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ABSTRACT. Suicide is one of the leading causes of death in jails. It is the role of the clinician to assess an inmate's risk for suicidal behavior. Typically this involves an assessment of an inmate's suicidal intent coupled with their access to lethal means. However, in a jail environment there are various environmental and psychological stressors which complicate suicide risk assessments. This paper examines suicide risk assessments using case examples of suicidal inmates that are typical of those found in jails.

KEYWORDS. Suicide, assessment, jail

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Despite a significant decrease in the last two decades, suicide is still one of the leading causes of death in American jails (Hayes, 1994). The suicide rate among jail inmates is significantly higher than that of the general population (Ivanoff, Jang & Smith, 1996). Furthermore, although suicide remains the third leading cause of death in state prisons throughout the country, the suicide rate in local jails is three times higher than that in prisons (47 per 100,000 inmates for jails compared to 14 per 100,000 inmates for prisons) (Metzner, Cohen, Grossman & Wettstein, 1998; Bureau of Justice Statistics, 2005).

Higher suicide rates among jail inmates are the result of numerous stressors that are unique to the jail environment. Jails hold a wide range of both minimum and maximum-security inmates. Thus, an inmate who is being held for unpaid parking tickets could be held in the same facility as someone who was arrested on suspicion of homicide creating a potentially terrifying environment. Many inmates experience the uncertainty and fear which are naturally associated with incarceration. They could be worried about their families' reaction to their arrest or they could be concerned about what will become of them. Most inmates in jails are there awaiting court dates and many are anticipating lengthy sentences. These inmates also ultimately find out the duration of their incarceration while housed at the jail (Bureau of Justice Statistics, 2005). Inmates who are addicted to drugs and alcohol may experience severe symptoms of withdrawal upon arrival into the jail and approximately 64% of inmates in a typical jail population have a serious mental illness which could be exacerbated by the stress of incarceration thus increasing their risk for suicide (James & Glaze, 2006). In addition, there are numerous familial, employment, and financial sequela that come as a consequence of being changed and convicted of a crime.

Suicide in jails is often preventable. One of the primary reasons that there has been a sharp decline in deaths by suicide is the strong focus by jails to train staff on how to identify and manage inmates who may be at risk for suicide. While several jurisdictions have developed their own suicide risk assessments, there is currently no standard suicide risk assessment that is utilized. As a consequence, jail staff is often left to use their clinical judgment in assessing suicide risk.

In conducting a suicide risk assessment, the two main domains that need to be assessed are intent to commit suicide and the access to lethal means. The intent to commit suicide is multifaceted and includes the following questions:

1. Has the inmate expressed a desire to end his/her life?
2. Does the inmate have a plan?
3. Is the plan specific?
4. How much thought/planning has the inmate given to his/her suicide attempt?
5. Has the inmate made a suicide attempt before?
6. Does the offender have any risk factors that are associated with suicide such as a stressful life event, substance withdrawal, depression, a diagnosis of borderline personality disorder or command hallucinations?

The risk that an inmate will attempt suicide increases with the number of affirmative responses. In addition to the inmate's intent to attempt suicide, the clinician must also consider the offender's access to lethal means necessary to make a suicide attempt. For example, an inmate who states that he will hang himself on his bed sheets may be at higher risk than the inmate who states that he is going to kill himself with a gun (as presumably an inmate would not have access to a gun). If it is determined that an inmate is suicidal and has access to lethal means of killing themselves, then those means should be removed immediately until the suicidal crisis passes. This could involve putting the offender in a room without sheets and cloth clothing, having a corrections officer conduct a thorough search of the inmate's cell to make sure there are no sharp objects accessible to the inmate or placing the inmate on a constant or close suicide watch.

While suicide risk assessment may appear relatively straight forward, in the jail environment there are numerous variables which may confound a clinician's ability to accurately assess an inmate's suicide risk. First, jails have limited resources. Between mid-year 2004 and mid-year 2005 the inmate population in county jails rose 4.7% (Bureau of Justice Statistics, 2005). With increasing numbers of inmates being housed in jails it is not possible to identify all inmates who may be at risk for suicide. Therefore it is often only after an inmate has made an overt gesture that they come to the attention of mental health professionals. Second, almost half of the jail suicides occur during the inmate's first week in custody (Bureau of Justice Statistics, 2005). This suggests that correctional officers and mental health staff may not have an opportunity to know the inmate well. This makes it difficult to notice a change in behavior as an inmate contemplates suicide. Third, once an inmate is identified as suicidal, they are often put on one-to-one observation. It is not uncommon to have numerous inmates per shift who require constant observation. This creates the

need for additional staffing, which is very taxing in a system that is already overburdened. Additionally, it is often not possible to accommodate all the requirements for one to one staffing and, if not, the clinician must decide how existing resources will be implemented. Finally, communication and discrepancies between mental health and custody staff are potential sources for ineffective detection. Custody staff tends to be unfamiliar with treatment-related policies and procedures and treatment staff may also be unaware of custody policies and procedures (Hayes, 1999).

In addition to artifacts of the environment which present challenges for conducting suicide assessments in jail, there are often a multitude of psychological variables that can clinically complicate suicide assessment. Estimates of severe psychopathology among jail inmates range from 6.4% (Teplin, 1990) to 15% (Teplin, Abram & McClelland, 1996; Guy, Platt & Zwerling, 1985). Diagnoses frequently seen in inmates include depression, psychosis, and Borderline Personality Disorder (BPD). In addition, some inmates may feign or malingering suicidal intent or behavior in an attempt to manipulate their environment or derive secondary gains, making it difficult to identify genuine disorders from feigned disorders. The following case presentations provide examples of inmates who may present for a suicide evaluation at a local jail followed by an assessment of risk factors for assessment.

DEPRESSION AND HOPELESSNESS

Case Study 1: Mr. E

Mr. E is a 49-year-old, single male who is in the county jail for attempted robbery. A corrections officer alerted the mental health department that a noose was found in Mr. E's locker on the pod. Mr. E was immediately called to the mental health unit for evaluation. When he arrived, Mr. E had no idea why he was invited to the mental health office. When questioned about the noose, he stated it was "nothing" and that he wished that the officer had not told the staff about the noose. He further stated that he was awaiting a court hearing and that he was facing a sentence of ten years. While Mr. E had a lengthy criminal history, this time he was caught with a weapon during the commission of a burglary and was thus facing a much longer sentence than had before. Mr. E continued to inform the staff that if he went to court and got sentenced to ten years, he would indeed "hang up." He stated that he had the noose ready

because he then did not have to think about making the noose when he returned from court. He also reported that since his noose was taken away he would merely make another noose. In addition, Mr. E spoke of his girlfriend and her children. He stated that he cared deeply for her children but felt they did not care the same about him. Mr. E refused all mental health services stating that he had nothing to live for.

Assessment: Mr. E reports high levels of hopelessness about his future. He no longer feels as if he has any reason to live. Hopelessness is one of the best predictors of both attempted and completed suicide (Beck, Brown, Berchick, Stewart & Steer, 1990). In addition to anticipating a long prison sentence, Mr. E is also facing the potential loss of his relationship with his girlfriend and his children. Significant life events such as these can be precursors to suicide attempts. Mr. E has a specific suicide plan and he has access to means to execute his plan (the noose and the ability to make a new noose). This combination of factors makes Mr. E a very high risk for a serious suicide attempt. Mr. E should be placed in a room where he can be monitored closely and where he has no access to means to commit suicide until the crisis passes.

BORDERLINE PERSONALITY DISORDER

Patients with BPD pose a challenge to jail mental health staff. One of the nine diagnostic criteria for the disorder includes recurrent suicidal or self mutilating behavior (American Psychiatric Association, 2000). While many patients with BPD present with self harm which serves as a method of mood regulation rather than suicide; jail staff cannot ignore patients who are injuring themselves.

Case Study 2: Mr. A

Mr. A is a single, 21-year-old, white male, diagnosed with Borderline Personality Disorder (BPD), Depression, and Posttraumatic Stress Disorder. Mr. A is being held in county jail following a physical altercation with another patient at a local psychiatric hospital and consequently he has been charged with aggravated assault. Mr. A was physically and sexually abused as a young child by both his mother and his father. Both of his parents died when he was age nine. Mr. A tells the jail staff that he does not want to hurt himself. However, when Mr. A is left alone he inflicts harm within minutes. He has a history of chronic, unpredictable and frequent self-injurious behavior. Mr. A cuts himself with plastic knives,

staples, or anything sharp he obtains. If he does not have a sharp object he will bang his head on his cell door or pick his old wounds with paint chips. Mr. A is cooperative with the clinicians, but responds to questions about his suicidality in a flat manner, devoid of emotion. As a consequence of his impulsive self-harming behavior he has been sent to the local crisis center on seven different occasions where he denies suicidal thoughts or intent and thus is returned to jail in less than 24 hours. Since his reception into the institution, Mr. A. has been on constant suicide watch.

Assessment: The two main criteria used to assess suicide risk are intent and lethality. In terms of intent, based upon Mr. A's history it appears that he may engage in the cutting and head banging as a way to deal with the trauma he has experienced. A history of childhood abuse correlates significantly with number of lifetime suicide attempts (Brodsky, Malone, Ellis, Dulit, & Mann, 1997). Therefore, Mr. A may be very ambivalent about his desire to end his life. Such behavior is congruent with his diagnosis of BPD. However, when we look at lethality, most of the harm he inflicts upon himself is non-lethal in nature. Some recent evidence suggests that self injury among individuals with BPD tends to increase in lethality over time (Soloff, Lynch, Kelly & Mann, 2000). Furthermore, a diagnosis of BPD is a risk factor for completed suicide, as 8–10% of patients with BPD will eventually commit suicide. In addition, impulsivity is a hallmark characteristic of BPD, therefore it is possible that even if Mr. A denies current ideation, a sudden stressor may precipitate a suicide attempt. Brodsky and colleagues (1997) examined the relationship between suicide and BPD and found that impulsivity was the only characteristic of BPD that was associated with a higher number of previous suicide attempts even after control for lifetime diagnoses of depression and substance abuse. Sometimes it can be helpful to look at what factors in the environment are maintaining a behavior. For example, in Mr. A's situation, he receives attention from jail staff when he cuts himself, he is put on one-to-one care and then he gets sent to the crisis center. This could be the way that Mr. A. has learned to get the attention he craves.

Mr. A is an example of a patient who would not be required to be on one to one suicide watch - although his access to means to engage in self harm should be taken seriously and corrections staff should regularly check his cell to make sure that it is free of sharp objects. If the jail is so equipped, Mr. A could be placed in a padded room where he would not hurt himself if he banged his head.

Psychosis

Patients with psychotic disorders are at greatest risk of completed suicide. It is estimated that between 10–13% of all patients diagnosed with a psychotic disorder will eventually kill themselves (Caldwell & Gottesman, 1990). In a jail setting, psychosis is difficult to manage. Psychosis may not be immediately detected and inmates with psychotic disorders may be placed within the general population which could elevate stress levels and hence increase symptoms of psychosis such as delusions, hallucinations, and paranoia.

Case Study 3: Ms. S

Ms. S is a 24-year-old, single, Hispanic female with no children. She has a history of being sexually abused by her father and his friends starting at the age of nine. She is charged with the aggravated assault of a social worker at the psychiatric hospital where she was being treated and she is currently being held at county jail until sentencing on these charges. Similar to Mr. A., Ms. S has been diagnosed with Borderline Personality Disorder; however, she presents quite differently as she exhibits psychotic symptoms. Ms. S. expresses intense feelings of irritability and anger. During these times she frequently becomes verbally abusive. Additionally, she escalates quickly and can become aggressive without warning. She is inconsistent with medication compliance and this has made her mental status more unstable.

As a consequence of her aggressive behavior and emotional lability, Ms. S is a behavior management problem and has constantly had problems on housing units as well as with custody staff. In addition, Ms. S is often sexually provocative with staff, and at times she removes her clothing while in her cell. She believes that she was raped by staff during her previous hospitalization insisting that she is pregnant. However, a pregnancy test revealed that she was not pregnant. Ms. S becomes most disorganized and delusional at times of perceived stress when she is pre-occupied with issues pertaining to hospitalization or medication. At such times she reports that her sister is taking over her body and that she is plagued with infectious diseases.

Ms. S's erratic and volatile behavior has resulted in several placements on suicide watch for suicidal and homicidal behaviors. While Ms. S has not actually made a serious attempt to harm herself, her recurrent expression of suicidal threats poses a particular challenge in a correctional setting.

Assessment: Patients such as Ms. S are extremely taxing on prison resources. Her behavior is both volatile and unpredictable. While she has not made a suicide attempt, the presence of delusions and possibly command hallucinations (when her sister takes over her body) increase her risk for engaging in suicidal behavior. While Ms. S does not have explicit intent to kill herself, she has carried a diagnosis of BPD with psychotic features, both of which increase the risk of suicidal behavior. Furthermore, Ms. S also has unpredictable behavior and a history of self harm which increases the likelihood of serious injury as she may be somewhat desensitized to pain (Leibenluft, Gardner, & Cowdry, 1987; Bohus, Limberger et. al., 2000).

The lifetime prevalence for suicide attempts for those with psychotic spectrum disorders has been estimated to be as high as 70% with between 10–13% actually completing suicide (Caldwell & Gottesman, 1990). While someone who is lucid is able to weigh the pros and cons of ending their lives, when someone is psychotic they may feel as if they have no power and control over their own behavior as they are being controlled by a force outside of themselves. Suicidal behavior among inmates with psychotic disorders should be taken very seriously. While these inmates may decrease their risk for suicide if appropriately medicated, it can often take days, weeks, and even months for inmates to respond to antipsychotic medication. When a psychotic person is suicidal, one does not have the luxury of time, and individuals such as Ms. S should be monitored and put in an environment where they are unable to hurt themselves such as a padded cell they become medically and psychologically stabilized.

FEIGNING OR MALINGERING MENTAL ILLNESS

Case Study 4: Mr. R

Mr. R is a 21-year-old, single male who is being held in the county jail for hindering apprehension and resisting arrest. He has a history of minor offenses. Mr. R has a polysubstance abuse problem, but declined treatment. After several days in jail, Mr. R was found hiding behind a wall in his cell with a sheet around his neck. He reported feeling suicidal and said he wished to go to the crisis center because he “couldn't take it any more.” When interviewed, Mr. R mumbled and his eyes were downcast. He was not able to articulate why he was feeling suicidal. He then proceeded to tell the assessor that he was experiencing both neurological and psychiatric symptoms. During the course of the evaluation Mr. R. shook

his left arm and reported that he was having a seizure. He also put this same arm up by his ear and began to touch it as he shook and said he was unable to stop this behavior. In addition, Mr. R reported that he was seeing “spirits.” Mr. R told the jail staff that he had to get out of jail and go home.

Assessment: Mr. R’s presentation is vague, inconsistent, and contradictory. There are several indications that he may be feigning suicidal intent. First, Mr. R was not able to provide intent for his actions. Generally, individuals who are thinking of taking their own lives have a reason for doing so. Second, Mr. R was reporting and exhibiting a motley assortment of neuropsychological impairments in which the presentation was inconsistent. For example, someone who is experiencing a seizure is not able to maintain a lucid conversation and stop shaking on cue. In addition, Mr. R managed to remain focused on a variety of common jail issues such as going home, moving to a different housing unit, being sent to crisis or the hospital, and reducing his charges all while feeling suicidal. This is not the typical presentation of a suicidal inmate. However, even though Mr. R did not have the intent to commit suicide, he did have the means to engage in a lethal suicide attempt as he was found in his cell with a noose around his neck. While it seemed apparent that Mr. R was using the noose for effect, it does happen that inmates can accidentally kill themselves in an attempt to feign mental illness. Therefore, Mr. R’s behavior must be taken seriously and he should be required to sleep in a cell without sheets or other materials that could be used to create a noose. In addition his cell should frequently be searched for materials that he could use to hurt himself.

CONCLUSIONS

Suicide assessments in jails are multifaceted. They involve an analysis of the inmate’s intent to engage in suicidal behavior as well as their access to lethal means. Further, the clinician is required to take into account the resources available in a jail setting, the purpose of the suicidal behavior (i.e. is it the manifestation of a depressive disorder or is this inmate seeking to manipulate their environment), as well as any acute stressors the inmate may be experiencing as a consequence of his or her incarceration. This is by no means an easy task and it requires the cooperation of numerous entities within the prison such as the correctional officers who monitor the offenders, the clinical staff who use their expertise to evaluate offenders, and the administration who provide the resources necessary to maintain a safe and secure environment for the inmates.

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