

# JAIL SUICIDE/MENTAL HEALTH UPDATE

(A joint project of the National Center on Institutions and Alternatives and the National Institute of Corrections, U.S. Department of Justice)

Summer 2002

Volume 11 • Number 2

## PREVENTING, MANAGING, AND TREATING SUICIDAL ACTIONS IN HIGH-RISK OFFENDERS\*

by  
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**S**uicide and other forms of suicidal behavior, including suicidal ideation, and direct, nonfatal self-harm, present significant problems in correctional settings. Examining the research literature, we know most about suicide in jails and adult detention facilities, somewhat less about the crises and characteristics associated with suicidal behavior in prison settings, and very little about suicide and suicidal behavior in juvenile correctional settings. Part of this knowledge comes from two comprehensive national studies of jail suicide (Hayes, 1983; Hayes, 1989) and one national survey of prison suicide (Hayes, 1995a). The sole national study of suicide in juvenile institutions (Flaherty, 1980) was reissued following correction of analysis errors (Memory, 1989).

Clinical prediction of a low-base rate behavior such as suicide involves joining knowledge of demographic and individual factors with clinical assessment. This assessment must be informed by an understanding of the risk characteristics that link individuals to suicidal behavior and the pathways that may lead those in confinement to suicide. This chapter summarizes what is known about characteristics and circumstances correlated with suicidal behavior and its prevention, management, and treatment. Our bias is empirical, weighted toward the use of well-documented and investigated methods.

The study of suicidal behavior in correctional settings has been hampered in several ways. Most obvious are problems arising from unstandardized reporting and under-reporting. However the methodological problems present in the studies of suicide in confinement warrant listing because they limit to anticipate, assess, and respond most effectively to suicidal behavior in these settings. First, most suicide research in prisons and jails is retrospective and descriptive, generally psychological autopsy and post hoc review. Second, few investigators use control groups when examining suicide or suicidal behaviors, making it difficult to identify characteristics that distinguish inmates who engage in these behaviors from those who do not. Base rates of demographic

risk factors and maladaptive behavior patterns are often higher in correctional populations than among nonincarcerated groups; what distinguishes suicidal inmates from the general population may not distinguish them from other inmates.

Third, awareness of suicide and suicidal behavior as processes, the end result of direct and indirect pathways, is ignored when stationary indicators are used. Demographic and other static indicators suggest little about an individual at a particular point in time in a particular life situation, nor do they inform intervention (Bonner, 1992; Toch, 1975).

Inattention to casual processes and a primary focus on developing rates and profiles is evident in the correctional suicide literature. A simplistic assumption is often made that, following the initial period of high risk in jail settings, all individuals adjust and find ways of coping with life in prison. Research on the incidence and prevalence of mental disorder in jails and prisons, estimating that between 15 and 25% of jail inmates suffer from major mental disorder (Jordan, Schlenger, Fairbank & Caddell, 1996; Teplin, 1994) suggests this may not be true for a significant number. Progress in preventing suicidal behavior in correctional settings is contingent upon developing an empirical understanding of the multiple pathways or processes that lead confined individuals to suicidal behavior and suicide.

### Suicidal Behavior in Correctional Settings

**S**taff often regard self-harm in jail and prison settings as manipulative behavior (Haycock, 1989). Although most staff will acknowledge that inmates who threaten suicide or engage in self-injurious behavior suffer from some emotional imbalance requiring special attention, too often correctional staff (with the collusion of mental health staff) conclude that the inmate is not dangerous and simply attempting to manipulative his or her

\*This article previously appeared as Chapter 12 in J. Ashford, B. Sales & W. Reid (Eds.), *Treating Adult and Juvenile Offenders with Special Needs* (pp. 314-331). Washington, DC: American Psychological Association. It is reprinted with permission. Copyright © 2001 by the American Psychological Association.

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environment. They often suggest that such behavior should be ignored and not reinforced through intervention or attention. In fact, it is not unusual for mental health professionals to label inmates engaging in deliberate self-harm as “manipulative” or “attention seeking,” and the “truly suicidal” (i.e., more lethal means) inmates seen as “serious” and “crying for help” (Franklin, 1988). Clinicians routinely differentiate behavior they regard as “genuine” suicide attempts from other self-injurious (or nonlethal) behavior labeled as self-mutilation, suicidal gestures, manipulation, or malingering (Haycock, 1989). Such labeling, however, may reflect more upon the clinician’s reaction to the inmate’s self-injurious behavior rather than the inmate’s risk of suicide (Thienhaus & Piasecki, 1997). A leading critic of such labeling has suggested that all staff relinquish the tendency to view self-injurious by inmates according to expressed or presumed intent because the term “manipulative” is misleading and harmful to the understanding and management of self-injurious behavior (Haycock, 1992).

Other clinicians disagree and argue that self-injurious behavior displayed by “truly suicidal” versus “manipulative” inmates should result in different interventions. For suicidal inmates, prescribed intervention would include close supervision, social support, and access to or development of psychosocial resources. For inmates attempting to manipulate — in other words, change their environment without suicidal intent — intervention would combine close supervision with behavior management (Bonner, 1992). There is no data suggesting that such a bifurcated strategy decreases either suicide or nonfatal suicidal behaviors. Based on nonincarcerated samples, reliably assessing suicide intent — that is, does the individual truly want to die? — is difficult, as intent may shift, sometimes even during the act of self-injury. Historically, manipulative behavior was ignored or met with punitive sanctions, including isolation. Manipulative inmates may be forced to escalate their behavior to obtain attention or care and die as a result. Although some of these suicides occur either by accident or miscalculation of staff responsiveness, others result from desperate agitation and distress. Demonstrated interventions for managing and reducing the incidence of suicidal and self-harm behavior in nonincarcerated populations, whether with or without suicidal intent, include behavioral contingencies, support and validation, close monitoring, and skills training to increase basic capacities and improve emotional regulation (Linehan, 1993).

Labeling self-harm as a manipulative behavior in correctional settings is highly charged: No staff wants an inmate “getting by with something” and response to such actions is often severe. Punitive attitudes and actions toward self-harming inmates make logical sense when self-harm is viewed as challenging security. Although some argue that the problem is not in how we “label” the behavior, labeling behavior in a secure setting as manipulative has particular connotations that may unwittingly prevent inmates from receiving appropriate attention and care. Staff who feel manipulated may be more likely to react to suicidal behavior with punitive measures such as isolation or unwillingness to listen to an inmate’s distress. Alternatively, behavioral contingencies may be applied that are more punitive than the inmate’s behavior warrants as a way of setting an example for other inmates.

In the general population literature on suicidal behavior and self-mutilation, a primary reason for repetitive and often impulsive self-injury concerns affect regulation: This is only obliquely

acknowledged in jail and prison settings. Although the majority of inmates that engage in self-injurious behavior do not go on to commit suicide, a history of such behavior places them at greater risk of suicide (Haycock, 1989; Ivanoff, Jang, & Smyth, 1996). Finally, there is little disagreement that all acts of self-injury reflect personal breakdowns resulting from crises of self-doubt, poor coping and problem-solving skills, hopelessness, and fear of abandonment (Toch, 1975), the ingredients of potentially suicidal behavior.

### Who Is At Risk in Jail?

**P**reincarceration and demographic characteristics are usually examined first for indicators of suicidal behavior. In jail suicide, extensive and replicated reviews find that most victims are young, White, males, single or divorced, who were intoxicated upon arrest (Davis & Muscat, 1993; Hayes, 1983, 1989). As previously noted, psychiatric history and a history of past suicidal behavior are also significantly linked to suicide in jail (Copeland, 1989; DuRand, Burtka, Federman, Haycox & Smith, 1995; Farmer, Felthous & Holzer, 1996; Marcus & Alcabes, 1993). Among detainees with a prior suicide attempt, the incidence of current mental disorder was 76% compared to nonattempters 56% (Holley, Arboleda-Florez, & Love, 1995).

The individual who engages in suicide attempts or deliberate self-harm in jail shares a similar background profile: history of psychiatric treatment, recent negative life events, and previous suicidal behavior, including recent verbalizations or gestures (Ivanoff, 1989). Other studies have found intoxication, depression, excessive stress, hopelessness, interpersonal loss, and anger to be precipitating factors in jail suicides (Bonner, 1992; Winkler, 1992).

### Prisons

There are similarities in the psychological profiles of jail and prison suicides. In prisons, the reasons for suicide and other suicidal behaviors may be different than in jails, however, psychiatric history and a prior suicide attempt or self-harm episode remain the two strongest background factors linked to suicidality (Anno, 1985; California Department of Corrections, 1991; Hayes, 1995, Ivanoff, Jang & Smyth, 1996; White & Schimmel, 1995). Placement in segregated housing or single cells is also related (Anno, 1985; California Department of Corrections, 1991; Hayes, 1995b; Jones, 1986a, 1986b; White & Schimmel, 1995). Taken together, however, the empirical data on suicidal behavior in prisons present a more mixed picture than in jails. There is generally less agreement about demographic factors distinguishing suicidal from non-suicidal prison inmates: age, marital status, and educational level are all inconsistent, although the criminal behavior histories among suicidal inmates are generally less severe. Suicide has been linked to longer sentences, (New York State Department of Correctional Services, [hereinafter NYS DOCS] 1994; Salive, Smith & Brewer, 1989; White & Schimmel, 1995), high percentages of violent felonies (NYS DOCS, 1994), and personal crimes (Anno, 1985; Salive et al., 1989). Comparing prison inmates who engaged in deliberate self-harm or suicide attempts while in jail or prison with those who did not engage in such behavior found no differences on demographic, criminal history, or life events factors. Homelessness and maladaptive

social support (suicidal behavior, alcohol abuse, and arrest), however, among primary social network members were linked to suicidal behaviors (Ivanoff, et al., 1996). Negative life events did not discriminate inmates who engaged in suicidal behavior from other inmates in this sample, inconsistent with previous research. The significant role that maladaptive social support may play in providing models for this dysfunctional behavior is consistent with other such patterns of behavior.

### **Juveniles**

Two recent suicides examined characteristics associated with suicidal behavior among confined juveniles. Suicidal ideation was associated with young age (13 or younger), female gender, White or "other" race, injected and other drug use, and sexual abuse. Suicide attempts, however, were associated with all of these risk factors plus a history of sexually transmitted diseases (Morris et al., 1995).

Rhode, Seely, and Mace (1997) found suicidal ideation among young men was most significantly correlated with current depression, major life events, poor social connections, and past suicide attempts. Among young women, however, ideation was most significantly correlated with impulsivity, current depression, and younger age. The most common correlate between both males and females was not living with a biological parent before detention (Rhode, et al., 1997). Past suicide attempts among males were associated with current ideation and ineffective coping skills. Among females, major factors were major life events and impulsivity. Not residing with a biological parent prior to confinement was again the only factor significantly correlated with past attempts among both females and males. Suicidal behavior of a friend was significantly associated with past and current suicidal ideation among boys, but not girls; previous mixed

findings concerning the potential influence of association or modeling on suicidal behavior limit interpretation of this result (Rhode et al, 1997).

### **Summation**

These often mixed results suggest that searching for predictable patterns in the preincarceration backgrounds of vulnerable individuals may have limited utility. Based on the absence of differences on many background variables, such factors do not appear to readily discriminate those at risk for suicidal behavior from other inmates. As noted earlier, background factors are also limited in their ability to identify targets for intervention.

More recently, investigators have adopted the stress-vulnerability-coping model used in the general psychological literature to explain suicidal behavior in jail and prisons (Bonner, 1992; Lazarus & Folkman, 1984; Smyth, 1991). Put simply, individual possess varying levels of vulnerability, whether biological, psychological or socio-cultural, or a combination thereof. The vulnerabilities interact with environmental demands posed by negative life events or extreme conditions and result in varying types of maladaptation, in this case suicidal behavior and self-harm. When personal coping options or problem-solving abilities are limited, overwhelmed or inhibited due to insufficient personal resources and skills, no solution is seen, and suicide or self-harm may be viewed as the only alternative for coping with intolerable life circumstances. This model suggests our efforts are best placed studying individuals' current emotional, cognitive and behavioral states to identify factors associated with suicidal behavior.

### **Prevention and Management**

The literature is replete with numerous examples of individual jail and prison systems that have developed effective suicide prevention programs (Cox and Morschauser, 1997; Hayes, 1994a, 1995a, 1995b; Hopes & Shaull, 1986; White & Schimmel, 1995). New York continues to experience a significant drop in the number of jail suicides following the implementation of a statewide comprehensive prevention program (Cox and Morschauser, 1997). Texas has seen a 50% decrease in the number of county jail suicides as well as almost a six-fold decrease in the rate of these suicides from 1986 through 1996, much of it attributable to increased staff training and a state requirement for jails to maintain suicide prevention policies (Hayes, 1996a). One researcher reported no suicides during a seven-year time period in a large county jail after the development of suicide prevention policies based upon the following principles: screening; psychological support; close observation; removal of dangerous items; clear and consistent procedures; and diagnosis, treatment, and transfer of suicidal inmates to the hospital as necessary (Felthous, 1994).

Comprehensive suicide prevention programming has also been advocated nationally by such organizations as the American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC). Both groups have promulgated national correctional standards that are adaptable to individual jail, prison and juvenile facilities. Although the ACA standards are the most widely recognized throughout the country, they provide severely limited guidance regarding suicide

### **UPDATE ON THE INTERNET**

Recent issues of the *Jail Suicide/Mental Health Update* are now available on the Internet at:

<http://www.igc.org/ncia/suicide.html>

**Check us out on the Web!**  
<http://www.igc.org/ncia/suicide.html>

Other jail suicide prevention and jail mental health resources, including several recent articles by Lindsay M. Hayes, can be found at the following web sites:

<http://www.hhpub.com/journals/crisis/1997>  
<http://www.nicic.org/pubs/jails.htm>  
<http://www.nicic.org/pubs/prisons.htm>  
[http://www.ncjrs.org/html/ojdp/jjjnl\\_2000\\_4/sui.html](http://www.ncjrs.org/html/ojdp/jjjnl_2000_4/sui.html)  
<http://www.performance-standards.org/resguides.htm>  
<http://www.gainsctr.com>

prevention, simply stating that institutions should have a written prevention policy that is reviewed by medical or mental health staff. ACA's broad focus on the operation and administration of correctional facilities (ACA, 1990, 1991) precludes these standards from containing needed specificity. The NCCHC standards, however, are much more instructive and offer the recommended ingredients for a suicide prevention program: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, review, and critical incident debriefing (NCCHC, 1995, 1996, 1997). The second author, utilizing a combination of ACA and NCCHC standards, has developed and recommended a comprehensive suicide prevention policy that addresses the following key components (Hayes, 1995a, 1995b).

### ***Staff Training***

The essential component to any suicide prevention program is properly trained correctional staff, who form the backbone of any jail or prison facility. Very few suicides are actually prevented by mental health, medical or other professional staff because suicides are usually attempted in inmate housing units, and often during late evening hours or on weekends when program staff are not present. Suicides, therefore, must be prevented by correctional staff who have been trained in suicide prevention and have developed an intuitive sense about the inmates under their care. Correctional officers are often the only staff available 24 hours a day and form the primary line of defense in preventing suicides.

All correctional staff, as well as medical and mental health personnel, should receive eight hours of initial suicide prevention training, followed by two hours of refresher training each year. Training should include why correctional environments are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, and details of the facility's suicide prevention-response policy and procedures. In addition, all staff who have routine contact with inmates should receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff should also be trained in the use of various emergency equipment located in each housing unit. In an effort to ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training.

### ***Intake Screening/Assessment***

Screening and assessment of inmates when they enter a facility is critical to a correctional facility's suicide prevention efforts. Although there is no single set of risk factors that mental health and medical communities agree can be used to predict suicide, there is little disagreement about the value of screening and assessment in preventing suicide (Cox & Morschauer, 1997; Hughes, 1995). Intake screening for all inmates and ongoing assessment of inmates at risk is critical because research consistently reports that two thirds or more of all suicide victims communicate their intent some time before death and that any individual with a history of one or more self-harm episodes is at a much greater risk for suicide than those without such episodes (Clark & Horton-Deutsch, 1992; Maris, 1992). Screening for

suicide risk may be contained within the medical screening form or as a separate form, and should include inquiry regarding: past suicidal ideation or attempts; current ideation, threat, plan; prior mental health treatment-hospitalization; recent significant loss (job, relationship, death of family member/close other, etc.); history of suicidal behavior by family member/close other; suicide risk during prior confinement; and arresting-transporting officer(s) belief that inmate is currently at risk. The process should also include referral procedures to mental health and/or medical personnel for assessment. Following the intake process, if staff hear an inmate verbalize a desire or intent to commit suicide, observe an inmate engaging in any self-harm, or otherwise believe an inmate is at risk for self-harm or suicide, known procedures should follow. Such procedures direct staff to take immediate steps ensuring that the inmate is continuously observed until appropriate medical, mental health, and supervisory assistance is obtained.

### ***Communication***

Certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and communicated to others, may prevent a suicide. There are essentially three levels of communication in preventing inmate suicides: between the arresting or transporting officer and correctional staff; between and among facility staff, including medical and mental health personnel; and between facility staff and the suicidal inmate.

In many ways, suicide prevention begins at the point of arrest. What an individual says and how they behave during arrest, transportation to the jail, and at booking are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time. Arresting officers should pay close attention to the arrestee during this time; thoughts of suicide or suicidal behavior may be occasioned by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers such as family and friends. Any pertinent information regarding the arrestee's well-being must be communicated by the arresting or transporting officer to correctional staff. Effective management of suicidal inmates in the facility is based on communication among correctional officers and other professional staff. Because inmates can become suicidal at any point during incarceration, correctional officers must maintain awareness, share information and make appropriate referrals to mental health and medical staff. Facility staff must use various communication skills with the suicidal inmate, including active listening, physically staying with the inmate if they suspect immediate danger, and maintaining contact through conversation, eye contact, and body language. Correctional staff should trust their own judgment and observation of risk behavior, and avoid being misled by others (including mental health staff) into ignoring signs of suicidal behavior. The communication breakdown between correctional, medical, and mental health personnel is a common factor found in the reviews of many inmate suicides (Anno, 1985; Appelbaum, Dvoskin, Geller & Grisso, 1997; Hayes, 1995b; Jones, 1986b).

### ***Housing***

In determining the most appropriate housing location for a suicidal inmate, correctional officials (with concurrence from medical or

mental health staff) often tend to physically isolate and sometimes restrain the individual. These responses might be more convenient for all staff, but they are detrimental to the inmate because the use of isolation escalates the inmate's sense of alienation and further removes the individual from proper staff supervision. To every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. Further, removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, straitjackets, etc.) should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Handcuffs should never be used to restrain a suicidal inmate. Housing assignments should be based on the ability to maximize staff interaction with the inmate, avoiding assignments that heighten the depersonalizing aspects of incarceration.

All cells designated to house suicidal inmates should be suicide-resistant, free of all obvious protrusions, and provide full visibility (Atlas, 1989; Jordan, Schmeckpeper & Strobe, 1987; Lester and Danto, 1993). These cells should contain tamper-proof light fixtures and ceiling air vents that are protrusion-free. Each cell door should contain a heavy gauge Lexan (or equivalent grade) glass panel that is large enough to allow staff a full and unobstructed view of the cell interior. Cells housing suicidal inmates should not contain any electrical switches or outlets, bunks with open bottoms, towel racks on desks and sinks, radiator vents, or any other object that provides an easy anchoring device for hanging. Finally, each housing unit in the facility should contain various emergency equipment, including a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool (to quickly cut through fibrous material). Correctional staff should ensure that such equipment is in working order on a daily basis.

### *Levels of Supervision*

The promptness of response to suicide attempts in correctional facilities is often driven by the level of supervision afforded the inmate. Medical experts warn that brain damage from strangulation caused by a suicide attempt can occur within four minutes, and death often within five to six minutes (American Heart Association, 1992). Standard correctional practice requires that "special management inmates," including those housed in administrative segregation, disciplinary detention and protective custody, be observed at intervals not exceeding every 30 minutes, with mentally ill inmates observed more frequently (ACA, 1990, 1991). Inmates held in medical restraints and "therapeutic seclusion" should be observed at intervals that do not exceed every 15 minutes (NCCHC, 1995, 1996, 1997). Consistent with national correctional standards and practices, two levels of supervision are generally recommended for suicidal inmates: close observation and constant observation. Close Observation is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) or has a recent prior history of self-destructive behavior. Staff should observe such an inmate at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes, etc.). Constant Observation is reserved for the inmate who is actively suicidal, either threatening or engaging in suicidal behavior. Staff should observe such an inmate on a continuous, uninterrupted basis. Other aids (e.g.,

closed-circuit television, inmate companions or watchers, etc.) can be used as a supplement to, but never as a substitute for, these observation levels. Finally, mental health staff should assess and interact with (not just observe) suicidal inmates on a daily basis.

### *Intervention*

The degree and promptness of staff intervention often determines whether the victim will survive a suicide attempt. National correctional standards and practices generally acknowledge that facility policy regarding intervention should contain three primary components. First, all staff who come into contact with inmates should be trained in standard first aid procedures and cardiopulmonary resuscitation (CPR). Second, any staff member who discovers an inmate engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. Third, staff should never presume that the inmate is dead, but rather should initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, medical personnel should ensure, on a daily basis, that all facility emergency response equipment is in working order.

### *Reporting*

In the event of a suicide attempt or suicide, all appropriate correctional officials should be notified through the chain of command. Following the incident, the victim's family should be immediately notified, as well as appropriate outside authorities. All staff who came into contact with the victim prior to the incident should be required to submit a statement including their full knowledge of the inmate and incident.

### *Follow-Up/Administrative Review*

An inmate suicide is extremely stressful for staff, who may feel angry, guilty, and even ostracized by fellow personnel and administration officials. Following a suicide, reasonable guilt is sometimes displayed by the officer who wonders: "What if I had made my cell check earlier?" When suicide or suicidal crises occur, staff affected by such a traumatic event should receive appropriate assistance. One form of assistance is Critical Incident Stress Debriefing (CISD). A CISD team, made up of professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, fire fighters, clergy, and mental health personnel), provides affected staff an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and develop ways of dealing with those symptoms (Meehan, 1997; Mitchell & Everly, 1996). For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident.

Every completed suicide, as well as each suicide attempt of high lethality (i.e., requiring hospitalization), should be examined through an administrative review process. If resources permit, clinical review through a psychological autopsy is also recommended (Spellman and Heyne, 1989). Ideally, the administrative review should be coordinated by an outside

agency to ensure impartiality. The review, separate and apart from other formal investigations that may be required to determine the cause of death, should include: (a) critical review of the circumstances surrounding the incident; (b) critical review of jail procedures relevant to the incident; (c) synopsis of all relevant training received by involved staff; (d) pertinent medical and mental health services/reports involving the victim; and (e) recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures.

Several recent national surveys examined the degree to which suicide prevention issues are reflected in state jail standards and in state prison policies and procedures (Hayes, 1996a, 1996b). One recent survey found that 32 states had standards regulating county and local jails, with 24 mandatory and 8 voluntary programs (Hayes, 1996a). Of the states with jail standards, only a third required suicide prevention policies, and only one state (Texas) required county jails to maintain procedures regarding six critical prevention components (staff training, intake screening, communication, housing, supervision, and intervention). Three other states had jail standards that required procedures addressing all but one of the critical components. With regard to suicide prevention policies in state and federal prison systems, a recent survey found that although 41 of 52 departments of correction (including the Federal Bureau of Prisons and District of Columbia) had a suicide prevention policy, only 15% of these agencies had procedures that contained either all or all but one critical component of suicide prevention (Hayes, 1996b).

In a recent landmark study of conditions of confinement in juvenile facilities, researchers found widespread variability using four suicide prevention assessment criteria: written procedures, intake screening, staff training, and close observation (Parent et al., 1994). Although the majority of juveniles were housed in facilities with written suicide plans, or in facilities with screening procedures, or in facilities with staff training, only 50% were in facilities with close observational procedures. Most important, only 25% of juveniles were confined in settings that met all four suicide prevention assessment criteria. Facilities that conducted suicide screenings at admission and trained their staff in suicide prevention had lower rates of suicidal behavior among their residents. Suicidal behavior rates were higher among youth housed in isolation. Finally, although written policies providing for close observation of suicidal residents did not appear to significantly reduce the rate of suicidal behavior, it was found to be very important in reducing completed suicides because many times the policy was implemented after the risk and/or attempt was recognized (Parent et al., 1994).

### *Exemplary Programs*

Why do some correctional systems experience an inordinate number of inmate suicides or deaths attributed to obvious deficiencies while others of comparable size are spared the tragedy? Some observers would call it good fortune, while others believe that organizational “attitude” and comprehensive policies and procedures are the keys to suicide prevention in correctional facilities (Hayes, 1997). It has been argued that negative attitudes — for example, “If someone really wants to kill themselves,

there’s generally nothing you can do about it” — impede meaningful jail suicide prevention efforts. Most effective suicide prevention programs in correctional facilities have extended incident-free periods of suicide arguably related to their implementation of the following suicide prevention components: (a) suicide prevention training for correctional, medical and mental health staff; (b) identification of suicide risk through intake screening; (c) procedures for referral to mental health or medical personnel, reassessment following crisis period; (d) effective communication between correctional, medical and mental health staff when managing a suicidal inmate; (e) supervision and safe housing options for suicidal inmates; (f) timely medical intervention following a suicide attempt; (g) proper reporting procedures following an incident; and (h) administrative and/or clinical review of suicide, availability of critical incident debriefing to staff and inmates (Hayes, 1998a). But what separates exemplary programs from very good programs is “attitude.” *Exemplary programs adhere to the philosophy that inmate suicide will not be tolerated.*

The Hamilton County Juvenile Court Youth Center in Cincinnati, Ohio is one example of an exemplary program. Opened in 1995, the 160-bed facility replaced a 30-year antiquated detention center plagued with numerous physical plant problems that precipitated, in part, three youth suicides in the 1980s. The most recent suicide in the system occurred in 1986 and became the impetus for dramatic change. In addition to building a new facility, all staff received eight hours of basic suicide prevention training followed by two hours of annual training; all youth entering the facility were subjected to several layers of screening and assessment by mental health staff; all youth were observed by facility staff at 15-minute-intervals, with high risk youth observed at 5-minute staggered intervals; and any suicide attempt, regardless of whether serious injury occurred, was subjected to an administrative review. Since the last suicide in the old facility in 1986, over 70,000 youth have passed through the Hamilton County Juvenile Court Youth Center system. When asked to explain such a lengthy incident-free period, the superintendent remarked that it was the result of

the cumulative impact of the worst three days of my career, those three days during and after the suicide of Dennis D. in our facility. I was at the hospital and witnessed Dennis’ parents being informed by hospital staff that Dennis had died. The agony I witnessed in the face of his parents and the sense of guilt and failure that I felt as superintendent regarding his death will be something I will carry with me for the rest of my life. After Dennis’ suicide, I promised myself that I would do everything possible to proactively reduce the odds of our facility ever experiencing another suicide’ (quoted in Hayes, 1998a)

The Orange County Jail system in California is the 12th largest jail system in the country (Bureau of Justice Statistics, 1998). On any given day there are approximately 5,400 inmates confined in five jail facilities. Since 1988, over 800,000 inmates have passed through the jail system, with only four of those inmates committing suicide — a ratio of one suicide per 200,000 admissions (Hayes, 1998b). While considered a “mega jail,” the jail system is operated

on a much smaller scale and few inmates “fall through the cracks” of needed services. For example, from the point an inmate is booked into the jail system, series of checks and balances is initiated to identify potentially suicidal behavior. All inmates are initially screened by medical staff at intake and the system is staffed by mental health clinicians 24-hours a day to further assess referred inmates. In addition, correctional, medical and mental health personnel informally communicate with each other on at-risk inmates on a daily basis and attend weekly interdisciplinary staff meetings. Another example of seriousness in which the jail system views suicide prevention is exemplified by the requirement that all correctional staff carry small laminated cards in their pockets or wallets. Each card lists the most prominent warning signs and symptoms of suicidal behavior in jail inmates and are used by staff as a continuing reminder of their responsibility to identify potentially suicidal behavior and make the appropriate referral to mental health staff. As offered by one facility commander in the Orange County Jail system,

Those cards are part of the uniform. Every time I change my uniform I have to take the card out of my breast pocket and put it into my fresh uniform. Whatever type of subliminal reminder it is, it reinforces the importance of suicide prevention to this jail administration and that deaths in custody will not be tolerated. (quoted in Hayes, 1998b).

The Hamilton County Juvenile Court Youth Center and Orange County Jail system are two very different correctional agencies, both in size and the clientele they incarcerate. Yet both agencies have exemplary suicide prevention programs in which the focal point is zero-tolerance of suicide.

### ***Treatment***

From a mental health perspective, treatment begins with crisis intervention, the immediate response to suicidal behavior. A synthesis of crisis intervention theories and principles yields six general procedures. (Roberts, 1990):

1. Establishing psychological contact and beginning relationship formation,
2. Defining the problem by examining its dimensions,
3. Encouraging an exploration of emotions and feelings,
4. Exploring and assessing past attempts to cope,
5. Generating and examining alternative solutions, and
6. Taking action to restore cognitive functioning (p. 12).

Crisis intervention is different in jail and prison settings from the typical mental health setting in two important ways. First, in jail and prison settings, those responsible for direct response, and in most cases, crisis intervention, are correctional, not mental health professionals. Once professional staff have left the facility for the day, they know little of what occurs during the next 18 hours

in holding facilities, crowded cell blocks, or dormitories. Necessarily, mental health staff rely on the communication of correctional staff; therefore, such individuals’ ability to functionally understand the behavior of suicidal inmates is critical. We feel strongly that comprehensive prevention training for correctional staff is the primary means of suicide prevention in confined settings. Programmatic prevention efforts focusing on systemic environmental interventions such as those described earlier in this chapter have demonstrated reductions in suicide and overt suicidal behaviors in uncontrolled evaluations.

Beyond prevention and crisis intervention, however, what treatment is indicated for the suicidal individual? To begin with, there are no psychosocial or pharmacological treatments demonstrated as empirically effective in reducing suicidal behavior in jail and prison settings. Treatments discussed below represent “free world” inpatient psychiatric and outpatient mental health settings. Treatment studies targeting suicidal behaviors such as ideation and overt behavior, and other self-harm (generally referred to as self-mutilating) behaviors, have been a relatively neglected area in treatment efficacy research. This is a result in part to the risks associated with conducting research with suicidal individuals and the assumption that we already know that some treatments, or the prevailing standards of care, are better than others for treating suicidal individuals. One of the major problems in identifying treatments is the definitional ambiguity noted earlier, or exactly what is the target of treatment? Ideation? Impulse? Actual behavior? Suicidal behaviors, intention, and treatment targets are so variously described that generalizing existing research is fraught with problems.

Treating suicidal behaviors is usually approached in one of two ways: (a) assuming that such behaviors are symptomatic of some other (usually mental) disorder with treatment focused on the underlying disorder, or (b) assuming ideation and other suicidal behaviors can be reduced independently of other behaviors and directly targeting (whether psychosocially or biologically) suicidal behaviors. There are roughly 20 clinical trials of psychosocial and behavioral interventions for suicidal behavior. Despite the relationship between major depressive disorder and suicidal behavior, most psychosocial and pharmacological treatment trials have excluded suicidal and self-mutilating individuals, making the generalizability of these studies unknown (Stanley, personal communication, 1999).

### ***Psychopharmacological Treatments***

Despite promising data from small clinical studies, general conclusions drawn by reviewers are to proceed with caution, highlighting that pharmacotherapy should not occur without equivalent attention to psychosocial factors linked to suicidal behavior. As with psychosocial treatments for suicidal behavior, there are no published studies, or even reviews, on psychopharmacology for suicidal inmates.

Well-known, however, are studies that found reduced levels of 5-hydroxyindoleacetic acid (5-HIAA) in the cerebrospinal fluid of completed suicides, fire setters, and impulsively violent criminals (Brown & Linnoila, 1990; Coccaro, 1989). These studies are largely responsible for the dominant research on the effects of serotenergic medications in treating aggression. Although

favorable effects were reported treating aggressive behavior pharmacologically, there are few studies beyond case reports or small series of uncontrolled series of studies. Recent success of newer SSRIs in treating violent behavior, including self-harm, is under examination, highlighting definitional issues: the success of SSRIs may be due to their effects on impulsivity rather than aggression (Conacher, 1997).

In general, carbamazepine, propranolol and lithium have been most researched in the treatment of impulsivity and aggression, all drugs which interact with central serotonin systems incorporating a range of receptor and cell membrane-affecting properties. Among these drugs which show a positive effect, there is little evidence supporting the selection of any particular class of drugs (Conacher, 1997)

Unfortunately, in addressing underlying disorder, the assumption that treating depression will reduce suicide ideation has not been borne out by data (Beasley et al., 1992). Beasley et al's meta analysis of fluoxetine and tricyclic antidepressants showed no significant reduction in overt suicidal behavior. The exclusion of actively suicidal individuals from initial enrollment in the study, however, may account for the absence of effect on suicidal behavior.

Ambiguous and uncertain, we are still far from clearly understanding the biochemical and neurological pathways predisposing individuals to suicidal behavior and the relationships among the behaviors, thoughts and intentions that suicidality comprises. The contextual issues surrounding the benefits and limitations of psychotropic medications for confined suicidal individuals are similar to those for the hospitalized inpatient. If we can presume that suicidal behaviors are directly related to a set of biopsychosocial factors, understanding the relationships between suicidal behaviors and other functional domains is critical. Six medical and psychiatric conditions that may be associated with suicidal behavior include

1. Onset or exacerbation of an underlying psychiatric disorder,
2. Current life stressors that overwhelm an at-risk individual,
3. Treatment of a psychiatric disorder (e.g., adverse reaction to medication or onset of suicidal behavior as depression lifts),
4. Underlying medical condition,
5. Medical treatment (e.g. adverse reaction to drug treatment), and
6. A learned response bias or inherited predisposition toward suicidal behavior in response to stress. (Silverman, et al., 1998, p.136)

General guidelines and recommendations for pharmacotherapy with suicidal individuals have basic applicability, but fail to

address the exigencies of providing service in correctional settings. Clinical signs and situations identified as requiring immediate consideration of pharmacological treatment in general inpatient settings (Silverman et al., 1998; Slaby, 1998) are not sensitive enough for jail and prison settings. Although they follow reasonable norms of clinical care, and include acute agitation or anxiety with suicidal intent, unmanageable psychotic or manic episodes, command hallucinations, and paranoid delusions, they also include substance abuse-dependence along with a history of impulsivity or violence, excluding few in correctional settings. Heavy emphasis should be placed on the critical nature of thorough assessment, the relationship between prescriber and patient, and the treatment team's awareness of medication goals (Silverman et al., 1998; Slaby, 1998).

### *Psychosocial Treatments*

A review of randomized clinical trials of psychosocial and behavioral treatments for suicidal behavior found only 18 studies, with only 4 reporting positive results. The other 14 did not. Of those 4, 2 suffered from inadequate description of the intervention, leaving 2 reasonably designed studies (Linehan et al, 1991; Salkovskis, Atha, & Storer, 1990).

In these two studies, Dialectical Behavior Therapy (DBT), a cognitive-behaviorally based treatment for borderline personality disorder, demonstrated significant effects in reducing suicidal behavior among women in randomized clinical trials. DBT is a one-year outpatient program comprised of weekly group-skills training and individual psychotherapy; skills-training targets include life-threatening behaviors, treatment interfering behaviors and quality of life behavior. Four skills modules address these issues: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. When compared to treatment as usual (TAU), DBT showed significant (a) decreases in suicidal behavior and self-mutilation; (b) maintenance in treatment; and (c) number of treatment days. Individuals participating in DBT engaged in fewer overall self-harm incidents than TAU subjects (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard & Armstrong, 1993). Applications of DBT to correctional and forensic mental health settings are currently underway in over a dozen state prison systems and forensic hospitals, as well as outpatient programs (Ivanoff, 1998).

What happens to jail and prison inmates after the crisis and after immediate treatment? There is little information available about either group. Examining the subsequent adaptation of state inmates who engaged in suicidal behavior during the first year of their incarceration, Smyth, Ivanoff and Jang (1994) found that a second episode of self-harm during year two continued to be most strongly associated with prior psychiatric history and dysfunction among primary social network members such as alcohol abuse, arrests, and drug problems. There were general, but not uniform, decreases in psychological maladaptation (notably not in anger levels) one year into incarceration. Those with higher levels of anger one year later had more suicidal ideation.

Identifying those vulnerable or at risk due to previous suicidal behavior and providing interventions to bolster emotional skills

and resources to cope with the demands of prison or jail are both part of suicide prevention. Another aspect concerns identifying the pathways out of suicide: What are the characteristics associated with subsequent adjustment following a suicidal crisis? How can we help these individuals find their niche? It is not enough to prevent only the ultimate act of suicide if the goal is to prevent harm to vulnerable individuals.

### Conclusion

The belief that suicidal behavior is a symptom of some other (usually mental) disorder is extremely strong in the United States. Primary prevention efforts by the National Institute of Mental Health are slowly working to shift this perception toward regarding suicidal behavior as behavior which may be associated with, but not caused by, other mental health disorders. Acknowledging the interactions and direct effects of the extreme environmental conditions in correctional institutions is essential in understanding this problem.

The strongest set of recommended strategies for preventing suicidal behavior in confinement involves initial screening and subsequent environmental adaptation to address identified risk characteristics. As knowledge about these characteristics increases, screening and intervention methods will need to be refined to not only meet the needs of the institution in preventing suicide but to assist in targeting and accessing appropriate mental health care and programming. Steps beyond environmental management, screening and crisis management involve the development of targeted group and individual skills-building approaches: What works best for whom under what circumstances?

Although the implementation of comprehensive prevention programs is universally advocated and has the potential to prevent many deaths, the effectiveness of these programs may be limited by their generic design. Effective prevention programs cannot assume and only operate as if suicide risk functions the same across all types of individuals in custody. Our response must be informed by an understanding of the individual crises that may precipitate suicidal behavior and the relationships among current behavioral factors that may affect risk. As clinical scientists we need to look for the signs, signals, indicators, and means of measuring these indicators that work across individuals for populations, or, at least for subsets of a population.

Finally, clinicians and researchers in this field share the belief that earlier intervention with suicidal individuals is linked to better prognosis for the individual and for those surrounding the suicidal individual. Over time and with practice, we have learned to attend to the environment, to the positive and negative symptoms of suicidality, and to the more subtle indicators that form the basis for clinical judgment. Our goal should be to develop methods of identification, risk assessment, and intervention based on the characteristics of both the vulnerable and the mentally disordered individuals at risk for suicide in correctional settings.

## JAIL MENTAL HEALTH SERVICES INITIATIVE FROM THE NATIONAL INSTITUTE OF CORRECTIONS (JAILS DIVISION)

Nearly 6 to 8 percent of the more than 10 million annual commitments to jails are individuals with severe mental illnesses. Many sheriffs and jail administrators view the challenge of responding to the needs of this population as one of the major issues in jail management. In response, the National Institute of Corrections (NIC) has worked collaboratively with the National Institute of Mental Health for the past several years, and more recently, with the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services to increase and improve these services. As a result of these collaborations, the NIC Jails Division has developed a mental health initiative for jails.

An important component of the initiative is the offering of regional workshops conducted in collaboration with state, regional, and local jurisdictions. The 21-hour regional workshops will be provided upon request to help small and medium-sized jails enhance mental health services and service delivery for inmates. Several jurisdictions in a region can each send a three-person team consisting of a jail administrator, a representative of the jail's community mental health provider, and the person who coordinates mental health services for inmates. Each workshop will include: overview of the problem, planning principles, contract development, leadership and managing change, implementation strategies, staffing and cross-training, and coalition building. The workshops are conducted at the request of a host agency, which is responsible for furnishing the training rooms and equipment. The NIC Jails Division provides two trainers, the curriculum and training materials. Participants are responsible for their own expenses.

In addition to the workshops, the NIC Jails Division's mental health initiative includes the following services:

- ◆ **On-site Technical Assistance:** This assistance usually consists of an assessment of a jail system's mental health needs, *but also can be targeted at suicide prevention issues in the jail;*
- ◆ **Newsletter:** The NIC Jails Division funds the *Jail Suicide/Mental Health Update*, a newsletter which is distributed free of charge on a quarterly basis;
- ◆ **Information Resources:** The NIC Information Center has compiled a jail mental health information resource order form that contains 22 items. The form is available at the mental health workshops held in Longmont, Colorado and at regional sites. It can also be obtained by calling the Information Center at (800) 877-1461.

For more information on the NIC Jails Division's mental health initiative, on-site technical assistance, and the mental health workshops, contact the agency at (800) 995-6429, or visit their website at: [www.nicic.org](http://www.nicic.org)

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## CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT

*The Criminal Justice/Mental Health Consensus Project was a two-year effort to prepare specific recommendations that local, state, and federal policymakers and criminal justice and mental health professionals could use to improve the criminal justice system's response to people with mental illness. Guided by a steering committee of six organizations (Association of State Correctional Administrators, Bazelon Center for Mental Health Law, Center for Behavioral Health, Justice, and Public Policy, National Association of State Mental Health Program Directors, Police Executive Research Forum, and Pretrial Services Resource Center) and advised by over 100 of the most respected criminal justice and mental health practitioners in the United States, the mission of the Consensus Project was to provide concrete, practical approaches that can be tailored to the unique needs of communities. The Consensus Project Report was released in June 2002, and its executive summary is reprinted below.*

### **I. The Problem: Impact on People and Systems**

People with mental illness are falling through the cracks of this country's social safety net and are landing in the criminal justice system at an alarming rate. Each year, ten million people are booked into U.S. jails; studies indicate that rates of serious mental illness among these individuals are at least three to four times higher than the rates of serious mental illness in the general population.

Because of sensational headlines and high-profile incidents, many members of the public and some policymakers assume, incorrectly, that the vast majority of people who are in prison or jail and have a mental illness have committed serious, violent crimes. In fact, a large number of people with mental illness in prison (and especially in jail) have been incarcerated because they displayed in public the symptoms of untreated mental illness. Experiencing delusions, immobilized by depression, or suffering other consequences of inadequate treatment, many of these individuals have struggled, at times heroically, to fend off symptoms of mental illness. Providers in the mental health system have been either too overwhelmed or too frustrated to help some of these individuals, who typically have a history of being denied treatment or refusing it altogether.

Whereas some of these individuals have no family, others have exhausted the resources or the patience (and often both) of their loved ones. Often, family members, fearful for their safety or because they are simply out of options, ask the police to intervene. In other cases, concerned members of the community alert law enforcement about situations such as these: a woman shouting obscenities at shoppers on Main Street; an unkempt man in the park making threatening gestures and urinating in public. Many times, police officers on their patrols encounter individuals with mental illness in various states of public intoxication. These are

individuals who have attempted to self-medicate using alcohol or any illegal substance they could obtain.

There are also cases in which a person with a mental illness commits a serious, violent crime, making his or her incarceration necessary and appropriate. Still, almost all of these individuals will reenter the community, and the justice system has the legal obligation (and the obligation to the public) to prepare these individuals for a safe and successful transition to the community.

Given the dimensions and complexity of this issue, the demands upon the criminal justice system to respond to this problem are overwhelming. Police departments dedicate thousands of hours each year transporting people with mental illness to hospitals and community mental health centers where staff often have to turn away the individual or quickly return him or her to the streets. Jails and prisons are swollen with people suffering some form of mental illness; on any given day, the Los Angeles County Jail holds more people with mental illness than any state hospital or mental health institution in the United States.

Most troubling about the criminal justice system's response in many communities to people with mental illness is the toll it exacts on people's lives. Law enforcement officers' encounters with people with mental illness sometimes end in violence, including the use of lethal force. Although rare, police shootings do more than end the life of one individual. Such incidents also have a profound impact on the consumer's family, the police officer, and the general community. When they are incarcerated, people with untreated mental illness are especially vulnerable to assault or other forms of intimidation by predatory inmates. In prisons and jails, which tend to be environments that exacerbate the symptoms of mental illness, inmates with mental illness are at especial risk of harming themselves or others. Once they return to the community, people with mental illness learn that providers already overwhelmed with clientele are sometimes reluctant to treat someone with a criminal record.

#### *Origins of the Problem*

The origins of the problem are complex and largely beyond the scope of this report. During the last 35 years, the mental health system has undergone tremendous change. Once based exclusively on institutional care and isolation, the system has shifted its emphasis almost entirely to the provision of community-based support for individuals with mental illness. This public policy shift has benefited millions of people, effecting the successful integration of many people with active or past diagnoses of mental illness into the community. Many clients of the mental health system, however, have difficulty obtaining access to mental health services. Overlooked, turned away, or intimidated by the mental health system, many individuals with mental illness end up disconnected from community supports. The absence of affordable housing and the crisis in public housing exacerbates the problem; most studies estimate that at least 20 to 25 percent of the single, adult homeless population have a serious mental illness.

Not surprisingly, officials in the criminal justice system have encountered people with mental illness with increasing frequency. Calls for crackdowns on quality-of-life crimes and offenses such as the possession of illegal substances have netted many people

with mental illness, especially those with co-occurring substance abuse disorders. Ill equipped to provide the comprehensive array of services that these individuals need, corrections administrators often watch the health of people with mental illness deteriorate further, prompting behavior and disciplinary infractions that only prolong their involvement in the criminal justice system.

## II. About the Criminal Justice/Mental Health Consensus Project

The *Criminal Justice/Mental Health Consensus Project* is a unique effort to define the measures that state legislators, law enforcement officials, prosecutors, defense attorneys, judges, corrections administrators, community corrections officials, and victim advocates, mental health advocates, consumers, state mental health directors, and community-based providers agree will improve the response to people with mental illness who are in contact (or at high risk of involvement) with the criminal justice system.

The target audience of the *Consensus Project Report* is those individuals who can be characterized as agents of change: state policymakers who can have a broad systemic impact on the problem and an array of practitioners and advocates who can shape a community's response to the problem. Legislators, policymakers, practitioners, and advocates can champion the detailed recommendations in the report knowing that each has been developed and approved by experts from an extraordinarily diverse range of perspectives who work in and administer the department, agencies, and organizations trying every day to address the needs of people with mental illness involved (or at risk of involvement with) the criminal justice system.

The *Consensus Project Report* addresses the entire criminal justice continuum, and it recognizes that actions taken by law enforcement, the courts, or corrections have ramifications for the entire criminal justice system. The report also recognizes that people with mental illness who are involved with the criminal justice system live in or return to communities, each of which has distinct issues, challenges, assets, and potential solutions to enable people with mental illness to avoid or minimize involvement with the criminal justice system.

The report provides 47 policy statements that can serve as a guide or prompt an initiative to improve the criminal justice system's response to people with mental illness. Following each policy statement is a series of more specific recommendations that highlight the practical steps that should be taken to implement the policy. Woven into the discussion of each recommendation are examples of programs, policies, or elements of state statutes that illustrate one or more jurisdiction's attempt to implement a particular policy statement. While promising, many of these initiatives are so new that they have yet to be evaluated to certify their impact on individuals and systems. Still, they demonstrate how partnerships and resourcefulness can be successfully replicated or tailored to the unique needs of a variety of communities. These examples should also help communities to build on the

achievements without duplicating the failures or inefficiencies of others.

State and local government officials and community leaders can use these policy statements, recommendations, and examples to get beyond *discussing* the issue and to begin developing initiatives that will *address* the problem. The following chart (not included here) presents the policy statements contained within the *Consensus Project Report*.

## III. Consensus Project Policy Statements

The policy statements in the *Consensus Project Report* reflect that — from a person's first involvement with the mental health system to initial contact with law enforcement, to pretrial issues, adjudication, and sentencing, to incarceration and re-entry — there are numerous opportunities for an agent of change to focus his or her efforts to improve the response to people with mental illness who come in contact with criminal justice system.

The first half of the following chart (not included here) corresponds to Part One of the report. These policy statements explain the opportunities available to practitioners in the criminal justice and mental health systems to identify a person who has a mental illness and to react in ways that both recognizes the individual's needs and civil liberties and promotes public safety and accountability. In addition, the policy statements below summarize elements of programs and policies that would enable law enforcement, court officials, corrections administrators, and mental health providers to provide access to effective treatment and services and to maintain the individual on a path toward recovery.

Policy statements describing the overarching themes (Part Two) of the report appear in the second half of the chart below (not included here). They reflect that the recipes for implementing each of the policy statements in part one of the report calls for many of the same ingredients: collaboration, training, evaluations, and an effective mental health system.

The policy statements concerning collaboration recognize that neither the criminal justice system nor the mental health system can, on its own, implement many of the recommendations in the report. For example, law enforcement officials need information about and access to mental health resources to respond effectively to individuals with mental illness in the community. To make informed decisions at pretrial hearings, adjudication, and sentencing, court officials need some information about an individual's mental illness. Corrections and community corrections administrators should be able to tap a clinician's expertise when evaluating whether a person eligible for parole meets the criteria for release.

The chapter regarding training calls for criminal justice practitioners to become familiar with the signs and symptoms of mental illness, the appropriateness of various responses, and the resources and organization of their local mental health system. Similarly, the implementation of many of the recommendations throughout the report depends on mental health clinicians and service providers who understand the criminal justice system and are willing to look beyond the stigma associated with a criminal record.

## NEWS FROM AROUND THE COUNTRY

Measuring the outcomes of programs designed to improve the response to people with mental illness involved in the criminal justice system is also of paramount importance. Program administrators must monitor the impact of a new initiative. Such information is essential to determine whether a program or policy is successful and how it can be improved. It also facilitates continued support for promising initiatives.

The last set of policy statements in the following chart recognizes that successful implementation of the policy statements throughout the report requires the delivery of mental health services to individuals who have complex needs and a long history of unsuccessful engagement in the community-based mental health system. Mental health services must be accessible, easy to navigate, culturally competent, and integrated; treatment provided should adhere to an evidence base. A community mental health system that does not meet these criteria is unlikely to maintain an individual with mental illness engaged in treatment, and thus will quickly cause criminal justice officials to lose confidence in the community's capacity to support people with mental illness.

### IV. Using the Report and Next Steps

**T**he *Consensus Project Report* should be used as a compendium of ideas that will help individuals identify and frame practices and programs that will improve the response to people with mental illness who are in contact with — or at risk of becoming involved with — the criminal justice system.

Deciding where to start — especially when familiar with the existing obstacles to improving the systems — is difficult. In more than one community, reform efforts have been derailed before getting underway because those involved could not decide where to begin. Similarly, attempting to implement many, if not all, of the policy statements in this report could overwhelm a community.

The single most significant common denominator shared among communities that have successfully improved the criminal justice and mental health systems' response to people with mental illness is that each started with some degree of cooperation between at least two key stakeholders — one from the criminal justice system and the other from the mental health system.

Indeed, the *Consensus Project* report reflects, on a national level, the value of substantive, bipartisan, cross-system dialogue regarding mental health issues as they relate to the criminal justice system. At a minimum, such discussions should be replicated in communities across the country. Where those discussions have already begun, agents of change should capitalize on the window of opportunity that now exists. The lives of people with mental illness, their loved ones, and the health and safety of communities in general depend on it.

*For more information regarding the Criminal Justice/Mental Health Consensus Project, including downloading of the Consensus Project Report, visit the Project's website at [www.consensusproject.org](http://www.consensusproject.org). The report is also available for purchase from the Council of State Governments, P. O. Box 11910, Lexington, KY 40578, (859/244-8000).* □

*Offered below are brief stories regarding jail suicide, mentally ill offenders, and other related topics that have recently occurred and/or been reported throughout the country.*

### New York

**A**s an emergency services police officer in New York City for 17 years, James Gunther was one of those steely, go-to guys, a natural in a crisis. Gunther, 45, had pulled people out of fiery car crashes, delivered babies in backseats and chased suspects down the streets of Queens. But when his second marriage began to break up a couple of years ago, it was more than he could handle.

He went to see a psychiatrist, who prescribed pills to make him feel better, but twice Gunther used them to try to kill himself. He missed child-support payments. He violated a judge's order to stay away from his wife. Three times the cop from Centereach was arrested and locked up in Nassau County jail. The last time, with pills he filched from another inmate, he tried to commit suicide yet again.

"He couldn't stand to be away from his kids," his daughter, Katherine Gunther, 19, recalled, "and he said if he didn't get out of there soon, he was going to kill himself." After Gunther recovered, he was put in the jail's mental health tier, where a correction officer checked on him every 15 minutes. In the unseen moments between rounds, shortly after midnight on September 15, 2000, James Gunther wrapped a bed sheet around his neck, looped it over a wall hook and hanged himself, finally succeeding in ending his life. When the state ordered jail officials to explain how, despite Gunther's clear and recent history of suicidal behavior, he had not been put under constant observation, they admitted: "This was an error."

Over the past four years, errors like this one have been all too frequent on Long Island. Of the 11 inmates who have killed themselves here since 1998, including three in the past nine months, seven had diagnosed mental illnesses or showed signs of mental illness. Two others suffered from depression and one had made previous suicide threats, family members said. In most of those cases, the state found serious problems with the way Nassau and Suffolk cared for the inmates. In a system that only will come under more pressure as the number of mentally ill inmates continues to grow, state records have shown a pattern of repeated failures:

- *Suicidal inmates have gone unwatched for long stretches.* The state repeatedly has told Nassau and Suffolk that inmates who are actively suicidal must be watched at all times because inmates can hang themselves with fatal results in less than five minutes. Yet the inmates — four in Suffolk and three

in Nassau — who killed themselves were being monitored only every 15 or 30 minutes.

- “ *Emergency mental health services that could prevent suicides have been delayed.* In one case in Nassau, officials flagged a new inmate as possibly suicidal and referred her to the mental health unit the next day. Before they could see her, she hanged herself. In Suffolk, an inmate asked for psychiatric help, but officials did not receive the request until four days later. In the meantime, he killed himself.
- “ *Mood-altering drugs have been inconsistently administered.* Inmate suicides sometimes followed abrupt changes in medications that doctors had ordered without consulting mental health experts. One Nassau inmate’s doctor took her off several types of medications, including anti-depressants and mood stabilizers, and only provided an explanation after the inmate had killed herself. “He attempted no diagnosis of a clearly ill patient ... He abruptly withdrew her medication and noted no provision for alternate therapy,” according to a state report.
- “ *Mentally ill inmates who should be sent to the hospital often have been incarcerated instead.* In two cases, inmates who committed suicide had been jailed when, the state said, they should have been hospitalized. One of the inmates had been charged with sex abuse and was arrested three days later after running in and out of traffic, purposefully trying to get hit while high on pills he had sprayed with insecticide.

“We’re taking into our jails people accused of small and large crimes — which sometimes they are not even guilty of — and they are supposed to be kept safe so that a judge can decide what will become of them. That doesn’t include letting them go untreated for their physical and mental ailments,” said Janet Ades, the chief of the Nassau Legal Aid Social Work Bureau, which represents mentally ill inmates.

Jail officials, especially in Nassau, have tried to make changes to comply with directives. But they say complying with such mandates is costly and often at odds with pressure from local government to cut costs. In some cases, local officials insist their care of inmates was adequate and the state was wrong. “Nobody wants to say there’s an acceptable rate of suicide, but there are people who kill themselves despite our best efforts,” said Howard Sovronsky, the Nassau mental health commissioner, who helped develop the suicide screening program for the jail and ran the mental health clinic from 1984 to 2000.

When inmates come into local jails, they are evaluated both physically and mentally. They also are given a suicide screening test, a series of questions designed to indicate whether they are depressed and thinking about killing themselves. If the inmate passes the test, correction officers can override the result based on such factors as the person’s mood or the nature of their crime, and refer the inmate to the mental health unit. All inmates also

have to go to the medical unit for a routine physical, and the physician there can refer inmates to the mental health unit.

In recent years, the state has ordered both jails to tighten these procedures, usually because an inmate suicide has pointed out deficiencies. In Nassau, staff have been hired, including a new mental health director, a new jail infirmary has opened and a new program has been set up to better monitor medication. In Suffolk, officials created a mental health cellblock but acknowledge they continue to struggle to provide adequate service with limited staff.

The challenge of dealing with mentally ill inmates is expensive. While jail officials in both counties said they could not break out the costs, they said it is a huge financial drain. In the past 20 years, the population of mentally ill inmates has risen to the point that in Suffolk, they constitute 15 percent to 20 percent of the jail population and in Nassau, about 12 percent. Experts say the actual numbers are probably higher because mentally ill people aren’t always identified as such.

The increase reflects a national trend fueled by the closing of many large psychiatric hospitals, a decline in community-based

### FORENSIC MENTAL HEALTH: WORKING WITH OFFENDERS WITH MENTAL ILLNESS

**T**he criminalization of mental illness is a fact. Increasing numbers of individuals with mental illness are arrested for both minor and major crimes and end up in our jails and prisons. As these offenders are “put up with” behind bars — their mental and emotional conditions all too often worsening — the challenge of reintegrating them into the community looms. There is a dearth of social service and community agencies to help this special class of offenders make the difficult transition back to the social and working world. All too soon, these persons cycle back through decompensation, re-offense and ultimate rearrest. This problem is not unique to the United States, nor are the solutions.

The recently released *Forensic Mental Health: Working With Offenders With Mental Illness* offers the latest insights and valuable practical guidance to professionals. Edited by Gerald Landsberg and Amy Smiley, this voluminous 656-page book presents 47 chapters from numerous contributor authors in seven categories: community interventions, institutional treatment, legal and law enforcement issues, juvenile treatment issues, women’s treatment issues, victims of offenders with mental illness, and training.

For more information regarding the cost and availability of *Forensic Mental Health: Working With Offenders With Mental Illness*, contact Civic Research Institute, P.O. Box 585, Kingston, NJ 08528, (609/683-4450; 609/683-7291-Fax.)

services for the mentally ill, and a growing number of encounters between police and mentally ill people. “The fact that hospitals are no longer an option is a factor, but it also reflects a failure to put sufficient resources into funding programs for the mentally ill,” said Ron Honberg, legal director of the National Alliance of Mental Health in Virginia and author of the book “The Mentally Ill in Jail.”

The trend poses a major challenge to jail officials. “It was a large population of people we weren’t prepared to manage,” said former Suffolk Under Sheriff Eileen Kelly, who supervised the jail until late last year. She said she started seeing a spike in the mentally ill population about five years ago.

Experts say suicidal behavior is associated with mental illness. “That’s why it is extremely important for jails to do good intake screening,” said Lindsay Hayes, a nationally known jail suicide expert, who noted the average suicide rate in jail is about nine times greater than in the general population.

While jail can be a depressing place for anyone, incarceration for the mentally ill is like a “magnifying glass for their problems,” said Louis Gallagher, who runs the mental health clinic at the Suffolk jail. The isolation from friends and family and the sense of despair that affects many inmates can put a mentally ill person over the edge. Mood-stabilizing medications also may be changed or stopped in jail, which can affect an inmate’s mental state.

“It comes down to the reality that jails and prisons are not mental health treatment facilities and the environment is almost guaranteed to make the symptoms of mental illness worse,” Honberg said. “It’s not a pleasurable place to be. It’s a scary place to be.”

Soon after Nassau police arrested Lorecia Cox on January 2, 2000, it became clear she would need mental health care: She was on medication and had been treated for multiple personality disorder and manic depression. And her arrest for passing a bad \$64,000 check for a luxury car seemed to cap a bizarre period for the 39-year-old Hempstead resident. The oldest of four siblings, Cox grew up a smart, fun-loving person with a great sense of humor, her brother Ken recalled. But in 1990 her father died and she had a partial hysterectomy. Afterward, she became depressed and evasive, her brother said. “It just seemed to throw her for a loop,” he said.

Cox, a state court officer in Brooklyn, went out on disability status, first for physical reasons and then emotional problems. “She would hide the truth,” Ken Cox said. Before her arrest, he recalled, “She told us that her boyfriend had bought her a Jaguar. But we knew he couldn’t afford it.”

When she was arrested, she told police about her history and they took her to the county medical center. A psychiatrist in the emergency room found her depressed and her judgment “limited,” according to a state Commission on Correction report. He continued the medications she was on for depression and other psychiatric disorders and sent her to the jail. At the jail, Cox failed a suicide screening test, and an officer referred her to the mental health unit. A jail doctor, who examined her upon admission,

also referred her there but abruptly took her off the five mood-altering drugs she was on because he did not think she needed them.

The referral landed on the desk of a secretary in the mental health unit, who was not medically trained and did not consider it an emergency. She scheduled Cox to be seen the next day. Cox was put in a cell block that an officer patrolled every 30 minutes. At 4:00 p.m., she asked to make a phone call but the officer refused because meal time was imminent. At about 5:30 p.m., another officer saw Cox apparently standing against the wall of her cell “in an odd way.” She was in the same position when the officer passed by a half-hour later. When the officer entered the cell, she found that Cox wasn’t standing. She was hanging by her shoelaces from a clothing hook and was pronounced dead at 6:41 p.m.

Recently, Cox’s family sued and won a \$200,000 settlement with the county. The state said the hospital and jail’s handling of the case was “inadequate care” because Cox was a “suicide risk” and needed immediate treatment — and she never should have been put in the jail at all. “The reality is the county was negligent in how they handled this,” said attorney Joel Levine of Mineola, who represented the family.

Marc Gunning’s mental state clearly should have put him in a hospital, state officials said. Instead, Gunning, a 38-year-old self-described hypnotherapist from Coram, arrived at the Suffolk County jail in December 1999, after being charged with sodomy and sexual abuse for allegedly molesting at least six boys, aged 8 to 14. The charges against Gunning shocked people who knew him and the parents of his victims. He had a master’s degree in human development from SUNY Stony Brook, where he had served as student government president. Several neighbors had him baby-sit their children and teach them martial arts.

Gunning twice had been hospitalized for mental problems, and in 1982 he had made a “very serious suicide attempt,” according to a state report. Just before he was arrested, he had taken an overdose of four different medications sprayed with insecticide, and then ran into night-time traffic, where he was hit by two cars. He jumped out of the ambulance taking him to Stony Brook University Hospital. Later, he told a jail psychiatrist he was trying to kill himself because he was “tired of it all.”

After receiving medical treatment for fractures and contusions, Gunning came to the jail in Riverhead. He was placed in a mental observation tier, where an officer patrolled every 15 minutes. Four days later, he was seen by mental health officials, who prescribed Lithium and Prozac. About a month later, a physician from the medical unit discontinued the Lithium because of the toxic effect it was having on his thyroid. A psychiatrist put Gunning on another mood-stabilizing drug a few days later.

Gunning continued to deteriorate. On March 30, his attorney called the jail, saying Gunning had sent him a letter indicating he was suicidal. He was placed in a special “stripped cell,” without anything that could be used for a suicide, such as sheets. But even after he returned to a regular cell several days later, when his mood seemed more stable, Gunning continued behaving erratically. On May 14, a correction officer found him acting

incoherently and he was taken off the tier in a wheelchair. Gunning apparently had been hoarding his medications and had taken an overdose. He was sent to Central Suffolk Hospital in Riverhead, where he died two days later.

In a scathing report in October 2000, the state questioned why a physician, instead of a psychiatrist, had taken Gunning off mood-altering drugs and why there were such sudden changes in his medication. Moreover, Gunning never should have been able to hoard his drugs, the state said: "The nursing staff should have been more vigilant in verifying that Gunning swallowed his medications when given to him." The state upbraided jail officials for not monitoring Gunning constantly, and said he should have been hospitalized based on his mental history and suicide attempts. Gallagher, who runs Suffolk's mental health clinic, said the case prompted jail officials to re-examine how they treat "high-risk" inmates. "Today," Gallagher said, Gunning 'would be sent to a psychiatric center.'

A year before Gunning's suicide, the state had reprimanded the Suffolk jail for virtually the same violations — suddenly changing medication and failing to constantly observe a suicidal inmate.

Penelope Silberbusch, 57, a retired teacher from Patchogue, had entered the jail in October, charged with harassment and violating probation for prior charges of driving while intoxicated and aggravated harassment. She had retired with a disability after suffering a head injury. Upon entering the jail, she told officials that she suffered from alcoholism and manic depression and that she had stayed in psychiatric hospitals at least four times in the past.

She also told them she had tried to kill herself three times with medication overdoses, and her mother had committed suicide by hanging herself in 1967. She had also expressed concern about returning home to what she said was her abusive and alcoholic husband. In early November, Silberbusch saw a jail psychiatrist who took her off all the mood-altering medications she had been taking, with no explanation in jail records. The psychiatrist told state investigators he did not see "any need for acute psychiatric treatment."

On November 11, after Silberbusch told a correction officer she wanted to harm herself, officers moved her to a cell closer to their station and referred her to mental health services. The next day, she saw a social worker who ordered a "suicide watch," but patrols came by only every 15 minutes. On November 14, at 1:30 a.m., an officer found Silberbusch hanging from the bars in her cell, and two days later she was pronounced dead at Stony Brook University Hospital.

The state report said Silberbusch should have been watched constantly, given her history. Former Under Sheriff Kelly, in her response to the state, said constant supervision was impossible because of staffing constraints and the physical layout of the jail. But in a letter on February 2, 2000, Frederick Lamy, chairman of the Medical Review Board for the Commission on Correction, called that response "inaccurate and unacceptable" and the jail has changed its policy.

The state was very critical of the psychiatrist for taking Silberbusch off her medications so abruptly and without documented reasons: "The psychiatrist provided clearly inadequate care." And the state chastised the social worker for not following up with Silberbusch about her fear of going home, despite diagnosing her as "depressed, anxious" and having thoughts of suicide. "He did not conduct any follow-up with Silberbusch that day or the following day," the report said. "He did not see Silberbusch again prior to her suicide ... on 11/14/98. The care afforded by the social worker was clearly inadequate."

But local officials say predicting whether someone will commit suicide is a tricky and complicated business. "There's no litmus test or blood test for someone being suicidal," said Sovronsky, the Nassau mental health commissioner.

Robert Vorbeck had no history of suicidal behavior or mental problems when he came to the Nassau jail in the summer of 1999. The 38-year-old bar owner from Bellerose was charged with selling cocaine to undercover police officers and potentially faced a long prison sentence.

Vorbeck was arrested on July 2 and arraigned at the Nassau University Medical Center because he was suffering from ulcerative colitis, a painful, chronic colon condition. Hospital records said he also had a "severe" cocaine addiction. When his family visited him, they were shocked. "He didn't look well at all. He was very drawn and thin and very pale ... He looked depressed, scared and confused," one family member said.

Over the next few days, his family said they called the hospital and the jail repeatedly to get information on his condition and to arrange for psychiatric help. Finally, they reached a jail chaplain, who went to see Vorbeck. "That was it — that was his psychiatric treatment," one family member said. Neither jail nor medical records list Vorbeck as being suicidal or depressed, although hospital records indicate he was given "emotional support." But Vorbeck returned to the jail July 9, and four days later, he committed suicide, hanging himself with a bed sheet tied to the bars of his cell.

Police investigating his death said he had told another inmate he was depressed. But the state did not find that the jail violated standards of care. Jail officials will not comment because of a wrongful-death suit his family filed. But one family member said: "We feel he wasn't watched. He wasn't cared for properly. Our goal is to change the rules so this doesn't happen to anyone else."

(Reprinted with permission from *Newsday*, March 24, 2002, "Suicide in Long Island Jails: Deadly Oversights, County Jails Faulted for Lack of Care Given to Suicidal Inmates," by Robin Topping, Staff Writer. © 2002 *Newsday, Inc.*)

## Arkansas

**I**n May, 2002, the state chapter of the American Civil Liberties Union (ACLU) won a significant victory for the mentally ill when a federal judge ruled that the state violated the rights of mentally ill inmates by allowing them to languish in jails and denying them court-ordered evaluations and treatment.

“We hope this is a new day for mentally ill incarcerated inmates in Arkansas jails and their families — and for jail personnel as well,” said Bettina Brownstein, a cooperating attorney with the ACLU of Arkansas.

In his ruling, United States District Court Judge Stephen P. H. Reasoner agreed with the ACLU that the long waits endured by inmates amounted to punishment and that the state was deliberately indifferent to their plight in contravention of their right to due process under the United States Constitution. “The lengthy and indefinite periods of incarceration, without any legal adjudication of the crime charged, caused by the lack of space at [the Arkansas State Hospital], is not related to any legitimate goal, is purposeless and cannot be constitutionally inflicted upon the members of the class,” Judge Reasoner said in his opinion. “No matter who is at fault, the State of Arkansas must address the mental health needs of the class members in this case.”

“The next step is to move forward to the remedy phase,” said Rita Sklar, Executive Director of the ACLU of Arkansas. “The judge set a date for the hearing on how to fix this problem, and we will be ready with plenty of ideas.”

The ACLU of Arkansas filed the class-action lawsuit in federal court on July 12, 2001, against the Arkansas Department of Human Services, Division of Mental Health and the Sebastian County, Arkansas sheriff on behalf of all those in Arkansas jails, both awaiting court ordered forensic evaluations (to determine fitness to stand trial), and those who have been evaluated and sent back to jail. In both cases, the ACLU lawsuit said, jail inmates — who are also pre-trial detainees and not guilty of any crime — are receiving very little or no mental health treatment while at jail.

Howard Erler and James Terry were the individuals named in the lawsuit. Mr. Erler had tried to commit suicide in a county jail three times, and was ordered by a court to receive a forensic evaluation. Even though Mr. Erler was clearly suicidal and in need of reparative surgery to his hands and arms from his suicide attempts, it took the ACLU lawsuit to get him into the State Hospital. Mr. Terry had already been diagnosed by the State Hospital staff with psychotic disorder and borderline intellectual functioning, and was recommended and then ordered by a court for commitment to the Hospital. Nevertheless, he waited in a county jail for more than six months before the ACLU action got him a bed at the state hospital.

In November 2001, Judge Reasoner agreed that the case could be brought as a class action on behalf of all Arkansas jail inmates.

### Tennessee

**J**ames Kirkendall, 19, committed suicide in the Gibson County Jail in Trenton on May 5, 2002. He was discovered hanging by a gauze bandage from a window grate in his cell. He had been arrested the previous day on drug charges. In the afternoon of his death, Mr. Kirkendall attempted to cut his wrists with an

unknown sharp object. Believing the cut was superficial and not requiring medical attention, a correctional officer simply wrapped gauze around the cut and moved Mr. Kirkendall to a holding cell for better observation. He was in the cell less than 15 minutes before being found.

“I never thought a piece of gauze bandage could be used like that. These cells are the busiest part of the jail. He was where somebody could see him all the time,” Chief Deputy Chuck Arnold told the *Humboldt Chronicle*. What the chief deputy and his staff were also unaware of was the fact that Dyer Police Department officers had seen Mr. Kirkendall throwing rocks at cars behind the police station two weeks earlier. When approached by officers, he yelled “Shoot me. I don’t want to live. If you don’t kill me, I’ll kill myself.” Mr. Kirkendall had to be restrained with pepper spray and was subsequently committed to Western State Hospital for psychiatric treatment. He was arrested on drug charges less than a week after his release from the hospital.

### Georgia

**A**s a Fulton County taxpayer, you can choose which publicly funded services you believe will make your streets safer and more pleasant. Consider these figures: It costs \$26 a day to house, feed and treat men for mental illness and substance abuse at Jefferson Place, a public facility in northwest Atlanta partially funded by a federal grant. The clients also receive vocational training and help with permanent housing and jobs. By contrast, it costs \$45 a day to house an inmate at the Fulton County Jail (in Atlanta), which is often overcrowded. Many of the jail’s inmates are in dire need of treatment for mental illness or substance abuse, having been arrested for minor offenses such as passing out on a park bench or urinating on the street. If an inmate is mentally ill — and 700 of them are on a typical day — his condition often worsens while he is in jail.

Would Fulton County taxpayers prefer spending their hard-earned dollars on more effective and cheaper programs for mental health and drug treatment — programs which help rehabilitate offenders so they don’t return to the streets? Or do the taxpayers of Fulton County prefer to spend hundreds of millions on bigger jails?

Therein lies the choice forced by dire conditions in the Fulton County jail, which have resulted in a lawsuit and oversight by a federal judge. Fulton County is not the only urban area facing such a choice. In June 2002, the U.S. Senate Judiciary Committee held a hearing on the need for collaboration between police and mental health professionals and comprehensive mental health treatment in many cities.

In Fulton County, United States District Court Judge Marvin Shoob presides over a lawsuit filed on behalf of HIV-positive inmates at the Fulton County Jail, who claimed that overcrowding at the facility had become a life-threatening circumstance. Overcrowding has proved intractable partly because police take mentally ill people to the jail; there is nowhere else to take them. In his latest order, the frustrated

judge ordered Fulton County to develop a plan for diverting mentally ill people from the criminal justice system and into treatment. But since there is little treatment available, Judge Shoob further ordered in a footnote that the county “provide adequate funding to expand mental health resources in the county, if necessary.”

The dysfunctional system — or non-system — of public health services for the mentally ill dates back 30 years, to federal court decisions forcing huge mental hospitals to release their patients. The decisions followed the development of new drugs, which allowed many patients to live in the community as long as they took their medication.

But the plan fell apart when local communities failed to provide follow-up services. As a consequence, many of the mentally ill live on the streets in cities around the country. “All these bucks we had been paying to warehouse people in the big institutions was supposed to be turned to community-based services. That funding was not forthcoming,” said Dr. Steve Katkowski, director of the Fulton County Department of Mental Health, Mental Retardation and Substance Abuse. “Then, all of a sudden, we had this terrible homeless problem.”

Experts estimate that at least two-thirds of the homeless population suffer from mental illness, drug or alcohol addictions or a combination. While political leaders refused to provide the funds to offer them treatment, the public demanded that mentally ill people — shouting obscenities, urinating on a sidewalk or muttering strangely in front of a store — be gotten out of sight.

“So the homeless problem became something that had to be handled,” said Katkowski, “and we handled it, finally, by putting them in jail. Most of these people don’t need to be there.”

Fulton County needs to recognize the practical benefits, including fiscal savings, of replacing incarceration with treatment. The county needs to provide intake centers where police can take mentally ill people for evaluation and referral. The county also needs to provide a range of community-based facilities, from outpatient treatment for addiction to intensive residential treatment for the severely ill. “Let’s multiply Jefferson Place,” said Katkowski. Fulton County would save money and do the right thing by spending \$26 a day to treat the mentally ill, rather than putting them out of sight at the overcrowded jail for \$45 a day.

(Reprinted with permission from the editorial section of the *Atlanta Journal-Constitution*, June 16, 2002, “Jailing Mentally Ill Strains Dollars, Sense.”)

### Missouri

Two correctional officers were suspended on June 12, 2002 as investigators tried to explain how a suspected serial killer under suicide watch could bind his hands behind his back and hang himself in the St. Louis County Jail in Clayton.

Maury Troy Travis, 36, arrived at the facility on June 8 and was to be held for the U.S. Marshals Service on two federal charges of kidnappings, as well as other charges linking him

to at least seven murders of prostitutes. Transporting officers from the U.S. Marshals Service had warned jail staff that Mr. Travis might be suicidal, but the inmate denied any suicidal ideation during an initial assessment by the jail nurse. He also refused to be seen by the psychiatrist. As a precaution, however, he was placed on a special watch which required checks by correctional staff at 15-minute intervals, and also assigned an inmate “suicide monitor” to sit outside the cell and provide continuous observation.

At approximately 7:00 pm on June 10, Mr. Travis was allowed out of his cell to shower and exercise in a vestibule adjacent to the cell. From this location, the inmate suicide monitor had limited visibility of Mr. Travis. At 8:00 pm, Mr. Travis was found hanging from a bed sheet that was tied to a wall vent. His wrists were bound behind his back, a cloth in his mouth, toilet paper in his nostrils and a pillowcase over his head. (Although the manner of death was unusual, the medical examiner confirmed that the death was self-inflicted and investigators have said that the inmate was proficient with ropes and straps to bind his victims for torture before strangling them.) Despite efforts to resuscitate the victim, Mr. Travis was pronounced dead at a local hospital later that evening.

Jail officials later determined that correctional officers failed to conduct the required 7:30 and 7:45 p.m. checks on the inmate. A former jail health worker who asked not to be identified told the *St. Louis Post-Dispatch* that there was “no way for these nurses to tell if someone is suicidal unless they say it. It’s funny that they rely on people to tell the truth during the screening.” As the jail director stated: “We’ve got to make some changes, and we know that.”

### New York

According to a class-action lawsuit filed in May 2002, at least 16,000 state inmates (or approximately 25% of inmates confined in the prison system) suffer from significant psychiatric illnesses and are not receiving adequate care. Many of inmates are confined are held in solitary confinement which, according to the lawsuit, exacerbates existing mental illness and is a violation of the U.S. Constitution’s Eighth Amendment ban on “cruel and unusual punishments.” In defining mental illness as a disability, the lawsuit also contends that the state’s prison policy violates the Americans with Disabilities Act and the Rehabilitation Act.

Three prisoner advocacy groups (Disability Advocates, Legal Aid Society, and Prisoner’s Legal Rights of New York) filed the lawsuit to seek more treatment services and reform of the methods in which the state Department of Correctional Services confines mentally ill inmates, particularly those held in 23-hour disciplinary lockdown in special housing units (or, “The Box,” according to inmates).

“This is an unprecedented case in bringing together three groups who’ve been working on this problem from various perspectives for years,” Sarah Kerr, staff attorney with the

Legal Aid Society, told the Albany *Times Union*. "By law, the Office of Mental Health and the Department of Correctional Services are supposed to set up 'appropriate treatment for prisoners in their care,' and that's not happening when prisoners are placed in solitary confinement for years on end," she said.

"The issue of the mentally ill in prisons has become critical in New York state," said attorney Betsy Sterling, an associate director with Prisoner's Legal Services of New York. "We've seen a higher and higher number of seriously mentally ill prisoners in solitary confinement for excessive periods of time. It's a recipe for disaster in the prisons," Sterling said. "We've joined this lawsuit because we don't see the state making any inroads to correct the problem and to put these inmates in a humane situation." During 1999, for example, four of the eight inmate suicides in the state prison system occurred in the special housing units (where roughly 8 percent of the inmate population is held). Between 1998 and 2000, 22 of the 38 inmate suicides occurred in "The Box."

Aside from what they consider the inhumane treatment of "The Box," the advocacy groups who filed the lawsuit say the problem stems from a lack of adequate treatment options. The number of inpatient beds at the Central New York Psychiatric Center near Utica, which provides all inpatient care to the state's prisoners, stands at 187. That number has not increased since 1981, while the prison population has risen sharply. In addition, according to the lawsuit, the number of prisoners who use Office of Mental Health outpatient services has risen from 1,800 in 1981 to 6,000 in 1996, yet the supply of treatment services has not kept pace with the demand.

Jim Flateau, spokesperson for the state Department of Correctional Services, declined to discuss the lawsuit and told the *Times-Union* that the "appropriate place for us to respond to a lawsuit is in the courtroom." A spokesperson for the state Office of Mental Health also declined to comment.

### **Pennsylvania**

**A**n inmate on suicide watch in the Fayette County Prison in Uniontown was found hanging in his cell in early July. Although jail officials said that 26-year-old Michael T. Adams was restrained at the time of his death, and had no access to shoelaces, he was found hanging from shoelaces tied into a makeshift noose during the early morning hours of July 3. District Attorney Nancy Vernon said during an emergency prison board meeting that state police were investigating the death. She refused to answer questions about the circumstances surrounding the suicide because of the pending investigation. An autopsy was also scheduled. Still, Sheriff Gary Brownfield, who also acts as chairperson of the county prison board, said he was satisfied that suicide watch procedures were followed and that jail staff acted properly. Warden Larry Medlock said that Mr. Adams had been scheduled to be transported to the state hospital for evaluation following his suicide attempt from an overdose of psychotropic medication in May. "Sometimes when people want to kill themselves, they succeed," he told the *Tribune-Review*. □

## **JAIL SUICIDE/MENTAL HEALTH UPDATE**

**T**his technical update, published quarterly, is part of the National Center on Institutions and Alternatives (NCIA)'s continuing efforts to keep state and local officials, individual correctional staff, mental health/medical personnel, and interested others aware of developments in the field of jail suicide prevention and jail mental health services. Please contact us if you are not on our mailing list. Readers are encouraged to offer opinions and/or submit pertinent materials for inclusion into future issues.

This publication is supported by Cooperative Agreement Award Number 00J04GIM2 from the National Institute of Corrections (NIC), U.S. Department of Justice. Points of view or opinions stated in this document do not necessarily represent the official position or policies of the U.S. Department of Justice.

Unless otherwise noted, all articles appearing in this newsletter are written by Lindsay M. Hayes, Editor/Project Director.

### **AVAILABLE JAIL/PRISON SUICIDE PREVENTION MATERIALS**

*And Darkness Closes In...National Study of Jail Suicides* (1981)  
*National Study of Jail Suicides: Seven Years Later* (1988)  
*Training Curriculum on Suicide Detection and Prevention in Jails and Lockups—Second Edition* (1995)  
*Curriculum Transparencies—Second Edition* (1995)  
*Prison Suicide: An Overview and Guide to Prevention* (1995)  
*Jail Suicide/Mental Health Update* (Volumes 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10)

For more information regarding the availability and cost of the above publications, contact either:

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