SUICIDE IN IOWA COUNTY JAILS

BEYOND THE NUMBERS:
SUICIDE IN IOWA'S JAILS AND HOW SHERIFFS CAN SAVE LIVES

Disability Rights Iowa
LEGAL PROTECTION AND ADVOCACY
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Since 2012 at least 23 individuals have committed suicide in county jails in Iowa. Suicide is the leading cause of death in jails above even heart disease and drug/alcohol intoxication.

From 2000 to 2014 the national jail suicide rate increased 28%. Recent U.S. Department of Justice statistics indicate that overall suicides account for approximately 35% of all jail deaths.

Over the last six years, more than half of all reported inmate deaths occurring in Iowa jails were caused by suicide.

Jail suicides are devastating to jail staff and to the family and friends of the individual who died. These events may also result in liability for the jail. Publicly available information indicates Iowa sheriffs' departments have settled for tens of thousands to hundreds of thousands of dollars for lawsuits brought by estates of inmates who committed suicide in the jails.

The Iowa Administrative Code governs requirements for county jail operations. The majority of regulations pertaining to suicide prevention training and practices have not been updated in decades, and do not require jails to comply with modern safety measures. This is concerning especially considering that Iowa sheriffs have estimated that 49% of inmates in county jails have a mental illness.

Disability Rights Iowa calls on each Iowa Sheriff to critically evaluate their jail operations and use the information in this booklet to implement an effective suicide prevention program tailored to their jail.
WHAT WE KNOW

NATIONAL STATISTICS

7.5% PERCENTAGE OF INMATES ON SUICIDE PRECAUTION AT TIME OF THEIR DEATH

47% PERCENT OF JAIL SUICIDES THAT OCCUR IN GENERAL HOUSING UNITS

9 MEDIAN NUMBER OF DAYS AN INMATE SPENT IN A JAIL BEFORE COMMITTING SUICIDE

80% PERCENTAGE OF INMATES WHO COMMITTED SUICIDE THAT HAD A COURT HEARING WITHIN TWO DAYS OF THEIR DEATH

IOWA STATISTICS

Of the inmates who committed suicide since 2012, 78% did so by hanging, often using bed sheets or articles of clothing. The remaining inmates died from self-injury, asphyxiation, or overdose. In Iowa, all but two deaths occurred when the inmate was alone in a private area, and 93% occurred in the inmate’s cell.

METHODS USED IN COMPLETED SUICIDES

- Hanging: 78%
- Asphyxiation: 9%
- Self-Injury: 9%
- Overdose: 4%

DATA ON COUNTY JAIL SUICIDES SINCE 2012 REVEALS:

- 87% were male
- Majority were Caucasian
- Most between 21-30 years old
- On average there are THREE SUICIDES PER YEAR IN IOWA’S COUNTY JAILS
WHY IS THIS HAPPENING?

Although jails and prisons both incarcerate individuals, jails have a higher incidence of suicide as a result of their role. While prisons typically house convicted individuals who are serving longer sentences, jails house individuals awaiting trial or who are convicted but serving short sentences. Jails are typically smaller facilities that experience a high turnover of inmates, including individuals who are in crisis.

In Iowa, there are 96 county jails, each operated differently by locally elected sheriffs who oversee the policies and practices of each jail. Suicides in jails occur at three times the rate of suicide deaths in prisons and nine times the rate of suicide deaths in the community.

TWO FACTORS MAKE COUNTY JAILS PARTICULARLY RISKY SETTINGS FOR SUICIDE:

1. The physical environment of a jail is conducive to suicidal behavior.
2. The individual is often facing a crisis situation.

RISKY ENVIRONMENT

Many of Iowa’s jails pose increased risk for potentially suicidal inmates because smaller jails have higher suicide risk. In fact, jails holding fewer than 50 inmates have suicide rates five times higher than larger facilities. In Iowa, 4% of our 96 county jails have fewer than 50 beds and those jails are at least 40 years old on average. Some of these jails currently operate with just one staff person on site who acts as both a decatcher and jailer, a dangerous risk often based on limited resources. Physical design flaws coupled with low supervision is especially dangerous.

COUNTY JAILS HOUSING INCREASING NUMBER OF MENTALLY ILL INDIVIDUALS

JAILS NOT DESIGNED AS THERAPEUTIC ENVIRONMENTS

- Linear layouts compromise sight lines
- Ligature points
- Single cells isolate inmates without direct supervision
- Bars
- Bed Rails

CRISIS SITUATION

BEING JAILED CAN BE A VERY DEHUMANIZING AND PSYCHOLOGICALLY STRESSFUL EVENT

- Loss of:
  - Privacy
  - Support
  - Housing
  - Intimacy
  - Feelings of guilt/shame
- Family separation
- Pre-existing mental health conditions
- Barriers to accessing mental health medications in jail
- Fears of:
  - Violence
  - Long term incarceration
  - Losing employment
  - Shame from family and community

Jails holding fewer than 50 inmates have suicide rates five times higher than larger facilities; 66% of Iowa’s county jails meet this criteria.
STATE REGULATIONS PROVIDE LITTLE GUIDANCE ON JAIL SUICIDE PRECAUTIONS

Iowa laws regulating county jail operations provide scant guidance on suicide prevention practices. Although the regulations do require initial screening, some general training, and the existence of a policy, these requirements are otherwise vague and outdated. Because there are 94 different county jails in Iowa, suicide precautions are inconsistent and vary widely.

<table>
<thead>
<tr>
<th>AREA</th>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
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<tbody>
<tr>
<td>INITIAL SCREENING</td>
<td>Requires booking staff to screen all inmates for suicide risk through observation and specific questions. Requires staff to take “reasonable measures” only if they have actual knowledge of a substantial risk that a prisoner intends to commit suicide.</td>
<td>Assumes jail staff will act if an inmate responds affirmatively to screening questions, but doesn’t require it. Sets the bar too high for action and relies on staff’s subjective determinations of what constitutes a substantial risk.</td>
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<tr>
<td>STAFF TRAINING</td>
<td>Requires some annual training on recognition of the potential for suicide.</td>
<td>No specifics on the length or depth of the training and doesn’t require drills or practice.</td>
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<td>SAFETY CHECKS</td>
<td>Requires 30-minute checks of inmates, deemed “in physical jeopardy” in event of serious harm due to mental condition.</td>
<td>No guidance for determining when an inmate should be deemed “in physical jeopardy”.</td>
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<tr>
<td>STAFFING</td>
<td>Requires 24-hour staffing of at least one staff person on site who is trained in first aid and CPR. Requires jail to have personnel available within a reasonable time but does not require those staff to be in the jail.</td>
<td>No requirement that there be sufficient staff on site to immediately respond to suicides or medical emergencies. Always have two staff members on site who could be performing a task and all duties simultaneously. Jail staff must not exit the building before entering a cell and rendering aid in an emergency.</td>
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<tr>
<td>POLICY</td>
<td>Requires that a policy exist, which describes staff communication, housing, and intervention procedures.</td>
<td>Vague and doesn’t require the policy to be guided by evidence-based practices.</td>
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JAIL SUICIDES REFLECT LARGER SYSTEMIC PROBLEM

As a result of deficiencies in staff training, supervision, and other contributing practices, several county jails have had completed suicides in recent years, resulting in significant staff trauma and financial liability.

Jail suicides are indicative of a larger systemic problem, starting far before a person is arrested and incarcerated. Although the majority of people with mental illness will not attempt suicide, research indicates a strong relationship between mental illness and suicide. It is well documented that many low-m_RESOURCE ERR: unknown word |

"The death was a blow to everyone at the jail. He was a human being and we are so discouraged that it happened here." - Former Polk County Sheriff Bill McCarthy

"In Iowa, someone dies of suicide every 20 hours."
WHAT CAN SHERIFFS DO?

SHOWING CONCERN WILL LIKELY HELP THE PERSON AND OPEN DIALOGUE WILL ASSIST IN IDENTIFYING PROBLEMS AND OBTAINING HELP.

TO SAVE LIVES, PREVENT TRAUMATIC LOSS TO FAMILIES, AND PROTECT STAFF...

Disable Rights Iowa calls on each Iowa Sheriff to evaluate their current jail policies and practices, and implement an evidence-based, effective suicide prevention program tailored to the needs of their specific jail.

RECOMMENDATIONS FOR PREVENTING SUICIDES IN IOWA COUNTY JAILS

National experts who study jail suicides and prevention methods have guidance specifically for Sheriffs and County Jail Administrators. These evidence-based recommendations include:

1. CHANGE ATTITUDES, DISPEL MYTHS, CREATE A CULTURE OF PREVENTION

Several myths about inmate suicide create attitudinal barriers that deter correctional administrators and officers from taking steps to prevent suicides in their jails.

**MYTH 1: DECISIONS ARE FINAL**

“If an inmate decides to commit suicide, they will find a way to do it no matter what we do.”

**Fact:** Suicidal impulses are often brief and most suicidal inmates have mixed feelings about dying. Influences the occurrence and outcome of suicidal acts by removing opportunities until the crisis passes.

**MYTH 2: SCREENING IS ENOUGH**

“If we ask about suicide and the inmate denies it, we’ve done our part.”

**Fact:** There are many ways an inmate may communicate suicidal intent. Screening is rarely enough to identify a person who is potentially suicidal and will likely not impulse the facility from liability if other information is ignored.

**MYTH 3: JUST PLAYING GAMES**

“Inmates who threaten suicide don’t really want to die, they are just being manipulative.”

**Fact:** Individuals who threaten suicide are at higher risk and the lethality of self-harming acts can be misjudged. Occasional death can occur.

**MYTH 4: DON’T TALK ABOUT IT**

“Talking to an inmate about suicide might give them the idea.”

**Fact:** Asking about suicidal thoughts or history will not cause suicidal behavior. Showing concern will likely help the person and open dialogue will assist in identifying problems and obtaining help.
**KNOW THE WARNING SIGNS**

A suicidal statement (at the time of arrest or thereafter).
- Rehearsing suicidal actions or behaviors
- Attempts to obtain a single cell
- Stressful court hearing, telephone call or visit

**PROVIDE ADEQUATE TRAINING**

Jail staff are the best defense in preventing inmate suicides. All staff who supervise inmates should:
- be trained in CPR and first aid
- receive 8 hours of initial suicide prevention training during orientation, and at least 2 hours of annual refresher training
- participate in on-site mock drills to ensure staff are able to replicate the training into practice

**IMPROVE POLICY**

- Provide initial and ongoing screening
- Double cell at-risk inmates or place them in high visibility and high staff contact areas to reduce isolation, privacy, and opportunity
- Close observation (staggered observations not to exceed every 10 minutes) should be used for inmates who are not actively suicidal, but who are at risk
- Constant observation should be used for inmates who are actively suicidal, threatening suicide or engaging in self-injury
- Inmates determined to have a mental illness, or determined to pose a suicide risk should be referred to a mental health professional for evaluation.
- A treatment plan should be developed for each inmate on suicide precautions and should include daily interaction with mental health staff
IDENTIFY AND REDUCE ENVIRONMENTAL RISKS IN THE JAIL

Each jail should have staff actively inspect the jail to identify risks posed by the physical structure or layout of the jail:
- Areas of low visibility
- Ligature points
- Live electrical switches/outlets
- Phones with long cords
- Exposed ventilation grates/sprinkler heads

Jails should reduce the presence of physical risk factors. Risks that cannot be modified should warrant alternative mitigation, such as increased supervision or restricted use. Each housing unit should contain an emergency response kit that includes a rescue tool and first aid supplies.

BE PREPARED FOR INTERVENTION AND EMERGENCY RESPONSE

Each jail must have sufficient staff available and be prepared to take immediate lifesaving action. Even in very small jails, it is essential to have multiple staff on site so that if a suicidal incident occurs, intervention can be done timely and safely.

Staff who discover an inmate engaging in self-harm should:
- Immediately alert other staff for assistance and communication with emergency medical if necessary
- Never presume the individual is deceased
- Begin lifesaving measures and sustain until medical personnel arrive. Even if a suicide attempt does not require emergency medical attention, all attempts should trigger immediate assessment by a mental health professional.

POST-INCIDENT NOTIFICATION, ANALYSIS, AND DEBRIEFING

NOTIFICATION

In the event of a serious suicide attempt or completed suicide, notify the state jail inspector as well as the victim’s emergency contact.

WRITTEN INCIDENT REPORTS

All staff who had contact with the victim prior to the incident and staff who were present for the incident should complete a written report containing any information they have.

INVESTIGATION

When an inmate does commit suicide, Sheriff’s should consider contacting the Iowa Division of Criminal Investigation to complete an independent review of the event to determine any policy changes that should be made to prevent future incidents.

DEBRIEFING

Finally, debrief with jail staff to discuss what occurred and offer resources. Inmate suicides can be traumatizing to staff, so staff who recently had contact with the inmate or were on shift during the suicide may feel guilty or feel ostracized by their coworkers. Critical Incident Stress Debriefing may assist these staff to process the event and identify ways to cope.

Most attempted suicides involve hanging or asphyxiation, and incapacitation can occur quickly. Resulting brain damage can take as little as 4 minutes, and death can occur within 5 minutes.
REFERENCES

1. DFI Produced this data as well as the other Iowa-specific data contained in this report that is not attributed to another source. From analysis of information including deaths reported to the State Jail Inspector as well as publicly available information including media reports. The final data set includes the time period from August 2012 through August 2018; however, it is possible additional deaths occurred that were not reported or publicized and are thus absent from this data.


3. Id. Table 4.

4. In Iowa 23 of the 44 known deaths were due to suicide, and 21 were due to natural causes.


7. OMA Admin. CODE §§ 201–205.1(1), 501.1(1), 503.1(1), 503.1(2), and 510.1(1) regulate jail suicide prevention operations. Although the regulations were updated in 2008 to require trainings to be annual, and added a requirement that jailers take measures when they have actual knowledge of an inmate being suicidal, the bulk of the regulations have been unchanged since at least the 1990’s.

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27. All recommendations included on pages 13–16 of the publication from Lindsey M. Hayes, National Center on Institutions and Alternatives “Guides to Developing and Revising Suicide Prevention Protocols Within Jails and Prisons” (2012) and U.S. Department of Justice, National Institute of Corrections. “National Study of Jail Suicide: 20 Years Later” (Apr. 2016). See also Lindsey M. Hayes,”Checklist for the ‘Suicide Resistant’ Design of Correctional Facilities” (2011).


Disability Rights Iowa (DRI) is the Congressionally-mandated protection and advocacy system for Iowans with disabilities, including individuals with mental illness. DRI's mission is to protect the human and legal rights of Iowans with disabilities and/or mental illness. Protection and advocacy agencies have the authority under federal law to engage in a wide variety of activities to protect individuals with disabilities and/or mental illness, including monitoring facilities, conducting investigations, issuing public reports, engaging in litigation and other dispute resolution activities, and educating policymakers. DRI's work to prepare, write, and distribute this report is funded under the Protection and Advocacy for Individuals with Mental Illness grant. DRI would like to thank Disability Rights North Carolina, whose own report and research inspired and informed this work. Visit www.driowa.org for additional resources and information on this topic.