no.3, (1997), p.285-294

SIEC No: 1998-0653

Title:

Mental Health Services in United States Jails: a Survey of Innovative Practices

Authors:

Morris S M, Steadman H J, Veysey B M

Abstract:

This study used a stratified sample to gather information about policies and procedures for managing detainees with mental illnesses in 5 sizes of jails. Findings indicate that much emphasis is on screening, evaluation and suicide prevention. Despite numerous barriers, many jails have designed and implemented innovative programs. These programs are divided into 5 core areas so that other jails, using the information provided, can develop a mental health service strategy within their resources.

Source: Criminal Justice and Behavior, v.24, no.1, (March 1997), p.3-19

SIEC No: 1998-0364

Title:

Suicide Litigation as an Agent of Change in Jail and Prison: an Initial Report

Authors:

Danto B L

Abstract:

Danto summarizes the most relevant organizational standards for practice guidelines for suicide prevention in correctional settings and illustrates how these can be applied as standards for liability. Using these standards and his extensive forensic experience in this area, Danto illustrates how suicide litigation and the expert's participation in this process can promote improved care for potentially suicidal inmates. (11 refs.)

Source: Behavioral Sciences and the Law, v.15, no.4, (Autumn 1997), p.415-425

SIEC No: 1998-0250

Title:

From Chaos to Calm: one Jail System's Struggle With Suicide Prevention

Authors:

Hayes L M

Abstract:

Profiles of 9 inmates who committed suicide over a 24-month period at a mid-western American jail are detailed. Links between these 9 case studies are discussed to account for the high suicide rate at the facility, including protective custody status of many of the inmates, low staff supervision and poor medical response. As a result, the jail implemented a prevention program, including staff training, increased supervision and modified housing. No additional suicides have occurred. (21 refs.)

Source: Behavioral Sciences and the Law, v.15, no.1, (1997), p.7-29

SIEC No: 1997-1383

Title:

A Solution to the Problem of Jail Suicide

Authors:

Cox J F, Morschauser P C

Abstract:

In 1985, the State of New York implemented a comprehensive suicide prevention program within its upstate local jail facilities. It addressed not only the immediate needs of inmates with high-risk profiles, but also focused on the impact of the stressful jail experience. Despite a nearly 100% increase in the jail population, there has been more than a 150% decrease in jail suicides since program implementation. (10 refs)

Source: Crisis, v.18, no.4, (1997), p.178-184

SIEC No: 1999-0590

Title:

The Role of Shame in Suicide [Louis I. Dublin Award Address]
Authors:
Lester D
Abstract:
The differences between shame and guilt were explored, with a focus on experiential and developmental factors and on behavioral reactions to these emotions. The role of shame as a motive for suicidal behaviors was illustrated with examples from Greek tragedy, Asian cultures, and jails, and among contemporary suicides, such as that in 1996 by Admiral Mike Boorda, Chief of U.S. Naval Operations. (Full text is in SIEC #971271.)
Source: Annual Meeting of the American Association of Suicidology, (30th: 1997: Memphis), p.7

SIEC No: 1997-0422

Title:
Characteristics and Management of Prisoners at Risk of Suicide Behaviour
Authors:
Power K G, Moodie E
Abstract:
Source: Archives of Suicide Research, v.3 no.2, (1997), p.109-123

SIEC No: 1997-0374

Title:
Jail Suicide and Prevention: Lessons From Litigation
Authors:
Welch M, Gunther D
Abstract:
This study examines 77 jail suicide lawsuits in which problems related to key areas of institutional policy and custom are scrutinized. Discusses problems with insufficient staff, inadequate training and supervision, poor jail conditions, lack of written rules and procedures and overcrowding. Concludes that from a policy perspective, the lessons from litigation support the need for comprehensive suicide prevention programs in jails.
Source: Crisis Intervention and Time-Limited Treatment, v.3, no.3, (1997), p.229-244

SIEC No: 2001-0991

Title:
Medically Serious Suicide Attempts in a Jail With a Suicide Prevention Program
Authors:
Farmer K A, Felthous A R, Holzer C E
Abstract:

A suicide prevention program was implemented at the Galveston County Jail (Texas) in 1986, reducing to the number of suicides to only one from that time to the present. Thirteen medically serious suicide attempts occurring between 1989 and July 1994 were studied. The cases were examined for demographic data, psychiatric history, circumstances surrounding the act, and results of psychiatric evaluations performed after the act. The findings were compared to studies of suicides and near-suicides. This study has provided information which should make the suicide prevention program even more effective as well as providing useful information for programs in other jails. (28 refs.)

Source: Journal of Forensic Sciences, v.41, no.2, (March 1996), p.240-246

SIEC No: 1997-0871

Title:
Prison Suicide: Suggestions From Phenomenology

Authors:
Rodgers L N

Abstract:
This article examines suicide from a phenomenological perspective. The perceived subjective world of the inmate subculture is given careful consideration. The relationship between inmates' ethnicity, socioeconomic status, and suicide is explained. For inmates most susceptible (white/middle-class) to a double-deviant status, reality becomes anomic and suicide becomes a cognitive alternative to a meaningless situation and an alternative to their socially constructed sense of reality. (39 refs.)

Source: Deviant Behavior: an Interdisciplinary Journal, v.16, no.2, (April-June 1995), p.113-126

SIEC No: 1995-0745

Title:
Vulnerability and Prison Suicide

Authors:
Liebling A

Abstract:
Some of the main results from 2 long-term research projects carried out between 1987 and 1992 on suicide and suicide attempts in British prisons are summarized. The studies showed that important differences could be found between suicide attempters and other prisoners, especially in descriptions of prison life which was seen as more difficult for the attempters. The concept of poor coping is discussed. Links are drawn between prison suicide and other related literature on prison life. (67 refs.)

Source: The British Journal of Criminology, v.35, no.2, (Spring 1995), p.173-187

SIEC No: 1995-0064

Title:
A Quarter Century of Suicide in a Major Urban Jail: Implications for Community Psychiatry

Authors:
DuRand C J, Burtka G J, et al

Abstract:
Factors that increase the risk of suicide in urban jails were identified by examining all 37 suicides from 1967-92 in a Detroit jail. Inmates charged with murder or manslaughter were 19 times more likely to commit suicide than were inmates with other charges. All suicides were by hanging and most occurred at night within 31 days of admission. A charge of murder or manslaughter is identified as an important risk factor. Treatment/prevention programs should recognize these inmates as very high-risk.

Source: American Journal of Psychiatry, v.152, no.7, (July 1995), p.1077-1080

SIEC No: 2001-1107

Title:
Rethinking the Problem of Custodial Suicide

Authors:
Kennedy D B

Abstract:

Source: American Jails, v.7, (January/February 1994), p.41-45

SIEC No: 1997-1387

Title:
Preventing Jailhouse Suicides

Authors:
Felthous A R

Abstract:
This article reviews risk factors for jailhouse suicide and then presents various measures that can be implemented to prevent inmate suicides. These include: screening all new inmates and identifying those who are acutely suicidal; providing psychological support; observing the suicidal inmate closely; disarming the suicidal inmate; having clear and consistent procedures; and diagnosing, treating and /or hospitalizing as necessary. The efficacy of suicide prevention in jails is also discussed.

Source: Bulletin of the American Academy of Psychiatry and the Law, v.22, no.4, (1994), p.477-488

SIEC No: 1994-0344

Title:

Suicide and Adolescence
Authors:
Harris T E, Lennings C J

Abstract:
The role of family background, substance abuse, depression, and hopelessness in predicting past suicidal behaviour in 47 incarcerated juvenile delinquents was studied. Depression was found to be the best predictor of both suicidal ideation and suicide attempts. Aside from depression, no other factors achieved significance for predicting suicide risk, although suicide ideation significantly predicted suicide attempts. (34 refs.)
Source: International Journal of Offender Therapy and Comparative Criminology, v.37, no.3, (1993), p.263-270

SIEC No: 1994-0310

Title:
Comparative Suicide Rates in Different Types of Involuntary Confinement
Authors:
Haycock J
Abstract:
This article reports on comparative suicide rates for different confinement institutions in Massachusetts and discusses the significance of findings for debates about 'importation' vs' deprivation' explanations of custodial suicide. Study results show few suicides in 3 populations: Addiction Center (1886-1990), Defective Delinquent Department (1922-71) and Treatment Center for Sexually Dangerous Persons) but considerably higher rates in the State Hospital. Conclusion: who gets confined does matter.
Source: Medicine, Science and the Law, v.33, no.2, (April 1993), p.128-136

SIEC No: 1994-0049

Title:
Suicide Behind Bars: Prediction and Prevention (HV 6545.6 L48 1993)
Authors:
Lester D, Danto B L
Abstract:
Source: Philadelphia: Charles Press, 1993. 168p.

SIEC No: 1993-0914

Title:
Suicides in Young Prisoners: a Summary
Authors:
Liebling A

Abstract:

This paper looks at studies that have been based on recorded information alone on the nature of the prison suicide problem. Then the author looks at new and important insights which were gained through talking openly and systematically to prisoners and staff involved in prison suicide attempts. The paper concludes that situational triggers may be decisive in a suicide attempt at different thresholds depending on the prisoner's vulnerability and the stress they are experiencing.

Source: Death Studies, v.17, no.5, (September-October 1993), p.381-409

SIEC No: 1993-0455

Title:

Characteristics of Suicides by Inmates in an Urban Jail

Authors:

Marcus P, Alcabes P

Abstract:

The authors' goals were to describe the characteristics of inmate suicide in the New York City Department of Correction between 1980-88. 48 suicides were identified during this period. 42% of suicides occurred within the first 30 days of incarceration, and 50% occurred within 3 days of a court appearance. More than 90% of the suicides were by hanging. 91% of the suicides took place in cells in which the inmate was alone, and 52% of the inmates who committed suicide had a major psychiatric diagnosis.

Source: Hospital and Community Psychiatry, v.44, no.3, (March 1993), p.256-261

SIEC No: 1992-0830

Title:

Assessing and Responding to Suicidal Jail Inmates

Authors:

Winkler G E

Abstract:

Assessing and responding to suicidal risk among inmates is discussed based on a literature review and personal experience. Sections detailing jail conditions, suicide risk factors, reasons for self-harm, and practical responses are included. Intoxication, isolation and the initial 24 hours of incarceration are significant risk factors. Determination of risk and considerations in decision making are emphasized, while the inmate's safety and mental health, as well as accountability, are deemed priorities.

Source: Community Mental Health Journal, v.28, no.4, (August 1992), p.317-326

No SIEC No.

Title:

Jail Suicide/Mental Health Update.
Authors:
Abstract:
Source: Technical newsletter published quarterly by the National Center on Institutions and Alternatives, Mansfield, Massachusetts.