NATIONAL STUDY OF JAIL SUICIDES: SEVEN YEARS LATER

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A B S T R A C T

This report comprises findings from a national study of jail suicides. Reject staff from the National Center on Institutions and Alternatives (NCIA) gathered information from all jails (county and city) and police department lockups throughout the country regarding the incidence of jail suicides during 1985 and 1986. The study resulted in the identification of 854 jail suicides during 1985-86, with 453 occurring in 1985 and 401 in 1986. Project staff analyzed demographic data on 339 of the 1986 suicides. Subsequent comparison with NCIA's prior national research revealed that, absent minor variations, there were not any appreciable differences in jail suicide characteristics from 1979 and 1986. Most of the key characteristics of jail suicide -offense, intoxication, method/ instrument, isolation, and length of incarceration - have remained virtually unchanged over time. The consistency of such findings could impact the ability to deter suicidal behavior. The authors discuss utilization of these findings in the prevention of jail suicides.

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PREFACE

In September, 1986, the National Center on Institutions and Alternatives (NCIA) received a one-year grant from the National Institute of Corrections, U.S. Department of Justice, to act as National Coordinabx of the Jail Suicide Prevention Information Task Force. In cooperation with Juvenile and Criminal Justice International, Inc., and with assistance from the National Sheriffs' Association, the Project: 1) Conducted 12 regional jail suicide prevention seminars throughout the country, training over 750 participants; 2) Acted as a clearinghouse by providing technical assistance materials to state officials and individual correctional facilities, and interested others regarding jail suicide prevention, including the dissemination of a quarterly newsletter, ***Jail Suicide Update; 3)*** Developed a model training manual on suicide detection and prevention for use in jails and lockups; and 4) Gathered information from county jails, city jails, and police department lockups on the incidence of jail suicides during 1985 and 1986, including a replication of NCIA's 1981 National Study of Jail Suicides. The following report presents the findings from this study.

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EXECUTIVE SUMMARY

Suicide is the leading cause of death in our nation's jails. Experts have projected that the rate of suicide in jail is several times greater than that of the general population. These suicides have created publicity, increased public awareness, and ultimately, litigation against jail facilities, city governments, county commissioners, etc. Local jailers have also felt the pressure and have increasingly asked for technical assistance in suicide prevention, often from the National Institute of Corrections (NIC), within the U.S. Department of Justice. In response, the NIC formed a National Jail Suicide Task Force in 1984, an advisory board whose mandate was to design strategies for reducing jail suicides nationwide. One strategy of the advisory board was to establish a national coordinator for jail suicide prevention and information.

In September, 1986, the National Center on Institutions and Alternatives (NCIA) received a one-year grant from the NIC to act as National Coordinator of the Jail Suicide Prevention Task Force. In cooperation with Juvenile and Criminal Justice International, Inc., and with assistance from the National Sheriffs' Association, the Project: 1) Conducted 12 regional jail suicide prevention seminars throughout the country, training over 750 jail personnel; 2) Acted as a clearinghouse by providing technical assistance materials to state officials and individual jail facilities, and others interested in jail suicide prevention, including the dissemination of a quarterly newsletter *(Jail Suicide Update);* ***3)*** Developed a model training manual on suicide detection and prevention for use in jails and lockups; and 4) Gathered information from county jails, city jails, and police department lockups on the incidence of suicides during 1985 and 1986, including a replication of NCIA's 1981 National Study of Jail Suicides.

The present study was divided into two phases. During Phase I, surveys were sent to 16,483 jail facilities in the United States. For purposes of this analysis, two facility types were identified: *Holding Facility* (which normally detains persons for less than 48 hours) and *Detention Facility* (which normally detains persons or houses committed/ sentenced offenders for more than 48 hours, but less than two years). Each jail was asked to complete a one-page survey if it had a suicide(s) or other death(s) during 1985 and/ or 1986. Further, in

order to supplement the verification of data, survey forms were also sent to state and county medical examiners; state jail inspection offices (within departments of correction) and other jail liaison agencies; state attorney general offices; and state police/ bureau of investigation offices. Finally, a newspaper clipping service was utilized to verify jail suicides not identified through other sources. Phase I resulted in the identification of 854 jail suicides during 1985-1986, with 453 suicides occurring in 1985 and 401 in 1986.

During Phase II, in-depth survey questionnaires were sent to jails which experienced a suicide(s) in 1986. Project staff subsequently received or gathered demographic data on 339 suicides. Holding facilities comprised 30% of the suicides, while detention facilities comprised 70% of such deaths. Highlights of the data included overall findings that:

- 72% of victims were white.
- 94% of victims were-male.
- Average (mean) age of the victim was 30.
- 52% of victims were single.
- 75% of victims were detained on non-violent charges, with 27% detained on alcohol/ drug related charges.
- 89% of victims were confined as detainees.
- 78% of victims had prior charges, yet only 10% were previously held on personal/ violent offenses.
- 60% of victims were intoxicated at the time of incarceration.
- 30% of suicides occurred during a six-hour period between midnight and 6:00 a.m.
- 94% of suicides were by hanging; 48% of victims used theirbedding.
- Two out of three victims were in isolation.
- 51% of suicides occurred within the first 24 hours of incarceration; 29% occurred within the first three hours.

- 89% of victims were not screened for potentially suicidal behavior at booking.
- 52% of all victims charged with alcohol/ drug-related offenses died within the first three hours of confinement.
- 78% of victims who were intoxicated died within the first 24 hours of incarceration; 48% died within the first three hours.
- The suicide rate in detention facilities is projected to be approximately nine times greater than that of the general population.

In addition, ***holding facility data*** included findings that:

- 46% of victims were held on alcohol/ drug-related charges.
- 82% of victims were-intoxicated at the time of their incarceration.
- 64% of victims died within the first three hours.
- 97% of victims were not screened for potentially suicidal behavior at booking.

Experts generally agree that certain signs and symptoms exhibited by the detainee often foretell a possible suicide and, if detected, could prevent such an incident. What an individual says and how he/ she behaves while being arrested, transported to the jail, and at booking, are vital in detecting suicidal. behavior. Properly trained personnel, who have a basic understanding of jail suicide research and victim profile construction, can assess suicide potential both at the booking stage and during subsequent phases of aninmate's incarceration. During the booking stage, intake screening is imperative for suicide prevention. Findings from the present study showed that 89% of all suicidevictims were not afforded any intakescreening at the time of their booking. Data from holding facility suicides showed that 97% of the victims were not screened.

In regard to suicide prevention programs within jail facilities experiencing a suicide in 1986, the study showed that such programs werefound in 58% of detention facilities and 32% of holding facilities. The quality of such programming is not analyzed in the present study.

Despite minor variations, findings from the present study are consistent with NCIA's 1981 National Study of Jail Suicides (utilizing 1979 data). Allowing for slight differences in jail suicide characteristics, most of the key indicators (offense, intoxication, method/ instrument, isolation, and length of incarceration) evidenced the same value over time.

While we know more about jail suicide prevention than ever before, the need for additional research has never been greater. Future research efforts should focus on control group (non-suicidal) comparisons, psychological autopsies, and evaluation of jail suicide prevention programs. By continuing to learn more about the problem and transmitting that knowledge to those entrusted with the custody and care of inmates, we will be in the best possible position to prevent the tragedy of jail suicide.

On an individual basis, experience has clearly demonstrated that almost all jail suicides can be averted with implementation of a prevention program that includes written rules and procedures, staff training, intake screening, communication between staff, and human interaction. The key to prevention remains a capable and properly trained staff, the backbone ingredient of a facility. Such a system, however, will not come to fruition without pro-active jail administrators who not only maintain an awareness of suicide as a-national problem, **but** take the initiative to prevent such an occurrence in their own facility.

I. INTRODUCTION

Suicide is the leading cause of death in our nation's jails. Experts have indicated that the rate of suicide in these facilities is several times greater than that of the general population. While jail suicide remains a serious problem, efforts toward prevention continue to show steady progress. Chief among these efforts are training and research. In recent years, jail suicide prevention training has gained wide popularity, chiefly a result of litigation and correctional standards which call for increased understanding and awareness of jail suicide. Research efforts have also increased in recent years, and havebecome an important ingredient in suicide prevention training.

II. PRIOR JAIL SUICIDE RESEARCH

A) And Darkness Closes In. . .A National Study of Jail Suicides

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

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

have found the victim, they say, within 15 minutes of the suicide. Later, jail records would indicate that the victim did not have a history of mental illness or previous suicide attempts. (Caution should be exercised, however, because a significant percentage of jails have inadequate screening procedures from which to derive this information. Research and psychological autopsies reveal a high correlation between these variables and jail suicide, see Section V.)

The scenario described above, according to the study, reflected a "hypothetical. construct" based on those characteristics appearing most often in jail suicide victims.

Data also showed that 73.6% of the suicide victims were charged with crimes that fell within the non-violent category. Alcohol/ drug related charges accounted for over 30% of these charges. In regard to the presence of intoxication upon arrest and confinement, almost **60%** of the suicide victims were under the influence of alcohol and / or drugs at the time of arrest and incarceration. Two out of every three inmates who committed suicide were being held in isolation. Over 50% of all suicide victims in the study were dead within the first 24 hours of incarceration, with 27% of the suicides occurring within the first three hours.

In addition, over 88% of victims under the influence of alcohol and/ or drugs at the time of incarceration committed suicide within the first 48 hours of confinement, with over half of these victims being found dead within the first three hours of confinement. In addition, the majority (63%) of the victims placed in isolation committed suicide within the first 48 hours of incarceration, with over 30% of these victims dying within the first three hours of confinement. Of 419 suicides, 73% occurred in county facilities, while 27% of the victims died in local jails and lockups.

A complete summary of ***And Darkness Closes In. . A National Study of Jail Suicides*** can be found in Appendix A.

B) Other Significant Research: 1981 to the Present

As our general awareness of the jail suicide problem increases, so do the number of research efforts. In addition to NCIA's 1981 study, subsequent research has reported increasingly consistent findings and generated feasible policy implications.

One example of the utility of research in suicide prevention can be found in Hamilton County, Ohio.* Jn 1982, a year-long study at the county jail was designed to identify factors that distinguished suicide attempters from nonattempters, and to use the most cost-effective of these factors in an early identification and prevention program based on improved screening, referral, and surveillance of those at risk. Data analysis yielded the following factors in predicting potentially suicidal behavior: self-report of alcohol/ drug abuse, self-report of suicidal thoughts, feelings of hopelessness, history of multiple suicide attempts, intoxication upon admission, and suicide impulse disorder.

As a direct result of this research, changes were made in the county jails' screening/ referral procedures. The predictors were used as screening criteria for reasons of objectivity, economy, and attempter/ nonattempter discriminability. Specific procedures were developed and taught to jail health screening staff for use during a six-month trial period. After Hamilton County officials instituted the procedures, data were collected on the number of suicide attempts and the number of suicide watches for a six-month period. Only 45 **suicide watches** (applied for prescribed periods of time) were initiated, as compared with 70 during the previous 4-l/ 2 months. This was a decrease from 15 suicide watches per month to 7.5 per month of shorter duration. The suicide attempt rate also decreased from about 2.5 per month to only two in six months.

In 1984, the Commonwealth of Massachusetts completed a study of suicides in police department lockups[2] In regard to age, race, marital status, and other demographic variables, findings in Massachusetts parallel those of NCIA's 1981 study. More dramatic are the study's findings concerning the victims' reason for detention and appearance of intoxication **upon**

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[1]**Bobbie Hopes and Ruth Shaull, "Jail Suicide Prevention: Effective Programs Can Save Lives,"** *Corrections Today,* **December, 1986, pp. 64-70.**

[2]**specialcommission to Investigate Suicide in Municipal Detention Centers, Final Report - Suicides in Massachusetts Lockup, 1973-1984. Boston, Massachusetts, 1984. Unfortunately, the study's data base was distorted by the lumping of completed suicides with attempts holding simple gestures). Despite this flaw, the Massachusetts study provided interesting data on lockup suicides.**

arrest. Almost 60% of the detainees were being confined on alcohol-related charges, including protective custody and drunk driving. In addition, 74% of the victims were intoxicated at the time of their arrival at the lockup. Finally, 85% of the completed suicides occurred within four hours of incarceration. Perhaps most importantly, the Massachusetts study found that 75% of the lockups in the sample did not provide suicide prevention training to its staff, and 89% of the lockups did not ask detainees any questions regarding suicidal behavior.

A South Carolina study, also completed in 1984, again provided data that paralleled NCIA's 1981 study.[3] Further, the researchers found that the suicide rate of inmates in police department lockups was approximately 250 times greater than the rate for the state's general population. In addition, the suicide rate for city and county jails (including county prisons) was approximately 14 times greater than the rate for the state's general population.

A two-year evaluation of 46 jail suicides in Ohio, completed in 1983; also rendered similar results[4] The researchers found that: 1) suicides were found to be most prevalent in city/ municipal detention facilities; 2) an overwhelming majority of victims chose hanging as the mode of death; 3) over two-thirds of the suicides occurred within the first 24 hours of incarceration; 4) the most serious crime of the victim tended to be either a misdemeanor property offense or alcohol/ drug-related; and 5) the victims tended to be young, single, unskilled males. The researchers concluded: "In short, the findings from. the study of the suicide rate, victims and circumstances in Ohio's jails and temporary detention facilities were very similar to the results of the previous studies of suicide in jails. . . .The fact that there were very few differences in the data obtained on the suicides in Ohio for 1980 and 1981 or between the findings of this study and the earlier studies suggested that the phenomena is not changing

[3] **John M. Memory,** *Jail Suicides in South Carolina: 1978-1984.* **Unpublished Paper. Columbia, South Carolina: Office of the Governor, Division of Public Safety Programs, 1984.**

[4] **Patricia L Hardyman,** *The Ultimate Escape: Suicide in Ohio's Jails and Temporary Detention Facilities, 1980-1981.* **Columbus, Ohio: Ohio Bureau of Adult Detention Facilities and services, March, 1983.**

rapidly. The increase in the number of reported suicides appears to be partially due to an increase in publicity. Yet, this trend should ***not*** alleviate the jail administrators' concern or need to develop adequate policies and operations to cope with the problem."[5]

Finally, the medical examiner's office in Los Angeles County, California, completed a 10-year study of jail suicides in 1987: Through the examination of 103 suicides, the researchers reported interesting findings concerning length of incarceration prior to suicide, method of suicide, and time span between cell checks and suicide: Similar to NCIA's 1981 study, 59% of the Los Angeles County jail **suicides** occurred during the first 24 hours of incarceration, with 35% taking place within the first six hours. In regard to the method of suicide, all the suicides were by hanging. More interesting, however, were findings concerning the position in which the victim was found. Contrary to popular belief, although 41% of the victims were found in the suspended position, 59% were found either slumped, sitting, or kneeling. Finally, only 2% of the suicide victims were found within 10 minutes of the last cell check, 52% were found between 20 and 60 minutes, and an astounding 37% were found between 2 and 4 hours.

C) A Word about Suicide Victim Profiles

As we attempt to come to grips with the problem of jail suicide, prevention efforts are sometimes geared toward quick-fix solutions. Such band-aid approaches as television monitors, tearaway blankets, and other "prevention tools" are usually mere attempts to treat only the symptom. Although these tools can be a necessary part of jail suicide prevention, experts agree that their use should never be utilized to overshadow staff training, intervention and supervision.

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[5] **Ibid, p. 20.**

[6] **Karl B. Harris, Jail Suicide in Los Angeles County: July 1, 1977 Through June 30, 1987. Los Angeles, California: Department of Chief Medical Examiner-Coroner, 1987.**

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

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

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

NCIA's suicide victim profile was not meant to be a death certificate of all inmates that commit suicide in our nation's jails. Nor was it intended for jail personnel to ignore those inmates that, while exhibiting suicidal tendencies, did not fit the profile's various demographic variables. The profile's intent was, and remains, simple - ***to sensitize jail personnel to those characteristics appearing most often in jail suicide victims,*** **while** ***acting as a supplement to the warning signs and behavior that are observed in the defection of suicidal behavior. In***

essence, to ignore more revealing signs of potentially suicidal behavior because the individual did not fit the profile would not only be foolish, but negligent.

Further, while some of the profile's variables mirror the typical jail inmate (i.e., sex, age, marital status, etc.), there were appreciable differences with other variables. As can be seen in Table 1, while Black inmates comprise 41% of the jail population, they accounted for only 22% of the jail suicides. Approximately 53% of jail inmates are confined as detainees, yet 91% of all suicide victims were detainees. While 31% of jail inmates are under the influence of alcohol upon arrest, over 60% of jail suicide victims were intoxicated upon arrest. Although the average length of stay in jail is approximately 6 to 11 days, 50% of all jail suicide victims were dead within the first 24 hours of incarceration, and 27% commited suicide within the first three hours. Finally, while alcohol/ drug related charges account for 20% of offenses for which jail inmates are confined, they represented 30% of all suicide victims.

As such, when utilized in conjunction with staff training/ awareness and intake screening, and adapted to reflect a facility's demographic characteristics, a victim profile can be a valuable supplementary tool in jail suicide prevention.

TABLE 1

CHARACTERISTICS	JAIL INMATE PROFILE*	NCIA 1981 SUICIDE VICTIM PROFILE**
SEX		
Male	92%	97%
Female	8	3
RACE		
White	58%	67%
Black	41	22
Other	1	11
AGE		
18-24	40%	(18-27) 54%
25-34	39	(28-37) 27
Other	21	(Other) 19
MARITAL STATUS		
Single	54%	54%
Married	21	30
Separated/Divorced Widowed	25	16
JAIL STATUS		
Detained	53%	91%
Sentenced	47	9
INTOXICATION	31%	60%
LENGTH OF INCARCERATION (AVERAGE)	6-11 Days***	24 Hours (50%) 3 Hours (27%)
OFFENSE		
Violent	30%	27%
Property	33	22
Alcohol/Drug Related	20	30
Minor Other	17	21

*See Bureau of Justice Statistics, *Jail Inmates 1986* and *Jail Inmates 1983*.

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

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

III. NATIONAL STUDY OF JAIL SUICIDES: SEVEN YEARS LATER

As previously stated, suicide is the leading cause of death in our nation's jails. These suicides have created publicity, increased public awareness, and ultimately, litigationagainst jail facilities, city governments, county commissioners, etc. Local jailers have also felt the pressure and have increasingly asked for technical assistance in suicide prevention, often from the National Institute of Corrections (NIC), within the U.S. Department of Justice, in preventing jail suicides. In response, the NIC formed a National Jail Suicide Task Force in 1984, an advisory board developed to design strategies for reducing jail suicides nationwide. One strategy of the advisory board was to establish a national coordinator for jail suicide prevention and information.

In September, 1986, the National Center on Institutions and Alternatives (NCIA) received a one-year grant from the NIC to act as National Coordinator of the Jail Suicide Prevention Information Task Force. In addition to conducting various training seminars and providing technical assistance in jail suicide prevention, the reject gathered information from county jails, city jails, and police department lockups on the incidence of jail suicides during 1985 and 1986. The following report presents the findings from this study.

A) Methodology: Phase I

This second national study of jail suicides was divided into two phases. During Phase I, surveys were sent to 16,483 jail facilities in the United States. Each jail was asked to complete a one-page survey if it had a suicide(s) or other death(s) during 1985 and/ or 1986 (see Appendix B). A jail was defined as any facility operated by a local jurisdiction (e.g., county, municipality, etc.), whose purpose was the confinement of inmates apprehended by law enforcement personnel. Jails, as defined here, include temporary holding and pre-trial detention facilities, lockups, "drunk tanks," etc., which normally detain persons for less than 48 hours, and facilities which normally detain persons or house committed/ sentenced offenders for more than 48 hours. In addition, all state police lockups were included within this definition, as well as local jails operated by state correctional agencies, i.e., Alaska, Connecticut,

Delaware, Hawaii, Rhode Island, and Vermont. By definition, therefore, state and federal prisons were *excluded* from this study.

Surveys were mailed to 13,458 city jails and police department lockups, and 3,025 county facilities.[7] Further, in order to supplement the verification of data, survey forms were also sent to 517 state and county medical examiners; 60 state jail inspection offices (within departments of correction) and other local jail liaison agencies; 50 state attorney general offices; and 70 state police/ bureau of investigation offices. Finally, a newspaper clipping service was utilized to verify jail suicides not identified through other sources.

Phase I resulted in the identification of 854 jail suicides during 1985-86, with 453 suicides occurring in 1985 and 401 in 1986. As can be seen by Table 2, each state, with the exception of Rhode Island and Vermont, experienced at least one jail suicide during 1985 and/ or 1986.

Texas led all states in jail suicides by a wide margin during 1985 and 1986. In addition, the states of Texas, California, New York and Illinois comprised 32% of all jail suicides in the country.

As previously discussed, data collected during Phase I was attributed to various sources, including self-reports, state departments of correction (jail inspection units), state/ county medical examiners, and newspaper articles. Table 3 provides a breakdown of data collection sources for 1986 jail suicides. As can be seen, 180 (45%) of the 401 jail suicides were identified through jail self-reporting. Data obtained from state departments of correction and medical examiners yielded an additional 175 (44%) suicides not identified through self-reporting. Project staff were able to identify an additional 46 (12%) suicides from other sources, principally through newspaper articles.

The reader is warned that self-reports were given primary recognition for jail suicide identification. For example, if a jail suicide was identified by more than one source, including

[7] Mailing lists were utilized from NCIA's 1981 National Directory of County and Local Jails, and the most current (1987) National Sheriffs' Association mailing list. Business reply envelopes were also utilized to assure a higher rate of return.

TABLE 2
JAIL SUICIDES BY STATE, 1985-1986

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

a self-report from the facility in which the suicide occurred, the source would be attributed to a self-report. Table 3, therefore, is meant to be more a reflection of the self-report accuracy,

TABLE 3

PHASE I: SOURCES FOR IDENTIFYING 1986 JAIL SUICIDES

SOURCE	N	PERCENTAGE
Jail Self Report	180	44.9
Departments of Correction/ Medical Examiners	175	43.6
Newspaper Articles	46	11.5
TOTAL	401	100.0

than data collection efforts of state reporting systems. (For a further discussion of state-reporting and the under-reporting of jail suicides, see pages 15 thru 19.)

In addition to jail suicide data, jail facilities and other agencies were requested to complete a survey on "other" jail deaths during 1985-86. As can be seen by Table 4, a total of 409 other jail deaths were identified during 1985-86. ***Caution, however, should be utilized with respect to all data concerning other jail deaths.*** Based upon correspondence with responding facilities, project staff believe that because the project was referred to as a national study of jail suicides, a sizeable number of jail facilities only supplied data on other deaths ***if they also*** had had a jail suicide. The same hypothesis holds true for other agencies supplying data. Further, in returning the survey forms, jail facilities provided differing interpretations or definitions of other deaths! It is felt, therefore, that due to problems of under-reporting, data listed in Table 4 should be considered the ***minimum*** number of jail deaths in those states.

[8] **For purposes of this study, the following definitions were offered. HOMICIDE: Any death of an individual while in the custody of any law enforcement agency resulting from or leading directly from any non-self-inflicted act perpetuated against that individual by a second party. ACCIDENT: Any death of an individual while in the custody of any law enforcement agency resulting from or leading directly from any non-intentional, identifiable act. UNDETERMINED CAUSES: Any death of an individual while in the custody of any law enforcement agency resulting from *or* leading directly from any unknown or unspecifiable act or agent. NATURAL/OTHER CAUSES: Any death of an individual while in the custody of any law enforcement agency resulting from or leading directly from any natural or other act.**

TABLE 4
OTHER JAIL DEATHS BY STATE, 1985-1986

STATE	1985					1986				
	HOMICIDE	ACCIDENT	UNDETER.	NATURAL/ OTHER	TOTAL	HOMICIDE	ACCIDENT	UNDETER.	NATURAL/ OTHER	TOTAL
Alabama	1	1	2	1	5					0
Alaska	2				2		1			1
Arizona		1			1			1		1
Arkansas					0					0
California	2	1	6	27	36	6	5		32	43
Colorado				1	1			1		1
Connecticut					0					0
Delaware					0					0
District of Columbia					0					0
Florida		2		1	3			1	1	2
Georgia				1	1				2	2
Hawaii					0					0
Idaho					0					0
Illinois		1		6	7	1			9	10
Indiana		11	1	4	16		10	2	2	14
Iowa					0	1				1
Kansas			1		1			1		1
Kentucky		3	1		4		3	1		4
Louisiana		5	1		6		6			6
Maine					0					0
Maryland			2		2			1		1
Massachusetts					0					0
Michigan		3			3		6	1	2	9
Minnesota					0					0
Mississippi			2	13	15				13	13
Missouri		1			1			1		1

TABLE 4 (Continued)
OTHER JAIL DEATHS BY STATE, 1985-1986

STATE	1985					1986				
	HOMICIDE	ACCIDENT	UNDETER.	NATURAL/ OTHER	TOTAL	HOMICIDE	ACCIDENT	UNDETER.	NATURAL/ OTHER	TOTAL
Montana					0		1			1
Nebraska	1			1	2		1			1
Nevada				2	2		3		1	4
New Hampshire					0					0
New Jersey		1	4		5	1		2		3
New Mexico		2	3	3	8		2	5		7
New York	2			33	35	4			44	48
North Carolina		1			1	1	2			3
North Dakota					0				1	1
Ohio		1			1		2		2	4
Oklahoma					0		1		3	4
Oregon		1			1		2			2
Pennsylvania					0		1	4		5
Rhode Island					0					0
South Carolina		1			1		3	1	1	5
South Dakota					0					0
Tennessee					0		2			2
Texas		10		7	17	5	5		8	18
Utah					0					0
Vermont					0					0
Virginia		3			3		3			3
Washington		1			1				1	1
West Virginia				1	1					0
Wisconsin					0		1		1	2
Wyoming				1	1		1			1
TOTAL	8	50	23	103	184	19	61	22	123	225

B) **Under-Reporting of Jail Suicides**

A common frustration in the area of jail suicide research surrounds under-reporting of the data. NCIA's 1981 study found that there are various reasons for the discrepancy in reporting suicides, including sensitivity of the subject matter and the reluctancy of jail administrators to participate in the face of litigation regarding the suicide; the lack of mandate on localities to report data; and the difference of opinion on where the suicide occurs (e.g., jail, ambulance, hospital, etc.).

Ten years ago, it was unusual for a jail to be sued for negligence following a suicide. Today, it is unusual if a suit is not filed. Although there are no statistics available on jail suicide litigation, the Bureau of Justice Statistics estimated that 27% of our nation's jails were under court order to improve one or more conditions of confinement, with 41% of such facilities cited for deficient medical services[9] Thus, due to liability concerns, issues of confidentiality and/ or a natural distrust of research inquiries from outside agencies, there is a reluctancy on the part of jails to accurately self-report suicide data.[10]

In response to mounting criticism of conditions within local jails, most states adopted jail standards in the late 1960's. Coupled with these standards was the advent of inspection programs, which graded jail facilities based upon such standards. In addition, there was the expectation that these inspection programs (housed within state departments of correction) would annually collect various data, e.g., suicides, from these facilities. According to a 1984 report by the Advisory Commission on Intergovernmental Relations, ". . .states still have a distance to travel to fulfill their standards/ enforcement responsibility. A substantial number either have not established standards or have made them only voluntary. Many states do not have inspection programs, and even in those that do, the effectiveness of enforcement

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[9] **US. Department of Justice, Bureau of Justice Statistics Bulletin, Jail Inmates 1986, Washington, D.C.: Bureau of Justice Statistics, October, 1987.**

[10] **All survey respondents were assured that data provided would be coded and held in the strictest confidence. Results of the study are presented in summary fashion, thus preventing the direct linkage of specific data to the particular facility from which the information originated.**

frequently is not assured."[11] Yet, most experts agreethat state jail standards/ inspection programs have made progress, however modest.

In NCIA's 1981 study, only 31% of the jail suicides were identified by jail inspection programs within state departments of correction. As can be seen from Table 5, states have made steady, yet uneven progress in collecting data on jail suicides. Only 25 states, plus the District of Columbia, have jail inspection units which collect such data. Together they account for 54% of all identified jail suicides in 1986, a steady improvement from the 31% in NCIA's 1981 study, yet still far below expectations. Table 5 also reveals that state medical examiner offices in -nine states collect jail suicide data not available from state departments of correction, and 15 states have no central repository for such data.

Texas and Michigan provide clear, yet contrasting, examples of two states going in opposite directions regarding jailsuicide reporting efforts. In NCIA's 1981 study, Texas was identified as having 25 jail suicides during 1979. At that time, Texas did not have a central repository for jail suicide data. In September, 1983, legislation was enacted which mandated that all jail deaths be reported to the state's Attorney General Office. As previously shown in Table 2, the state of Texas reported having 46 jail suicides during 1986. This substantial increase, approximately 100% from the 1979 data, can perhaps more legitimately be attributed to mandatory reporting than a dramatic increase in jail suicides throughout that state.

The state of Michigan provides a different picture. The state's jail inspection unit (Office of Facility Services) has always had an aggressive reputation for collecting accurate jail suicide data. In NCIA's 1981 study, Michigan was identified as having 22 jail suicides during 1979, most of which were reported from the Office of Facility services (OFS). Further, according to statistics from the OFS, the state averaged 17 jail suicides a year from 1980 through 1983. In May, 1984, however, the state legislature removed local lockups from the jurisdiction of the OFS after the state Association of Chiefs of Police argued that it was too costly to comply with state jail standards. As previously shown in Table 5, the state of Michigan reported only five

[11] **Advisory Commission on Intergovernmental Relations, *Jails: Intergovernmental Dimensions of a Local Problem.*. Washington, D.C.: May, 1984, p. 103.**

TABLE 5

STATE-REPORTED 1986 JAIL SUICIDES BY TOTAL IDENTIFIED

STATE	TOTAL REPORTED	TOTAL IDENTIFIED
Alabama*	4	9
Alaska	1	1
Arizona**	0	5
Arkansas	6	9
California	25	32
Colorado**	0	10
Connecticut*	2	5
Delaware**	0	1
District of Columbia	1	1
Florida	13	15
Georgia*	2	10
Hawaii	1	1
Idaho**	0	3
Illinois	18	25
Indiana	4	8
Iowa**	0	1
Kansas	7	8
Kentucky*	3	3
Louisiana	0	8
Maine	1	1
Maryland*	11	11
Massachusetts*	7	9
Michigan	5	9
Minnesota	4	4
Mississippi**	0	3
Missouri**	0	4
Montana*	3	3
Nebraska**	0	2
Nevada**	0	1
New Hampshire**	0	2
New Jersey	8	14
New Mexico*	1	1
New York	25	25
North Carolina	5	7
North Dakota**	0	1
Ohio	7	19
Oklahoma	4	10
Oregon**	0	5
Pennsylvania	7	18
Rhode Island	0	0
South Carolina	5	6
South Dakota**	0	4
Tennessee	5	10
Texas	46	46
Utah	1	1
Vermont	0	0
Virginia*	13	18
Washington	4	4
West Virginia**	0	2
Wisconsin	3	4
Wyoming**	0	2
TOTAL	252	401

*Data obtained through state medical examiners office, not available from departments of correction.

**Data not available through any state agency.

jail suicides during 1986, with an additional four being-identified by NCIA project staff. In contrast, 24 jail suicides were identified in Michigan during 1985, presumably before the full force of the new law was felt.

A third determinant of jail suicide under-reporting concerns the difference of-opinion on where the suicide occurred (e.g., jail, ambulance, or hospital). *There are incidents, the number of which are unknown, where a detainee attempts suicide in his jail cell, is immediately removed from the facility and transported by ambulance to a hospital, and subsequently dies. The jail facility might list the case as an attempted suicide, or have no record at all of the incident. Thus for reliability purposes, jail suicides are at times inappropriately listed as hospital suicides.*

As previously discussed, the state of Ohio completed a statewide study on jail suicides in 1983. The researchers hypothesized that "the number of suicides indicated on the reports as occurring in jails and temporary detention facilities was understated. This hypothesis was based on the fact that jails often transport suicide victims to a hospital as part of the jails' standard emergency procedure. Unfortunately, on the computerized files, the 'transported' prisoners could not be differentiated from any others who attempted suicide in a hospital or nonprisoners taken to a hospital as an emergency procedure. Therefore, the total number of suicides reported on the computerized files as occurring in a jail or temporarydetention facility was believed unreliable."[12]

To test their hypothesis, the researchers obtained annual computerized suicide reports from the state Department of Health - Data Section. The reports highlighted persons who "reportedly" committed suicide and died within a hospital or jail facility. Staff then reviewed the death certificates of all persons listed in the suicide report as having died in a jail facility or hospital. These death certificates were obtained by the state's Division of Vital Statistics. Collected from the death certificates were locations of death (name of city) and location of injury (name of facility). The suicide victims who had been jail inmates were identified by

[12] **Patricia L. Hardyman,** p. **2.**

carefully checking a variety of entries on the death certificate, i.e., location of injury, date of death, how the injury occurred, and immediate cause. ***Their findings revealed that although jails reported 22 suicides occurring between 1980 and 1981, a further analysis*** of ***death certificates from hospital suicides found that there were, in*** fact, ***46 suicides that should have been identified as jail suicides. Thus, an additional 24 jail suicides were uncovered.***

The researchers concluded: 'The suicide rate in Ohio's jails and temporary detention facilities indicated that the number of reported suicides occurring in Ohio facilities was understated by about half on the official suicide reports."[13]

C) Methodology: Phase II

During Phase II of the present study, project staff developed a four-page, in-depth survey questionnaire aimed at identifying characteristics of the 1986 suicide victim and suicide act. Information sought regarding the victim included race; sex; age; marital status; current offense(s); custody status; relationship, if any, of victim's confinement to state's drunk driving law; prior arrests; and presence of intoxication (alcohol and/ or drugs) at the time of incarceration. In regard to the suicide act itself, information was sought concerning date and time of suicide; method; instrument used; time span between suicide and finding of the victim; use of isolation; previous suicide attempts; indications of mental illness and/ or medical problems; use of suicide screening forms; length of incarceration prior to suicide; and facility capacity/ population at the time of the suicide.

In addition, data was also sought on the type and location of the facility; year of original construction and last renovation; incidence of suicide in 1984 and 1985; presence of a suicide prevention program; and procedures of external reporting requirements utilized following a suicide.

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[13] **Ibid, p. 18. Further, the national scope and size of the data base in this NCIA study precluded the same death certificate analysis as was done in Ohio. As previously stated in NCIA's 1981 National Study of Jail Suicides - ". . after au exhaustive search for existing data, Project staff identified 419 suicides in jails during 1979. However, because of the problems in suicide reporting, as discussed, care must be taken in considering this number of suicides the final one. The number could be, and probably is, greater." See Lindsay M. Hayes and Barbara Kajdan, *And Darkness Closes In. . .A National Study of Jail Suicides*. Washington, DC.: National Center on Institutions and Alternatives, October, 1981, p. 15.**

The four-page survey was modeled after NCIA's1981 survey instrument to allow for appropriate data comparison, see Section V. (A copy of the survey instrument can be found in Appendix B.)

The four-page survey was distributed by mail to those 349 jails accounting for the 401 suicides during 1986. This process was initiated in June, 1987. As can be seen by Table 6, the

TABLE 6
PHASE II: SURVEY RESPONSES FOR 1986 JAIL SUICIDES

	N	PERCENTAGE
RESPONSES BY MAIL		
From First Mailing	233	58.1
From Second Mailing	58	14.5
After Telephone Contact	15	3.7
OTHER SOURCES		
Date Reported by Medical Examiners and Newspapers Clippings	33	8.2
SUB-TOTAL RESPONSES	339	84.5
NO RESPONSE/REFUSAL	62	15.5
TOTAL SUICIDES	401	100.0

initial mailing resulted in 233 (58%) completed surveys being returned. A second mailing was done in late July, 1987, yielding 58 (15%) additional completed surveys. Subsequent telephone contact to those facilities not responding to previous survey requests, culminated in 15 (4%) more completed surveys. Finally, data on 33 (8%) suicides were obtained from medical examiner reports and newspaper articles. The total demographic data base became 339 suicides, or an 85% response/ collection rate on 401 identified jail suicides in 1986.

IV. DEMOGRAPHIC FINDINGS OF 1986 JAIL SUICIDE DATA

As previously reported, project staff analyzed data on 339 of the 401 jail suicides identified for 1986. The following demographic findings will be presented in relationship to *jail facility type."* For purposes Of this analysis, two facility types were utilized: *Holding Facility* (which normally detains persons for less than 48 hours) and Detention *Facility (which normally* detains persons or house committed/ sentenced offenders for more than 48 hours, but less than two years). Thus, the two facility types are more distinct by the length of time an individual is confined (i.e., more or less than 48 hours), rather than the jurisdictional agency which controls a facility.

With a data base of 339 cases, 30% (102) of the jail suicides took place in ***holding*** facilities, while ***detention*** facilities accounted for 70% (237) of the deaths. In regard to the location of the facility, 65.8% of the suicides occurred in urban facilities, 21.6% in suburban facilities, and 126% in rural facilities.

A) Personal Characteristics of the Victim

1. Race

As can be seen by Table 7, 71.6% of the victims were White, 15.7% were Black, and 12.7%

TABLE 7 — RACE

RACE	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
White	72	70.6	170	72.0	242	71.6
Black	20	19.6	33	14.0	53	15.7
Other*	10	9.8	33	14.0	43	12.7
Unknown			1		1	
TOTAL	102	100.0	237	100.0	339	100.0

*Includes Spanish Heritage, Chicano, Mexican American and American Indian.

[14] As previously reported, a jail is defined as an facility operated by a local jurisdiction (e. g., county, municipality, etc.), whose purpose is the confinement of inmates apprehended byl aw enforcement personnel. Jails, as defined here, will, to the maximum extent possible, include temporary holding and petrial detention facilities, lockups, "drunk tanks," etc., which normally detain persons for less than 48 hours, and facilities which normally detain persons or house committed/sentenced offenders for more than 48 hours, yet usually less than two years In addition, all state police lockups are included within this definition, as well as local jails operated by state correctional agencies, i.e., Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont.

were designated as "Other." Therewere no significant differences foundbetween holding and detention facility suicides in regard to race.[1s] These findings compare favorably with previous studies that indicate Whites commit suicide in greater numbers than Blacks. Of interest, however, is the fact that although Blacks comprise approximately 41% of the jail population, they accounted for only 15.7% of the jail suicides in this study. The cause of this disportionate relationship is outside the purview of this analysis.

2. Sex

As presented in Table 8, an overwhelming majority (94.4%) of the victims were male, while only 5.6% were female. There were no significant differences found between holding

TABLE 8 — SEX

SEX	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Male	96	94.1	224	94.5	320	94.4
Female	6	5.9	13	5.5	19	5.6
TOTAL	102	100.0	237	100.0	339	100.0

and detention facility suicides in regard to sex. These findings were not surprising since it was closely proportionate to male-female, ratio in our nation's jails.

3. Age

Table 9 shows that over one quarter (26.5%) of all victims were between the ages of 23 and 27. Almost half (47.5%) of the victims were between the ages of 23 and 32. The average

[15] **For purposes of this study, percentage differences greater than 10 will be considered a significant difference.**

TABLE 9 — AGE						
	FACILITY TYPE					
AGE	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Low-17	1	1.0	11	4.7	12	3.6
18-22	17	16.8	37	15.9	54	16.2
23-27	20	19.7	69	29.6	89	26.5
28-32	21	20.8	49	21.1	70	21.0
33-37	21	20.8	29	12.4	50	15.0
38-42	8	7.9	21	9.0	29	8.7
43-47	5	5.0	6	2.6	11	3.3
48-53	5	5.0	6	2.6	11	3.3
54-High	3	3.0	5	2.1	8	2.4
Unknown	1		4		5	
TOTAL	102	100.0	237	100.0	339	100.0

age was 30. There were no significant differences found between holding and detention facility suicides in regard to age. These findings also seem to be proportionate to those age groups found in the jail population.

4. **Marital Status**

As indicated by Table 10, 51.6% of the victims were single, 4.2% separated, 12.7% divorced, and 1.4% widowed. The remaining 30.1% were married or living under a common-law relationship. There were no significant differences found between holding and detention

TABLE 10 — MARITAL STATUS						
	FACILITY TYPE					
MARITAL STATUS	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Single	43	55.8	103	50.0	146	51.6
Married	22	28.6	56	27.2	78	27.6
Separated	2	2.6	10	4.8	12	4.2
Divorced	7	9.1	29	14.1	36	12.7
Widowed	1	1.3	3	1.5	4	1.4
Common-Law	2	2.6	5	2.4	7	2.5
Unknown	25		31		56	
TOTAL	102	100.0	237	100.0	339	100.0

facility suicides in regard to marital status. These findings are also proportionate to that of the jail population. Although marital status alone can not be utilized as an indicator of suicidal behavior in jail, the quality of a marriage and/ or the recent loss of a "significant other" can impact upon suicidal behavior.[16]

5. Most Serious Charge

For purposes of this study, the most serious charge was broken down in four offense categories. As can be seen by Table 11, 75.3% of the most serious charges were of a non-violent nature. Minor other offenses accounted for 28.6% of the most serious charges, followed by

TABLE 11 — MOST SERIOUS CHARGE

MOST SERIOUS CHARGE*	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Violent/Personal	15	14.7	68	29.1	83	24.7
Serious Property	17	16.7	50	21.4	67	19.9
Minor Other	23	22.5	73	31.2	96	28.6
Alcohol/Drug	47	46.1	43	18.3	90	26.8
Unknown			3		3	
TOTAL	102	100.0	237	100.0	339	100.0

*For purposes of this study, offense categories were broken down as follows: *Violent/ Personal* offenses included murder, negligent manslaughter, armed robbery, rape, indecent assault, assault, battery, aggravated assault, and kidnapping; *Serious Property* offenses included burglary, grand larceny, auto theft, robbery (other), receiving stolen property, arson, breaking and entering, entering without breaking, vandalism, and carrying a concealed weapon and/or firearms; *Minor Other* offenses included shoplifting, petit larceny, prostitution, sex offenses (other), trespassing, unauthorized use of a motor vehicle, traffic offenses (other), violation of probation, contempt of court, vagrancy, indecent exposure, status offenses, escape, forgery, embezzlement, and other; and *Alcohol/Drug* related offenses included public intoxication, driving while intoxicated, disorderly conduct, resisting arrest, possession and/or distribution of a controlled dangerous substance, and narcotics (unspecified).

alcohol/ drug-related offenses (26.8%), violent/ personal offenses (24.7%), and serious property ***offenses*** (19.9%). Further, ***significant differences were found between holding and***

[16] See Joseph R Rowan and Lindsay M. Hayes, Training Curriculum on Suicide Detection and Prevention in Jails and Lockups, Alexandria, Virginia: National Center on Institutions and Alternatives, February, 1988.

detention facility suicides in regard to the most serious charge. While alcohol/drug related offenses accounted for 46.1% of holding facility suicides, they were credited with only 18.3% of ***such deaths in detention facilities. Further, while violent/personal offenses accounted*** for ***only 14.7% of holding facility suicides, they were credited with*** 29.1% **of** ***such deaths in detention facilities.***

In regard to individual charges, seven particular offenses were found in almost 50% of the jail suicides. As such, 35 suicide victims (or 10% of the entire study) had been confined on driving while intoxicated charges, 28 for murder, 26 for burglary, 24 for public intoxication, 18 for assault, 17 for traffic offenses, and 17 for disorderly conduct.

Further, while minor other and alcohol/ drug-related offenses account for approximately 37% of the jail populaton (see Table l), they represent over 55% of the suicide victim offenses. The cause of this disportionate relationship is outside the purview of this analysis.

6. Additional Charges

In regard to additional charges, 47.5% of the victims had a second charge. Traffic offenses, resisting arrest, and violation of probation accounted for 29% of these second charges. Only 23.7% of the victims had a third charge.[17] (The distribution of second and third charges can be found in Appendix C.)

7. Jail Status

As presented in Table 12, the overwhelming majority (88.7%) of the suicide victims were being detained at the time of their death. Since holding facilities, by their definition, have very few sentenced inmates, there were no significant differences found between holding and detention facility suicides in regard to jail status. As was previously shown in Table 1,

[17] **It should be pointed out that project staff recoded data on only the three most serious charges against the victim. However, very few victims had more than three charges against them.**

approximately 53% of all jail inmates are combined as detainees, yet almost 89% of the suicide victims in this study were detainees. The substantial difference between these two groups is closely associated with the length of incarceration prior to suicide (see page 36).

TABLE 12 — JAIL STATUS

JAIL STATUS	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Detained	100	98.0	199	84.7	299	88.7
Sentenced	2	2.0	36	15.3	38	11.3
Unknown			2		2	
TOTAL	102	100.0	237	100.0	339	100.0

8. DWI Statute

Prior publicity and research has hypothesized that, if an individual is arrested for a DWI-related offense, the risk of suicide is greater if their incarceration is mandated by the state's drunk driving law. In March, 1983, one week after a new law in Ohio mandating 72-hour jail terms for drunk drivers went into effect, three people arrested for DWI-related offenses committed suicide. Newspaper stories on the three deaths and the new law appeared throughout the country.[18] However, the only prior jail suicide research that espouses to such a relationship is inconclusive. [19]

In an effort to gain greater insight into the potential relationship, project staff inserted a question into the survey instrument dealing with a state's DWI statute. As can be seen by

18 See the Wall Street Journal; June 7, 1983.

19 Special Commission to Investigate Suicide in Municipal Detention Centers, pp. 48-49.

Table 13; the issue of DWI statutes was applicable in 11.5% of the suicide cases. Of those cases, only one-third (3.8%) of respondents stated the victim's confinement was due to the state's drunk driving law. Although the research is consistent in linking intoxication to jail suicide, these data do not seem to show a significant link between jail suicide and the presence of a state's drunk driving law. More comprehensive analysis, outside the purview of this study and perhaps in psychological autopsy form, is necessary.

TABLE 13 — DWI STATUTE

DWI STATUTE	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Yes	8	7.8	5	2.1	13	3.8
No	16	15.7	10	4.2	26	7.7
Not Applicable	78	76.5	222	93.7	300	88.5
TOTAL	102	100.0	237	100.0	339	100.0

9. Most Serious Prior Charge

Table 14 shows that only 21.8% of the suicide victims did not have a history of prior arrests. Of those victims having a prior arrest record, minor other offenses accounted for 23.5% of the most serious charges, followed by alcohol/ drug-related offenses (23%), serious property offenses (21.8%), and violent/ personal offenses (9.9%). There were no significant differences found between holding and detention facility suicides in regard to prior charge, although holding facilities had a higher percentage of victims with alcohol/ drug-related prior offenses, while detention facilities had a higher percentage of victims with serious property prior offenses. In regard to additional prior charges, 62.7% had two prior charges, and 51.3% had three prior charges. (The distribution of second and third prior charges can also be found in Appendix C.)

TABLE 14 — MOST SERIOUS PRIOR CHARGE						
	FACILITY TYPE					
MOST SERIOUS PRIOR CHARGE	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Violent/Personal	7	9.9	17	9.9	24	9.9
Serious Property	12	16.7	41	24.0	53	21.8
Minor Other	18	25.0	39	22.8	57	23.5
Alcohol/Drug	20	27.7	36	21.1	56	23.0
None	15	20.7	38	22.2	53	21.8
Unknown	30		66		96	
TOTAL	102	100.0	237	100.0	339	100.0

10. Intoxication

As indicated by Table 15; 60.3% of the suicide victims were under the influence of alcohol, drugs, or both at the time of their incarceration. Alcohol intoxication accounted for 43.8% of this finding; drugs, 6.8%; and the presence of both alcohol and drugs, 9.7%. ***Further,***

TABLE 15 — INTOXICATION						
	FACILITY TYPE					
INTOXICATION	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Alcohol Only	48	64.8	48	33.1	96	43.8
Drugs Only	5	6.8	10	6.9	15	6.8
Alcohol/Drugs	8	10.8	13	9.0	21	9.7
Neither	13	17.6	74	51.0	87	39.7
Unknown	28		92		120	
TOTAL	102	100.0	237	100.0	339	100.0

significant differences were found between holding and detention facility suicides in regard to intoxication. The ovrewhelming majority (82.4%) of suicide victims confined in holding facilities were intoxicated (from alcohol, drugs, or both) upon their incarceration. In contrast, *49%* of ***suicide victims confined in detention facilities were intoxicated (from alcohol, drugs or both) upon their incarceration. These findings are not surprising since jail suicide research***

literature is replete with evidence *that equates suicide with intoxication. Further, persons taken into custody for alcohol-related offenses are often initially transported to a holding facility.*

B) **Characteristics of the Suicide Act**

1. **Time**

Experts theorize that jail suicides are more prevalent when staff supervision is reduced. Findings from this study generally suppor tthis explanation. As can be seen by Table 16, over 30% of all suicides occurred during a six-hour period between midnight and 6:00 a.m. Midnight to 3:00 a.m. was the highest period for suicides with 58 such deaths. Other peak hours

TABLE 16 — TIME OF SUICIDE

TIME OF SUICIDE	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
12:00 Midnight - 3:00 a.m.	14	14.0	44	19.2	58	17.6
3:00 a.m. - 6:00 a.m.	13	13.0	32	14.0	45	13.8
6:00 a.m. - 9:00 a.m.	10	10.0	27	11.8	37	11.2
9:00 a.m. - 12:00 p.m.	11	11.0	21	9.2	32	9.7
12:00 p.m. - 3:00 p.m.	9	9.0	23	10.0	32	9.7
3:00 p.m. - 6:00 p.m.	10	10.0	27	11.8	37	11.2
6:00 p.m. - 9:00 p.m.	19	19.0	29	12.6	48	14.6
9:00 p.m. - 12:00 Midnight	14	14.0	26	11.4	40	12.2
Unknown	2		8		10	
TOTAL	102	100.0	237	100.0	339	100.0

were 6:00 p.m. to 9:00 p.m. **(48); 3:00 a.m.** to 6:00 a.m. (45); and 9:00 p.m. to 12:00 midnight (40). There were no significant differences found between holding and detention facility suicides in regard to the time of suicide, although the 6:00 p.m. to 9:00 p.m. time period experienced the most suicides in holding facilities, while the 12:00 midnight to 3:00 a.m. time period experienced the most suicides in detention facilities.

2. Date

As presented by Table 17, suicides were evenly distributed over all seven days of the week, although Monday experienced the most suicides (16.2%). There were no significant differences found between holding and detention facility suicides in regard to day of week.

TABLE 17 — DAY OF WEEK

DAY OF WEEK	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Sunday	11	10.8	32	13.5	43	12.7
Monday	17	16.7	38	16.0	55	16.2
Tuesday	15	14.7	26	11.0	41	12.1
Wednesday	9	8.8	37	15.6	46	13.6
Thursday	17	16.7	32	13.5	49	14.5
Friday	18	17.6	34	14.3	52	15.3
Saturday	15	14.7	38	16.0	53	15.6
TOTAL	102	100.0	237	100.0	339	100.0

Table 18 shows that suicides were evenly distributed overall 12 months of the year, with December having experienced the most suicides (11.6%). There were no significant differences found between holding and detention facility suicides in regard to month of year.

TABLE 18 — MONTH

MONTH	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
January	9	8.8	21	8.9	30	8.8
February	9	8.8	17	7.2	26	7.7
March	8	7.8	16	6.8	24	7.1
April	10	9.8	20	8.4	30	8.8
May	14	13.7	16	6.8	30	8.8
June	6	5.9	21	8.9	27	8.0
July	5	4.9	18	7.6	23	6.8
August	7	6.9	19	8.0	26	7.7
September	7	6.9	14	5.8	21	6.2
October	5	4.9	27	11.4	32	9.4
November	7	6.9	24	10.1	31	9.1
December	15	14.7	24	10.1	39	11.6
TOTAL	102	100.0	237	100.0	339	100.0

3. Method and Instrument

As indicated by Table 19, the overwhelming majority (93.5%) of suicide victims chose hanging as their method of suicide. There were not any significant differences found between holding and detention facility suicides in regard to method of suicide.

TABLE 19 — METHOD

METHOD	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Hanging	101	99.0	216	91.1	317	93.5
Overdose			4	1.7	4	1.2
Cutting			4	1.7	4	1.2
Shooting	1	1.0	3	1.3	4	1.2
Jumping			2	.8	2	.5
Ingestion of Foreign Object			1	.4	1	.3
Other			7	3.0	7	2.1
TOTAL	102	100.0	237	100.0	339	100.0

As can be seen by Table 20, 47.9% of the victims used their bedding to commit suicide. Over 33% used clothing other than shoelaces or belts. *Further, significant differences were*

TABLE 20 — INSTRUMENT

INSTRUMENT	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Shoelace	8	7.9	9	4.0	17	5.2
Belt	2	1.9	3	1.4	5	1.5
Other Clothing	64	63.3	46	20.4	110	33.7
Bedding	21	21.0	135	60.0	156	47.9
Razor Blade			1	.4	1	.3
Gun	1	1.0	3	1.3	4	1.3
Towel			12	5.3	12	3.7
Knife	1	1.0			1	.3
Glass			2	.9	2	.6
Drugs			3	1.4	3	.9
Other	4	3.9	11	4.9	15	4.6
Unknown	1		12		13	
TOTAL	102	100.0	237	100.0	339	100.0

found between holding and detention facility suicides in-regard to instrument used. Clothing (other than shoelaces and belts) was utilized in 63.3% of the holding facility suicides, followed by bedding 21%. In wide contrast, beddingwas used in 60% of all detention facility suicides, followed by other clothing, 20.4%. These differences can presumably be attributed to the fact that, due to nature and functions, holding facilities do not always confine individuals overnight and, therefore, have less a reliance on bedding.

4. Time Span Suicide and Finding Victim

As presented by Table 21, 42.3% of the respondents stated that they found the suicide victim in less than 15 minutes after the act. However, almost 25% of the respondents admitted

TABLE 21 — TIME SPAN

TIME SPAN	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Less Than 15 Minutes	44	47.3	89	40.3	133	42.3
15-30 Minutes	26	28.0	73	33.0	99	31.5
30-60 Minutes	14	15.0	33	14.9	47	15.0
1-3 Hours	8	8.6	17	7.7	25	8.0
Greater Than 3 Hours	1	1.1	9	4.1	10	3.2
Unknown	9		16		25	
TOTAL	102	100.0	237	100.0	339	100.0

to finding the victim between 30 minutes and 3 hours. There were no significant differences found between holding and detention facility suicides in regard to time span.

5. Isolation

Table 22 shows that two out of every three victims (66.9%) had been held in isolation prior to their suicides. There were no significant differences between holding and detention facility suicides in regard to isolation.

Isolation has many uses in jails. The "drunk tank" is used for the intoxicated individual during the withdrawal process. The "juvenile wing," as it is often referred to, is an isolation cell

used to keep juveniles separate from adults both in "sight and sound." The "observation tank" might be used for those individuals expressing suicidal tendencies. A "padded cell" is used for the inmates diagnosed as being mentally ill. The "hole" is used for problem inmates. In most

TABLE 22 — ISOLATION

ISOLATION	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Yes	70	69.3	154	65.8	224	66.9
No	31	30.7	80	34.2	111	33.1
Unknown	1		3		4	
TOTAL	102	100.0	237	100.0	339	100.0

instances, the use of isolation is for the convenience of the staff, and usually to the detriment of the inmate because it unconsciously causes reduced staff supervision/ observation. whether its use is disciplinary or observational, isolation can pose a special threat to inmates who have limited abilities to cope with frustration. Experts have theorized that "inmates 'react to solitary confinement with surges of panic, despair, or rage. They lo& control, break down, regress.' Others conclude: 'it appears that inmates in dissociation and, to a lesser extent, in protective dissociation, commit suicide proportionately more than inmates situated in other areas'."[20]

6. Mental Health/Medical History

As part of the survey, respondents were asked if the suicide victims had any indications of prior suicide attempts, mental illness, and/ or medical problems. As indicated by Table 23, 84.1% of the victims did not have a prior suicide attempt that was *known* to officials. As

[20] See Lindsey M. Hayes and Barbara Kajdan, And Darkness Closess In.. .A National Study of jail Suicides Washington, D.C: National Center on Institutions and Alternatives, October, 1981, pp. 34-35 and 48-49.

TABLE 23 — PRIOR SUICIDE ATTEMPTS (KNOWN TO OFFICIALS)						
	FACILITY TYPE					
PRIOR SUICIDE ATTEMPTS	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Yes	6	11.1	27	17.5	33	15.9
No	48	88.9	127	82.5	175	84.1
Unknown	48		83		131	
TOTAL	102	100.0	237	100.0	339	100.0

detailed in Table 24, when asked whether there was any indication of mental illness in the victims prior to their suicides, 80.7% of the respondents said they were not aware of any.

TABLE 24 — MENTAL ILLNESS (KNOWN TO OFFICIALS)						
	FACILITY TYPE					
MENTAL ILLNESS	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Yes	7	9.6	45	23.0	52	19.3
No	66	90.4	151	77.0	217	80.7
Unknown	29		41		70	
TOTAL	102	100.0	237	100.0	339	100.0

Finally, as can be seen in Table 25, 79.4% of the victims did not have any medical problems ***known*** to officials.

TABLE 25 — MEDICAL PROBLEMS (KNOWN TO OFFICIALS)						
	FACILITY TYPE					
MEDICAL PROBLEMS	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Yes	12	15.8	45	22.4	57	20.6
No	64	84.2	156	77.6	220	79.4
Unknown	26		36		62	
TOTAL	102	100.0	237	100.0	339	100.0

There were differences between holding and detention facility suicides in regard to prior suicide attempts, mental illness, and medical problems. Although in the minority, suicide victims identified by respondents as exhibiting any of these three variables were more likely to be found in detention, rather than holdingfacilities, i.e, 17.3% versus 11.1% for prior suicide attempts, 23% versus 9.6% for mental illness; and 22.4% versus 15.8% for medical problems. These differences can presumably be attributed to the likelihood of intake screening being found more frequently in detention facilities. However, a closer examination of each table also reveals a significant percentage (18 to 39%) of "unknown" responses to survey questions regarding the three variables and, thus, calling into question the frequency and extensiveness of screening see Section IV. Further, caution should also be exercised because a significant percentage of jail facilities have inadequate intake screening procedures from which to derive information regarding prior suicide attempts and history of mental illness and/or medical problems. Research and psychological autopsies reveal a high correlation between these variables and jail suicide.

7. Suicide Screening Forms

As can be seen by Table 26, an overwhelming majority (88.5%) of the victims were not screened for potentially suicidal behavior prior to their death? In regard to holding facilities, ***only*** 3.4% of the victims were screened. A further discussion of screening can be found in Section IV.

TABLE 26 — SUICIDE SCREENING FORMS

SUICIDE SCREENING FORMS	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	
Yes	3	3.4	33	14.7	36	11.5
No	85	96.6	191	85.3	276	88.5
Unknown	14		13		27	
TOTAL	102	100.0	237	100.0	339	100.0

[21] In addition, project staff asked for, and received, 75 screening forms from respondents. Upon closer examination, however, 58 of these forms were found to be inadequate in regard to suicide prevention screening, see Section IV.

8. Length of Incarceration

As presented in Table 27, over 50% of the victims were dead within the first 24 hours of incarceration, and 28.5% occurred within the first three hours. ***Further, there were significant diffeences between holding and detention facility suicides in regard to length of incarceration. Data revealed that 64.3%*** of ***all holding facility suicides took place within the***

TABLE 27 — LENGTH OF INCARCERATION

LENGTH OF INCARCERATION	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	
0-3 Hours	65	64.3	30	12.9	95	28.5
4-6 Hours	16	15.8	15	6.5	31	9.3
7-9 Hours	8	7.9	7	3.0	15	4.5
10-12 Hours	2	2.0	5	2.2	7	2.1
13-18 Hours	1	1.0	5	2.2	6	1.8
19-24 Hours	3	3.4	14	6.0	17	5.2
25-48 Hours	4	4.0	18	7.8	22	6.6
2-14 Days			50	21.5	50	15.0
15-30 Days	1	1.0	25	10.7	26	7.8
1-4 Months	1	1.0	38	16.4	39	11.7
5-7 Months			19	8.2	19	5.7
8-12 Months			5	2.2	5	1.5
More than 1 Year			1	.4	1	.3
Unknown	1		5		6	
TOTAL	102	100.0	237	100.0	339	100.0

first three hours of incarceration; 80.1% within the first six hours. In contrast, 12.9% of all detention facility suicides occurred within the first three hours of incarceration; 19.4% within the first six hours. Such differences are probably a result of the criteria by which each facility operates, (i.e., 0-48 hours versus over 48 hours). Despite this probable explanation, however, the fact remains that while the average length of stay in detention facilities is 6 to 11 days (see Table I), over 30% of all suicide victims in these facilities are dead within the first 24 hours of incarceration.

9. Possible Relationships

The initial entry into a jail can be a frightening experience. For the first time arrestee, the feeling is one of fear, confusion, and uncertainty of the immediate future. For the chronic offender, re-entry might engender frustration at finding oneself in a situation to which he or she vowed never to return. NCIA's 1981 study found a significant relationship between suicide and length of incarceration. Specifically, the characteristics of *most serious charge, isolation,* and *intoxication were* found to be closely associated to the victim's *length* of *incarceration* prior to death.

In regard to most serious charge, 56% of victims charged with alcohol/ drug-related offenses died within the first three hours of confinement. In contrast, almost 50% of victims charged with violent/ personal offenses died after 15 days of confinement, and usually between two and seven months. Only 8.5% of arrestees died within the first three hours. In addition, 63% of the victims placed in isolation committed suicide within the first 48 hours of incarceration, with over 30% of these victims dying within the first three hours of confinement. Finally, over 88% of victims under the influence of alcohol and/ or drugs at the time of incarceration committed suicide within the first 48 hours of confinement, with over half of these victims dying within the first three hours of confinement (see Appendix A).

In conducting the present study, project staff again analyzed these three variables as they each relate to length of incarceration. The findings are presented below.

a) Length of Incarceration By Most Serious Charge

Table 28 shows that 51.7% of all victims who were charged with alcohol/ drug related offenses died within the first three hours of confinement. In contrast, almost 60% of all victims charged with violent/ personal offenses died after three days of confinement, usually between two and four months.

Although a table is not shown, alcohol/ drug-related offenses did impact upon the length of incarceration for detention facility victims. Over 35% of detention facility victims arrested for alcohol/ drug-related offenses died within the first three hours of confinement. In contrast, 28% of detention facility victims arrested for violent/ personal offenses died between

TABLE 28 — LENGTH OF INCARCERATION BY MOST SERIOUS CHARGE*

LENGTH OF INCARCERATION	MOST SERIOUS CHARGE									
	VIOLENT/ PERSONAL		SERIOUS PROPERTY		MINOR OTHER		ALCOHOL/ DRUG		COMBINED	
	N	Percentage	N	Percentage	N	Percentage	N	Percentage	N	Percentage
0-3 Hours	14	16.9	10	15.6	25	26.3	46	51.7	95	28.7
4-6 Hours	1	1.2	8	12.5	7	7.3	15	16.9	31	9.4
7-9 Hours	4	4.8	1	1.6	2	2.1	8	9.0	15	4.5
10-12 Hours	3	3.6	2	3.2	1	1.1	1	1.1	7	2.1
13-18 Hours	3	3.6	1	1.6	2	2.1			6	1.8
19-24 Hours	4	4.8	3	4.7	7	7.4	3	3.4	17	5.2
25-48 Hours	5	6.0	5	7.8	8	8.4	4	4.5	22	6.6
2-14 Days	15	18.2	11	17.2	20	21.1	4	4.5	50	15.1
15-30 Days	3	3.6	7	10.9	14	14.7	1	1.1	25	7.6
1-4 Months	19	22.9	7	10.9	8	8.4	5	5.6	39	11.8
5-7 Months	8	9.6	7	10.9	1	1.1	2	2.2	18	5.4
8-12 Months	3	3.6	2	3.1					5	1.5
More Than 1 Year	1	1.2							1	.3
TOTAL	83	100.0	64	100.0	95	100.0	89	100.0	331	100.0

Unknown = 8

*Only Column Percentage Shown

two and four months; 23% of serious property offense victims died between 2 and 14 days; and 28% of minor other offense victims died between 2 and 14 days.

There was no appreciable relationship found between length of incarceration and most serious charge in regard to holding facility victims.

b) Length of Incarceration By Isolation

As indicated by Table 29, over 62% of suicide victims placed in isolation died within the first 48 hours of incarceration. In addition, over 31% of these victims died within the first three hours of confinement. There was no appreciable difference between holding and detention facility suicides in regard to length of incarceration and isolation.

However, further analysis revealed that, absent the isolation variable, 58% of all suicide victims in the study were dead within the first 48 hours; with almost 29% occurring within the first three hours (see prior reference to Table 27). When the use of isolation is introduced as a

variable; there is only a slight increase in suicides occurring within the first 48 hours (from 58% to 62%). Therefore, ***although two out*** of ***every three suicides occur in isolation, such a phenomenon can perhaps be attributed more to a lack of supervision/observation than to stress and other factors associated with length of incarceration.***

TABLE 29 — LENGTH OF INCARCERATION BY ISOLATION

LENGTH OF INCARCERATION	ISOLATION					
	YES		NO		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
0-3 Hours	70	31.4	24	22.6	94	28.6
4-6 Hours	16	7.2	15	14.2	31	9.4
7-9 Hours	12	5.4	2	1.9	14	4.3
10-12 Hours	7	3.1			7	2.1
13-18 Hours	3	1.3	2	1.9	5	1.5
19-24 Hours	12	5.4	5	4.7	17	5.2
25-48 Hours	19	8.5	3	2.8	22	6.7
2-14 Days	36	16.1	14	13.2	50	15.2
15-30 Days	16	7.2	9	8.5	25	7.6
1-4 Months	21	9.4	18	17.0	39	11.9
5-7 Months	8	3.7	11	10.4	19	5.7
8-12 Months	2	.9	3	2.8	5	1.5
More Than 1 Year	1	.4			1	.3
TOTAL	223	100.0	106	100.0	329	100.0

Unknown = 10

c) Length of Incarceration By Intoxication

The study found a very strong relationship between intoxication and length of incarceration prior to suicide. As can be seen by Table 30, the vast majority (77.7%) of suicide victims who were intoxicated died within the first 24 hours of confinement; and 48.1% of the intoxicated victims died within the first three hours of confinement.

TABLE 30 — LENGTH OF INCARCERATION BY INTOXICATION						
	INTOXICATION					
LENGTH OF INCARCERATION	YES		NO		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
0-3 Hours	63	48.1	8	9.4	71	32.9
4-6 Hours	20	15.3	6	7.1	26	12.0
7-9 Hours	10	7.6	2	2.3	12	5.6
10-12 Hours	1	.7	2	2.3	3	1.4
13-18 Hours	1	.7	1	1.2	2	.9
19-24 Hours	7	5.3	2	2.3	9	4.2
25-48 Hours	5	3.8	6	7.1	11	5.1
2-14 Days	6	4.6	22	25.9	28	13.0
15-30 Days	4	3.1	12	14.1	16	7.3
1-4 Months	9	6.9	13	15.3	22	10.2
5-7 Months	3	2.3	10	11.8	13	6.0
8-12 Months	2	1.6			2	.9
More Than 1 Year			1	1.2	1	.5
TOTAL	131	100.0	85	100.0	216	100.0
Unknown = 123						

V. SPECIAL CONSIDERATIONS

A) Intake Screening and Suicide Prevention

Experts generally agree that certain signs and symptoms exhibited by the detainee often foretell a possible suicide and, if detected, could prevent such an incident. What an individual says and how he/ she behaves while being arrested, transported to the jail, and at booking, are vital in detecting suicidal behavior. An individual may exhibit warning signs and symptoms that include:[22]

- Depression (Physical Signs)
  - a. sadness and crying
  - b. withdrawal or silence
  - c. sudden loss or gain in appetite
  - d. insomnia
  - e. mood variations
  - f. lethargy
- Intoxication/ Withdrawal
- Talking about or threatening suicide
- Previous suicide attempts
- History of mental illness
- Projecting hopelessness or helplessness
- Speaking unrealistically about future and getting out of jail
- Increasing difficulty relating to others
- Not effectively dealing with present; is preoccupied with past
- Giving away possessions; packing belongings
- Severe aggressiveness
- Paranoid delusions or hallucinations

Properly trained jail personnel can effectively assess suicide potential both at the booking stage and during subsequent phases of an inmate's incarceration. During thebooking stage, intake screening is imperative to suicide prevention. In addition to assessing suicide potential, intake screening serves to detect most medical and mental health problems, and addresses classification needs. ***Experts stress that intake screening must be performed on***

[22] See Joseph R Rowan and Lindsay M. Hayes, Chapter 11.

every arrestee immediately upon entry into the jail facility. Although intake screening can be utilized to detect a great portion of potentially suicidal behavior, inmates can become suicidal at any stage of their incarceration. Therefore, ***continued observation and awareness*** of potentially suicidal behavior is an added key to prevention.

Intake screening is not meant to be an in-depth, time consuming evaluation of an arrestee's health needs. It is designed to be utilized by the booking officer as a form of triage to detect suicidal behavior; physical injuries/ trauma and infectious diseases; chronic and acute mental illness; medications taken and special health requirements; and alcohol or drug intoxication._

1. Screening Forms

It was once offered - 'The American jail obtains very little information about the prisoners committed to its keeping, retains little of what is obtained in any usable form, and reports almost nothing of what is useable to higher authorities.'= Although this harsh criticism was directed toward jail record-keeping practices in general, it seems apropos to suicide prevention screening.

While the importance of intake screening is fully realized by experts, there is skepticism regarding its extent and quality. Although incomplete, previous research efforts have pointed to the inadequacy of screening. In a 1982 survey of over 2,600 jails throughout the country, the National Sheriffs' Association reported that only 41% of such facilities conducted initial medical screening on detainees.[24] Further, a 1984 survey of police departments in Massachusetts found that 89% of the responding facilities did not ask any questions regarding

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[23] Hans Mattick, The Contemporary Jails of the United States," in Handbook of Criminology, ed. Daniel Glaser, New York Rand McNally, 1974.

[24] National Sheriffs' Association, *The State of Our Nation's Jails.* Alexandria, Virginia, 1982, p. 207-212. The authors reported that "only a quarter of the jails in the smallest category (l-16 inmates) conduct an initial medical screening whereas nearly 75% conduct medical screening in the largest category (63 up). This might have something to do with the larger jails being sued over a badly run medical operation. Medical reasons ranked third for the category (63-up) as the basis for being currently under court order."

suicidal behavior of detainees upon their booking - "Some lockups, in responding to the questionnaire, reported having the fear that asking about suicide may 'put the idea into their heads'."[25]

Screening was first promulgated in 1978 (later revised in 1981) by the American Medical Association (AMA)'s *Standards for Health Services in Jails.* [26] These forms, nationally recognized and utilized throughout the country, are broken down into two sections - booking officer's visual opinion and officer-inmate questionnaire (see Appendix D). According to the AMA, receiving screening is a system of structured inquiry and observation designed to prevent newly arrived inmates who pose a health or safety threat to themselves or others from being admitted to the facility's general population and to get them rapidly admitted to medical care."[27]

Some critics argue that these forms can not sufficiently be utilized alone to identify potentially suicidal behavior. In fact, the 1978 and 1981 versions include only one specific reference to suicidal behavior - "Does the inmate's behavior suggest the risk of suicide?" (1978); and "Behavior suggests risk of suicide or assault?" (1980). It should benoted, however, that the early AMA forms were later revised in 1982 by the American Health Care Consultants, Inc., and in 1986-1987 by the National Commission of Correctional Health Care (NCCHC). [28] The new form offers some improvement over the earlier forms in regard to suicide detection - "Does inmate appear to be despondent?", "Does inmate appear to be irrational or 'crazy'?", "Have you ever tried to kill yourself or done serious harm to yourself?", "Is this the first time

[25] Special Commission to Investigate Suicide in Municipal Detention Centers, p. 30.

[26] See American Medical Association, *Standards for Health Services in Jails,* Chicago, Illinois: American Medical Association, September, 1981.

[27] Ibid, p. 22.

[28] See American Health Care Consultants, Inc., Receiving Screening for Medical Emergencies and Potential Suicide in District Lockups - A Training Program for the Chicago Police Department. Chicago, Illinois, 1982, and the National Commission of Correctional Health Cam, Standards for Health Services in Jails, Chicago, Illinois, January, 1987.

you have ever been incarcerated?", (short version); "Behavior suggesting risk of suicide or assault?", Admits to previous "suicide attempt" (long version).[29] These forms are accompanied by detailed screening guidelines, designed to assist the examiner in making a better determination of health risk assessment. The NCCHC screening forms were not critiqued for purposes of this present study because survey respondents had not yet had access to them.

Thus, it can be argued that the above referenced screening forms, while nationally recognized as models for overall health assessment, are somewhat limited in their ability to detect suicidal behavior. As such, and as a supplement to initial health screening, various jurisdictions have begun to develop screening forms that are specifically designed for jail suicide prevention. One such jurisdiction is the state of New York.

In March, 1986, under the auspices of the Office of Mental Health, Commission of Correction,UlsterCounty Mental Health Services, and Division of Criminal Justice Services - Bureau for Municipal Police, the state of New York began to implement ***Suicide Prevention Screening*** Guidelines in all of its jails and **lockups.** The screening form (see Appendix D) is divided into four sections: observations of transporting officer, personal data, behavior/ appearance, and criminal history. Answers to the following questions/ observations are obtained:

- Arresting or transporting officer believes that detainee may be a suicide risk.
- Detainee lacks close family or friends in the community.
- Detainee has experienced a significant loss within the last six months.
- Detainee is very worried about major problems other than legal situation.
- Detainee's family or significant other has attempted or committed suicide.
- **Detainee has psychiatric** history.
- Detainee has history of drug or alcohol abuse.
- Detainee holds position of respect in community and/ or alleged crime is shocking in nature.
- Detainee is thinking about killing himself.
- Detainee has previous suicide attempt.

[29] Ibid, p. 65.

- Detainee feels that there is nothingto look forward to in the future.
- Detainee shows signs of depression.
- Detainee appears overly anxious, afraid or angry.
- Detainee appears to feel unusually embarrassed or ashamed.
- Detainee is acting and/ or talking in a strange manner.
  (a) Detainee is apparently under the influence of alcohol or drugs.
  (b) If YES, is detainee incoherent, or showing signs of withdrawal or mental illness?
- No prior arrests.

Many experts agree that the ***Suicide Prevention Screening Guidelines*** form is, by far, the most comprehensive screening form developed to date, and it is beginning to be utilized in other jail facilities outside the state of New York.

In conducting the present study, survey respondents were asked - 'Were any written forms utilized at booking to screen for potentially suicidal behavior in the victim? If 'Yes,' please enclose such form when returning this survey." As previously indicated, only 11% of the jail facilities were found to adequately screen detainees for potentially suicidal behavior.[30] Project staff received 75 screening forms from respondents experiencing a jail suicide during 1986. A review of those forms points to further inadequacy in screening of the 1986 jail suicide victims. As can be seen by Table 31, project staff distributed these 75 screening forms into five categories. The vast majority ***(77.3%)*** of forms received were judged ***inadequate*** because they were either facsimiles of the previously discussed AMA forms (1978 or 1981 versions), or they

[30] This figure is admittedly "soft" for several reasons. First, if respondents answered "unknown" to previous survey questions regarding prior suicide attempts, mental illness, and/or medical problems, yet answered "yes" to screening the victim prior to his/her suicide, such affirmative answers were changed to "no" by project staff. Second, if respondents answered "yes" to screening the victim prior to his/her suicide, yet enclosed an inadequate screening form or one that more resembled a booking form/arrest card, such affirmative answers were also changed to "no" by project staff. In all, only 58 of 339 surveys were adjusted by project staff to more accurately reflect screening of suicide victims. Regardless, had the surveys not been corrected, 70% of the respondents still reported having no screening procedures.

were medical assessment forms with little or no reference to suicidal behavior (Category A, B, and C). Reference to suicidal behavior on these forms was, for the most part, limited to prior

TABLE 31 — SCREENING FORMS RECEIVED FROM SURVEY RESPONDENTS

CATEGORY/FORM DESCRIPTION	N	PERCENTAGE
A Inadequate, arrest-booking, exclusively medical, no mention of suicidal behavior.	13	17.3
B Inadequate, classification, "check-list" of ailments, one reference (prior attempt) to suicidal behavior.	15	20.0
C Inadequate, AMA facsimile, medical, booking officer's visual opinion/officer-inmate questionnaire, limited specific reference to suicidal behavior.	30	40.0
D Acceptable, medical, increased specific reference to suicidal behavior.	11	14.7
E Exceptional, New York State facsimile, or independent form with exclusive reference to suicidal behavior, observation of transporting officer.	6	8.0
TOTAL	75	100.0

history of suicide attempts. Only Category D and E forms, comprising 22.7% of the respondents, were deemed acceptable because they were either independently and exclusively utilized for the detection of suicidal behavior, or they adequately combined medical and suicidal assessment criteria. In addition, such forms solicited observations from the transporting officers.

Project staff are fully cognizant of the fact that an arrestee's booking can be a chaotic, time consuming process. Often, one officer is responsible for multiple bookings. However, as previously discussed, intake screening is not meant to be an in-depth or unusually lengthy evaluation of an arrestee's health needs. It should be utilized for every arrestee immediately

upon entering into the facility as a form of *triage*. What an individual says and how he/ she behaves while being arrested, transported to the jail, and at booking, are vital for detecting suicidal behavior. The importance of proper intake screening is magnified when as the present research indicates, 89% of the suicide victims were not afforded any screening at the time of their booking.

2. Suicide Prevention Program

Recent research suggests that "there is clearly an inter-relationship between the issues of staff numbers, staff training and written policies and procedures. . . and that the factors in combination would have a powerful effect on reducing problems of suicides. . . ." [31] Experts generally agree that a facility's suicide prevention program should include the following elements: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting and review?

In conducting the present study, survey respondents were asked -"Does your facility ***operate*** a suicide prevention program? If 'Yes,' briefly list the procedures utilized to identify and ***observe*** potentially suicidal inmates. (If necessary, please attach additional sheets.)" As can be seen by Table 32, survey respondents were almost evenly divided regarding the issue

TABLE 32 — SUICIDE PREVENTION PROGRAM

SUICIDE PREVENTION PROGRAM	FACILITY TYPE					
	HOLDING (0-48 HOURS)		DETENTION (OVER 48 HOURS)		COMBINED	
	N	Percentage	N	Percentage	N	Percentage
Yes	29	31.9	133	58.3	162	50.8
No	62	68.1	95	41.7	157	49.2
Unknown	11		9		20	
TOTAL	102	100.0	237	100.0	339	100.0

[31] See Kimme Planing and Architecture, The Nature of New Small Jails: Report and Analysis, Champaign, Illinois, October, 1985, p. 59.

[32] See National Commission of Correctional Health Care, pp. 37-38.

of whether their facility had a suicide prevention program - 50.8% (yes) versus 49.2% (no). The table reveals, however, that *a number of respondents did not know whether their facility had such a program or not.*

Due to survey design, the question was structured in such a way to solicit a quantitative, rather than qualitative, understanding of the extent of suicide prevention programs. However, when respondents were asked to "briefly" list the procedures utilized to identify and observe potentially suicidal inmates, answers commonly received included referral to mental health services, screening, increased observation, and television monitoring. Further research and analysis would be necessary to examine the quality and extent of these programs.

The findings also show that, in holding facilities, almost 32% of suicides took place in the presence of a prevention program. In contrast, 58.3% of detention facility suicides occurred despite the presence of a prevention program. Such findings are disturbing and, in lieu of the fact that 85% of the detention facility victims were not screened (see Table 26), calls into question the extent of suicide prevention programming in these facilities. Further research and analysis is necessary to examine this issue.

B) NCIA's National Studies of Jail Suicide: Comparison of 1979 and 1986 Data

As previously discussed, NCIA completed the study - *And Darkness Closes In..A National Study of Jail* Suicides for the National Institute of Corrections in October, 1981. The study documented 419 suicides occurring in county and local jails during 1979, the year selected for analysis. Demographic data was subsequently collected on 344 of these suicides. The current study, which documented 401 jail suicides occurring in 1986, had a demographic data base of 339 cases.

Table 33 comprises various demographic characteristics of the 1979 and 1986 jail suicide samples. As can be seen, despite a seven-year interval, jail suicide demographic data has not substantially changed. In the 1986 data, there was a slight increase in the percentage of White suicide victims over the 1979 data. In addition, the average age increased from 28 to 30 years old. In regard to the most serious charge, there was an increase in "minor other" offenses, with

TABLE 33

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

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

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

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

a corresponding, although slight, decrease in the otheroffense groups. Further, there was a significant increase in victims with prior charges, from 53% in 1979 to 78% in 1986.

There were also slight differences in regard to the instrument used to commit suicide -most notably shoelaces and belts, two instruments that are most often routinely confiscated from incoming arrestees. Although bedding clearly remained the instrument of choice, there was a significant drop in the number of victims who utilized their belts, and a slight increase in the use of shoelaces.

Absent the above variations, there were not any appreciable differences in jail suicide characteristics from the 1979 and 1986 samples. Most of the key characteristics of jail suicide - offense, intoxication, method/ instrument, isolation, and length of incarceration - have remained constant over time.

C) Jail Suicide Rates[33]

As previously stated, suicide is the leading cause of death in our nation's jails. Jail suicide rates, based upon average daily population figures, are often compared to the suicide rate for the general population.[34] Previously, experts have projected that the rate of suicide in jail facilities is several times greater than that of the general population. For example, the suicide rate for the general population in Texas during 1981 was 12.6 suicides per 100,000. The suicide rate for all Texas jails was 137.5 suicides per 100,000, or approximately 11 times as high as the suicide rate for the general population.[35] A 1984 study of South Carolina jails found the suicide rate in jails to be 14 times greater than that of the general population.[36] Earlier research

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[33] The calculation of jail suicide rates, as detailed within, does not not represent the official position of the National Institute of Corrections.

[34] Average daily population figures are utilized because yearly admission statistic are dramatically unreliable and the vast majority of individuals spend considerably less time in jail during the year than in the general population, thus making comparisons baaed upon yearly admissions inappropriate. (Conversation with U.S. Department of Justice's Bureau of Justice Statistics staff on February 11, 1988.)

[35] William E. Stone, "Jail Suicide," *Corrections Today,* December, 1987, p. 84.

[36] John M. Memory, p. 2

efforts had documented a rate of 108 suicides per 100,000 inmates of Los Angeles county jails, and 57.5 suicides per 100,000 in a sample of county jails in a midwestem state.[37]

There are several explanations for the higher rate of suicide in jail. First, an inmate can be facing a crisis situation involving: 1) recent excessive drinking and/ or use of drugs; 2) recent loss of stabilizing resources; 3) severe guilt or shameover the offense; 4) sexual assault or threat of such; 5) current mental illness; 6) poor physical health or terminal illness; and. 7) an emotional breaking point. Second, from the inmate's perspective, there are certain unique characteristics of jail environments which enhance suicidal behavior. They include: 1) fear of the unknown; 2) authoritarian environment; 3) no apparent control over the future; 4) isolation from family and significant others; 5) shame of incarceration; and 6) dehumanizing aspects of incarceration.

Some theorists argue that jail populations are biased in a number of ways that affect and, perhaps, distort suicide rates. Stone has stated that: "It would be very easy to simply assume that high suicide rates in jails are the result of poor conditions, poor administration and a larger of public concern; however, the problem is much more complex. Many of the factors that influence jail suicides stem from jails' unique functions. This is not to say that jail administrators do not bear the responsibility for suicide prevention, but that a larger perspective is needed on the subject of jail suicides. Two of the primary problems that make jails high suicide risk points are their unusual population and the high cyclic rate or the total number of people exposed to a jail in the course of a year."[38]

Stone argues that there are certain variables (including sex, age, marital status, occupational status, alcoholism, etc.) which relate to suicide in the general population that are predominantly found in jails and, therefore, making such environments more suicide prone.

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[37] **See Bruce Danto (Editor), Jail House Blues, Orchard Lake, Michigan: Epic Publication, 1973, pp. 27-46 and 47-54.**

[38] **William E. Stone,. p. 84.**

He states: "The second major problem affecting the jail suicide rate is the 'cyclic rate'. . . .What is occurring in jails is that large numbers of a very suicide-prone population are submitted to short periods of stay. You might say that our jails are 'testing' the suicide potential of a suicide-prone group.-

Despite this possible distortion, the examination of suicide rate comparisons enhances our general understanding of the jail suicide problem. During this national study of jail suicides, project staff examined the most recent statistics available on suicide in the general population. According to the Census Bureau, there were 12.3 suicides per 100,000 people in the United States for the year ending 1985."'

As previously reported, project staff identified 401 jail suicides for 1986. Of these deaths, 285 occurred in detention facilities, 116 in holding facilities. For purposes of this study, rates of suicide in holding facilities were not computed due to the unreliability of average daily population data. *As such, with a base of 285 suicides and an average daily jail population of 265,517, there were 107 suicides per 100,000 inmates in detention facilities during 1986." Therefore, based upon this national study of jail suicides, it is projected that the suicide rate in detention facilities is approximately nine timesgreater than that of thegeneral population.*

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[39] Ibid, p. 85.

[40] Rate based upon 29,453 suicides for a United States population of 240,344,000.

[41] Average daily population statistics found in US. Department of Justice, Bureau of Justice Statistics Bulletin, *Jail Inmates 1986,* Washington, DC: Bureau of Justice Statistics, October, 1987.

VI. SUMMARY/ CONCLUSION

As previously discussed, project staff analyzed data on 339 of the 401 jail suicides identified for 1986. Holding facilities comprised 30% of the jail suicides, while detention facilities accounted for 70% of such deaths. Highlights of the data included findings that:

- 72% of victims were white.
- 94% of victims were male.
- Average (mean) age of the victim was 30.
- 52% of victims were single.
- 75% of victims were detained on non-violent charges, with 27% detained on alcohol/ drug related charges.
- 89% of victims were confined as detainees.
- 78% of victims had prior charges, yet only 10% were previously held on personal/ violent offenses.
- 60% of all victims were intoxicated at the time of incarceration.
- 30% of suicides occurred during a six-hour period between midnight and 6:00 a.m.
- 94% of suicides were by hanging; 43% of victims used their bedding.
- Two out of three victims were in isolation.
- 51% of suicides occurred within the first 24 hours of incarceration; 29% occurred within the first three hours.
- 89% of victims were not screened for potentially suicidal behavior at booking.

- 52% of all victims charged with alcohol/ drug related offenses died within the first three hours of confinement.

- 78% of victims who were intoxicated died within the first 24 hours of incarceration; 48% occurred within the first three hours.

- The suicide rate in detention facilities is projected to be approximately ***nine times*** greater than that of the general population.

In addition, ***holding facility*** data included findings that:

- 46% of victims were held on alcohol/ drug-related charges.

- 82% of victims were intoxicated at the time of their incarceration.

- 64% of victims died within the first three hours.

- 97% of victims were not screened for potentially suicidal behavior at booking.

Suicide remains the leading cause of death in our jails. We have learned from experience that preventing jail suicide is a ***shared*** responsibility, beginning at the point of arrest and ending with those who determine a facility's budget. Further, tools to prevent such deaths - research, written rules and procedures, staff training, intake screening, communication between staff, and human interaction - work efficiently only if they too are ***shared.***

Research remains an important tool in jail suicide prevention efforts. A leading criminologist once stated, perhaps intrinsically, that "In the complex and costly business of social action we should not leave to chance any area of decision-making or any aspect of any situation that can be properly studied."[42] We have and will continue to learn from jail suicide research. This report represents the second wide glimpse at the problem in seven years. Its

[42] Leslie Wilkins, Social Deviance, Englewood Cliffs, New Jersey: Prentice-Hall, 1965.

strength lies in the fact that the findings confirm, with few differences, data from NCIA's 1981 survey. The characteristics of intoxication, isolation and length of incarceration continue to be key indicators of suicidal behavior. In addition, we can also begin to analyze for the first time differences between holding and detention facility suicides.

While we know more about jail suicide prevention than ever before, the need for additional research has never been greater. Future research efforts should focus on control group (non-suicidal) comparisons, psychological autopsies, and successful jail suicide prevention programs. Only by continuing to learn more about the problem and transmitting that knowledge to those entrusted with the custody and care of inmates, will we be in the best possible position to prevent the tragedy of jail suicide.

On an individual basis, experience has clearly demonstrated that almost all jail suicides can be averted with implementation of a prevention program that includes written rules and procedures, staff training, intake screening, communication between staff, and human interaction. The key to prevention remains a capable and properly trained staff, the backbone ingredient of a facility. Such a system, however, will not come to fruition without proactive administrators who not only maintain an awareness of jail suicide as a national problem, but take the initiative to prevent such an occurrence in their own facility.

VII. APPENDICES

A) **Summary of *And Dark Closes In. . .A National Study of Jail Suicides* (1981)**

B) **Survey Instruments from Current Study**

C) **Frequency Distributions of Additional Charges and Prior Charges**

D) **Intake Screening Forms**

E) **Bibliography: Jail Suicide Literature Review**

APPENDIX A

APPENDIX A

AND DARKNESS CLOSES IN. . A ÑATIONAL STUDY OF JAIL SUICIDES

SUMMARY

A) PROFILE OF THE SUICIDE VICTIM

In October, 1981, NCIA completed the study - *And Darkness Closes In.. A National Study of Jail Suicides* for the National Institute of Corrections. The study documented 419 suicides occurring in county and local jails during 1979, the year selected for analysis.

As can be seen by Table 1, these suicides were distributed in 48 states, plus the District of Columbia.

TABLE 1 — JAIL SUICIDES BY STATE IN 1979

California	43	District of Columbia	5
New York	27	Hawaii	5
Texas	25	Kentucky	5
Michigan	22	Minnesota	5
Ohio	22	New Hampshire	5
Florida	21	West Virginia	5
Pennsylvania	16	Colorado	4
Massachusetts	16	New Mexico	4
Illinois	15	South Dakota	4
Virginia	15	Tennessee	4
Georgia	12	Wyoming	4
Indiana	11	Mississippi	3
Louisiana	10	Nebraska	3
New Jersey	10	Delaware	2
Missouri	9	North Dakota	2
Alabama	8	Rhode Island	2
North Carolina	8	Utah	2
Oklahoma	8	Alaska	1
South Carolina	8	Idaho	1
Washington	8	Iowa	1
Arkansas	8	Kansas	1
Maryland	6	Nevada	1
Montana	6	Vermont	1
Oregon	6	Arizona	0
Wisconsin	6	Maine	0
Connecticut	6		
	5	TOTAL:	419

From demographic data collected on 344 of these suicides, the NCIA study constructed a profile of the victim. The victim was most likely to be a 22-year-old White, single male. He would have been arrested for public intoxication, the only offense leading to his incarceration, and would thereby be under the influence of alcohol. Further, the victim would not have had a significant history of prior arrests. He would be taken to an urban county jail and immediately placed in isolation for his own protection and/or surveillance. However, less than three hours after incarceration, the victim would be dead. He would have hanged himself with material from his bed (i.e., sheet or pillowcase). The incident would have taken place on a Saturday night in September, between the hours of midnight and 1:00 a.m Jail staff would have found the victim, they say, within 15 minutes of the hanging. Later jail records would indicate that the victim did not have a history of mental illness or previous suicide attempts

The scenario described above is, of course, based solely on a "hypothetical construct." Detailed findings of this study are presented below.

B) PERSONAL CHARACTERISTICS OF VICTIM

1. Race

As can be seen in Table 2, this study found that 67.3% of the victims were White, 21.6% were Black, and 11.1% were designated "Other" (including Spanish/Mexican, American Indian, and Unspecified).

TABLE 2 — RACE

	N	PERCENTAGE
White	231	67.3
Black	74	21.6
Other	38	11.1
TOTAL	343	100.0
UNKNOWN = 1		

2. Sex

As shown in Table 3, NCIA found that an overwhelming 96.5% of the victims were male, while only 3.5% were female. This can most likely be attributed to the preponderance of males in our nation's jails.

TABLE 3 — SEX

	N	PERCENTAGE
Male	332	96.5
Female	12	3.5
TOTAL	344	100.0

3. Age

As can be seen in Table 4, NCIA found that almost 75% of the victims in its study were 32 years old or younger, with 28.7% coming from the 18 to 22 year old category. Over SO% of the victims were between the ages of 18 and 27. The average age was 28. It should also be noted that 13 juvenile suicides (17 years or below) were recorded, comprising 45% of the suicide population.

TABLE 4 - A G E

	N	PERCENTAGE
17 and Below	15	4.5
18-22	96	28.7
23-27	85	25.4
28-32	55	16.4
33-37	35	10.4
38-42	23	6.9
43-47	9	2.7
48-53	9	2.7
54andOver	8	2.4
TOTAL	335	100.0
UNKNOWN=9		

4. Marital Status

As can be seen in Table 5, 53.5% of the victims were single, 9.4% divorced, and 1.0% widowed. An additional 5.9% were separated. Only 30% were married or living under a common-law relationship.

TABLE 5 — MARITAL STATUS

	N	PERCENTAGE
Single	154	53.5
Married	82	28.5
Separated	17	5.9
Divorced	27	9.4
Widowed	3	1.0
Common-Law	5	1.7
TOTAL	288	100.0
UNKNOWN = 56		

5. Most Serious Charge

Table 6 lists the victim's most serious and/or only charge at time of incarceration. As can be seen, 73.6% of the most serious offenses fall within the non-violent Category. Alcohol/drug related charges account for over 30% of the most serious charges. Serious property offenses account for 222%; and the "minor other" category, including such items as petit larceny, traffic offenses, violation of probation, etc., comprise 21.1% of these offenses. In regard to the most serious offense being a violent crime, 26.4%, or only slightly more than one quarter, indicated the presence of violence.

TABLE 6 — MOST SERIOUS CHARGE

	N	PERCENTAGE
Alcohol/Drug Related[1]	102	30.3
Serious Property[2]	75	22.2
Minor Other[3]	71	21.1
Violent/Personal[4]	89	26.4
TOTAL	337	100.0
UNKNOWN = 7		

[1] Offenses included in this category are public intoxication, driving while intoxicated, disorderly conduct, resisting arrest, possession of a controlled dangerous substance, distribution of a controlled dangerous substance, and narcotics (unspecified).

[2] Offenses included in this category ate, burglary, grand larceny, auto theft, robbery (other), receiving stolen property, arson, breaking and entering, entering without breaking, vandalism, and carrying a concealed weapon and/or firearms.

[3] Offenses included in this category are shoplifting, petit larceny, prostitution, sex offenses (other), trespassing, unauthorized use of a motor vehicle, traffic offenses (other), violation of probation, contempt of court, vagrancy, indecent exposure, status offenses, escape, forgery, embezzlement, and other.

[4] Offenses included in this category are murder, negligent manslaughter, armed robbery, rape, indecent assault, assault, battery, aggravated assault, and kidnapping.

6. Jail Status

As can be seen in Table 7, the overwhelming majority (91.4%) of suicide victims were on detention status at the time of their death.

TABLE 7 — JAIL STATUS		
	N	PERCENTAGE
Detained Sentenced	308 29	91.4 8.6
TOTAL	337	100.0
UNKNOWN = 7		

In regard to prior charges, data was obtained on 257 victims. Of these, 133 (51.7%) had one prior charge; 77 (30%) had two prior charges; and 47 (18.3%) had three charges[5]

Further, out of the 133 cases with one prior charge, only 16 were violent offenses; of 77 cases with two prior charges, six were violent; and of 47 cases with three prior charges, eight were violent. Thus, out of a total of 257 prior charges, only 30, or 11.6% were violent in nature.

8. Intoxication (Drug and/or Alcohol)

As can be seen in Table 8, almost 60% of the suicide victims in this study were under the influence of alcohol, drugs, or both at the time of incarceration. Alcohol accounted for almost 40% of this finding; drugs, 9.4%; and the presence of both alcohol and drugs, 113%.

TABLE 8 — INTOXICATION		
	N	PERCENTAGE
Alcohol Drugs Both Neither	82 20 24 87	38.5 9.4 11.3 40.8
TOTAL	213	100.0
UNKNOWN = 131		

[5]It should be pointed out that Project staff recorded data on only the three most serious prior charges of the victim. However, only a small percentage of victims had more than three prior charges.

C) CHARACTERISTICS OF THE SUICIDE ACT

1. Time

As can be seen in Table 9, almost 50% of the suicides occurred during the nine hour period between 9:00 p.m. and 6:00 a.m Midnight to 3:00 a.m. was the highest period for suicides with 65. Other peak hours were 3:00 a.m. to 6:00 a.m., (48); 6:00 to 9:00 a.m., (36); and 9:00 p.m. to 12.00 p.m. (49).

TABLE 9 — TIME

	N	PERCENTAGE
12 Midnight - 3:00 a.m.	65	20.0
3:00 a.m. - 6:00 a.m.	48	14.8
6:00 a.m. - 9:00 a.m.	36	11.1
9:00 a.m. - 12:00 p.m.	23	7.1
12:00 p.m. - 3:00 p.m.	23	7.1
3:00 p.m. - 6:00 p.m.	40	12.3
6:00 p.m. - 9:00 p.m.	41	12.6
9:00 p.m. - 12:00 p.m.	49	15.0
TOTAL	325	100.0
UNKNOWN = 19		

2. Date

As can be seen in Table 10, almost 50% of the suicides occurred on either a Thursday, Friday, or Saturday, with Saturday having the most suicides, 57.

TABLE 10 — DAY OF WEEK

	N	PERCENTAGE
Sunday	50	14.7
Monday	46	13.6
Tuesday	31	9.1
Wednesday	48	14.2
Thursday	52	15.3
Friday	55	16.2
Saturday	57	16.8
TOTAL	339	100.0
UNKNOWN = 5		

As can be seen in Table 11, more suicides occurred during the month of September than any other single month. Forty-two inmates took their lives during this month. The second greatest number of suicides occurred during June when 40 inmates took their lives.

TABLE 11 — MONTH		
	N	PERCENTAGE
January	28	8.3
February	22	6.5
March	33	9.7
April	23	6.8
May	33	9.7
June	40	11.8
July	28	8.3
August	26	7.7
September	42	12.4
October	24	7.1
November	21	6.2
December	19	5.6
TOTAL	339	100.0
UNKNOWN = 5		

3. Method and Instrument

As can be seen in Table 12, an overwhelming majority of victims (95.9%) chose hanging as their method of suicide.

TABLE 12 — METHOD		
	N	PERCENTAGE
Hanging	329	95.9
Overdose	5	1.5
Cutting	1	0.3
Shooting	2	0.6
Jumping	4	1.2
Ingestion	1	0.3
Other	1	0.2
TOTAL	343	100.0
UNKNOWN = 1		

In regard to the instrument used to commit suicide, Table 13 shows that 43.6% of the victims used their bedding. Over 30% used clothing other than shoelaces or belts.

TABLE 13 — INSTRUMENT		
	N	PERCENTAGE
Shoelace	11	3.3
Belt	28	8.5
Other Clothing	105	31.8
Bedding	144	43.6
Rope	1	0.3
Razor Blade	1	0.3
Gun	2	0.6
Towel	16	4.8
Drugs	5	1.5
Other (Unspecified)	17	5.2
TOTAL	340	100.0
UNKNOWN = 4		

4. Time Span Between Suicide and Finding Victim

As can be seen in Table 14, over 35% of the respondents stated that they found the suicide victim in less than 15 minutes after the act. However, 43.6% of the victims were not found until a 15 minute to one hour time-span had elapsed, with 26.8% not found until 30 minutes to 3 hours had gone by.

TABLE 14 — TIME SPAN		
	N	PERCENTAGE
Less than 15 Minutes	112	36.4
15 - 30 Minutes	94	27.3
30 - 60 Minutes	56	16.3
1 - 3 Hours	36	10.5
Over 3 Hours	10	2.9
TOTAL	308	100.0
UNKNOWN = 36		

5. Isolation

As can be seen in Table 15, two out of every three victims (67.7%) identified in the NCIA study had been held in isolation.

TABLE 15 — ISOLATION		
	N	PERCENTAGE
Yes	228	67.7
No	109	32.3
TOTAL	337	100.0
UNKNOWN = 7		

6. Prior Suicide Attempts/Mental Health

As Table 16 indicates, when jailers were asked how many previous suicide attempts by the victims were known to jail officials, almost 83% said that none were known. As detailed in Table 17, when asked whether there was any indication of mental illness in the victim prior to his/her death, 70.6% of the jailers said they were not aware of any.

TABLE 16 — SUICIDE ATTEMPTS (KNOWN TO OFFICIALS)		
	N	PERCENTAGE
Yes	37	17.1
No	180	82.9
TOTAL	217	100.0
UNKNOWN = 127		

TABLE 17 — MENTAL ILLNESS (KNOWN TO OFFICIALS)		
	N	PERCENTAGE
Yes	73	29.4
No	175	70.6
TOTAL	248	100.0
UNKNOWN = 96		

7. **Length of Incarceration**

In one of the most alarming findings of the NCIA study, Table 18 shows that over 50% of the victims were dead within the first 24 hours of incarceration, and an astounding 27% occurred within the first three hours.

TABLE 18 — LENGTH OF INCARCERATION		
	N	PERCENTAGE
0 - 3 Hours	87	27.0
4 - 6 Hours	29	9.0
7 - 9 Hours	12	3.7
10 - 12 Hours	14	4.3
13 - 18 Hours	9	2.8
19 - 24 Hours	14	4.3
25 - 48 Hours	21	6.5
2 - 14 Days	44	13.7
15 - 30 Days	27	8.4
1 - 4 Months	41	12.7
5 - 7 Months	16	4.9
8 - 12 Months	5	1.6
More than 1 Year	3	.9
TOTAL	322	100.0
UNKNOWN = 22		

As can be seen in Table 19, 55.7% of all victims who were charged with alcohol/drug related offenses died within the first three hours of confinement. In contrast, almost 50% of all victims charged with violent/ personal offenses died after 15 days of confinement, and usually between two and seven months. Only 85% of those offenders died within the first three hours.

TABLE 19 — LENGTH OF INCARCERATION BY MOST SERIOUS CHARGE					
LENGTH	ALCOHOL/ DRUG RELATED	SERIOUS PROPERTY	MINOR OTHER	VIOLENT/ PERSONAL	TOTAL
0-3 HOURS	54 (55.7)	12 (17.4)	13 (19.1)	7 (8.5)	86 (27.2)
4-6 HOURS	15 (15.5)	2 (2.9)	6 (8.8)	6 (7.3)	29 (9.2)
7-9 HOURS	5 (5.2)	3 (4.3)	2 (2.9)	2 (2.4)	12 (3.8)
10-12 HOURS	0 (0.0)	5 (7.2)	3 (4.4)	6 (7.3)	14 (4.4)
13-18 HOURS	2 (2.1)	1 (1.4)	3 (4.4)	2 (2.4)	8 (2.5)
19-24 HOURS	5 (5.2)	2 (2.9)	5 (7.4)	2 (2.4	14 (4.4)
25-48 HOURS	3 (3.1)	4 (5.8)	7 (10.3)	7 (8.5)	21 (6.6)
2-14 DAYS	6 (6.2)	13 (18.8)	14 (20.6)	10 (12.2)	43 (13.6)
15-30 DAYS	1 (1.0)	13 (18.8)	7 (10.3)	13 (15.9	34 (10.8)
1-7 MONTHS	5 (5.2)	12 (17.4)	8 (11.8)	24 (29.4)	49 (15.5)
OVER 7 MONTHS	1 (1.0)	2 (2.9)	0 (0.0)	3 (3.7)	6 (2.0)
TOTAL	97 (100.0)	69 (100.0)	68 (100.0)	82 (100.0)	316 (100.0)
UNKNOWN = 28					

The NCIA study also found a strong relationship between isolation and the length of incarceration prior to suicide. As can be seen in Table 20, the majority (63%) of victims placed in isolation committed suicide within the first 48 hours of incarceration. Moreover, over 30% of these victims died within the first three hours of confinement.

TABLE 20 — LENGTH OF INCARCERATION BY ISOLATION ISOLATION			
LENGTH	YES	NO	TOTAL
0-3 HOURS	67 (30.6)	20 (20.0)	87 (27.3)
4-6 HOURS	20 (9.1)	9 (9.0)	29 (9.1)
7-9 HOURS	10 (4.6)	2 (2.0)	12 (3.8)
10-12 HOURS	11 (5.0)	3 (3.0)	14 (4.4)
13-18 HOURS	7 (3.2)	2 (2.0)	9 (2.8)
19-24 HOURS	9 (4.1)	5 (5.0)	14 (4.4)
25-48 HOURS	14 (6.4)	7 (7.0)	21 (6.6)
OVER 48 HOURS	81 (37.0)	52 (52.0)	133 (41.6)
TOTAL	219 (100.0)	100 (100.0)	319 (100.0)
UNKNOWN = 25			

The NCIA study also found a very strong relationship between intoxication and length of incarceration prior to suicide. As can be seen in Table 21, an overwhelming majority, 88.996, of victims under the influence of alcohol and/or drugs at the time of arrest committed suicide within the first 48 hours of confinement. In addition, over 50% of these victims died within the first three hours of confinement.

TABLE 21 — LENGTH OF INCARCERATION BY INTOXICATION

LENGTH	INTOXICATION YES	INTOXICATION NO	TOTAL
0-3 HOURS	60 (51.3)	4 (4.7)	64 (31.7)
4-6 HOURS	21 (17.9)	4 (4.7)	25 (2.4)
7-9 HOURS	6 (5.1)	4 (4.7)	10 (5.0)
10-12 HOURS	3 (2.6)	6 (7.1)	9 (4.5)
13-18 HOURS	3 (2.6)	4 (4.7)	7 (3.5)
19-24 HOURS	5 (4.3)	3 (3.5)	8 (4.0)
25-48 HOURS	6 (5.1)	9 (10.6)	15 (7.4)
OVER 48 HOURS	13 (11.1)	51 (60.0)	64 (31.5)
TOTAL	117 (100.0)	85 (100.0)	202 (100.0)
UNKNOWN = 142			

D) FACILITY CHARACTERISTICS

As part of its research efforts, NCIA previously identified 16,909 county and local jail facilities in the United States. There were 3,343 (19.8%) county facilities and 13,566 (80.2%) local facilities. However, as can be seen in Table 22, county facilities accounted for 70% of the suicides in the study.

TABLE 22 — TYPE OF FACILITY[6]

	N	PERCENTAGE
County	196	70.3
Local	75	26.9
Other	8	2.9
TOTAL	279	100.0
UNKNOWN = 65		

[6] County jails are defined as commitment and pretrial (over 48 hours) detention facilities. Local jails are defined as temporary holding facilities (less than 48 hours). "other" is defined as state facilities which detain or commit individuals for less than one year.

In addition, NCIA discovered that 70.2% of all facilities experiencing suicide were located in urban areas; 17.4% in suburban areas; and 12.4% in rural areas. Whites comprised 69.8% of the victims in urban jails; Blacks comprised 223%; "Other" (including Spanish/Mexican, American Indian, and Unspecified) comprised 93%.

In regard to facility and most serious charge, NCIA found that almost 32% of the victims charged with violent/personal crimes committed suicide in county facilities, with 26.7% charged with serious property crimes. In contrast, local facilities accounted for almost 50% of the victims charged with alcohol/drug related crimes and 26.3% with "minor other" crimes.

APPENDIX B

SECOND NATIONAL STUDY OF JAIL SUICIDES

INFORMATION REQUESTED BY:

THE NATIONAL CENTER ON
INSTITUTIONS AND ALTERNATIVES
ON BEHALF OF THE
NATIONAL INSTITUTE OF CORRECTIONS
U.S. BUREAU OF PRISONS
U.S. DEPARTMENTOF JUSTICE

Dear Sheriff/Police Chief:

The National Institute of Corrections, within the U.S. Justice Department, has requested the National Center on' Institutions and Alternatives (NCIA) to serve as the coordinator of the Jail Suicide Prevention Information Task Force. In cooperation with Criminal and Juvenile Justice International, Inc.. and with. assistance from the National Sheriffs' Association, the NCIA is now conducting a second national study of all suicides. You might recall that a similar study was conducted in 1981. With your assistance, the Project will utilize collected data on inmate suicides to generate programmatic recommendations to confront this issue. This information can then be employed by your agency and others in an effort to prevent future jail suicides.

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

Data requested for this study (see over) should be limited to suicides or other deaths occurring between

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

For your convenience in submitting the completed form, we have enclosed a self-addressed, business reply envelope. We ask that the completed form be returned within thirty (30) days of its receipt. We also ask that you return the completed form only if you had a suicide(s) or other death(s) during 1986 and/or 1986.

If you have any questions regarding completion of this form or the study, please contact Mr. Lindsay Hayes of NCIA at (703) 684-0373. Thank you for your cooperation. Copies of the final report will be available upon request.

Sincerely,

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

Joseph R. Rowan
Executive Director
Juvenile and Criminal Justice
international, Inc.

L. Cary Bittick
Executive Director
National Sheriffs' Association

PLEASE TURN OVER

DEFINITIONS

SUICIDE: Any death of an individual while in the custody of any law enforcement agency resulting from or leading directly from any self-inflicted act perpetrated by that individual. (NOTE: For purposes of this study, an inmate found hanged in a facility yet who later dies enroute to hospital or other health care provider, is classified as a "jail" suicide and should be reported below.)

HOMICIDE: Any death of an individual while in the custody of any law enforcement agency resulting from or leading directly from any non-self-inflicted act perpetrated against that individual by a second party.

ACCIDENT: Any death of an individual while in the custody of any law enforcement agency resulting from or leading directly from any non-intentional, identifiable act.

UNDETERMINED CAUSES: Any death of an individual while in the custody of any law enforcement agency resulting from or leading directly from any unknown or unspecifiable act or agent.

JAIL: Any facility, operated by a local jurisdiction (e.g., county, municipality, etc.), whose purpose is the confinement of inmates apprehended by law enforcement personnel. Jails, as defined here, will, to the maximum extent possible, include temporary holding and pre-trial detention facilities, lockups, "drunk tanks," etc., which normally detain persons for less than 48 hours, and facilities which normally detain persons or have committed/sentenced offenders for more than 48 hours. In addition, all state police lockups are included within this definition, as well as local jails operated by state correctional agencies, i.e., Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont.

NATIONAL: All 50 states plus the District of Columbia.

INMATE: Any individual in the physical custody of any law enforcement agency.

In the spaces provided below, please indicate the TOTAL NUMBER OF INMATE DEATHS IN EACH CATEGORY occurring at your facility BETWEEN JANUARY 1, 1985, THRU DECEMBER 31, 1985, AND JANUARY 1, 1986, THRU DECEMBER 31, 1986. **Please only complete the form below if your facility had a suicide(s) or other death(s) during 1985 and/or 1986.**

Please call Mr. Lindsay Hayes at 703/684-0373 if further clarification is needed.

QUESTIONS

1. Number of inmate deaths between:

January 1, 1985 and December 31, 1985	January 1, 1986 and December 31, 1986
(a) Suicide_____	(a) Suicide_____
(b) Homicide_____	(b) Homicide_____
(c) Accident_____	(c) Accident_____
(d) Undetermined Causes_____	(d) Undetermined Causes_____

2. Which of the following categories best describes your facility? **(Please check only one category.)**
   - (a) Facility for committed/sentenced offenders_____
   - (b) Temporary holding facility for 0 to 4 hours_____ or 4 to 48 hours_____
   - (c) Pre-Trial detention facility (over 48 hours)_____

3. Additional remarks (e.g., differences in definitions and/or reporting practices; attach additional sheets if necessary).

The following will be used for internal purposes only:

4. Completed by (name/title):
5. Name of facility:
6. Address (street):
   (City, State, Zip Code):
   (County):
7. Telephone:
8. Date completed:

Please return to: NCIA, 814 North Saint Asaph Street, Alexandria, VA 22314, within 30 days of receipt.

SECOND NATIONAL STUDY OF JAIL SUICIDES

JAIL SUICIDES OF 1986

STATE OF_____ COUNTY OF_____
(If appropriate)

JAIL FACILITY NAME	VICTIM'S NAME	DATE OF SUICIDE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

(Please Use Additional Sheets as Needed)

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

Please return to: NCIA, 814 North Saint Asaph Street, Alexandria, VA 22314, within 30 days of receipt.

SECOND NATIONAL STUDY OF JAIL SUICIDES

JAIL SUICIDES OF 1985

STATE OF_____ COUNTY OF_____
(If appropriate)

	JAIL FACILITY NAME	VICTIM'S NAME	DATE OF SUICIDE
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

(Please Use Additional Sheets as Needed)

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

Please return to: NCIA, 814 North Saint Asaph Street, Alexandria, VA 22314, within 30 days of receipt.

NATIONAL STUDY OF JAIL SUICIDES

PHASE II

SURVEY QUESTIONNAIRE

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

items contained in this questionnaire refer to suicide(s) occurring at your facility In 1988 as identified during Phase I of this National Study of Jail Suicides. As appropriate in each question, please check the appropriate box(es) and/or fill in the blanks. Use a separate questionnaire for each victim.

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

if you have any questions regarding completion of this form or the study, please contact Mr. Lindsay Hayes of NCIA at (703) 634-0373. Thank you for your cooperation.

NAME OF FACILITY_____**STATE**_____

PART A: PERSONAL CHARACTERISTICS OF VICTIM

1) **Victim's Name (or any other identifiable notation):**

_____
Last First Middle

2) **Race/Ethnicity:**
(1) ____White
(2) ____Black
(3) ____Spanish Heritage/ Chicano/Mexican American/Etc.
(4) ____American Indian
(5) ____Other (Please Specify_____)
(9) ____Unknown

3) **Sex:** (1) ____Male (2) ____Female

4) **Age:** _____Years

5) **Marital Status:**
(1) ____Single
(2) ____Married
(3) ____Separated
(4) ____Divorced
(5) ____Widowed
(6) ____Common-Law Relationship
(9) ____Unknown

6) **Please specify charge(s) for which victim was incarcerated at time of suicide and whether victim was being detained or had been sentenced on those charge(s).**

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

(OVER)

7) If the victim had been arrested for Driving While Intoxicated or a related charge, was his/her confinement mandated by your state's drunk driving law?

(1) ____Yes
(2) ____No
(8) ____Not Applicable
(9) ____Unknown

If yes, please explain the mandatory conditions they were under. _____
_____
_____

8) Did the victim have a record of prior arrests?

(1) ____Yes (2) ____No (9) ____Unknown

9) If the victim did have a prior arrest record, please specify the prior charges.

CHARGE(S)	DATE
_____	_____
_____	_____
_____	_____

(10) At the time of incarceration, was the victim under the influence of:

(1) ____Drugs Only
(2) ____Alcohol Only
(3) ____Drugs and Alcohol
(4) ____Neither Drugs or Alcohol
(9) ____Unknown

PART B: SUICIDE CHARACTERISTICS

1) What was the date and time of victim's death?

Date: / /86 Time: a.m. p.m.

2) What was the method of suicide and instrument used?

a) Method

(1) ____Hanging
(2) ____Overdose
(3) ____Cutting
(4) ____Shooting
(5) ____Jumping
(6) ____Ingestion of Foreign Object(s)
(7) ____Other (Specify)
(9) ____Unknown

b) Instrument

(01) ____Shoelace
(02) ____Belt
(03) ____Other Clothing
(04) ____Bedding
(05) ____Rope
(06) ____Razor Blade
(07) ____Gun
(08) ____Towel
(09) ____Knife
(10) ____Glass
(11) ____ Drugs (Specify) _____
(12) ____Other (Specify) _____
(99) ____Unknown

3) What was the time span between suicide and finding of the victim?

(1) ____Less Than 15 Minutes
(2) ____Between 15 and 30 Minutes
(3) ____Between 30 and 60 Minutes
(4) ____Between 1 and 3 Hours
(5) ____Greater Than 3 Hours
(9) ____Unknown

4) Was the victim isolated from other inmates at the time of his/her death?

(1) ____Yes
(2) ____No
(9) ____Unknown

If "Yes," explain the type of isolation_____

5) Were there any known **previous suicide attempts** by the victim?

(1) ____Yes If "Yes," how many?_____
(2) ____No
(9) ____Unknown

6) Were there any indications of **mental illness** concerning the victim prior to his/her suicide?

(1) ____Yes If "Yes," explain these indications and method(s) by which
(2) ____No they were identified. _____
(9) ____Unknown _____

7) Were there any indications of **medical problems** concerning the victim prior to his/her suicide?

(1) ____Yes If "Yes," explain these indications and method(s) by which
(2) ____No they were identified. _____
(9) ____Unknown _____

8) Were any written forms utilized at booking to **screen** for potentially suicidal behavior in the victim?

(1) ____Yes **If "Yes," please enclose such form when returning**
(2) ____No **this survey.**
(9) ____Unknown

9) What was the total number of **hours, days, months, or years** that the victim had been held in your facility prior to his/her death? (If less than two days, indicate in hours.)

_____Hours _____Years
_____Days _____Unknown
_____Months

10) What was the maximum inmate **capacity** and **population** of your facility at the time of the victim's suicide?
_____Capacity _____Population

PART C: FACILITY CHARACTERISTICS

1) **Name of Facility:**_____

2) **Address** (Street):_____

(City, State, Zip Code):_____

(County):_____

3) **Telephone:** ( )_____

4) In what year was your facility originally **constructed**? Date_____

5) What was the year of **last renovation**, if any? Date_____

6) What is the **location** of your facility? (1) ____Urban (2) ____Suburban (3) ____Rural

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

(a) Facility for Committed/Sentenced Offenders _____
(b) Temporary Holding Facility for 0 to 4 Hours_____ or 4 to 48 Hours_____
(c) Pre-Trial Detention Facility (Over 48 Hours)_____
(d) Other (Please Specify)_____

(OVER)

8) How many suicides occurred in your facility in 1984 and 1985?

(1) _____1984 (2) _____1985 (3)_____None

9) Does your facility operate a suicide prevention program?

(1) ____Yes
(2) ____No
(9) ____Unknown

If "Yes," briefly list the procedures utilized to identify and observe potentially suicidal inmates. (If necessary ,please attach additional sheets.)

_____

_____

_____

10) Are there any external reporting requirements following a suicide?

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

If "Yes," explain these requirements and to whom reports are made. (If necessary, please attach additional sheets.)

_____

_____

_____

Survey Completed By (Name/Title):_____

_____

_____

Date Completed: _____

Please check if you would like a copy of survey findings. _____

THANK YOU FOR YOUR COOPERATION

PLEASE RETURN THIS SURVEY AND SCREENING FORM (IF UTILIZED) TO:

LINDSAY M. HAYES
THE NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES
814 NORTH SAINT ASAPH STREET
ALEXANDRIA, VIRGINIA 22314

APPENDIX C

APPENDIX C

DISTRIBUTION OF ADDITIONAL CHARGES

SECOND CHARGE AGAINST VICTIM		
Charge	N	Percentage
Violent/Personal	34	10.2
Serious Property	29	8.7
Minor Other	57	17.0
Alcohol/Drug	39	11.6
None	176	52.5
Unknown	4	
TOTAL	339	100.0

THIRD CHARGE AGAINST VICTIM		
Charge	N	Percentage
Violent/Personal	15	4.5
Serious Property	16	4.8
Minor Other	32	9.6
Alcohol/Drug	16	4.8
None	255	76.3
Unknown	5	
TOTAL	339	100.0

DISTRIBUTION OF PRIOR CHARGES

SECOND PRIOR CHARGE AGAINST VICTIM		
Charge	N	Percentage
Violent/Personal	22	9.1
Serious Property	35	14.5
Minor Other	48	19.9
Alcohol/Drug	46	19.2
None	90	37.3
Unknown	98	
TOTAL	339	100.0

THIRD PRIOR CHARGE AGAINST VICTIM		
Charge	N	Percentage
Violent/Personal	23	9.7
Serious Property	20	8.4
Minor Other	38	16.0
Alcohol/Drug	41	17.2
None	116	48.7
Unknown	101	
TOTAL	339	100.0

APPENDIX D

Sample Form

Sample Form

Receiving Screening Form*

DATE _____

NAME _____ SEX D.O.B. _____ TIME _____

INMATE NO. _____ OFFICER OR PHYSICIAN _____

BOOKING OFFICERS VISUAL OPINION

1. Is the inmate conscious? YES No
2. Does. the new inmate have obvious pain or bleeding or other symptoms suggesting need for Emergency Service? YES NO
3. Are there visible signs of trauma or illness requiring immediate Emergency or Doctors care? YES NO
4. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection which might spread through the jail? YES NO
5. Is the skin in good condition and free of vermin? YES NO
6. Does the inmate appear to be under the influence of alcohol? YES NO
7. Does-the inmate appear to be under the influence of barbiturates, heroin or any other drugs? YES NO
8. Are there any visible signs of Alcohol/Drug withdrawal symptoms? YES NO
9. Does the inmate's behavior suggest the risk of suicide? YES NO
10. Does the inmate's behavior suggest the risk of assault to staff or other inmates? YES NO
11. Is the inmate carrying medication or does the inmate report being on medication which should be continuously administered or available? YES NO

OFFICER-INMATEQUESTIONNAIRE

12. Are you presently taking medication for diabetes, heart disease, seizures, arthritis, asthma. ulcers, high blood pressure. or psychiatric disorder? Circle Condition YES NO
13. Do you have a special diet prescribed by a physician? Type _____ YES NO
14. Do you have history of venereal disease or abnormal discharge? YES NO
15. Have you recently been hospitalized or recently seen a medical or psychiatric doctor for any illness? YES NO
16. Are you allergic to any medication? YES No
17. Have you fainted recently or had a recent head injury? YES No
18. Do you have epilepsy? YES No
19. Do you have a history of tuberculosis? YES No
20. Do you have diabetes? YES NO
21. Do you have hepatitis? YES NO
22. If female, Are you pregnant? Are you currently on birth control pills? YES No
23. Do you have a painful dental condition? YES NO
24. Do you have any other medical problem we should know about? YES No

REMARKS:

1. _____
2. _____
3. _____
4. _____

(A copy of this form is included in the inmate's medical record)

*See American Medical Association (in cooperation with the Department of Governmental Affairs, University of Wisconsin). Training of Jailers in Receiving Screening and Health Education. Chicago. Illinois: March. 1978.

DATE _____
TIME _____

_____
(Name of Institution)

INMATE NAME _____ SEX _____ D.O.B. _____

INMATE NO. _____ OFFICER/EXAMINER NAME: _____

BOOKING OFFICER/EXAMINER OBSERVATIONS
(Where applicable, circle specific condition)

	YES	NO	COMMENTS
1. Unconscious?			
2. Visible signs of trauma or illness requiring immediate emergency or doctor's care? Describe: _____			
3. Obvious fever, swollen lymph nodes, jaundice or other evidence of infection which might spread through the jail? Describe: _____			
4. Poor skin condition, vermin, rashes, or needle marks?			
5. Under the influence of alcohol, barbiturates, heroin or other drugs?			
6. Visible signs of alcohol/drug withdrawal? (Extreme perspiration, pinpoint pupils, shakes, nausea, cramping, vomiting)			
7. Behavior suggests risk of suicide or assault?			
8. Carrying medication or report being on medication? List: _____			

9. Deformities (List): _____

OFFICER/EXAMINER-INMATE QUESTIONNAIRE

10. Admits To The Following (Indicate by number and letter below):

1. (Over one year ago)
2. (Within one year)
3. (Present now)

H (Hospitalized)
M (Medications - current)

_____ Allergies
_____ Arthritis
_____ Asthma
_____ Delirium Tremens (DT's)
_____ Dental Condition
_____ Diabetes
_____ Epilepsy
_____ Fainting
_____ Heart Condition
_____ Hepatitis
_____ High Blood Pressure
_____ Physician Prescribed Diet
_____ Psychiatric Disorder
_____ Tuberculosis
_____ Ulcers
_____ Urinary Tract Problems
_____ Venereal Disease (VD) (Which)
_____ Other (Specify): _____

11. Use alcohol?
    a) If yes, how often? _____ b) How much? _____

    c) When were you drunk last? _____

    d) When did you drink last? _____

12. Use any "street" drugs?

    a) If yes, what type, (s)? _____

    b) How often? _____ (c) Row much? _____

    d) When did you get high last? _____

    e) When did you take drugs last? _____

13. If female, is she:

    a) Pregnant? _____ (Months)

    b) Delivered recently? _____ (Date)

    c) On birth control pills?

REMARKS (i.c. Unusual behavior, special diet, type of VD, ctc)

_____

_____

_____

DISPOSITION/REFERRAL TO' (Please underline applicable response):'

a) General population b) Emergency care c) Sick call d) Isolate

Developed by: The American Medical Association
Jail Medical Technical Assistant Program
March 18, 1980 Rev. July 1, 1980

(A **copy** of this form is included in the inmates medical record)

 Sample Form

Receiving Screening: Guidelines for Disposition

Question

1. If yes, arrange for immediate transfer to hospital and refer to page 30 in "Emergency Care Guidelines." (E.C.G.)

2. If yes, call doctor now and describe symptoms.

3. If yes, isolate from other inmates, monitor condition frequently and call doctor immediately if condition of inmate appears to get worse. Use-paper plates-plastic utensils, dispose of immediately. Keep all bedding separate from others-sterilize. In case of fever administer aspirin as ordered by doctor. Call doctor during next regular office hours and describe symptoms.

4. If yes because of rash or other unusual skin eruptions, isolate and follow instructions in question number 3. If vermin is present, isolate and instruct inmate in use of Kwell or other scabicide.

5. If yes to alcohol, transfer to detoxification unit at hospital. Refer to page 14 in E.C.G. If yes to drugs, find out if possible what and how much the inmate has been taking (refer to page 14 in E.C.G.) and call doctor now.

6. If yes, monitor closely and call doctor now. (See page 14 in E.C.G.)

7. If yes for suicide risk, follow instructions on page 28 in E.C.G. for suicide. If yes for risk of assualt, isolate, monitor closely, call a doctor or mental health center now. (See page 5 in E.C.G.)

8. If yes to carrying medications; place in inmate's locker, check that medications in bottle are actually what was prescribed, and try to check with prescribing doctor whether medication is to be continued, If cannot accomplish the preceding, check with jail doctor for instructions before administering any medication. If inmate reports being on medication, check with doctor to get prescriptions.

9. If yes, note and inform appropriate personnel.

10. If the inmate admits to the following specifics:

    Currently on medications = check with doctor to get prescriptions.

    Currently on special diet = inform doctor and notify kitchen staff.

    Recently hospitalized = report to doctor during next regular office hours unless there are symptoms indicating need for immediate attention.

    Allergic to mediciations= note names of drugs and inform doctor.

    Painful Dental Condition = Refer to page 29 in E.C.G.

    Diabetes now = report to doctor for orders for appropriate medication and or diet plan.

Epilepsy now = check for any medication being taken and follow steps in question 8.

Fainting = check for recent head injury and refer to page 6 in E.C.G.

Hepatitis now = isolate and report to doctor during next regular office hours.

Tuberculosis history or now = isolate and report to doctor during regular office hours.

Venereal Disease = isolate and have testing done as soon as possible, follow by administration of appropriate prescribed medication.

13. If pregnant or delivered recently, report to doctor during next regular office hours. If on birth control pills follow sequence in question number 8.

SUICIDE PREVENTION SCREENING GUIDELINES

DETAINEE'S NAME	SEX	DATE OF BIRTH	MOST SERIOUS CHARGE(S)	DATE	TIME

NAME OF FACILITY	NAME OF SCREENING OFFICER	*Detainee showed serious psychiatric problems during prior incarceration.* Yes _____ No _____

Check appropriate column for each question.

	Column A YES	Column B NO	General Comments/Observations
OBSERVATIONS OF TRANSPORTING OFFICER			
1. **Arresting or transporting officer believes that detainee may be a suicide risk.** *If* **YES**, *notify Shift Commander.*			
PERSONAL DATA			
2. **Detainee lacks close family or friends in the community.**	No Family/ Friends		
3. **Detainee has experienced a significant loss within the last six months** (e.g., loss of job, loss of relationship, death of close family member).			
4. **Detainee is very worried about major problems other than legal situation** (e.g., serious financial or family problems, a medical condition or fear of losing job).			
5. **Detainee's family or significant other** (spouse, parent, close friend, lover) **has attempted or committed suicide.**			
6. **Detainee has psychiatric history.** *(Note current psychotropic medications and name of most recent treatment agency.)*			
7. **Detainee has history of drug or alcohol abuse.**			
8. **Detainee holds position of respect in community** (e.g., professional, public official) **and/or alleged crime is shocking in nature.** *If* **YES**, *notify Shift Commander.*			
9. **Detainee is thinking about killing himself.** *If* **YES**, *notify Shift Commander.*			
10. **Detainee has previous suicide attempt.** *(Check wrists and note method.)*			
11. **Detainee feels that there is nothing to look forward to in the future.** (expresses feelings of helplessness or hopelessness). *If* **YES**, *to 10 and 11, notify Shift Commander.*	Nothing to Look Forward to		
BEHAVIOR/APPEARANCE			
12. **Detainee shows signs of depression** (e.g., crying, emotional flatness).			
13. **Detainee appears overly anxious, afraid or angry.**			
14. **Detainee appears to feel unusually embarrassed or ashamed.**			
15. **Detainee is acting and/or talking in a strange manner** (e.g., cannot focus attention, hearing or seeing things which are not there).			
16. A. **Detainee is apparently under the influence of alcohol or drugs.**			
B. **If YES, is detainee incoherent, or showing signs of withdrawal or mental illness?** *If* **YES** *to both A & B, notify Shift Commander.*			
CRIMINAL HISTORY			
17. **No prior arrests.**	None		

TOTAL Column A _____

ACTIONS

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

Shift Commander notified: **Yes** _____ **No** _____

Supervision instituted: **Routine** _____ **Active** _____ **Constant** _____

Detainee Referred to Medical/Mental Health: **If Yes:**

Yes _____ **No** _____

EMERGENCY	NON-EMERGENCY
medical _____	medical _____
mental health _____	mental health _____

Medical/Mental Health Personnel Actions: (To be completed by Medical/MH staff)

INSTRUCTIONS FOR COMPLETING
SUICIDE PREVENTION SCREENING GUIDELINES - FORM 330 ADM

GENERAL INFORMATION

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

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

Comment Column:	Use to note: 1. information about the detainee that officer feels is relevant and important 2. information requested in questions 6 and 10, and 3. information regarding detainee's refusal or inability to answer questions (See Below - General Instructions)
Detainees's Name:	Enter detainee's first and last name and middle initial.
Sex:	Enter male (m) or female (f).
Date of Birth:	Enter day, month and year.
Most Serious Charge(s):	Enter the most serious charge or charges (no more than two (2)) from this arrest.
Date:	Enter day, month and year that form was completed.
Time:	Enter the time of day the form was completed.
Name of Facility:	Enter name of jail or lock-up.
Name of Screening Officer:	Enter name of officer completing form.
Psychiatric Problems During Prior Incarceration:	Check YES if facility files show that during prior detention detainee attempted suicide and/or was referred for mental health services. If "unknown", write unknown across space.

INSTRUCTIONS FOR ITEMS 1-17

General Instructions

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

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

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

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

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

Observation of Transporting Officer

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

Personal Data Questions

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

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

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

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

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

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

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

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

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

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

Behavior Appearance Observations

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

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

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

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

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

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

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

Criminal History

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

SCORING

Be sure to count all checks in column A and enter total in the space provided. Notify shift commander 1) total is 8 or more, or 2) any shaded boxes are checked, or 3) if you feel notification is appropriate.

DISPOSITION

Officer Actions

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

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

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

Medical/Mental Health Actions

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

APPENDIX E

APPENDIX E

BIBLIOGRAPHY: JAIL SUICIDE LITERATUREREVIEW

The following bibliography is a comprehensive history of publications and videotapes regarding jail suicide research, prevention and training. Included within, this bibliography is a listing of all documents utilized and produced by the Jail Suicide Prevention Information Task Force.

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