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Trapped Inside: A Qualitative Study Assessing the Psychosocial Factors of Suicide in Jails

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Abstract

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By Mary Mbaba

Suicide is a pressing and multifaceted public health concern in the United States. Currently, it is the tenth leading cause of death among adults in the U.S. population, and the number one cause of death in U.S. jail institutions. The current suicide rate among inmates is 41 deaths per 100,000 detainees. The jail population is particularly vulnerable to the incidence of suicide. Psychological and social factors include an inmate's past mental health history, an inmate's interpersonal relationships with others, and the overall threatening jail environment in which suicide occurs.

The present study examined the psychosocial factors that precipitate the occurrence of suicide in U.S. jails. A social ecological framework was utilized in conjugation with the social cognitive theory of behavior to assess inmate suicide. Qualitative methods of data collection were employed in the form of interviews and focus groups at a local Atlanta jail; participants included correctional mental health professionals and jail chaplains. Also, mental health services and/or protocols that the jail has implemented to protect against the occurrence suicide were examined.

Results of this study present psychosocial risk factors that predict suicide in a jail setting. Future recommendations call for a structured multidisciplinary approach to holistically address the problem of inmate suicide in the correctional setting. Additionally, a recommended need for increased resources dedicated to successful community integration is suggested. Future public health research calls for appropriate interventions that address the increased uptake of the mentally ill/disordered in U.S. jail systems with use of socially- and culturally-informed techniques to accurately identify inmates at high risk for suicide.

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My dear parents (Victor and Margaret Mbaba) and siblings (Itoro, Christine, Michael, Emmanuel, Emma) have seen me through my journey towards attaining my Master's degree in Public Health. Their wisdom, love, and courage have guided me throughout this process and have longitudinally shaped me into the person who I am today. I am thankful for my parents' hard work and dedication towards my education; I hope to make them proud thru compilation of this thesis and all future academic endeavors.

The miserable have no other medicine,

But only hope.

~William Shakespeare

Introduction

Suicide remains a significant public health issue and is marked as a national and global phenomenon. The occurrence of suicide is systematically defined as "death caused by self-directed injurious behavior with any intent to die as a result of the behavior" (CDC, 2011). An often tabooed and avoided topic of discussion, rates of suicide among the U.S population are higher than commonly presumed. The act of suicide is essentially a matter of life and death and can often be avoided. Suicide rates in the United States are concentrated mostly in correctional institutions; with high rates of U.S. suicides particularly apparent among U.S jail detainees/inmates. The rate of inmate suicide is situated at four times higher than rates of the U.S. general population (Noonan, 2011). Though suicide rates in jails have steadily decreased over time (Noonan, 2010), there was a recent increase in inmate suicide rates in 2009 (41 deaths per 100,000) (Noonan, 2011):

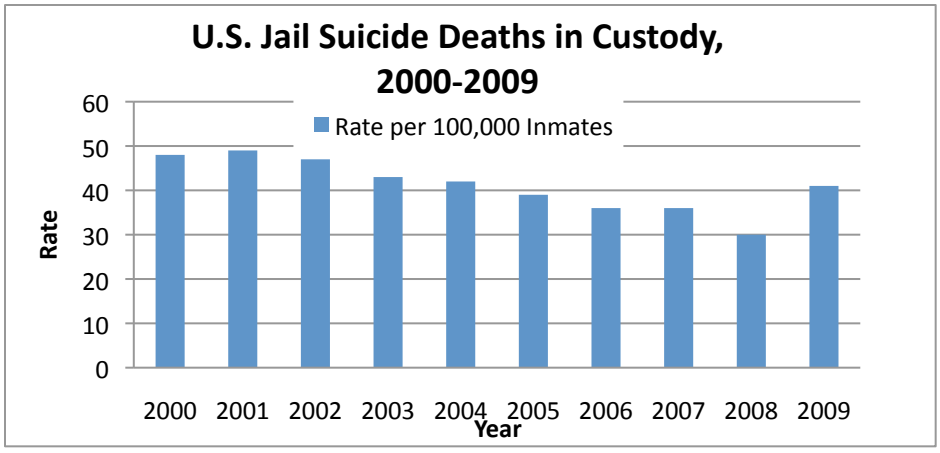

***Figure 1*. Jail Suicide Deaths in Custody from years 2000-2009.** *Note.* Data from Noonan, M. E., Carson, E.A. (2011 Dec.) Prison and Jail Deaths in Custody, 2000-2009-Statistical Tables. US Department of Justice, Bureau of Justice Statistics [BOJ].

Historically, the prevalence of suicide is seen higher in jails when compared to the general U.S. population. During the late 20th century, suicide by jail inmates had been approximately nine times greater than suicides occurring in the U.S. general population, in which will be termed the "free world" (Bonner, 2000; Hayes, 1989; Ivanoff 1989). Although rates of suicide in jails continue to decrease, this incidence is the leading cause of death among jail inmates. A Bureau of Justice Statistics report notes that suicide was the leading cause of death in local jails between 2000 and 2007 (29 percent of all deaths), although since the 1980's, the rate of inmate suicide has declined (Noonan, 2010).

Jails mark an entry point to the criminal justice system. The jail environment is often a shameful and tenebrous place to find oneself, thus representing a dark hollow of human society. Incarceration is systematically defined as the physical detainment of an individual who has done wrong in society, as defined by society's moral standards and as coded and governed according to national, federal, and state laws. The determination of one's fate, or criminal sentence, comes soon after a detainee arrives into the jail and upon final order of adjudication. Some inmates are ruled life sentences while others remain in these particular jail institutions for a few days, perhaps only for a few hours. A few definitions must be considered before proceeding, thus distinguishing jails from prison institutions. In the United States, jails are city or county-governed institutions that house defendants for a short period of time. Jail detainees are usually awaiting trial or have been found guilty of committing a minor offense. Detainees serve brief periods of confinement in jail upon sentencing, usually less than one year (Bonner, 2000; Felthous, 2011). In addition, some detainees are awaiting transfer to prison. Prisons, on the other hand, are federal and state-governed institutions, housing inmates who have been convicted of more serious crimes and are serving longer terms of imprisonment (Felthous, 2011).

Jails are disproportionately populated with mentally ill/disordered persons. At midyear 2005, it was reported that sixty-four percent of jail detainees (479, 900 detainees) had a mental health problem, ranging from mild to more serious forms (James, 2006). Among inmates who reported symptoms of a mental disorder, 54 percent of local jail inmates had symptoms of mania, 30 percent had symptoms of major depression and 24 percent had symptoms of psychotic disorder (e.g. delusions, hallucinations, etc.) (James, 2006).

Within the past 30 years, the scope of inmate suicide has become more focused, with current research providing socio-demographic profiles of inmates whom are at high risk for suicide. However, much of the focused literature is ambiguous and presents inconclusive findings on the psychosocial factors germane to jail suicides. Little research utilizes qualitative methods to fully understand the situational, psychological and social precipitants of increased U.S. detainee suicide rates. This study is designed to introspectively illuminate the lived psychological and social experiences that put jail inmates within the highest subpopulation at increased risk for suicide in the United States.

Background/Literature Review

Suicide in America

Suicide is one of the leading causes of death in the United States (AAS, 2007). It is the second leading cause of death among 25-34 year olds and the third leading cause of death among 15- to 24- year olds (CDC, 2009). Rates of suicide among the U.S. population have remained relatively constant over time within the past 10 years, with the current annual rate of suicide at 11.5 per 100,000 (AAS, 2010). In general, depression and major Axis I psychiatric disorders (DSM-IV) are predisposing risk factors for suicide (AAS, 2010). As a result, suicide outcomes are disproportionately found among those whom are mentally ill and depressed (AAS, 2007). In 2008,

an estimated 3.7 percent of U.S. adults age 18 or older had experienced serious suicidal thoughts in the past year. Additionally, 2.3 million adults (1 percent) made a suicide plan and 1.1 million adults (0.5 percent) actually attempted the act (SAMHSA, 2009).

In addition to age, U.S. suicide rates vary by sex/gender and race/ethnicity. Males complete suicide at a rate 3.6 times greater than that of females (AAS, 2007). However, females attempt suicide 3 times more than males, usually through nonlethal methods (e.g. poisoning). Whites (12.9 suicides per 100,000) generally have higher rates of completed suicides than their Black (4.9 suicides per 100,000) counterparts, with rates also seen highest among divorced, separated, and widowed persons in contrast to the married (AAS, 2010). Relative to those whom are younger, completed suicide occurs most frequently among the elderly U.S. population (age 80 and over) (AAS, 2010).

Signifying the magnitude of this public health concern, the goal of reducing the overall U.S. suicide rate was identified as a *Healthy People 2010* objective and has been retained for the current *Healthy People 2020* initiative (HHS, 2012). In 2007, the suicide rate was 11.26 for every 100,000 people:

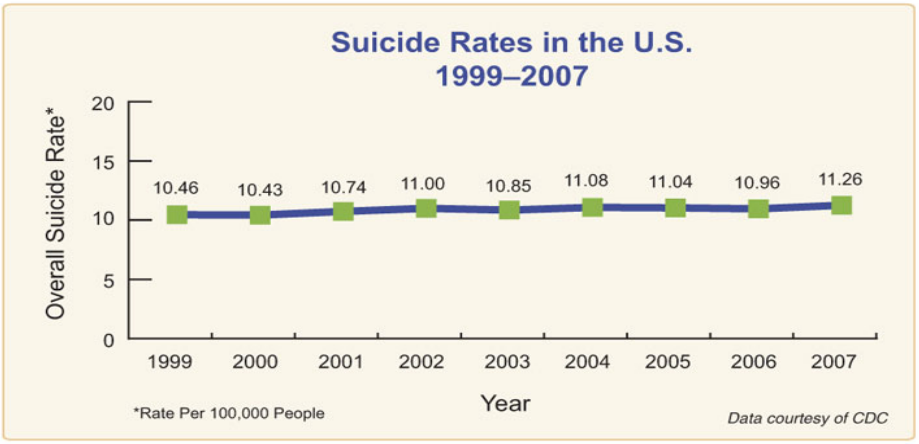

Figure 2: **Suicide Rates in the United States, 1999-2007 (per 100,000).** *Note.* From National Institute of Mental Health [NIMH] (2011) *1999-2007 Suicide Rate Trends (per 100,000).* National Institutes of Health, U.S. Department of Health and Human Services.

In 1999, Surgeon General David Satcher declared suicide as a public health concern, bringing the nation's attention to high rates of the phenomenon. During 1996, suicide was the ninth leading cause of death in the United States, accounting for far more deaths than homicides (USPHS, 1999). In the same year, World Health Organization (WHO) introduced *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies,* drawing attention of high suicide rates to nations around the world. From this effort sprung a national strategy for the United States through the creation of a sound public/private partnership involving many agencies, including the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administrations (SAMHSA), and the National Institute of Mental Health (NIMH), among others (USPHS, 1999). Consequentially, the surgeon general's call to action identified 15 risk factors of suicide (USPHS, 1999):

1. Previous suicide attempt
2. Mental disorders—particularly mood disorders such as depression and bipolar disorder
3. Co-occurring mental and alcohol and substance abuse disorders
4. Family history of suicide
5. Hopelessness
6. Impulsive and/or aggressive tendencies
7. Barriers to accessing mental health treatment
8. Relational, social, work, or financial loss
9. Physical illness
10. Easy access to lethal methods, especially guns

11. Unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts
12. Influence of significant people—family members, celebrities, peers who have died by suicide—both through direct personal contact or inappropriate media representations
13. Cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma
14. Local epidemics of suicide that have a contagious influence
15. Isolation, a feeling of being cut off from other people

The aforementioned list includes specific psychosocial factors that may predict suicide among predisposed individuals, especially among jail inmates. Detainees who enter jails are subject to mental health screening and assessment by jail mental health professionals with other protocols to follow. The Surgeon General's report also stressed the importance of ongoing prevention and treatment programs directly supporting and maintaining protection against suicide. Such programs may also be beneficially applied to jail settings where there is often lost hope, decreased social support, and increased mental illness among detainees.

Incarceration: a Public Health Concern

The last thirty years of America's history reflects the greatest rates of U.S. imprisonment when compared to other nations around the world (ICPS, 2010; Levy, 2006; Alexander, 2010). Since the 1980's, America's criminal justice system has sought to create tougher laws and increased enforcement of those who pose greatest threats to the community in regards to drug use and possession. Under the administration of President Ronald Reagan, the War on Drugs initiative was born into existence on June 24, 1982 (Beaver, 2010) with the goal of reducing illegal drug trade in the United States and cross-continentally. In response to the War on Drugs, The Anti-Drug Abuse

Act of 1986 (PL 99-570) was signed into law under the presidency of Ronald Reagan. This was the first major law implemented by the U.S. Congress under the political climate of the War on Drugs, calling for new mandatory minimum sentences for possession of illegal drugs including cocaine, marijuana, and heroin (Alexander, 2010). Drug possession arrests have been continuously on the rise (Berman, 2011), even tripling since the mid-1980's.

Unequal sentencing laws for crack and powder cocaine (sentencing based on 100 grams of crack cocaine for every 1 gram of powder cocaine) precipitated the inrush of Black and Hispanic populations in U.S. correctional institutions; crack cocaine was more commonly used among lower income minorities (Mauer, 2000; Alexander, 2010). Today, Blacks are overrepresented among those incarcerated and it is estimated that on any given day, 1 in 9 Black men between the ages of 20 and 34 years is incarcerated (Wang & Wildeman, 2011), placing the United States as the country with the highest number of its racial or ethnic minorities imprisoned. The Fair Sentencing Act of 2010 (PL 111-220) is the currently revamped Anti-Drug Abuse Act of 1986. In an effort to better equalize legal consequences suffered by the initial Anti Drug Abuse Act of 1986, President Barack Obama signed The Fair Sentencing Act of 2010 (PL 111-220) into law on August 3, 2010. This law reduced disparate sentencing of crack versus powder cocaine from the previous ratio of one-hundred-to-one (100:1) (in terms of grams possessed) to the current eighteen-to-one (18:1).

With the launch of the War on Drugs in the early '80's, the United States has experienced inflated increases among its penal population. In a 2006 study done by Spaulding et al. (2009), it was found that 9 million individuals were admitted to jails. A 2010 Bureau of Justice Statistics report indicates that the U.S. jail incarceration rate is currently 242 inmates per 100,000 U.S. residents (Minton, 2011). Males account for 87.7 percent while females account for 12.3 percent of this population (Minton, 2011). In addition, Whites represent 44.3 percent of the U.S. jail population;

Blacks comprise 37.8 percent and Hispanics represent 15.8 percent of the jail population (Minton, 2011).

With this increase in the correctional population, the health status of incarcerated men and women remains a significant matter of concern for U.S. communities (Heines, 2005). Largely unrecognized as a public health issue and as a socio-contextual determinant of health, mass incarceration derails millions of citizens from experiencing the social benefits that are often offered in mainstream society (Levy, 2006). Individuals are subject to detainment in cells for varying lengths of time as determined by sentencing of offense, ranging from a few days to perhaps, several years. Upon incarceration, extensive opportunities for re-integration into society are often difficult to attain. After release, the lives of inmates in the community are often plagued by financial instability, high-risk behaviors (e.g. intravenous drug use/abuse and multiple sex partners), and transiency (Tartaro, 2009). The effects of mass incarceration and the disparities of its application among the nation's most vulnerable populations are stark and may essentially contribute to health disparities and recurring patterns of recidivism and mental health syndromes/disorders in the United States.

Suicide in Jails: A Public Health Concern

Inmate suicide is a major public health and correctional issue, remaining the most common form of death among male and female detainees in jail. Quantitative research has identified a demographic profile for those who commit suicide while incarcerated in jail; however, risk factors relating to an inmate's psychological and social experience while detained have not been thoroughly assessed. The most recent suicide rate in jails is 41 deaths per 100,000 inmates, approximately four times higher than that of the general population (Noonan, 2011). Marking a moment of crisis in one's life, incarceration often elicits feelings of depression, shame, frustration, guilt, and despair.

Stress and related problems, most importantly depression, also tend to summate into depression and suicidal outcomes as a means to escape from life itself (Maris, 1997). Furthermore, untreated depression represents substantial risk when vulnerable populations of jails (e.g. the poor and minorities) are exposed to the severe stresses of arrest, interrogation and jail detainment (Harrison, 2007). The risk of suicide is increased by more than 50 percent in depressed individuals (AAS, 2007). In 2006, A Bureau of Justice Statistics report showed that 29.7 percent of detainees exhibited symptoms of major depressive disorder (James, 2006).

Furthermore, the environmental stressors of incarceration can result in greater psychological and physiological distress, thus increasing suicide risk among detainees. Certain factors leading to illness and crime seem to be closely intertwined (Schnittker, 2007). These links lie engrained in the overall socioeconomic status (SES) of specific populations. Though there is little research devoted to assessing the health effects of incarceration, there has been vast research on the present health of incarcerated individuals. Due to low SES and economic disadvantages (i.e. low education, homelessness, unemployment), jail and prison inmates experience disproportionately high levels of substance abuse, mental illness, and infectious and chronic diseases when compared to the general U.S. population (James, 2006; Spaulding, 2009; Narevic, 2006).

Various STIs, viral hepatitis and HIV/AIDS are among those diseases experienced by jail detainees (Levy, 2006; Spaulding, 2009). With time, medical conditions can contribute to inmate suffering and diminished ability to cope (Felthous, 2011). The compounded stress, overcrowding, and violence of the jail environment may further exacerbate these ailments (Levy, 2006; Lindquist, 1999). Gender and age are specific variables hypothesized to influence health outcomes and the uptake of medical care in correctional settings, with females and older inmates reporting higher morbidity and higher numbers of medical encounters (Lindquist, 1999). These problems are further

compounded by the stressful conditions that the jail environment evokes upon inmates as self-reported health problems were found to increase with inmate's increased duration of incarceration.

There are traditionally limited resources within a jail's medical and psychiatric/mental health service structures to buffer against suicides in jail (Lindquist, 1999; Fagan 2010; Markowitz, 2011). U.S. suicide rates are generally higher in correctional facilities; however, these rates are particularly highest in jails. Data suggest that the rate of suicide in jails is 41 suicides per 100,000 inmates (Noonan, 2011) when compared to the rate in prisons, 16 suicides per 100,000 inmates (Fagan, 2010). The following graph depicts the declining trend of jail suicides in comparison to prison suicides:

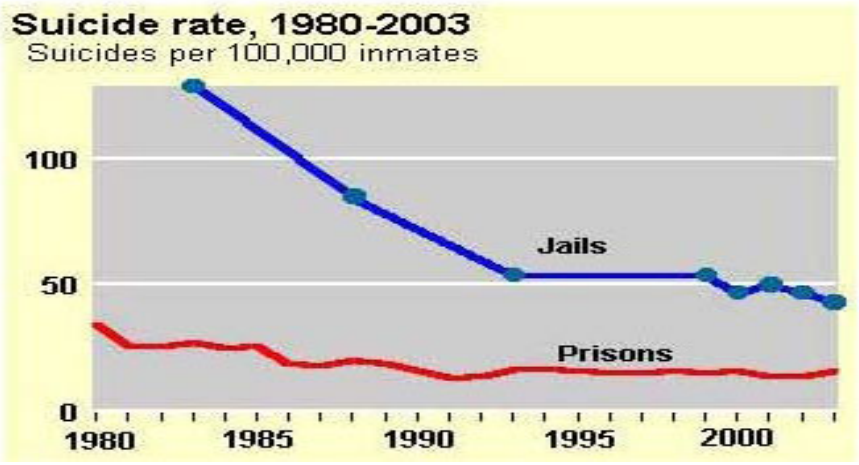

Figure 3: **Suicide Rates in Local Jails, 1980-2003 (per 100,000).** Note. From Mumola, C.J. (2005 August) *Suicide and Homicide in State Prisons and Local Jails.* US Department of Justice, Bureau of Justice Statistics.

Higher rates of jail suicides can be explained by many precipitating factors, including the initial shock and trauma of being incarcerated, the increased incarceration of the mentally ill and disordered in jails, and intoxication upon entrance into the jail facility. There is a quick inmate turnover rate in jails, often varying between individual jails. In a recent Bureau of Justice Statistics report, it was found that the average weekly turnover rate for jail jurisdictions was 64.9 percent

(Minton, 2011) in which weekly turnover rate was calculated by adding weekly admissions and releases, and dividing by the average daily population and multiplying by 100.

Detainees are often in great crisis at time of arrest: occasionally they are uncertain about the length of time that they will be held custody, and are often under the influence of alcohol and/or other drugs when arrested (Cummings & Thompson, 2009). Additionally, the size of the jail facility may influence the rates of detainee suicide. A Bureau of Justice Statistics report claims that during 2002, the nation's smallest jails (defined as fewer than 50 inmates) had a suicide rate that was 5 times greater than that in larger jails (2,000 or more inmates) (Mumola, 2005). These factors, among many, place jail inmates at highest risk for suicide within the first few days of confinement.

The initial days and weeks of incarceration are especially crucial, as this is when most suicidal attempts occur. These rates also vary with time of inmate stay in jail. In a recent national study on jail suicides, Hayes et al. (2010) estimated that 23 percent of jail suicides occurred within the first 24 hours of detainment and 27 percent occurred between 2 and 14 days. In addition, nearly half of jail suicides from 2000-2002 occurred within the first weeks of custody, with 13.7% occurring on the same day, 9% on the next day, and the highest percent of 24.9% occurring 2-7 days after admission into jail(Mumola, 2005). Data from one study indicate that out of 52 suicide deaths in South Carolina jails between 1985 and 1994, 33 suicides (63.5 percent) took place during the inmate's first day in jail (McKee, 1998). This is comparatively different to past statistics on U.S. jail suicide rates during the 1970's and -80's in which it was estimated that most suicides occurred within the first 24 hours (Hayes, 1989). Although these statistics examine the number of suicides per day, they are not adjusted for the proportion of a jail population that represents recent arrivals. For example, if the median LOS of detainees is 2 days, and the majority of inmates exit within a week, then the jail population is largely composed of persons who have been present for less than a week.

Consequently, if the risk of suicide per inmate per day were steady, most suicides would be experienced by persons who had entered the jail facility and had a LOS for less than a week.

Transinstitutionalization of the Mentally Ill

In tandem with an increased incarcerated U.S. populace due to drug policy changes, the last thirty years of American history also marks a shift of mental health care for individuals who are mentally ill and/or disordered (Markowitz, 2011). For more than 30 years, United States policy has called for a reduction of state psychiatric hospital populations (i.e. deinstitutionalization) without the substantial development of community alternatives (Primm, 2005; Banks, 2000; Tartaro, 2009). Fiscal policy changes included the shifting of costs for mental health care from states to federal government agencies such as Medicare, Medicaid, and Social Security Disability Income (Markowitz, 2011). Simultaneous with the shift in mental health alternatives and alongside concurrent shift of sentencing policies, jails currently encounter higher numbers of those who suffer from substance abuse and mental health problems (James, 2006; Levy, 2006). A Bureau of Justice Statistics report notes that one in six jail inmates had received mental health treatment since admission into jail (James, 2006) and in reaction to condensed rates of the mentally ill in correctional populations, Congress enacted the Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008 (PL 110-416). This law granted increased funds towards improved mental health treatment and services provided to offenders with mental illnesses.

Due to the recent decline of mental health institutions and the increase of mentally disordered individuals in jails, there exists some degree of a transinstitutionalization process. This process indicates that those who are in need of mental health services are often displaced from one societal institution to another, in this case, U.S. penal institutions. Disparate numbers of mentally ill are persons incarcerated: At midyear 2005, it was found that an estimated 64 percent of jail inmates

had a mental health problem (James, 2006). Additionally, those whom are incarcerated are at a much greater risk of developing mental illnesses and disorders as a result of experiences encountered due to the psychological trauma of being incarcerated under brutal circumstances including routine abuse, humiliation, and disregard of fundamental human rights (Levy, 2006).

Psycho-Social Factors of Jail Suicides

The suicidal detainee is often a mid-aged, unmarried White male who has encountered his first time in a penal institution. Hanging (e.g. hanging, suffocation, self-suspension, or strangulation) is the method used by more than 90% of inmate suicides (Hayes, 1989; Hayes, 2010). The majority of inmate suicides occur in the male population. A 2005 Bureau of Justice Statistics report notes that between the years 2000 and 2002, males were 56 percent (50 suicides per 100,000) more likely to commit suicide than female jail detainees (32 suicides per 100,000) (Mumola, 2005).In a national study of jail suicide conducted from 2005 to 2006, it was found that 67 percent of suicides were White, 93 percent were male, 42 percent were single, and the average age was 35 years (Hayes, 2010). Older detainees (age 55 and older) had the highest rate of suicide (58 per 100,000) among adult detainees, while jail detainees under 18 exhibited the highest suicide rates among all persons in local jails (101 per 100,000) (Mumola, 2005).

Though age and sex do not predict the occurrence of suicide in jail, an inmate's race and situational factors (i.e. condition at arrest, type of charge, hours after booking, and size of jail) were better indicators to assess increased risk of the outcome (McKee, 1998). Additionally, more than one-third (37.7 percent) of the inmates who committed suicide did not have a prior history of arrest. The high numbers of young Black men entering the penal system suggests that this may be the demographic group who may be at greatest risk for suicide while behind bars, however, current research shows that White males are at greatest risk.

Blacks experience disproportionately higher rates of morbidity and mortality than Whites in the U.S.; however, the suicide rate among this demographic has remained a consistent exception to these unfavorable health outcomes (Rockett, Samora, & Coben, 2006), even when assessed in a jail setting. A Bureau of Justice Statistics report indicates that between the years 2000 and 2002, White jail inmates were six times more likely to commit suicide than Black inmates and more than three times more likely than Hispanic inmates (Mumola, 2005). This trend, however, has slightly shifted within the past few years. In 2009, Whites still accounted for the highest rates of suicide in jails (80 deaths per 100,000), but were 3 times more likely than Hispanics, and 1.6 times more likely than Blacks (Noonan, 2011).

Because there is an increase of the mentally ill and disordered in jail, The high overall incidence of inmate suicide can be attributed to the high rate of psychiatric illness in jail facilities; one study shows that more than 95 percent of those who completed suicide in jail had a treatable psychiatric illness (DuRand, 1995). The mentally ill comprise approximately 10 to 19 percent of those who are detained in jails (Fagan, 2010). Jails are also environments that hold high concentrations of inmates who have had a history of substance use and abuse (James, 2006; Tartaro, 2010). Many inmates are initially detained while under the influence of drugs and alcohol (Hayes, 1989; Hayes, 2010) and are unsure of their future circumstances and sentencing lengths. Approximately 82 percent of inmates had ever used drugs once and at least 64 percent had used drugs regularly (Wilson, 2000). Inmates who have a history of drug and alcohol problems or who are incarcerated while under the influence of these substances are shown to be more likely to commit suicide while detained due to the exacerbation of depressive effects (Davis, 1993).

Other psychosocial factors additionally account for high rates of suicide in U.S. jails. One variable is the fact that most inmates are members of higher-risk groups and are in acute crisis by

definition (Durand, 1995). Jail settings are stressful environments, particularly for newly incarcerated individuals. Experiencing a "jail term" is ranked fourth in Holmes and Rahe's Life Events Stress Scale (Blaauw, 2002; Maris, 1997). For some individuals, incarceration represents a difficult life event or additional stressor that increases their vulnerability to commit the act (Fagan, 2010). Stress can further precipitate into physiological changes, causing increased strain on the body and mind. Additionally, incarceration can undermine coping strategies and abilities, particularly diminishing the flexibility to cope with stress in different situations and environments (Schnittker, 2007). Younger inmates, also, have not yet developed the necessary coping skills that may assist in surviving the experience of incarceration and in dealing with negative affect induced by incarceration (e.g. fear and anxiety). When placed in this situation, numerous psychological factors can attribute to the increased risk of detainee suicide.

Jail bars not only mark a physical barring from society, from the community, and from one's own family, but they also demark the psychological agony that is experienced when placed in a situational environment as that of a jail setting. Inmates find incarceration as a new social environment, away from friends and family. Communication between inmates and other individuals is often limited, making inmates increasingly predisposed to feelings of seclusion and loneliness (Danto, 1973). Lethal inmate suicide attempts most commonly occur when there is decreased contact with other people (McKee, 1998). A recent study shows that 38 percent of inmate suicide victims were held in isolation (Hayes, 2010).

Intoxication by drugs and alcohol is common among jail inmates upon arrest and is a risk factor for suicide in this setting. Furthermore, intoxication may alter one's behavioral decisions. In a Bureau of Justice Statistics Report, 20 percent of local jail inmates said they had used drugs at the time of the offense, as compared to 34 percent of those inmates who had a mental health problem

(James, 2006). Depending on the charge for which individuals are initially arrested, the risk of suicide varies. The suicide rate of violent offenders was nearly triple that of nonviolent offenders between the years 2000 and 2002 (Mumola, 2005). One explanation for increased suicide rates among violent offenders is an emotional repression to kill another individual (van Wormer, 1999). Many inmates who have attempted or committed suicide have been previously violent both towards other as well as towards themselves (Danto, 1973). Sigmund Freud's classic paper "Mourning and Melancholia" explains the repressed self-hatred that is reflected from the desire to kill someone else upon extension of depressive behavior (Freud, 1957). Another explanation involves the role of shame in suicide occurrence. Individuals in jail are detained because they are charged with committing some offense against the law. Whether it is a minor offense or a more serious crime and many times, inmates feel intense shame and guilt after committing their crimes. Suicide in jails is often attributed to the shame that inmates experience due to some crime committed. Research shows that shame is the most salient and commonly described precipitant of inmate suicide (Lester, 1997). Confronting their friends and family is often a shameful situation that detainees would rather not deal with while incarcerated (Lester, 1997). Furthermore, the increase of jail detainees with mental health problems compounds the shame that inmates experience from crimes committed.

Specific social factors are unique to jail suicides. Interpersonal relationships and the nature of these relationships influence inmate suicide rates. Most detainees who commit suicide are single and not married (Hayes, 1989; Hayes 2010). Additionally, most inmates have experienced some traumatic events as children and young adults; disproportionate numbers of inmates have family backgrounds that include some form of abuse, divorce, criminality, and/or alcoholism (Blaauw, 2002). The experience of such traumatic events has been found to be related to attempted suicide in adulthood (Arensman, 2001). A Bureau of Justice Statistics report indicates that among those

inmates who had mental health problems, 24 percent of inmates reported past physical or sexual abuse (James, 2006).

Jails are often homes to the homeless (Markowitz, 2011), less educated and/or unemployed (Harlow, 2003). In a study done by Greenberg, et al., it was found that detainees who had been homeless comprised 15.3 percent of the U.S. general adult population (Greenberg, 2008). In these cases, jails represent a safe haven from the realities of life circumstances, often times including such personal dealings as mental distress and/or disorder. The same study concluded that homelessness and incarceration appear to reciprocally increase the risk of the other, with mental illness and poverty as mediators of the relationship (Greenberg, 2008).

A norm of manliness and inviolability is often universal in penal institutions (Johnson, 1976). Furthermore, there is significant parallel between the high rates of suicide in the confined institutions of both the army and jail facilities. In 2009, the suicide rate among soldiers was 21.7 per 100,000 (Kovach, 2010), nearly half of the current rate of jail suicides. Gender issues within these institutions are analogous; the masculine culture in jails can be compared to the masculine culture of the army. Kushner et al. (2010) describe how a masculine army culture may increase suicide among in the army by placing "soldiers in a particularly arduous double-bind: it traumatizes them and then, by feminizing their trauma, reinforces its most damaging aspects." In the same respect, gender dynamics influencing inmate suicide rates may be reminiscent of inherent masculine ideologies of jails.

Masculinity is central to survival and coping in jail. There is a 'male code' that exists in this environment that defines a 'real man' as one who is invulnerable, does not display weakness of any kind, does not snitch, does not display emotions (other than anger), and suffers pain in silence (Kupers, 2005). Additionally, the jail environment may foster psychological tendencies that prevent

integration and intimacy (Schnittker, 2007); interpersonal distrust and suspicion are often resultant consequences of the stresses brought about from the incarceration experience (Haney, 2002). Some inmates experience their first onset of mental health symptoms while incarcerated. Fear, anger, and anxiety are common emotions that shape relationships among the incarcerated. As a result, there is heightened resistance to mental health treatment among male inmates due to provider mistrust and an unwillingness to appear weak (Kupers, 2005). In a study done by Drapalski, et al. (2009), it was found that female inmates are, in fact, more likely than their male counterparts to seek jail-based mental health treatment.

Bullying often occurs between and among jail inmates and is a risk factor for suicide. A study by Blaauw et al. (2001) found that the prevalence of bullying was greatest among inmates with a high suicide risk than among inmates with a low suicide risk. Inmates who exhibit suicidal gestures in correctional facilities are considered vulnerable and easy targets by other detainees (Blaauw, 2001; Tartaro, 2009). In the jail setting, bullying can also take on the form of sexual assault of inmates (Danto, 1973). Correctional officers and other jail staff also engage in bullying behavior and harassment of inmates. The additional stress caused by bullying and harassment may further fuel feelings of suicide and self-destruction among inmates (Danto, 1973; Blaauw, 2001). Suicide in these situations occurs when an inmate seeks to remove him/herself from an otherwise unavoidable circumstance in an otherwise inescapable environment.

Social capital is further decreased under the limits of incarceration (Rose, 1998); imprisonment limits one's accessibility for social cohesion, community involvement, and sustenance of healthy interpersonal relationships (Schnittker, 2007; Lynch, 2004). Inmates are unable to develop normal work credentials and marketable skills while incarcerated (Schnittker, 2007). Additionally, detainees often do not have adequate health insurance upon release (Schnittker, 2007). The social

capital of previous inmates is also compromised due to stigma associated with being incarcerated. Abnormal psychological functioning patterns are adapted to enhance coping mechanisms in jail and may serve to increase the likelihood of psychological isolation in the free world (Haney, 2002). Detainees are quickly returned to their communities, just as abruptly as they are separated from their families and peers, and reintegration to society is a difficult and long process. The stress and stigma induced from this process can lead to further psychological distress post-release. Incarceration illicit feelings of shame and anger within families and negatively affects trust relationships even among close friends (Schnittker, 2007).

Culture, Religion/Spirituality, and Suicide

A society's perception of suicide and its cultural traditions can influence a society's rates of suicide (Lester, 2008). The methods and the degree in which suicide is condemned varies between different cultures (Lester, 2008). Furthermore, culture conflict and acculturation may also impact suicidal behavior (Lester, 2008); coping strategies and survival patterns remain predispositions that stem from specialized cultural experiences (Johnson, 1976). For example, unique to Hispanic cultures is the centrality of family (Johnson, 1976) in which an engrained cultural identity may serve as protective factor for suicide via the unending support of loved ones.

Religion is an integral part of culture that impacts overall suicide rates. Historically speaking, religious beliefs have served as a protective factor against suicide, in any setting and among any group of people. Research shows that religion may serve as a buffer against suicidal occurrence, as it contributes to overall emotional well-being and positive self-esteem (Stark, 1983; Gearing, 2009). Historically, Blacks have been subject to social, political, and economic disadvantages as a result of racial discrimination and oppression (Rockett et al., 2006) but despite this historical oppression and increase of Blacks within the jail populace, suicide rates among Blacks remain lower than that of

their White counterparts. Research suggests that strengthened religious beliefs may reduce the risk of suicide among Blacks (Burr, 1999; Fagan, 2010). Furthermore, researchers have identified religiosity (i.e. church attendance or affiliation) as a crucial protective factor against suicide among Blacks (Burr 1999; Gibbs, 1997). Religiosity is symbolized in the Black Church, which has traditionally provided Blacks with a refuge from the hardships of belonging to a marginalized minority subpopulation in American society by providing social cohesion, social support, and stress reduction (Griffin-Fennell, 2006).

Effective screening/preventive programs

Suicidal inmates who do not receive the appropriate attention or mental health services may be near their fatal destiny. In recent years, there have been various efforts to ameliorate the incidences of jail suicides as findings from 1980's jail suicide research emerged. As such, suicide rates have steadily decreased with a surprising spike within the past few years. During the past decade, correctional health administrators have implemented recommended screening protocols at intake, with the addition of other measures, to assess and determine inmate suicide risk. Given the diverse population of detainees, however, few studies have evaluated the cultural competence of mental health treatment services in the criminal justice system, thus influencing the accuracy of suicide assessment and treatment protocols (Primm, 2005). Though an inmate may be reluctant to report suicide ideation due to cultural stigma and possible repercussions (Tartaro, 2009; Knoll, 2010), several studies highlight the importance of proper screening of all inmates during the intake process in order to identify detainees who are at highest risk for suicide.

Initiated in 1981 and revised in 1990, The American Correctional Association has (ACA) developed widely recognized standards for detainee suicide prevention. According to these standards, written policy is firstly required to ensure that at-risk inmates are observed at staggered

30-minute intervals. Second, suicidal inmates are required to be under constant observation by correctional staff. Third, a written suicide prevention program must be approved by certified mental health staff. And fourth, all staff must be trained in the implementation of this prevention program, including intake screening, identification, and supervision of inmates who are at-risk for suicide.

The following high risk periods for inmates was identified by The National Commission on Correctional Health Care's (NCCHC) standards: (1) immediately after adjudication, (2) immediately after admission to facility, (3) following an inmate's return to the facility from court, (4) following the receipt of bad news regarding family or him/herself, and (5) upon suffering humiliation or rejection. According to the literature, New York was one of the first states to implement suicide assessment protocols during their intake process (Cox, 1997). Under the New York Local Forensic Crisis Service Model, comprehensive and standardized policies were implemented in 1985 within upstate local jails based on the tenets of ACA and NCCHC standards, including the use of a specific suicide intake screening measure and linkage with community mental health resources (Bonner, 2000). The program addressed not only the special needs of high-risk inmates, but also focused on the impact of the stressful jail experience among this vulnerable population. Since the implementation of this program, the occurrence of suicides in New York correctional facilities continues to decrease over time (Hayes, 1997; Bonner, 2000).

Intent among suicidal detainees may be difficult to assess; inmates are often manipulative and may mutilate themselves without having any suicidal intent (Tartaro, 2009). An inmate's intent to die is the most critical factor in assessing an inmate's proclivity towards suicide, however, there is no standard nomenclature or classification system for distinguishing behaviors that are determined as 'self injurious behavior' (Fagan, 2010). Most importantly, mental health providers must determine if the behavior exhibits an attempt to die, an outward expression of anxiety and frustration, a

meaningful cry for help, a symptom of a mental disease or illness, or simply a method of manipulation for some external gain. Inmates who present suicidal behaviors and tendencies are often mislabeled as malingerers by mental health professionals, though some may actually be suicidal (Tartaro, 2009).

The belief that manipulative intent is not suicidal has been a common barrier to assessing suicide intent in a jail setting (Fagan, 2010) The reasons and motives for this gain vary, but are mostly concentrated on an inmate's preference to leave the current institution or to simply occupy a cell by him/herself, away from other inmates. Through self injury, an inmate may successfully move to a different cell location, transfer to an external hospital, or transfer to another jail or prison (Danto, 1973; Fagan, 2010),as part of jail protocol. These motives may also be considered as part of an inmate's coping mechanism to relieve growing stress and anxiety or to express anger, hostility or emotional pain (Knoll, 2010), however, death is often an unintended consequence(Fagan, 2010). Current research proposes that self-injurious behavior often coexists with other mental health conditions and may occur more frequently in a jail setting. In 2007, the World Health Organization (WHO) and the International Association for Suicide Prevention reported that individuals with antisocial or psychopathic personalities may be more inclined to exhibit self injurious behaviors in correctional settings as they are more likely to be maladaptive to the controlled conditions present in these institutions (Fagan, 2010).

In general, suicide rates are prone to bias due to limited research study options of psychological profiles prior to death: most suicidal occurrences are commonly conducted retrospectively. There is further common frustration in the research of jail suicide, speculating increased bias of suicide data (Tartaro, 2009). Certification of death is determined by medico-legal authorities in most communities and among other reasons, this certification must be accurate for

determination of criminal liability and accurate mortality statistics (Spellman & Heyne, 1989). There is speculation that jail suicide rates are often underreported (Hayes, 1989) and may be, in fact, higher than the current rate (Cummings & Thompson, 2009). Concerns about family stigma, insurance policies, and political factors are often determinants of a suicide ruling. Suicide rates are socially constructed and misclassified rates can vary directly with the degree of professional medical training of those who categorize suicides (Rockett, 2006). Additionally, coroners and medical examiners use implicit and very diverse criteria for certifying a death as actual suicide (Maris, 1997). With the passage of the Death in Custody Reporting Act of 2000 (PL 106-297), the systematic collection of individual death records for prison and jail fatalities was mandated for report to the Attorney General. Currently, the United States Bureau of Justice Statistics (BJS) is responsible for collecting these death records, which include information regarding name, age, sex, race, a brief description of the circumstances surrounding the death, etc (Mumola, 2005).

With the often politically-driven culture that is descriptive of correctional institutions, suicide investigation often raises the inquest of liability. The process involves certifying the cause, pathological process, mode, manner and/or method of the death (Spellman & Heyne, 1989). Determining the inmate's intent, the precipitating situations that lead up to, and the future corrective action necessary to prevent future occurrences of suicide in the jail are the expected outcomes of the overall suicide investigation (Spellman & Heyne, 1989). Though correctional mental health staff encounter increased rates of suicide in jails and operate in an environment where they have decreased loci of control over many aspects of treatment (Knoll, 2010), when an inmate commits suicide in jail, they may become subjects of intense scrutiny by those investigating the case and by the community at large (Spellman & Heyne, 1989). Correctional mental health professionals may face two general forms of legal liability: (a) allegations of civil rights violations (claims of deliberate indifference violating 42 USC 1983) and (b) allegations of professional negligence (i.e. malpractice)

(Knoll, 2010). Though proper measures may have been enacted to protect the inmate from such outcome, the inclination to place liability on jail staff is common practice in the current medico-legal climate (Spellman & Heyne, 1989).

High rates of suicide present major concerns for jail mental health professionals. Faced with unique challenges, these staff members offer varying expertise while working within a unique organizational structure. Correctional facilities are often dangerous and stressful places to work, with staff facing various occupational issues (Tartaro, 2009). In a study done by Senter et al., it was found that correctional psychologists experience greater degrees of burnout relative to psychologists employed in Counseling Center and Veteran Affairs settings, with reported lower job satisfaction (Senter, 2010).

Correctional officers and other jail staff usually have minimal mental health knowledge and are often not properly trained to recognize the signs of a potential suicide victim or the mental health issues that he/she may be harboring (Markowitz, 2011). These staff members often believe that it is out of their job descriptions to deal with suicidal inmates (Fagan, 2010). Correctional officers must be mindful of combative or aggressive inmates who suddenly become quiet and meek, as this may substitute as an internal cry for help (Danto, 1973). If a correctional officer does not realize that an inmate is in serious need of help, an inmate may potentially continue self-injurious behaviors, perhaps accidentally dying in the process. Reducing the rate of self-harm and death within correctional institutions can be done by firstly identifying what constitutes as suicidal behavior in jail settings and by secondly finding, adapting, and utilizing effective ways that mental health counselors can collaboratively communicate with other correctional staff, in general.

Aim

The elevated numbers of jail suicides occurring in U.S. jails indicate that the unique experience of incarceration increases suicide risk among detainees, or that perhaps, those who are at-risk for suicide are over-represented in jail populations. Essentially, all inmates may entrap a variable range of emotions within their psychological capacities. These cognitive processes may occur immediately upon initial detainment and elicits intertwined field notions of suicidology, psychology, sociology, and criminology in an attempt to understand how the negative feelings and attitudes brought about by exposure to human confinement potentially influence one's predisposition to suicide.

The purpose of this research study is to elucidate common psychological and social risk factors associated with jail suicides by taking into account the qualitative experiences and perspectives of mental health professionals and chaplains, often the last persons who come into contact with inmates who commit suicide while incarcerated. The following research question is examined: What psychosocial and situational factors contribute to an increased occurrence of detainee suicide? From this question, the risk factors that make one detainee more likely to commit suicide than another detainee, despite a common incarceration experience, will be examined. This research also aims to explore services and/or protocols that one local Atlanta jail has implemented to protect against the occurrence of such.

Theoretical Foundation: Suicidology and Characterization of Jail Suicide

Genetics and individual biochemistry have become generally accepted root causes of depression and suicide; however, complex psychological and social factors may account for increased risk of suicides among detainees. The social cognitive theory is utilized to explain this particular health phenomenon in jails, describing the interactive personal, behavioral, and

environmental processes involved in determining health outcomes. Under this theory, learned behavior and thought processes can be attributed to social influences and other factors (Sharma, 2008). Personal factors predicting detainee suicide include age, sex/gender, and the overall decreased mental and physical health among detainees. Substance use and abuse, intent, and prior suicide ideation/ attempt are risk factors for detainee suicide. Cognitive views and beliefs regarding suicide are also crucial to assess. Conclusively, one's ability to cope in a threatening jail environment, away from friends and family, should be examined to assess risk for detainee suicide.

Over the years, there have been many developed social theories to explain the incidence of suicide. Most salient is that of Emile Durkheim; the French social scientist proposed several structural correlates of suicide that spawned considerable research on suicide over the last century. Durkheim's late nineteenth-century work on suicide focuses on society's role in determining suicide outcomes and suggested that modern life disrupts social cohesion and can result in self-destructive behaviors and suicide (Durkheim, 1951). Suicide is essentially a 'marker of society': specific social factors and social integration processes of individuals can exert powerful influences over suicidal behavior. Distinguishing between egoistic, anomic, altruistic, and fatalistic suicide as broad classifications, Durkheim viewed egoistic suicide as a consequence of deteriorating social and familial bonds, linking anomic suicide to moral disillusionment and confusion, and minimizing altruistic and fatalistic suicides as marginal occurrences (as cited in Kushner, 2005). Durkheim ultimately theorized that suicide rates vary inversely with the degree of an individual's social integration and moral regulation (Durkheim, 1951).

Emile Durkheim's theories seemed most relevant within their past timeframes; however, current researchers found that increases in suicide were linked to increased social integration (Kushner, 2005). Durkheim's definition of fatalistic suicide as "resulting from excess regulation"

whose "passions [were] violently choked by oppressive discipline (Durkheim, 1951)" existed as an anomaly to his overall thesis; however, this definition applies directly to inmate suicide. All socially integrated relations do not increasingly protect against suicide. Furthermore, integration and social regulation may protect against suicidal occurrence only if the norms and behaviors of one's social group are against suicide. In general, when social relations/interactions are negative or punitive in nature, these relations tend to raise suicide rates (Maris, 1997), perhaps due to an internalization of social anger (Lane, 1979). Jails represent institutions of high social integration. The nature of this integration is currently understudied and can potentially lead to emotional collapse, fear, and increased risk of suicide among detainees.

Jails constitute distinct social environments; mutually reinforcing mechanisms predicting inmate suicide exist at many levels and are intrinsically connected by multifaceted processes. Accounting for complex interactions between detainees and their environments, the social ecological framework more broadly assesses the psychosocial characteristics of jail suicides on an ecological platform. Individual, peer, family and community factors are taken into consideration under this framework.

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Figure 4: **The Social Ecological Model: Suicide in Jails.** *Note.* From The Centers for Disease Control and Prevention website. Retrieved February 10, 2012 from http://www.cdc.gov/cancer/crccp/sem.htm

The overall social factors applicable to jail suicides include the social/economic instability of detainees, the stigma associated with incarceration, and present-day US correctional mental health policies and resources. Interpersonal factors of detainee suicide involve the quality and nature of familial and friend relationships, social isolation, past criminal history, and loss events leading to shame, guilt, humiliation and despair. Incarceration further creates recurring systems of overall decline in community health by causing decomposition of family structure, misplacing the mentally ill into correctional institutions, decreasing social capital among vulnerable populations, and increasing rates of depressive symptoms among these subpopulations. Community-level factors highlight decreased SES among those incarcerated, including vast gaps in poverty, education levels, homelessness and unemployment between inmates and the general U.S. population.

Incarceration influences the social capital of detainees thru decreased social cohesiveness, increased isolation, and the limited availability of mental health treatment resources, also risk factors for detainee suicide. National laws and shifting trends of federal and state policy (as seen among U.S. sentencing policies and the recent U.S. deinstitutionalization of mental health facilities) proportionately reshape interpersonal, communal, social, and institutional structures, thus precipitating psychosocial risk factors for detainee suicide.

Methods

Every occurrence of suicide in a jail setting is influenced by a myriad of unique situational circumstances. Qualitative research methods have the capacity to better understand the sensitive notions of human behavior and experience, rather than utilizing quantitative methods. To assess the psychosocial factors relating to inmate suicide, the current study utilized qualitative methods in the form of interviews and focus groups. Descriptions of these factors were obtained from jail mental health associates and chaplains, whom have had substantial interaction with suicidal detainees and

mentally ill/disordered detainees. The research was carried out a local metropolitan Atlanta jail. Semi-structured focus groups were conducted with 11 jail mental health staff members, including nurses, counselors, and re-entry officers. Additionally, 3 interviews were conducted with jail chaplains and pastors. This study received ethical approval from the Institutional Review Boards [IRB] of Emory University (IRB study no. 00054584).

Participants were eligible to participate in the current study if they were (1) a current mental health professional at the local Atlanta jail and (2) able to consent to participation in focus group or interviews. Eligible participants were recruited by the principal investigator and were approached by staff directors for participation in the study. Participants were notified all matter discussed in the interviews and focus groups would be kept anonymous and confidential. Written consent to participate was collected from each participant. Focus groups and interviews were held on the premises of the jail facility and were tape-recorded to identify pertinent themes relating to psychosocial factors of jail suicides. Prior to each focus group discussion and interview, demographic information was collected from participants.

Focus group and interview questions were developed to obtain a broad picture of factors precipitating inmate suicides, including questions assessing staff perception of the current suicide prevention system at the local Atlanta jail. Questions were open-ended and additional inquiries were used to further probe responses if the participants did not give a clear and detailed explanation to the primary question. Additionally, initial observation provided the researcher personal and direct contact with correctional staff during day-to-day procedures involving detainee mental health screenings and counseling sessions, thus allowing better understanding of the context in which the process takes place.

Focus Group with Mental Health Staff

Focus groups were implemented; the first focus group comprised of 6 participants and was administered by a facilitator of the research team. The second focus group comprised of 4 participants and was administered by the principal researcher. A total of ten participants were present between both focus groups, including correctional mental health staff and re-entry coordinators. The average age among participants was 48 years old; half of the participants were male. One participant self-identified as being of Hispanic ethnicity, while nine participants identified as non-Hispanic. Of the ten participants, 7 identified as Black or African descent, 2 as White or Caucasian and one refused to disclose his/her race. Participants were experienced mental health professionals, reporting working in correctional facilities for over 8 years, on average.

Focus group members described demographic trends and psychological and social experiences of inmate suicides. Systematic risk factors predicting inmate suicide were discussed. Each focus group lasted between 45-60 minutes. Topics of discussion included:

- Mental health of inmates
- Psychosocial characteristics of detainee suicide,
- Suicide screening and prevention,
- Psychiatric services received during and after incarceration,
- Life circumstances during incarceration,
- Experiences of mental health professionals and chaplains,
- Detainee experiences and thoughts concerning transitioning between jail and the community,
- Detainee experiences during incarceration
- Experiences with suicide, if applicable.

Interview with Jail Chaplains

Jail chaplains were interviewed on a one-to-one basis by the principal researcher and were asked questions regarding detainee suicide and the role that religion may play in shaping psychosocial determinants of jail suicides. Two interviews were administered in the chaplain's office; one interview was administered at a local church, in which the third pastor serves. Each interview lasted between 45 to 60 minutes. Topics of discussion included:

- Mental health of inmates
- Psychosocial characteristics of detainee suicide,
- Suicide screening and prevention,
- Psychiatric services received during and after incarceration,
- Life circumstances during incarceration,
- Experiences of mental health professionals and chaplains,
- Detainee experiences and thoughts concerning transitioning between jail and the community,
- Detainee experiences during incarceration
- Experiences with suicide, if applicable.

Each tape-recorded conversation was transcribed by manually entering text data using word processing software. All qualitative data analyses were conducted by the principal investigator and other research assistants utilizing Hennink et al.'s (2011) circular approach of analysis. In accordance with this method, verbatim transcripts were read several times to obtain a thorough understanding of the material and identify any persistent patterns in narratives. Transcripts were read at least twice, summarized, and coded by the researcher and other research assistants for inter-rater reliability. Speakers in the transcripts were identified and differentiated by the research team to identify prominent tones and ideas of participants.

Codes were identified as any issues, topics, ideas, concepts, or processes that were evident in the qualitative data (Hennink, 2011). Inductive and deductive coding was performed by identifying salient themes within the transcripts regarding psychosocial experiences of inmate suicide and grouping quotes based on similarity of content. Recurring themes were constantly compared and overarching categories were constructed. For validation purposes, triangulation of data was utilized to corroborate findings. Based on discussion from jail mental health staff and chaplains, numerous factors were identified as influencing inmate suicide and/or suicidal behavior.

Results

Upon analysis of the qualitative data, several thematic categories assessing the psychosocial factors that predict inmate suicide emerged, each theme having several subthemes. Mental health and suicide risk was described by participants as the summation of a detainee's psychological and social experiences. Several participants expressed that the mental health of individuals should be considered as a whole and is quite dependent on situational factors, family background, and belief values of oneself and of society. One mental health staff member said,

> *Mental health, to me, is how a person functions in the community, how they feel about themselves, their emotional state, capabilities of problem-solving, decision making, being able to function within a community. It also has to do with the spiritual nature of humanity. It has to deal with the family system and all those things play into a person's mental health. So it's more of a holistic, it's a whole person; it's a lot of stuff going on: the psychological, spiritual, emotional.*

In general, participants felt that the issue of mental health in jails is very serious, and that the migration of mental health patients from mental health facilities into correctional facilities may also contribute to the increased rates of those who are mentally ill in jails. Most participants estimated the percentage of mentally ill inmates in jails to be between 25-40%. Another mental health staff

member added, "Even some of those who are mentally ill committing the crimes and they end up in jail so now the jails, as well as the communities on the outside, they need to be more prepared to deal with the increasing mental health population, especially in jails."

Another participant asserted that "It's only within the past so many years that the jail population increased with mental health inmates, mentally ill inmates."

There was a general consensus among participants that in many cases of jail suicides, the occurrences happen with no previous warnings and/or signs exhibited by the inmate. However, negative symptoms (e.g. withdrawal, abnormal silence, isolation) often did occur prior to the suicide of an inmate. One mental health staff member indicated,

> *I find that there are no real clear cut indicators for if somebody is suicidal or not because when I first started working here, people would say that they're suicidal and they're really not and in every case where I've seen a serious attempt, there was no referrals put in, nobody called it to my attentions that this inmate's been acting funny. They just find them hanging or the find them bleeding in their cell. And these are the ones that don't say anything, they don't complain.*

Another mental health professional added, "Some of them, they make their mind up. It's really nothing else to talk about. They have nothing else to say to me about it. They pretty much know [that] their future is bleak and they've made their mind up about it, taking themselves out is better than the alternative."

Additionally one chaplain explained,

> *I would say that 90% of them that have committed suicide have not asked us for help because I usually try to look up the people we deal with , give a bible, bible studies and stuff, anything, even counseling, we file it. We*

> *give them a bible, we keep a record. The ones that have committed suicide… I don't think either one of them we had given bibles to.*

There was overall consensus that societal factors influence the mental health and increased feelings of suicide among inmates. These factors include the quality and diversity of family backgrounds and relationships, the feelings experienced towards others and society, and the status of one's socioeconomic position in society. Additionally, societal events and phenomena, such as the current economic status of one's country, may increase the uptake of mental health inmates in jails, and may even create downward shift of an inmate's mental health status while incarcerated. One re-entry coordinator elicited that, "I also think that with the way the economy, and the down spiraling of the economy…I think because of the economy, times have gotten harder for people and some people, they're committing more crimes."

Another mental health professional spoke of inmates' response following the intense media coverage of a final death sentence conviction:

> *When you think about just recently, when they had the Troy Davis [execution]…after he was executed, inmates here who have been on the death sentence, they know that they received the death sentence, but it didn't become reality until after they knew or heard or saw it on the news that this inmate had actually been executed…and so the risk, the suicide risk went up, it increased.*

Suicide in a jail environment is a distinct experience, when compared to the occurrence in other situational environments. Salient characteristics of jail suicide, including inmate psychological and social factors, were identified from the qualitative data and were then categorized. Individual factors were identified distinctively from social factors since there was no certainty of causality between the determinants. Each category was, in a way, synergistically related to other categories and provided a holistic assessment of those whom are likely to commit the act while incarcerated. In this

case, reciprocal effects of psychological and social factors are apparent. For instance, individual factors were inherently intertwined with other large-scale and socio-contextual factors. Additionally, family problems and/or instability often take a negative toll on the personal psyches of jail inmates.

Table 1: **Identified Psychological and Social Factors Related to Jail Suicides: Categories, Themes and Subthemes of Focus Groups and Interviews**

Categories	*Themes/Subthemes*
Psychological/Mental Health Factors	Depressive Symptoms • Feelings of hopelessness and despair • Feelings of helplessness and loss of freedom • Feelings of loneliness • Feelings of guilt/shame Difficulty adjusting to Jail Setting/Difficulty Coping Anxiety and Fear Elusive Behavior • Tendencies to Lie • Attention seeking/Intent Religious Beliefs/Spirituality Medical Problems • Distress from medical status • Substance Use/Abuse and Medication-related issues
Social Factors	Decreased Social Support • Relationship problems with family and/or partner Homelessness Low education/high unemployment Social support provided by jail chaplains
Jail Factors	Screening and assessment of at-risk individuals • Untrained correctional staff • Cultural barriers between inmates and staff Jail sentence Jail environment • Bullying • Masculine Culture

Psychological/Mental Health Factors

Theme 1: Depressive Symptoms. Depression is often the best predictor of inmate suicide, with apparent symptoms exhibited near the time of occurrence. Accordingly, four subthemes were identified within the overall theme of depressive symptoms: feelings of hopelessness and despair, feelings of helplessness and loss of freedom, feelings of loneliness, and feelings of guilt/shame related to the crime.

Feelings of Hopelessness and Despair. Participants of focus groups and interviews indicated that inmates display feelings of hopelessness prior to suicidal ideation and action. Inmates have diminished hope for their future upon detainment and may often feel as if they have no reason to live. One participant noted, "I think it's just no hope, no outlook on life." A jail chaplain explained that, "They come to a point where there is no hope for me: I can't help myself. Medical science can't help me. Mental health can't help me." A third participant conveyed, "It is that they come to a place where they don't have any hope getting out of the situations that they're in." In other words, suicidal inmates feel as though any inkling of hope is distanced from their situational positioning while in jail.

Feelings of Helplessness and loss of freedom. Suicidal inmates tend to feel helpless about their current detainment and often feel as if they are trapped from escaping their circumstances. For example, one participant verbalized, "They just feel like they're world has caved in, there's no reason to live." Sense of personal value often declines when inmates realize their loss of freedom while behind jail bars. One mental health professional explained that "there's that sense that I don't have anything to contribute" apparent in most inmates. One mental health professional provides the metaphor of a bird's ability to fly in relation to an inmate's loss of freedom:

> *When a person is incarcerated anyway, the suicide risk goes up because first of all, what you've done, you've taken away their freedom. When you think about an example, I think about a bird. When a bird is free,*

> *flying around out here, you know, in the skies, in the blue skies, going from North to South, South to North, he's happy. But if you ever take that bird and put him in a cage (that's what we do with inmates, we put people in cages, we don't have a choice…those cells, some of them look like a cage), you have removed their freedom…Do I want to live in a cage for the rest of my life, to know that the freedom I had before has been removed? Or do I become hopeless, helpless, and despair?*

Feelings of loneliness. Many participants reported that suicidal inmates exhibited feelings of loneliness. Separation from the outside world and detachment from friends and family often precipitated these feelings among inmates. One jail chaplain related that "many of the inmates, they have no one, they get not mail, they have no one to call and there's no one to visit them." Another mental health staff member asserted that "they have no support on the outside so why not just, you know, take [their] life." Furthermore, another chaplain explained that, "I think a lot of them burn all their bridges and they don't have nobody to turn to and no help, nobody wants to help them." Inmates also begin to isolate themselves prior to suicide ideation and attempt; one participant noted that "They begin to isolate themselves from the other inmates."

Feelings of guilt/shame. Focus group participants and interviewees noted that inmates were deeply shamed and experienced feelings of guilt toward the crime that they had committed, insomuch that these feelings could contribute to their suicidal behaviors. One jail chaplain provided an example of an inmate who "had given up his will to live and he felt that because of his charges, because of the things he had done, because of his guilt…he just felt that there was no need for [him] to live anymore." Shame can predict an inmate's likelihood of committing suicide, as one mental health professional recalls the example of "One man [who] molested his granddaughter and felt shame, it's the shame behind a lot of that too, and he had just got here (wasn't even here for 24 hours) and went ahead and hung himself."

Theme 2: Difficulty Adjusting to Jail Setting/Difficulty Coping. Many inmates who are incarcerated lack the emotional stability to adequately adjust and cope in a jail setting, thus making it difficult for inmates to assimilate in this often threatening environment. The jail setting can cause the mental breakdown of an inmate, thus leading one to be suicidal while behind bars. One mental health staff member claimed that "a lot of people that come in, come in with difficulty adjusting to being here and their state of mind, you got to seriously look at their state of mind when they get here because they could actually get worse while they're here…the setting is definitely, probably the biggest factor." One jail chaplain asserted,

> *Because many of [the inmates] are young and they are afraid, they are in a strange environment. They are locked away. It's strange they have never been there, they're accustomed to doing their own thing. Today they've got to answer to somebody and they've never answered to anybody before.*

Theme 3: Anxiety and Fear. Self harm, a common precedent to suicide, is often a form of anxiety experienced by inmates, as research shows that some tend to do is in order to mitigate some worrisome aspect of their life. One mental health professional said that "so many of the people came in as cutters and that was a way of relieving tension in their lives." This is an important aspect to recognize among suicidal inmates. The same participant continued that "they weren't cutting because they were trying to commit suicide because if you really want to commit suicide, you hit the vein and take it out."

Inmates often commit suicide due to increased fear of detainment and uncertainty of outcomes. For example, one chaplain explained:

> *It's out of fear, it's out of weakness. These were considered to be strong guys on the outside but that jail, it has a way of doing something to them; and despite how strong or how wicked they were on the outside, they start to be afraid. And again, fear has no respect towards a person. They long for the date when it's over.*

Somehow, a release date that they look forward to and there are those that will make an attempt on their life because they know what they're not ever going to get out or somebody is going to be asked that they're given the death penalty for their life.

Theme 4: Elusive Behavior. Elusive behavior is common in a jail setting. Inmates often have nothing to lose as a consequence of lying and many times utilize manipulative efforts to distract jail staff from daily activities. For example, one participant explains, "Sometimes, they might not intend to commit suicide, they're just making a threat." One mental health staff member spoke of an inmate "who cut himself all the time and it was never to cut himself because 'I want to die,' he was punishing us! He knew that disrupts our day. We have to stop what we're doing." Another mental health staff member describes the importance of determining whether or not an inmate is being manipulative: "You can pretty much tell some of the ones, I'm sure they have some problems, I'm sure they do need our help and you can just tell from the assessment skills the ones who just playing games. But I don't think I've ever been surprised by an outcome."

Tendencies to Lie. Participants were in general agreement that inmates tend to manipulate correctional staff, including concerning their mental status and well being. A jail chaplain stated, "What I see mostly is a lot of deception. I've seen it where, lying is the biggest thing." Reasons for lying, however, were variable. Another chaplain said, "So they actually try to access the system because they think if they're on a mental health case, they'll get special treatment and they can go into mental health court and then they can get released early." When asked about the common reasons that some inmates may seek religious involvement or speak to a chaplain, a jail chaplain noted, "Well, I think a lot of it is that they might find favor with the judge, with the judicial system, to try to convince them that they have changed."

Attention Seeking/Intent. Detainees may intentionally attempt to kill themselves, or as a result of attention seeking and threatening behavior, detainees may accidentally commit suicide. Many participants suggested that detainees claim to be suicidal for the purpose of attention seeking or as a means of manipulation. One mental health professional expressed, "Many times, it's manipulation, or they use the term suicide to just move from area to another, to get attention." Consequentially, suicide attempt and suicide completion must be differentiated, with attempt possibly ending in completion. Another mental health professional noted that "they do something else to get our attention. And in the interim, mistakenly, unintentionally kills themselves." A third mental health professional observed:

> *Sometimes what might happen is they might be doing a suicidal attempt but there's an accident and they actually kill themselves. Like someone might put something around their neck and get on their knees and something happens, they slip and fall then that's an accident or someone who starts a fire in the cell and what happens is, nobody's going there, that he or she is expecting to get assistance and if it's not caught or the fire alarm doesn't work, then that was not their intent.*

Theme 4: Religious beliefs/Spirituality. Several participants observed that many inmates have religious beliefs and/or are spiritual in some way, thus influencing their decision to commit suicide. One mental health staff member claimed:

> *The majority of the guys and women who come here are spiritual beings; they have some belief, some type of belief. And many of them know if they attempt to commit suicide, that it's going to go against the grain of their family and their faith although they're not practicing anything. So for some of them it's very important.*

Inmates with mental health issues are not exempt from this group, as a jail chaplain explains:

> *I think many of the people that we deal with have some mental issues but they're always for whatever reason, they seek spiritual help. And I think it's because they probably were brought up in it. The ones that were brought up in it, definitely, because I've seen inmates that stand back here, kicked the door, cussed, screamed, use every source of language you can think of and then just in the middle of it, stop and start quoting verses and quote just as many verses as they would curse words. So even though they have mental issues, that religion or that faith or those things they've been taught about God are up there on that little disk somewhere and it's just a matter of what triggers it to bring it forth.*

Participants noted that a detainee's view of suicide is also important in relation to their religion and/or spirituality. One mental health staff member notes that:

> *Most people that I've talked with here, most people believe that if you kill yourself, you automatically go to hell so, therefore, they wouldn't do that, do you see what I'm saying? So most people that are doing it or are looking at it or thinking about it from a spiritual standpoint, would not commit suicide because many of them believe that if you do it, unpardonable sin, that you would immediately go to hell.*

Theme 5: Medical Problems

Distress from medical status. Many inmates, while incarcerated, suffer from other medical issues, other than mental health problems. This, however, may bear effect on an inmate's mental status and likelihood of committing suicide in jail as one chaplain explains:

> *An inmate come[s] and he has no knowledge that he is HIV positive or that he has hepatitis and to what degree…Sometimes this news [is] shocking to an inmate…and I have been told by inmates, that they would rather die than see their body succumb to full blown AIDS. So from a psychological standpoint, just the fear from those diseases…'Am I going to die and how much time do I have?' These are some of questions that are*

> *posed to me…many will go on to say I don't want to die but many will say I would rather die than to live this way.*

Substance Use/Abuse and Medication-related issues. Medicines administered in jail may have negative effects on an inmate's mindset and mental wellbeing. One participant noticed, "I've seen that drugs will cloud the mind and that's what it does. And these guys here tell me that drugs don't do no good but just make…it's a state…it brings them down to a level where they're not as wild but they didn't depend on it and then it becomes a dependence in their life."

Social Factors

Theme 1: Decreased Social Support Many suicidal inmates have had relationship problems with their loved ones and have often distanced themselves from family and friends. In most cases, an inmate's support system is fractured, as one jail chaplain explains, "Because that support system is important. Without that, and I think that's a lot of what we get here from mental hygiene is the fact that these guys will say 'Well my mom don't care, my dad don't care, my wife don't care, you know my children do, it goes on and on."

Relationship problems with family and/or partner. Relationship issues with family can distance detainee's from loved ones. One chaplain said:

> *When mom won't come and see you, it's either mom has got some real issues, mental issues or something, or you have caused her to come to that point where it's easier for me not to see you.' Over the years, that I've been here, parents, relatives, sometimes it's easier just to stay away.*

Relational issues with spouses or boy/girlfriends are common among suicidal inmates, as the same chaplain explains:

> *I've seen men in here that felt that they loved their girlfriend or loved their wife to the point where if she left them, and as a result of them continuously coming back, she says, 'I can't deal with this anymore' and so she would leave him and he might say 'My world is ended' and they might do something to hurt themselves from that perspective.*

Another chaplain added:

> *A person…will get a letter and it's called, in a jail setting, it's called a 'Dear John' letter and it's the most difficult time in an inmate's life. That letter has arrived and they're told that 'I'm seeing somebody else and I want you to know that I love you but life goes on and this person is so nice to me'. It's difficult to accept that you are being replaced so I try to encourage an inmate…but, there are many that, at the moment, they're so hurt. They say 'I wish I could die'.*

Theme 2: Homelessness. Many mentally ill and suicidal detainees are homeless. One mental health professional commented, "Well, you know a lot of them, number one: they don't have a place to live. They live from one place to another. So they don't have no foundation." Another participant noted, "A lot of them, they're homeless when they come out, they have nowhere to go, they have no resources and they also have no support system pattern that they need."

Theme 3: Low education/ High unemployment

Participants noted that many detainees who enter into jail are jobless, perhaps due to the current U.S. economic landscape. Additionally, one jail chaplain notes the importance of education in determining jail detainee suicide rates, "So a lot has to do with no formal education, and then with our school system, the way they do it, I mean you know what's happening here in Atlanta. They pass them right through."

Theme 4: Social support provided by jail chaplains. Detainees often seek social support from religious services offered in jail via interaction with chaplains. According to participants, jail chaplains and pastors often remind inmates that there is hope beyond their current circumstances. One chaplain said:

> *We become family. We become that contact person, we become that one that try to instill in that inmate that you are somebody and that you made a mistake and we show love and try to encourage that inmate that there is life beyond crime, that there is a life beyond the jail…I'm grateful to God that I can say something to encourage a person and to do something that will turn that person's life around from a negative to a positive.*

Many religious services are offered by the chaplain's office, as another chaplain asserts: "We provide about 52 services a week for the inmates here and we have Bibles, Korans, for whatever religion that they may be, we provide free of charge. Plus, literature for them to read." In addition, another chaplain felt as though religion can be a protective factor against suicide in jails:

> *Religion serves as that barrier that would prevent an inmate from making these attempts on their life. At no time would I think religion would encourage a person to do such. We constantly tell a person that there is life after crime, that there is life when all this is over…that there is a life. So we encourage them to be positive, to be strong and wait to see what the end, what the climax will be.*

A third chaplain explained:

> *I think religion, God, whatever, offers people a hope…I think that the average deputy, the average jail leader, the average sheriff, the average warden would agree that the religious services are very important to them. And I think it helps them to change their overall view because if they look at the scriptures, any religion is gonna teach them to do right, to do the right thing.*

Chaplains often serve as an inmate's link to the outside world and as a source of social support, as one notes that:

> *Many are without the aid, or the assistance of any resources or contact with any family member or anyone other than the chaplain's office and for this reason, the only contact with the outside world is done through the chaplain's office. We contact family, we contact friends…we address the spiritual issue and we try to make contact with family and friends for them and to gain access to the outside world.*

Jail Factors

Theme 1: Screening and assessment of at-risk individuals. The jail environment often influences an inmate to commit suicide; however, several protocols are in place within this setting. One mental health counselor explained: "What [security guards] do is if the person tells them they're suicidal, they'll contact mental health and then we'll say 'Well send them down,' and then that's when the mental health folks go and do an assessment to determine what level of care they're going to be on."

Another mental health professional made further comment:

> *If they say that they have suicidal plans, they get stripped of their clothes and possessions. They get what they call is the 'turtle suit' now…They can't tear or rip because what they were finding when they were using paper gowns [is] that some of them were still making a nuisance out of those. And they put them, generally in a padded cell if that's available…We put them in a padded cell and just constantly check on them.*

Even after proper assessment and follow up of at-risk suicidal individuals, one participant commented, "Some of them will change their mind quickly, say 'No I'm not suicidal, it's just being here."

In general, participants felt that the intake screening of inmates appropriately screens those whom are at risk; however, it is the appropriate training of staff with adjunct use of screening questions and answers that appropriately determines which inmates are at greatest risk for suicide. One mental health professional explains:

> *All in all, I think it catches the more serious things that go on whereas if someone is suicidal or if somebody is on medication where if they miss it for a couple of days, then it's going to affect how they're acting, how they react, and how they interact with other people in the jail setting, so I think its thorough in that sense where it keeps, in most case, crises from happening or prevents conflict between inmates and security and other inmates.*

Additionally, another mental health staff member said:

> *I was thinking about the screening tool…it is pretty generic but it doesn't actually capture whether or not the person is suicidal when he or she comes in here because it doesn't ask specific questions and you actually don't do as assessment because what happens is, you know, you ask 'Are you suicidal?', those kinds of things and many times like they're saying when you interview the inmate when they initially come in, you got to have a sense of what's actually happening with them.*

Untrained correctional staff. Several participants exclaimed that there is minimal mental health/suicide training and knowledge among other jail correctional staff. One mental health counselor said:

> *For one, in our intake process here, we have our nurses down there. I think maybe there needs to be some changes because maybe we need to have someone down there who can identify and screen the mentally ill clients but so far, we have some nurses down there…but nurses that we have down there do not have any psychiatric training at all…Because a lot of people get missed and sometimes a lot of people are being seen that don't really have any issues going on.*

Several participants suggested that due to untrained other correctional staff, many times, the mental health staff is responsible for not only attending to mental health patients but is also involved in curbing behavioral crises that occur in the jail. One participant said,

> *Even with people who have behavioral problems, they act out in some way if they curse a deputy out, they assume that this person is crazy because 'they are cursing me out, they need to see mental health.' So a lot of that goes on. It's for mental health [staff] to curve things that the deputies really don't want to deal with.*

One other mental health staff member pointed out, "The staff has not been trained for mental health and…for crisis intervention because I think a lot of the issues that we have could be stopped early on if they had crisis intervention training."

Cultural barriers between inmates and staff. Participants felt that the screening process could be more culturally or ethnically sensitive so that the process is more accurately undertaken. A mental health professional explained that,

> *I think it's more the person asking the questions is where the bias comes from and as far as the reliability from getting information that was asked, what I think is kind of questionable…As far as bias goes, I think ethnicity and all those other things affects information that is obtained.*

Theme 2: Jail Sentence. Several participants suggested that an inmate's final sentence can determine the likelihood of that individual committing suicide: "So you look at those factors….You already committed a heinous crime, you have a long sentence, you have a life sentence, so when you see things that really happen, it becomes reality then…they begin to process and then the risk factor goes up."

A jail chaplain describes an example of an inmate on death sentence attempting suicide: "Wherever there is an attempt, suicide is out of fear, fear of a death sentence…There's another [inmate] who was in a carjacking experience…He has been offered life without parole and he has made an attempt on his life."

Theme 3: Jail Environment. Inmate moves within the jail and inmates being placed on lockdown, isolation, or in a padded cell are further factors that can lead to increased risk of suicide in jail. One chaplain said, "They're trying to get to a single cell where they can do their thing." The jail environment can also precipitate thoughts and feelings among inmates of wanting to escape by means of suicide. The same participant shared the example of a female inmate who attempted suicide:

> *We had a young lady and she was putting her head in the toilet and she was trying to get water up her nose, she was trying to drown herself…she felt unclean, she felt contaminated: 'I don't need to go back to my family, I don't need to go back to my friends because I've been here in the dirt pile. I don't want anybody to see me this way.' And that becomes a problem to some people because of who you are and where you come from.*

One mental health staff member explains the effect of being on lockdown for long amounts of time, putting an inmate at higher risk for suicide:

> *Another thing that I definitely have witnessed before while working here is any type of mental health person whose…on lock down here for 23 hours a day, that has an enormous effect on them, mentally, where they're only coming out for one hour a day. For the most part, that's high-risk, those persons who are not able to adjust to that type of setting here and they just lose it! You're on lockdown for 23 hours a day and it's nothing here, no communication, other than the people in the cell when you get out for that one hour a day. That's definitely high-risk.*

Bullying. Additionally the threatening environment in jail produces numerous inter-inmate crises. One chaplain asserted:

> *You'll find some inmates, say small in stature and size and again, there is that aggressive inmate… These inmates will take advantage of another inmate and there are some, rather than to be a part of that, they'll make an attempt on taking their own life. Jail is difficult. There is nothing easy about jail…He might have been a dealer or a robber or violent in the outside world but one you're [in jail], there's someone there that will meet any challenge that you have and for this reason there're some that would rather die than to be take or to have someone take their food, and we actually have that happen.*

Masculine culture. A culture of masculinity and manliness is inherent to the jail setting. One chaplain describes:

> *In the jail, they have rules or they have codes: Don't snitch, don't tell. Although there's protection…we have assisted in moving an inmate and putting them in kind of a gentle are for that inmate's own protection. It doesn't always happen because there is that same code in jail that exists in the free world: Don't snitch, don't tell, and it causes a lot of inmates to suffer.*

The jail environment, along with other psychological and social factors, can increase risk for suicide in this setting.

Discussion

Central themes were gleaned from focus groups and interview that should inform future public health practice and research in an effort to decrease rates of suicides in U.S. jails. Comprehensively understanding and addressing psychosocial factors intrinsically related to incarceration and detainment may decrease the occurrence of suicides among jail detainees. The present study investigated psychological, social and situational factors of jail suicides through qualitative data collection and analysis. Personal experiences of those who directly service mentally ill and suicidal inmates (i.e. jail mental health staff and jail chaplains) were shared via focus groups and

interviews. Additionally, vital staff thoughts and concerns surrounding protocols to reduce the occurrence of inmate suicide were discussed.

Participants generally stated the importance of recognizing mental health as a summation of psychological, social, and situational determinants. The number of mentally ill patients in jail institutions has significantly increased within the past thirty years. Findings from this study suggest that the mentally ill and/or disordered persons are overrepresented in correctional populations. With this increase, rates of inmates who commit suicide in these institutions remain higher than the rate of the general U.S. population.

Suicide is not easy to predict among jail inmates. Results from this study indicate that there are often very few visible signs of suicide prior to a detainee committing the act. Many participants asserted that often, inmates just do it with no prior signs or calls for help. Suicidal detainees seldom illustrate this potential to jail and mental health staff. Some inmates manipulate correctional staff for external gain, while other inmates self-mutilate to relieve anxiety and stress. Incarceration marks a time of great crisis for individuals, therefore creating intense feelings of hopelessness, helplessness, and loneliness. In an attempt to gain some locus of control in an otherwise powerless situation, detainees often manipulate jail staff to move outside of their current cell positions. With experience, staff are able to better accurately diagnose true signs of jail suicide (i.e. isolation, somberness, hopelessness, etc) despite an inmate's self-injurious behavior in order to seek attention.

Guilt and shame for crimes committed are negative emotions that may recur during incarceration. The shock of initial incarceration makes it difficult for inmates to appropriately cope in a threatening environment as that of a jail. Anxiety and fear are emotions encountered as an inmate remains unsure of the sentencing given for his/her initial charge. The fact that inmates remain uncertain about their charged sentence increases the risk for suicide in jails. In addition,

inmates with more severe charges are at higher risk for suicide; some would rather die than to live the rest of their lives behind bars.

Upon release from jail, detainees may be uncertain about their living arrangements, especially if they have burned bridges between their family and friends. Socioeconomic factors, including opportunities for employment and housing, are important in assessing suicidal risk. Many mentally ill or disordered individuals in jails are homeless and do not have stable living conditions post-incarceration. Detainees experience broken relationships with family and friends. This may be exacerbated by their current detainment, further distancing detainees from contact and dissolving relationships with loved ones. Jail chaplains and pastors provide hope and social support to inmates. According to participants, chaplains often serve as the communication link between inmates loved ones in the free world and religion often serves as a protective factor for inmate suicide.

The status of the economy and the media attention of relevant social crises (e.g. the media portrayal of a prisoner sentenced and killed on death row) in the free world may further predict increased risk for suicide within jail institutions. One's status in society may be a precipitant towards suicide occurrence in jail. Inmates may feel embarrassed of their detainment, due to their high position in society. Screening forms assessing an inmate's mental health are commonly used in jail settings; however, screening procedures and practices that utilize these forms have reflected a "one size fits all" approach. This approach assumes that an inmate's risk of suicide is an overall trans-situational phenomenon and does not properly address the specific context in which jail suicide occur.

Feedback from focus group discussions iterates that suicide among inmates is highly situational especially given the jail environment in which it occurs and that assessment protocols and tools may not be culturally competent in nature. Cultural barriers may further complicate the

screening process among culturally-diverse inmates, and inaccurately identify those whom are at higher risk for suicide while in detainment. The threatening and masculine culture of the jail environment may be responsible for increased suicides in jails, especially if a detainee is incarcerated for his/her first time. Adequate coping skills are required in this situation, but are usually not primed prior to entrance into the facility. There is also a 'male code' existent among jail populations and inmates may further encounter crisis with staff and other inmates during their time in jail.

Jail protocols are in place for suicidal inmates. Referrals are sent on an inmate's behalf to jail mental health staff via guards and other correctional staff. Once an inmate is identified as suicidal, they are separated from the general population and are sent to areas in the jail where the mental health staff can keep close observation of the inmate. If an inmate is considered especially suicidal, he/she is transferred to a padded cell to ensure safety from harmful objects. Being on lockdown and/or placed in a padded cell may further increase risk for suicide behind bars due to increased isolation of inmates. After an inmate is no longer considered suicidal, they are returned to the general population, with regular intermittent visits from the mental health staff soon thereafter.

Strengths and Limitations of the Current Study

There are inherent strengths and weaknesses associated with the qualitative nature of the present study. Considering strengths, the openness and flexibility of focus group and interview formats led to the accumulation and analysis of rich data detailing the experiences and knowledge of jail mental health professionals. Few studies on jail suicides implement such methods to assess perspectives of staff who directly serve the mentally ill/disordered while behind bars. Findings of psychosocial characteristics and jail protocols for jail suicides may not be generalizable to other jail populations because standards for general care of inmates and suicide prevention policies vary within the United States and between other countries.

The present study included a diverse sample of 13 participants in the form of 2 focus groups and 3 interviews, an ideal sample size for a qualitative study. Participants additionally offered experienced accounts of working directly with suicidal inmates. Another strength of the present study is the exploration of the role of religion and religious services in influencing suicide rates in jails. There is currently limited research and practice concerning the use of religious services used in tandem with mental health services for correctional populations. Jail chaplains and pastors were interviewed to determine their role and the role in which religion may serve as protective factors of inmate suicide. Initial research protocols called for inclusion of jail psychiatrists in focus group samples; however, due to limited time and work burden of the correctional staff, these individuals were not included and may have offered varying perspectives on psychiatric treatment of suicidal inmates.

Qualitative research methods are not exempt from bias. Qualitative data is subject to researcher bias of interpretation. To address this limitation, two research assistants provided input during the coding of data. Different participants were included in both focus groups: fluid group dynamics may have occurred between and within these two focus groups, thus presenting a limitation and adding bias to the present study. Experiences shared among participants remain a function of the context in which they were told, thus facilitator orientation and experience are momentary influences of data collection. Another limitation of this study was the differential use of facilitators to conduct two focus groups. This could have added potential bias in some respect: the rapport between interviewer and interviewee and between the facilitator and group members may have been influential in eliciting specific information. Several measures were enacted to minimize these limitations (e.g. prior rapport building and shadowing of mental health professionals prior to the research study).

Finally, it is believed that the major strength and unique contribution to the literature rests on the extensive description of symbiotic psychological, social, and situational processes involved in predicting risk of suicide among U.S. jail detainees. These active processes highlight risk factors (and some protective factors) influencing the significant rate of suicide occurring among U.S. jail detainees.

Future Interventions and Research

Suicide can be prevented in a risk-inducing environment as that of a jail. The development of behavioral management programs to deal with a variety of special-needs inmates is crucial (Bonner, 2000). The initial shock of incarceration and the decrease in social support may influence the mental health of an inmate. Future investigation is needed to determine the most appropriate protocols for treating the mental ill/disordered in jail institutions. Proper identification of those individuals at highest risk for suicide will ultimately reduce the risk of suicides in jails.

Because suicide always occurs within a particular society and cultural context, it is inevitable that this 'marker of society' will vary in spectrum across psychological, social, and environmental dimensions and across age, sex/gender, race/ethnicity of specific populations. Future research needs to examine protective factors associated with these demographics. For instance, one researcher suggests that Blacks do not experience higher suicide rates while incarcerated perhaps due to similar experienced environmental circumstances as that of the masculine, threatening jail environment but does not explicate further (Johnson, 1976). Although characteristics of suicide victims have been identified repeatedly in the literature, the sole consideration of these profiles should not remain an integral part in development of treatment and prevention programs in jails. Overreliance on such data including race and sex/gender has the potential to over-identify those who are not truly suicidal (false positives) and to under-identify those who are at true risk for committing suicide (false

negatives). Furthermore, assessment tools should be culturally sensitive so that an inmate is better able to accurately describe personal factors (i.e. medications taken, family background, living arrangements) and emotions (i.e. hopelessness, anxiety, fear) experienced at the time of intake and/or counseling sessions.

Compounded with such factors as the overall stress-inducing experience of incarceration and the threatening environment of the jail setting, the risk of suicide while in jail is often a difficult occurrence to predict. As this is the case, accurate assessments of an inmates' mental health should be appropriately established for a jail setting. In addition, interventions in jail settings must be tailored to the patterns of the specific jail in which they will be implemented (Spaulding, 2011), thus addressing such issues as high inmate turnover rates. Research should be geared towards calculating inmates' median length of jail stay in order to better accurately depict days upon incarceration in which detainees are at highest risk for committing suicide. Without this necessary denominator, time and situational contexts will remain ignored in relevance to suicidal outcomes among this specific subpopulation.

More research should be devoted to developing an accurate definition and nomenclature of self injurious behaviors as this often precedes suicide among inmates who are at greatest risk (Fagan, 2010). The definitions presented in current literature are ambiguous and do not provide a clear method of assessing inmates who may attempt suicide, in general, and among incarcerated populations. Suicide can be considered as part of a spectrum ranging from suicide ideation, self-injurious behaviors, suicide attempt, down to the actual act of suicide itself. Suicide risk also varies with norms of society, the risk factors may also be differential according to different norms. For example, in correctional populations, inmate culture recognizes self-mutilation as a form and line of communication between inmates and institutional and governmental authority. Self-injuries that

occur in the free world would be characterized as baffling and bizarre (even representing risk factors for suicide); however, these instances are antagonistically considered part of the "recognized repertoire" of jail culture, thus producing a different response from others. Due to this notion, self-injury is not considerably deviant behavior as applied to the jail environmental context. An inmate who engages in such behavior may have varying intents of doing so: there may be an intention to gain attention, relieve anxiety, or perhaps to commit the actual act. Essentially, better predictors and epidemiological measurements should remain integral in determining risk of suicide in jails. When intent is better understood by mental health staff in the jail, the inmate's cognitive and emotional state is made clear and his/her intended consequences are brought to light (Fagan et al., 2010).

Limited research has directly addressed the use of standardized measures in labeling malingering and how this process may potentially facilitate or hinder suicide prevention and mental health care administration in correctional systems (Cummings & Thompson, 2009). The lack of research in this area may be due in part to overarching national and state standards that recommend specific policies and procedures enacted towards suicide prevention but do not necessarily mandate specific tools for mental health staff to utilize in determination of risk (Cummings & Thompson, 2009).Despite the high rates of suicide behind bars, currently, there is no national standardized suicide measure developed for use in a correctional setting. Most jails, however, do have proper protocols for assessing suicidal inmates, but the extent to which these are maximally effective is unclear.

Although the cultural and political orientations of professional groups are often at odds, there is general consensus among these parties on the importance of public safety in U.S. jails. There should be a collaborative effort between law enforcement, judges, prosecutors, mental health professionals, and other correctional staff to identify, assess, and treat inmates who are suicidal

and/or engaging in other self-injurious behaviors while in jail. Police officers have the duty to appropriately deal with mentally ill offenders through crisis intervention practices and other procedures. Once incarcerated, it is in the hands of nurses, mental health professionals, psychiatrists, and correctional officers, to ensure the public wellbeing and safety of those individuals that present potential signs of suicide. One NCCHSC standard suggests that mental health care should be a collaborative effort among custody, administrative and mental health staff (Fagan, 2010). More specifically, counselors can assist correctional staff to recognize these signs and properly train them to identify behaviors unique to those individuals who are suicidal. Research shows that correctional staff who have been properly trained are more likely to make referrals to mental health staff, thus providing help to those inmates who may be considering suicide (Cummings & Thompson, 2009). Manipulation of the physical environment should also be an integral aspect of jail prevention plans (Tartaro, 2003).

The amount of caseload overlap between criminal justice and mental health service systems suggests that practice patterns in this area need to be examined and further enjoined to provide service coordination between the two sectors (Banks, 2000). In addition, greater mental health behavioral treatment options, including one-on-one and group counseling, should be implemented in a jail setting. Protective factors should also be considered in addition to risk factors in the development of appropriate jail protocol. Religion has been shown to create a buffering effect against suicide and may better enhance an inmate's overall mental wellbeing and ways to cope with the experiences of incarceration. Religious programming offered in jails is often not coordinated with mental health administrators. Most facilities offer religious services and although religion is shown to buffer against suicide, little research has been shown to support the utilization of religious services as part of suicide prevention in jails (Fagan, 2010). Additionally, it must be specifically recognized that social support does not necessarily equivocate to social support services. This is

where the dual role of chaplains in the present study is greatly highlighted. Jail chaplains provide both social support by contacting loved ones in the free world and also by providing religious social support services to detainees while incarcerated. Often, chaplains may serve as the only source of social support in a system when differential circumstances render difficulty developing new, and positive relationships while maintaining old ones.

Greater societal efforts to provide increased social support towards rehabilitation and re-entry into society should be instituted in jails. Successful community reentry is especially difficult for returning inmates with serious mental illness as they are more likely to experience homelessness and less likely to find employment when compared to other releasees (Baillargeon, 2010). Additionally, due to an insufficient number of community-based mental health programs and resources in the community, many recently released mentally inmates find difficulty obtaining adequate health care. Improved linkage to care and transition planning provided to detainees can result in increased health outcomes among recent releasees (Spaulding, 2011). Jails and prisons populate and are most concentrated with individuals at high risk for substance abuse, mental illness, and infectious and chronic diseases. The correctional system has the potential to link its vulnerable populations with needed health and social services and to play a positive role in health promotion and disease prevention and treatment (Narevic, 2006). Programs offering inmates enhanced linkage to health care and other community resources are paramount in regaining one's agency and providing adequate mental and physical health care.

It is important to recognize the cyclical nature of the criminal justice system when developing programs and interventions targeted for prisoners and jail inmates. Recidivism is high among previous offenders, whom may repeatedly enter the system stemming from merely one offense and may consequentially remain trapped inside these correctional institutions. The

psychological detriments of incarceration may also put individuals at higher risk for drug use (e.g. cocaine use), thus further increasing the risk and continuing the cycle of entrance into the criminal justice system. In an era of mandatory minimum sentencing laws and increased incarcerated populations, correctional services dedicated to the mental health of incarcerated populations is both cost efficient and morally sound.

Conclusion

The jail experience represents a critical period in one's life. Suicides typically occur when coping strategies are exhausted or are at a minimum. The chilling societal reality of increased suicides in U.S. jails should be considered more thoroughly in public health. Those who are mentally ill/disordered harbor increased risk for incarceration and are at increased risk for committing suicide while incarcerated. Emphatic introspection on the dynamic psychosocial risk factors for suicidal outcomes among incarcerated individuals may offer implications for reducing health disparities in the United States. Additionally, epidemiological factors, including exposure, time, and context are relevant to consider suicidal risk in specific subpopulations.

As jail suicide represents a tipping point between high mortality rates of suicide in the United States and high rates of incarceration of the United States populace, risk factors predicating the two are generally similar, with mental health serving as the often compromised link between the two incidences. Mental health is indeed a flexible arrangement of instrumental patterns of risk and protective factors alike. So too, is the occurrence of suicide, as it is a natural reflection of one's mental health; however this is not a simple and one-dimensional reflection, often occurring as part of a spectrum of suicidal behavior. Perhaps, incarceration should be considered a spanning risk factor for suicidal outcomes (along with other negative health outcomes) in the United States. With

increased U.S. rates of imprisonment, incarceration creates social disparities that can manifest in greater mental health disparities and mortality rates among vulnerable populations.

The power of comparison is paramount in the field of public health. To better understand comparable factors predicating suicide in jails, cultural contexts across institutions that have similar detainment purposes (i.e. prisons) and across institutions that have similar rates of suicide (i.e. the Army) should be better identified and understood. In addition, the health of those in jails has not been significantly compared to the health of those in prisons. Prison suicide rates are significantly lower than rates occurring in jail populations, perhaps due to a variance in psychosocial factors determined to predict suicide in jails. Firstly, jail inmates are more likely to have mental illnesses and disorders than their prison counterparts. They are essentially experiencing higher modes of stress and crisis. Additional social factors include various social advantages that prisoners may have over jail inmates. These social advantages include increased social cohesion and higher social support among prisoners, as shown in the literature.

Perhaps risk and protective factors should be applied differentially across, between, and within group processes as a whole. It is important to consider what current public health academia and research considers as social support or social integration and best ways to measure these standards. Sociological theories of population health hold true accordingly with psychological theories of population health and vice versa. These are often overlapping spheres of influence, as can be seen particularly within the phenomenon of jail suicides. For instance, current public health theories stem from notions of social capital and the increased benefit of great social support and high integration in determining both individual and public health. However, in jail populations, an opposite effect of these factors can be seen to predict suicidal behavior and outcomes due to a working symbiosis of psychological, social and environmental factors.

Cultural factors of the jail environment (including the inherently masculine culture of jails) should be dismantled for proper understanding of inmate suicide risk. Essentially, an inmate's mental health status must be considered as a complex interactional system of psychological, social, cultural, and situational factors. The influx of the mentally ill into jail facilities marks a societal phenomenon in United States history. Socio-political considerations and shortcomings may broadly influence the occurrence of suicide in political institutions as that of correctional facilities. Correctional staff should remain cognizant of diverse factors relating to inmate mental health and risk for suicide, in order to decrease suicidal occurrence under often fleeting circumstances. Furthermore, it must be appropriately understood that correctional mental health professionals work within an industry that is constantly adjusting to changes in public opinion, policy, and budgetary constraints.

Ultimately, correctional institutions must orient adherence to their primary goal of ensuring public safety in which the health of its populace remains equally paramount. Though a number of risk factors for inmate suicide are explored, this area is continually in need of an organizing framework and application of measurement technology to ensure valid and reliable methods of assessing suicidal inmates. A national, systematic and multidisciplinary approach is necessary to decline high rates of suicide in U.S. jails.

With hope, detainees can better cope in this deep furrow of society.

References

1. Alexander, M. (2010). The New Jim Crow: Mass Incarceration in the Age of Colorblindness. New York: New Press.
2. American Association of Suicidology [AAS] (2007). *Suicide in the U.S.A. Based on Current (2007) Statistics.* Accessed on December 10, 2011 from http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-244.pdf
3. American Association of Suicidology [AAS] (2010). *Risk Factors for Suicide and Suicidal Behaviors.* Accessed on December 8, 2011 from http://www.suicidology.org/c/document_library/get_file?folderId=248&name=DLFE-486.pdf
4. Arensman, E., Hawton, K.E., Townsend, E., Gunnell, D., Hazell, P., House, A., van Heeringen, K. (2001). Psychosocial and pharmacological treatments for deliberate self harm: The Methodological Issues Involved in Evaluating Effectiveness. *Suicide and Life-Threatening Behavior*, 31.2, 169-80
5. Banks, S.M., Stone, J.L., Pandiani, J.A., Cox, J.F., Morschauser, P.C. (2000). Utilization of local jails and general hospitals by state psychiatric center patients. *The Journal of Behavioral Health Services & Research,* 27(4), 454-459
6. Beaver, Alyssa L. (2010) Notes - Getting a Fix on Cocaine Sentencing Policy: Reforming the Sentencing Scheme of the Anti-Drug Abuse Act of 1986. *Fordham Law Review*, 78(5) 2531.
7. Berman, Douglas A. (2011). The Many (opaque) Echoes of Compromise Crack Sentencing Reform. *Federal Sentencing Reporter*, 23(3), 167-170.

8. Blaauw, E., Winkel, F. W., Kerkhof, A.J.F.M. (2001). Bullying and Suicidal Behavior in Jails. *Criminal Justice and Behavior*, 28(3), 279-299

9. Blaauw, E., Arensman, E, Kraaij, V., Winkel, F.W., Bout, R. (2002). Traumatic life events and suicide risk among jail inmates: the influence of types of events, time period and significant others. *Journal of Traumatic Stress,* 15(1), 9-*16*

10. Bonner, R. L. (2000). Correctional Suicide Prevention in the Year 2000 and Beyond. *Suicide and Life-Threatening Behavior, 30*(4), 370-376.

11. Burr, J.A., Hartman, J.T., Matteson, D.W. (1999). Black Suicide in U.S. Metropolitan Areas: An Examination of the Racial Inequality and Social Integration-Regulation Hypotheses. *Social Forces, 77(3)*, 1049-1080

12. Centers for Disease Control And Prevention [CDC], National Center for Injury Prevention (2009). (n.d) *Suicide: Facts at a Glance*. Retrieved September 12, 2011 from http://www.cdc.gov/ViolencePrevention/pdf/Suicide-DataSheet-a.pdf

13. Centers for Disease Control And Prevention [CDC], National Center for Injury Prevention (2011). (n.d) *Definitions: Self-Directed Violence*. Retrieved March 9, 2011 from http://www.cdc.gov/ViolencePrevention/suicide/definitions.html

14. Cox, J. F., & Morschauser, P. C. (1997). A solution to the problem of jail suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 18*(4), 178-184. doi: 10.1027/0227-5910.18.4.178

15. Cummings, D. L., & Thompson, M. N. (2009). Suicidal or manipulative? The role of mental health counselors in overcoming a false dichotomy in identifying and treating self-harming inmates. *Journal of Mental Health Counseling, 31*(3), 201-212.

16. Danto, B.L. (1973). Jail House Blues: Studies of Suicidal Behavior in Jail and Prison. Orchard Lake, M.I.: Epic Publications, Inc.

17. Davis, M.S., Muscat, J.E. (1993) An epidemiological study of alcohol and suicide risk in Ohio jails and lockups, 1975-1984. *Journal of Criminal Justice,* 21(3), 277-283
18. Death in Custody Reporting Act of 2000. H.R. 1800, 106d Cong., 1st Sess. (2000).
19. Drapalski, A.L, Youman, K., Stuewig, J. Tangney, J. (2009). Gender Differences in jail inmates' symptoms of mental illness, treatment history and treatment seeking. *Criminal Behavior and Mental Health,* 19, 193-206
20. DuRand, C. J., Burtka, G. J., Federman, E. J., & Haycox, J. A. (1995). A quarter century of suicide in a major urban jail: Implications for community psychiatry. *The American Journal of Psychiatry, 152*(7), 1077-1080.
21. Durkheim, Emile. [1897] 1951. *Suicide: A Study in Sociology.* Glencoe: Free Press
22. Fagan, T. J., Cox, J., Helfand, S. J., & Aufderheide, D. (2010). Self-injurious behavior in correctional settings. *Journal of Correctional Health Care, 16*(1), 48-66. doi: 10.1177/1078345809348212
23. Fair Sentencing Act of 2010. S. 2304, 110d Cong. 2nd Sess. (2010).
24. Felthous, A. R. (2011). Suicide Behind Bars: Trends, Inconsistencies, and Practical Implications. *Journal of Forensic Sciences, 56*(6), 1541-1555. doi: 10.1111/j.1556-4029.2011.01858.x
25. Freud, Sigmund (1957). Mourning and Melancholia. *Standard Edition of the Complete Psychological Works of Sigmund Freud.* Ed and trans James Strachey et al, London: The Hogarth Press. vol 14. 239-258
26. Gearing, R.E., Lizardi, D. (2009). Religion and Suicide. *Journal of Religion and Health,* 48, 332-341
27. Gibbs, J.T. (1997). African-American Suicide: A Cultural Paradox. *Suicide and Life-Threatening Behavior,* 27(1), 68-79

28. Griffin-Fennell, F., Williams, M. (2006). Examining the complexities of suicidal behavior in the African American community. *Journal of Black Psychology,* 32, 303-319

29. Greenberg, G. A., and R. A. Rosenheck(2008). Jail Incarceration, Homelessness, and Mental Health: A National Study. *Psychiatric Services* 59(2), 170-77.

30. Haney, Craig. (2002) *Psychological Impact of Incarceration: Implications for Post-Prison Adjustment.* Print

31. Harlow, C. W. (2003 January). Education and Correctional Populations. U.S. Department of Justice, Bureau of Justice Statistics. NCJ 195670. Accessed 6 March 2012 from: http://bjs.ojp.usdoj.gov/content/pub/pdf/jim10st.pdf.

32. Harrison, K.S. and Rogers, R. (2007). Axis I Screens and Suicide Risk in Jails: A Comparative Analysis. *Assessment,* 14 (2), 171-180

33. Hayes, L. M. (1989). National study of jail suicides: Seven years later. *Psychiatric Quarterly, 60*(1), 7-29. doi: 10.1007/bf01064362

34. Hayes, L. M. (1997). From Chaos to Calm: One Jail System's Struggle with Suicide Prevention. *Behavioral Sciences and the Law,* 15, 399-413

35. Hayes, L. M. (2010 April) *National Study of jail suicide: Twenty years later.* US Department of Justice, National Institute of Corrections. NIC 024308. Retrieved August 3, 2011 from http://nicic.gov/Library/024308

36. Heines, V. (2005). Speaking out to improve the health of inmates. *American Journal of Public Health*, 95(10), 1685-1688

37. Hennink, M.M., Bailey, A., Hutter, I. (2011) *Qualitative Research Methods.* London: SAGE

38. International Centre for Prison Studies [ICPS] (2010). *World Prison Brief.* King's College London, University of London. Retrieved February 10, 2012 from

http://www.prisonstudies.org/info/worldbrief/wpb_stats.php?area=all&category=wb_poprate

39. Ivanoff, Andre (1989). Identifying Psychological Correlates of Suicidal Behavior in Jail and Detention Facilities. *Psychiatric Quarterly,* 60(1), 73-84

40. James, D. J., and Glaze, L.E. (2006 Sept.) *Mental Health Problems of Prison and Jail Inmates.* US Department of Justice, Bureau of Justice Statistics. NCJ 213600. Accessed on September 1, 2011 from http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf

41. Johnson, Robert (1976). Culture and Crisis in Confinement. Lexington, M.S.: D.C. Heath and Company

42. Knoll, James L. (2010). Suicide in Correctional Settings: Assessment, Prevention and Professional Liability. *Journal of Correctional Health Care,* 16(3), 188-204.

43. Kovach, G.C. (2010, May 2). Suicide the unseen enemy for marines. *San-Diego Union-Tribune.* From: http://www.utsandiego.com/news/2010/may/02/suicide-unseen-enemy-marines/ Retrieved April 2, 2012.

44. Kupers, T.A. (2005). Toxic Masculinity as a barrier to mental health in prison. *Journal of Clinical Psychology,* 61(6), 713-724

45. Kushner, Howard I (1989). Self-destruction in the Promised Land: A Psychocultural Biology of American Suicide. New Brunswick, N.J.: Rutgers UP

46. Kushner, H. I., and C. E. Sterk (2005). The Limits of Social Capital: Durkheim, Suicide, and Social Cohesion. *American Journal of Public Health*, 95 (7), 1139-143.

47. Kushner, H.I., Braswell, H. (2010). Suicide, social integration, and masculinity in the U.S. military. *Social Science and Medicine,* 74, 530-536

48. Lane, R. (1979). *Violent death in the city: Suicide, accident, and murder in nineteenth-century Philadelphia.* Cambridge, MA.: Harvard University Press.

49. Lester, David. (1997). The role of shame in suicide. *Suicide and Life-Threatening Behavior*, 27(4), 352-361

50. Lester, David. (2008). Suicide and Culture. *World Cultural Psychiatry Research Review, 3*(2), 51-68

51. Levy, Barry S., and Victor W. Sidel (2006). *Social Injustice and Public Health*. Oxford: Oxford UP

52. Lindquist, C.A. and Lindquist, C.H. (1999). Health Behind Bars: Utilization and Evaluation of Medical Care among Jail Inmates. *Journal of Community Health,* 24 (4), 285-303

53. Lynch, James P., and Sabol, W. J. (2004) Assessing the Effects of Mass Incarceration on Informal Social Control in Communities. *Commentary*. 3(2). 267-294

54. Maris, Ronald W (1997). Social and Familial Risk Factors in Suicidal Behavior. *The Psychiatric Clinics of North American*, 20 (3), 519-550

55. Markowitz, Fred E (2011). Mental illness, crime, and violence: Risk, context, and social control. *Aggression and Violent Behavior,* 16, 36-44

56. Mauer, Marc. (2000) Race to Incarcerate. 2nd ed. New York, N.Y.: The New Press

57. McKee, G. R. (1998). Lethal vs nonlethal suicide attempts in jail. *Psychological Reports, 82*(2), 611-614. doi: 10.2466/pr0.82.2.611-614

58. Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008. S. 2304, 110d Cong. 2nd Sess. (2008).

59. Minton, Todd D., (2011 April). Jail Inmates at Midyear 2010. U.S. Department of Justice, Bureau of Justice Statistics. NCJ 233431. Accessed January 5, 2012 from http://bjs.ojp.usdoj.gov/content/pub/pdf/jim10st.pdf.

60. Mumola, C.J. (2005 August) *Suicide and Homicide in State Prisons and Local Jails*. US Department of Justice, Bureau of Justice Statistics. NCJ 210036. Accessed on September 12, 2011 from http://bjs.ojp.usdoj.gov/content/pub/pdf/shsplj.pdf

61. Narevic, E, TF Garrity, NE Schoenberg, ML Hiller, JM Webster, CG Leukefeld, and Tindall M. Staton(2006). Factors Predicting Unmet Health Services Needs Among Incarcerated Substance Users. *Substance Use & Misuse*. 41(8), 1077-94.

62. National Institute of Mental Health [NIMH] (2011) *1999-2007 Suicide Rate Trends (per 100,000)*. National Institutes of Health, U.S. Department of Health and Human Services. Accessed on November 11, 2011 from http://www.nimh.nih.gov/statistics/4SR99.shtml

63. Noonan, Margaret. (2010 July) *Deaths in Custody Reporting Program: Mortality in Local Jails, 2000-2007*. US Department of Justice, Bureau of Justice Statistics. NCJ 222988. Accessed on August 21, 2012 from http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1744

64. Noonan, M. E., Carson, E.A. (2011 Dec.) Prison and Jail Deaths in Custody, 2000-2009-Statistical Tables. US Department of Justice, Bureau of Justice Statistics. NCJ 236219. Accessed on September 3, 2012 from http://bjs.ojp.usdoj.gov/content/pub/pdf/pjdc0009st.pdf

65. Primm, A. B., Osher, F.C., Gomez, M.B. (2005) Race and Ethnicity, Mental health Services and Cultural Competence in the Criminal Justice System: Are we Ready to Change? *Community Mental Health Journal,* 41(5), 557-569

66. Rockett, I. R. H., Samora, J. B., & Coben, J. H. (2006). The black-white suicide paradox: Possible effects of misclassification. *Social Science & Medicine, 63*(8), 2165-2175. doi: 10.1016/j.socscimed.2006.05.017

67. Rose, D. A. & Clear, T. R. (1998) Incarceration, Social Capital, and Crime: Implications for Social Disorganization Theory. *Criminology*. 36(3), 441-480

68. Schnittker, J., John, A. (2007). Enduring Stigma: The long-term effects of incarceration on health. *Journal of Health and Social Behavior*, 48, 115-130

69. Senter, A., Morgan, R.D., Serna-McDonald, C., Bewley, M. (2010). Correctional Psychologist Burnout, Job Satisfaction, and Life Satisfaction. *Psychological Services,* 7(3), 190-201.

70. Sharma, M & Romas, J.A. (2008). Theoretical Foundations of Health Education and Health Promotion. Sudbury, M.A.: Jones and Bartlett Publishers

71. Spaulding, A. C., Seals, R.M., Page, M.J., Brzozowski, A.K., Rhodes, W., Hammett, T.M. (2009). HIV/AIDS among Inmates of and Releasees from US Correctional Facilities, 2006: Declining Share of Epidemic but Persistent Public Health Opportunity. *PLoS ONE,* 4(11), 1-8

72. Spaulding, A. C., Perez, S. D., Seals, R. M., Hallman, M. A., Kavasery, R., & Weiss, P. S. (2011). Diversity of Release Patterns for Jail Detainees: Implications for Public Health Interventions. *American Journal of Public Health, 101*(S1), S347-S352. doi: 10.2105/ajph.2010.300004

73. Spaulding, A. C., Seals, R. M., McCallum, V. A., Perez, S. D., Brzozowski, A. K., & Steenland, N. K. (2011). Prisoner Survival Inside and Outside of the Institution: Implications for Health-Care Planning. *American Journal of Epidemiology, 173*(5), 479-487. doi: 10.1093/aje/kwq422

74. Spellman, A. A., & Heyne, B. (1989). Suicide? Accident? Predictable? Avoidable? The psychological autopsy in jail suicides. *Psychiatric Quarterly, 60*(2), 173-183. doi: 10.1007/bf01064943

75. Stark, R., Doyle, D.P., Rushing, J.L. (1983). Beyond Durkheim: Religion and Suicide. *Journal for the Scientific Study of Religion,* 22(2), 120-131

76. Substance Abuse and Mental Health Services Administration [SAMHSA] (2009) *The National Survey on Drug Use and Health: Suicidal Thoughts and Behaviors Among Adults.* Office of Applied Studies. United States Department of Health and Human Services.

77. Tartaro, C., and Lester, D. (2009). *Suicide and Self-Harm in Prisons and Jails*. Lanham, MD.: Lexington Books.

78. U.S. Public Health Service [USPHS] (1999). *The Surgeon General's Call to Action To Prevent Suicide*. Washington, D.C.

79. United States Department of Health and Human Services [HHS] (2012). *2020 Topics and Objectives*. Retrieved January 16, 2012 from http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=28

80. Van Wormer, K., Odiah, C. (1999). The Psychology of Suicide-Murder and the Death Penalty. *Journal of Criminal Justice,* 27(4), 361-370

81. Wang, E. A., & Wildeman, C. (2011). Studying health disparities by including incarcerated and formerly incarcerated individuals. *JAMA: The Journal Of The American Medical Association, 305*(16), 1708-1709.

82. Wilson, D.J. (2000 May) *Drug Use, Testing, and Treatment in Jails*. US Department of Justice, Bureau of Justice Statistics. NCJ 179999. Accessed on September 23, 2011 from http://bjs.ojp.usdoj.gov/content/pub/pdf/duttj.pdf