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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THE ISSUE

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

Since 2012 at least 23 individuals have committed suicide in county jails in Iowa.[1] Suicide is the leading cause of death in jails above even heart disease and drug/alcohol intoxication.[2]

From 2009 to 2014 the national jail suicide rate increased 28%.[3] Recent U.S. Department of Justice statistics indicate that overall suicides account for approximately 35% of all jail deaths.[4]

Over the last six years, more than half of all reported inmate deaths occurring in Iowa jails were caused by suicide.[5]

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.[6]

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[7], 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.[8]

1. SAVE LIVES
2. PREVENT TRAUMATIC LOSS TO FAMILIES
3. PROTECT YOUR STAFF

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

PERCENTAGE OF INMATES ON SUICIDE PRECAUTION AT TIME OF THEIR DEATH[9] — **7.5%**

PERCENT OF JAIL SUICIDES THAT OCCUR IN GENERAL HOUSING UNITS[10] — **47%**

MEDIAN NUMBER OF DAYS AN INMATE SPENT IN A JAIL BEFORE COMMITTING SUICIDE[11] — **9**

PERCENTAGE OF INMATES WHO COMMITTED SUICIDE THAT HAD A COURT HEARING WITHIN TWO DAYS OF THEIR DEATH[12] — **80%**

IOWA STATISTICS

Of the inmates who committed suicide since 2012, 78% did so by hanging, often using bedsheets 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 83% occurred in the inmate's cell.

METHODS USED IN COMPLETED SUICIDES

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?

Jails holding fewer than 50 inmates have suicide rates five times higher than larger facilities; 66% of Iowa's county jails meet this criteria.

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[13] and nine times the rate of suicide deaths in the community.[14]

TWO FACTORS MAKE COUNTY JAILS PARTICULARLY RISKY SETTINGS FOR SUICIDE: [15]

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.[16] In Iowa, 64 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 dispatcher 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**
- **Single cells isolate inmates without direct supervision**
- **Ligature points**
  - Bars
  - Bed Rails

CRISIS SITUATION

BEING JAILED CAN BE A VERY DEHUMANIZING AND PSYCHOLOGICALLY STRESSFUL EVENT

- **Loss of:**
  - Privacy
  - Support
  - Housing
- **Intoxication**
- **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

STATE REGULATIONS PROVIDE LITTLE GUIDANCE ON JAIL SUICIDE PRECAUTIONS

Iowa laws regulating county jail operations provide scant guidance on suicide prevention practices.[17] Although the regulations do require initial screening, some general training, and the existence of a policy, these regulations are otherwise vague and outdated. Because there are 96 different county jails in Iowa, suicide precautions are inconsistent and vary widely.

ANALYSIS OF CURRENT REGULATIONS

AREA	STRENGTHS	WEAKNESSES
INITIAL SCREENING[18]	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.	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.
STAFF TRAINING[19]	Requires some annual training on recognition of the potential for suicide.	No specifics on the length or depth of the training and doesn't require drills or practice.
SAFETY CHECKS[20]	Requires 30-minute checks of inmates deemed "in physical jeopardy" (in peril of serious harm) due to mental condition.	No guidance for determining when an inmate should be deemed "in physical jeopardy".
STAFFING[21]	Requires one staff person on site that is trained in first aid and CPR. Requires jails to have personnel "available within a reasonable time" but does not require those staff to be at the jail.	No requirement that there be sufficient staff on site to immediately respond to suicides or medical emergencies. Allows jails to operate with just one staff person on site who could be performing dispatch and jail duties simultaneously. Jail staff often must wait for back-up before entering a cell and rendering aid in an emergency.
POLICY[22]	Requires that a policy exist which describes staff communication, housing, and intervention procedures.	Vague and doesn't require the policy to be guided by evidence based practices.

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.[23] It is well documented that many Iowans with mental illness who are not incarcerated do not have meaningful access to much needed treatment. Until our communities develop a full and accessible range of mental health treatment options, jails will continue to house increasing numbers of individuals with mental illness.

As such, sheriffs must act now to evaluate their own operations and implement an individualized suicide prevention program based on best practices to prevent future suicides in Iowa county jails.

"The death was a blow to everyone at the jail. He was a human being and we are so discouraged that it happened here." [24]

– Former Polk County Sheriff Bill McCarthy

In Iowa, someone dies of suicide every 20 hours.[25]

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 ...

Disability 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:[26]

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. [27]

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. Influence 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 insulate 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. Accidental 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 assist the person and open dialogue to identify problems and obtain help.

2

KNOW THE WARNING SIGNS

A suicidal statement (at the time of arrest or thereafter).

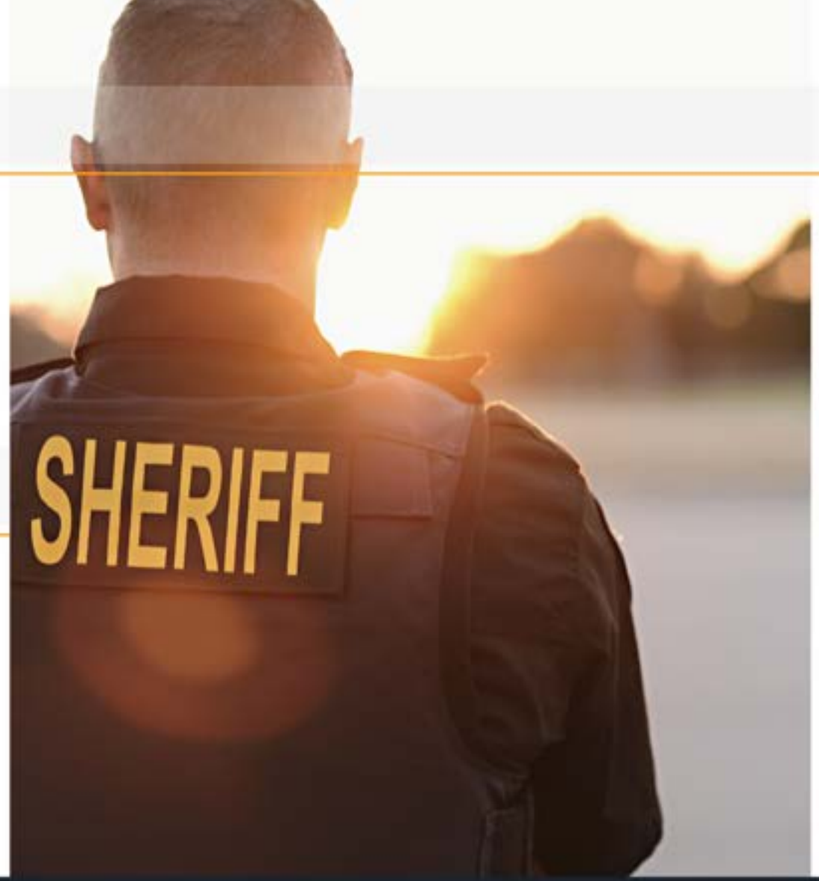
- Rehearsing suicidal actions or behaviors
- Attempts to obtain a single cell
- Stressful court hearing, telephone call or visit

3

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



4

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

5 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
- Live electrical switches/outlets
- Exposed ventilation grates/sprinkler heads
- Ligature points
- Phones with long cords

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.

6 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 medical emergency such as a suicide attempt 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.

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.[28]

7 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 inquiry into the death, and should also conduct an internal 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. 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.

REFERENCES

[1] DRI 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.

[2] Margaret E. Noonan, U.S. Department of Justice, Bureau of Justice Statistics, "Mortality in Local Jails and State Prisons, 2000-2014," Table 1 (Dec. 2016) available at http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5865.

[3] Id. Table 4.

[4] Id.

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

[6] Recent settlement amounts include $25,000, $35,000 and $500,000. See https://www.desmoinesregister.com/story/news/investigations/2018/10/16/iowa-jail-suicide-hanging-death-grundy-county-settlement-disability-rights/1660030002/ ; https://www.desmoinesregister.com/story/news/2017/10/30/polk-county-settles-lawsuit-family-man-who-died-after-running-headfirst-into-jail-wall/807808001/; https://wcfcourier.com/news/local/bhc-settles-family-s-lawsuit-over-inmate-suicide/article_63b0ab73-eee5-5ac3-9295-34d7afded80e.html.

[7] IOWA ADMIN. CODE §§ 201— 50.11(3), 50.13(1)(f), 50.13(2)(a), 50.15(6)(c) 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.

[8] Whitney E. Driscoll for Disability Rights Iowa, "In Jail and Out of Options," (Dec. 2016) available at https://disabilityrightsiowa.org/wp-content/uploads/Jail-Project-Report-FINAL-Compilation-PDF.pdf.

[9] U.S. Department of Justice, National Institute of Corrections, "National Study of Jail Suicide: 20 Years Later" 27 (Apr. 2010) available at https://s3.amazonaws.com/static.nicic.gov/Library/024308.pdf.

[10] Noonan, "Mortality in Local Jails and State Prisons," Table 13.

[11] Noonan, "Mortality in Local Jails and State Prisons," Table 10.

[12] U.S. Department of Justice, National Institute of Corrections, "National Study of Jail Suicide: 20 Years Later" 30.

[13] Suicide Prevention Resource Center, "The Role of Adult Correctional Officers in Preventing Suicide," (Mar 2014) available at https://www.sprc.org/sites/default/files/resource-program/CorrectionOfficers.pdf.

[14] Anasseril E. Daniel MD, "Preventing Suicide in Prison: A Collaborative Responsibility of Administrative, Custodial, and Clinical Staff," Journal of American Academy of Psychiatry Law (2006).

[15] Disability Rights North Carolina, "Suicide in North Carolina Jails" 6 (2017) citing to E. Fuller Torrey et. al, "The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey, see also Suicide Prevention Resource Center, "The Role of Adult Correctional Officers in Preventing Suicide," (Mar 2014).

[16] Noonan, "Mortality in Local Jails and State Prisons," page 5.

[17] IOWA ADMIN. CODE § 201—50 (2018).

[18] IOWA ADMIN. CODE §§ 201—50.13(1)(f), 50.15(6)(c) (2018).

[19] IOWA ADMIN. CODE §§ 201—50.13(1)(f), 50.15(6)(c) (2018).

[20] IOWA ADMIN. CODE § 201—50.13(2)(a)(3) (2018).

[21] IOWA ADMIN. CODE §§ 201—50.11(3), 50.13.(2)(a)(2) (2018).

[22] IOWA ADMIN. CODE § 201—50.15(6)(c) (2018).

[23] U.S. Department of Justice, National Institute of Corrections, "National Study of Jail Suicide: 20 Years Later" 17.

[24] Tony Leys "Training, jail design make suicides rarer" Des Moines Register (June 27, 2015)(quoting former Polk County Sheriff Bill McCarthy).

[25] Joy Lukachick Smith "My Brother's Keeper: Iowa Communities Grapple with Suicide Prevention," Boone News Republican (Jul 8, 2018).

[26] All recommendations included on pages 13–16 of this publication from: Lindsay M. Hayes, National Center on Institutions and Alternatives "Guide to Developing and Revising Suicide Prevention Protocols within Jails and Prisons," (2011) and U.S. Department of Justice, National Institute of Corrections, "National Study of Jail Suicide: 20 Years Later" (Apr. 2010); See also Lindsay M. Hayes, "Checklist for the "Suicide Resistant" Design of Correctional Facilities," (2011).

[27] "Myths" and related content from Alison Leukefeld and Jaime Brower "Basics and Beyond: Suicide Prevention in Jails," (2012) available at https://nicic.gov/basics-and-beyond-suicide-prevention-jails.

[28] U.S. Department of Justice, National Institute of Corrections, "National Study of Jail Suicide: 20 Years Later" 28, citing to the American Heart Association.

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