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SUICIDE IN PRISONS: OVERCROWDING AND THE NEED TO STRENGTHEN SUICIDE WATCH PROCEDURES

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ABSTRACT

Suicide rates for people in jails and prisons far exceed the suicide rates of the general public. Prison overcrowding has aggravated the problem of prisoner suicide by placing further stresses on prisoners without resources for psychological help. Currently, prisons deal with the risk of suicide by placing prisoners identified to be at risk of self harm on suicide watch. This paper examines the current practices in place for determining which prisoners are at risk for suicide and suggests ways that the process can be improved to reduce the risk of suicide among prisoners. Ultimately, these policies will have limited effectiveness as long as prisons remain overcrowded. Overcrowding is the root of the problem and needs to be remedied for the long term effectiveness of the proposed policies.

INTRODUCTION

Suicide is a leading cause of death among prisoners in the United States. Behind natural causes and Acquired Immune Deficiency Syndrome (AIDS), suicide is the third most common cause of death in prison. Studies have shown that “overcrowding is a critical feature of prison environments that dramatically raises the risk of prison suicide.” Many inmates suffer from mental health disorders and have substance abuse problems, placing them in groups already at risk for suicide. When placed in an overcrowded

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4 “There is a fifty-six percent chance that an inmate in state prison is suffering from a mental health problem.” Stephen Allen, Mental Health Treatment and the Criminal Justice System 4 J. Health & Biomedical Law 153 (2008).
5 Michelle Westhoff, An Examination of Prisoners’ Constitutional Right to Healthcare: Theory and Practice 20 No. 6 Health Law. 1, 9 (2008) (“An estimated 70 percent of U.S. inmates have an addiction to an illicit substance...”).
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environment riddled with additional stress factors and a poor staff per inmate ratio, these inmates are unable to get their mental health needs addressed. The overcrowding plaguing many United States prisons creates difficulties for prison officials to give inmates at risk for suicide the attention needed to help them through personal crises.

Over the past few decades, it has become increasingly difficult for families of inmate suicide victims to prevail in litigation against prison officials who failed to prevent the suicide of their loved one. Prison officials will only be able to adequately care for at risk prisoners when the overcrowding crisis has ended, but until then there is still a viable solution to reducing the number of suicides in prisons. Prisons should implement and adhere to policies that have been proven to reduce the numbers of inmate suicides. These measures involve better training of prison personnel as to the risks and signs of suicide and what to do in case of an attempt; screening of inmates during intake and throughout their incarceration; adequate supervision and housing choices for prisoners at risk; an organized record keeping system for mental health records and an incident reporting and investigative process in the event of a suicide; and positive and negative incentives for prison officials to encourage willing and effective participation in these policies and procedures.

In the first section of this paper, I discuss risk factors for suicide in the general public as well as for inmates. In the second part of this paper, I discuss what it is that differentiates prison suicide from jail suicide. In part three, I demonstrate how overcrowding increases the risks of prisoners committing suicide. In part four, I discuss the inadequacy of current suicide procedures in prisons. In part five, I look at case law from section 1983 and tort claims and show that prison officials have a duty to protect inmates from suicide. In the final section of this paper, part six, I examine what policies and procedures have seen success in suicide prevention and recommend that prisons in the United States implement programs for training of prison guards, better screening of inmates at intake and throughout their period of incarceration, how supervision and housing of prisoners on suicide watch should work, an incident reporting and investigation plan in the case of a suicide incident, and suggest incentives for prison personnel to follow the new policies.

States suffer from a mental disorder and/or a substance abuse disorder.)}
I. Risk Factors for Suicide

Suicide is a major public health problem. In the United States, more than 34,000 people take their own life each year.\(^7\) For every suicide death, there is an estimated eight to twenty-five attempted suicides.\(^8\) The National Institute of Mental Health reports that over ninety percent of people who attempt suicide suffer from depression, mental health disorders, substance abuse problems, or all three.\(^9\) Other factors that increase the risk for suicide include prior suicide attempts, family history of mental disorders, substance abuse problems or suicide, violence in the home (including physical and/or sexual abuse), firearms in the home, incarceration, and exposure to the suicidal behavior of others.\(^10\)

Many inmates belong to groups that are at a heightened risk for suicide.\(^11\) It has been determined that about half of all prisoners have at least one mental health condition,\(^12\) and about seventy percent of inmates in the United States have a substance abuse problem.\(^13\) In California, it is estimated that about eighty percent of inmates have a problem with either drug or alcohol addiction.\(^14\) Among male inmates in state prison, about thirty-three percent of mentally ill inmates, and thirteen percent of other inmates reported being physically or sexually abused prior to incarceration.\(^15\) When placed in environments that are overcrowded and filled with stressors, mental health issues are further exacerbated and inmates become at an even higher risk for suicide.\(^16\) Stressors include

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\(^10\) Id.


undesired unit placement, work assignment, disciplinary confinement, interpersonal conflicts, legal processes, parole setbacks, and chronic medical conditions; all which may trigger suicidal behavior.\textsuperscript{17}

Prisons have been shown to be the type of place where suicide clusters may occur.\textsuperscript{18} Suicide clusters are defined as three or more suicides in one geographic location in a short time frame.\textsuperscript{19} Due to this phenomenon, prison guards should be placed on alert and extra mental staff should be on call for one month after a successful suicide has occurred.\textsuperscript{20}

II. JAIL VS. PRISON SUICIDE

Suicide is a serious problem in both jails and prisons. In jails, suicide rates are about ten times higher of that than the general public, and suicide rates in prisons are about three times higher than that of the general public.\textsuperscript{21} While suicide is the third leading cause of death in prisons,\textsuperscript{22} it is the leading cause of death in jails.\textsuperscript{23} Many differences between suicides in jail versus suicides in prison exist, and because of higher numbers of suicides in jail, jail suicide has received much more attention than suicide in prisons.\textsuperscript{24}

In jails, suicide attempts are usually made within the first twenty-four hour period of being taken into custody.\textsuperscript{25} Suicide attempts not made in the first twenty-four hours usually occur within the following fourteen day period.\textsuperscript{26} These inmates are typically unmarried young men who were intoxicated when arrested and have never before been charged with an offense.\textsuperscript{27} The offense they have been placed in custody for is usually some

\begin{footnotes}
\footnotetext{17}{Id.}
\footnotetext{18}{World Health Organization, \textit{supra} note 55 at 12.}
\footnotetext{19}{Michelle Trudeau, \textit{Media Should Tread Carefully in Covering Suicide} (NPR Nov. 18, 2009).}
\footnotetext{20}{World Health Organization, \textit{supra} note 55 at 12 (“The examination of suicide clusters in prisons has suggested that the increased risk of subsequent suicide appeared to be limited to the four week period following the initial suicide, and appeared to reduce over time.”).}
\footnotetext{21}{Cropsey, \textit{supra} note 2 at 213}
\footnotetext{22}{\textit{Id.}}
\textit{[hereinafter Hayes Key Ingredients].}}
\footnotetext{24}{Lindsey M. Hayes, \textit{Suicide in Adult Correctional Facilities: Key Ingredients to Prevention and Overcoming the Obstacles} 27 J.L. Med. & Ethics 260, 260-261 (1999)
\textit{[hereinafter Hayes Key Ingredients].}}
\footnotetext{25}{Cropsey, \textit{supra} note 2 at 214}
\footnotetext{26}{\textit{Id.}}
\footnotetext{27}{\textit{Id.}}
\end{footnotes}
type of minor substance abuse offense. 28

Two factors have been suggested as being the primary factors contributing to jail suicides: 1) the environment; and 2) the inmate being in a crisis situation. 29 The environment in jail is conducive to suicidal behavior because the inmate has a fear of the unknown, lack of control, isolation from friends and family, shame, distrust of authority, and there are dehumanizing aspects of imprisonment. 30 Some inmates are ill-equipped to handle the stresses of jail, and when placed in jail face a personal crisis. 31 This crisis can be brought on by recent excessive drinking and/or drug use, loss of resources, severe shame and/or guilt, a mental illness, a prior suicide attempt, and/or an approaching court appearance. 32 As the inmate sits in jail trying to cope with his situation and any aggravating factors, the result can be suicidal behavior. 33

In contrast, inmates who commit suicide in prison are usually older males serving a long sentence for a violent offense who have a history of mental illness. 34 Additionally, prison inmates are typically incarcerated for a few years before attempting suicide. 35 It seems that once the appeals process is exhausted, inmates are more likely to attempt suicide. 36

Many aggravating factors have been suggested as possible precipitating factors of suicide in prisons. Factors include overcrowding, previous suicide attempts, new legal problems, marital or relationship difficulties, inmate-related conflicts, 37 family history of suicide, strength of any support system outside the prison walls, and mental illness. 38

Prison suicide victims are typically further removed from their community and family than are jail suicide victims. 39 Prison suicide victims have been removed from their community for years, while jail suicide victims have been gone for two weeks or less before committing suicide. 40 The fact that jail suicide victims are usually less removed from their families and communities than prison victims means that there are probably

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28 Id.
29 Hayes Key Ingredients, supra note 21 at 260.
30 Id.
31 Id.
32 Id.
33 Id.
34 Cropsey, supra note 2 at 214
35 Id.
36 Id.
37 Hayes Key Ingredients supra note 21 at 261.
40 Id.
more family members interested in pursuing suicide litigation for jail suicides then for prison suicides. This combined with the fact that there are significantly more suicides in jails than prisons, helps to explain the staggering difference in the amount of jail suicide litigation than prison suicide litigation, another way in which jail and prison suicides are different. Prison suicide litigation is discussed in part five of this paper, but it is helpful to note the distinctions between jail and prison suicide to more fully understand the problem and how overcrowded prisons exacerbate this issue.

III. OVERCROWDING IN PRISONS CAUSES INCREASED RATES OF SUICIDE

Prison overcrowding is related to a host of issues, including prisoner suicide. Studies have shown that overcrowding in prisons is one feature of prison environments that significantly increases risks of suicide. Overcrowding may cause increased risks of suicide because of increased levels of deprivation of necessities and increased levels of stress in crowded facilities. Another theory behind why overcrowding is linked to increased rates of suicide is because crowding reduces the availability of meaningful activities and programs available to prisoners. Prison overcrowding causes difficulties for prison officials to maintain tolerable conditions and minimum standards in their institutions, which leads to poor prisoner health and higher death rates, including increases in suicides. Many prison facilities have experienced increased rates of suicide when the inmate population has increased. Exposure to “long term, intense, inescapable crowding...can lead to [the] physical and psychological impairment” of prisoners. Seven experts who testified in the case Coleman v. Schwarzenegger stated that overcrowding is the principal cause of the inability of California to provide inmates with “constitutionally

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41 Id.
42 Id.
44 Id.
45 Id.
48 Human Rights Watch, supra note 11.
adequate care." Medication delivery systems are overwhelmed, inmates who need mental health supervision are forced into the general population because there is a shortage of beds in the appropriate facility, and inmates in the general population become “medication-noncompliant.” Additionally, the medical records system is in disarray, making it difficult for prison doctors to treat the mentally ill. Inability to provide such care leads to higher rates of suicide, particularly when overcrowding overwhelms medical personnel and inhibits their ability to administer medication.

Prisons across the nation are facing overcrowding and the multitude of issues that come along with that. For years, California prisons have been operating at double capacity, with some institutions nearing triple capacity, despite court rulings demanding the state to reduce the population of prisons to 137.5% of capacity. Experts have, however, stated that prisons were actually designed to be operated at below 100% capacity, so that room would be available for moving prisoners and for mental and health care initiatives. Secretary Woodford, the former head of the CDCR and former warden of San Quentin correctional institution, said that “a five percent vacancy rate is necessary to manage the movement of prisoners appropriately…Without the flexibility that this vacancy rate provides, it is very difficult to ensure that prisoners are housed appropriately for their…mental health needs.” Because of the importance of space and staffing to the mental health care of prisoners, the prison suicide problem cannot be fully alleviated until the problem of overcrowding is eliminated. However, effective suicide watch procedures can positively impact the rates of prison suicide.

IV. CURRENT SUICIDE WATCH PROCEDURES ARE INADEQUATE TO PREVENT PRISONER SUICIDE IN OVERCROWDED PRISONS

Although awareness of the issue of prison suicide and need for effective prevention procedures has become more prevalent in the past few decades,

50 Id.
51 Id.
52 Id.
54 Id. at 126.
55 Id.
56 Id. at 165.
prison systems in the United States are still not doing enough to prevent suicide among inmates. The fact that many prisons are overcrowded exacerbates this problem.

The greatest percentage of suicide attempts occur among prisoners who are housed in isolated settings, including administrative segregation. Segregation is the worst possible setting for a suicidal prisoner because it worsens the emotional state of the prisoner, hinders problem solving abilities, and can amplify the risk of life threatening behavior. In spite of this, a suicide attempt in Alabama can result in being thrown alone and naked into a cold observation cell for days with nothing but a rubber mat to sleep on.

To make matters worse, at some prison facilities psychiatric evaluations are only done once a week, causing suicidal inmates to be locked alone in a cell for up to six days, with nobody to talk to. Psychiatrists are essential to treat inmates with mental disorders. In Alabama, not only were prisons found to be understaffed with mental health professionals, but the medical professionals who were hired to work in mental health are not properly qualified. Alabama prisons are severely overcrowded, which means there is not enough space for meaningful programming or even individual interventions.

California has reasonable policies for the treatment of suicidal prisoners, however overcrowding has crippled the system’s ability to effectively carry out such policies. Each prison in California is required to implement a program to prevent suicide that includes suicide watch and follow up treatment. However, chronic overcrowding in the California prison system

57 Hayes Key Ingredients, supra note 21 at 261 (1999) ("Although forty-one [state and federal prison] systems have suicide prevention policies, only a small percentage have comprehensive procedures.").
60 Raymond Bonner, Rethinking Suicide Prevention and Manipulative Behavior in Corrections Jail Suicide/Mental Health Update 7-8 (2001).
62 Burns, supra note 58 at 28.
63 Id. at 61.
64 Id. at 62-63.
65 Dennis Sherer, Prison Overcrowding, Times Daily, November 27, 2007. ("Brian Corbett, a spokesperson for the Alabama Department of Corrections, said that the state has 24,622 convicts locked up in prisons designed to hold 12,682 inmates.").
66 Burns, supra note 58 at 66-67.
67 15 CCR § 3365(b).
has seriously impacted the ability of the system to provide enough beds and adequate staffing for mentally ill patients.68

V. PRISON OFFICIALS HAVE A DUTY TO PROTECT INMATES FROM SUICIDE

Prison officials have a duty to protect inmates from self inflicted harm, including suicide, when such harm is foreseeable.69 If an inmate commits suicide while in prison, there are two possible remedies for families of the now deceased inmate, Section 1983 civil rights claims and tort claims. Section 1983 claims expose prison officials who were deliberately indifferent to the mental health and protection of a suicidal inmate to damages and remedial court injunctions.70 Such deliberate indifference constitutes a violation of the Eighth Amendment.71 If a prison employee is negligent in protecting the inmate from suicide, absent a state statute protecting the employee from liability, the family of a suicide victim may bring a tort suit against prison personnel.72

When reviewing litigation involving suicide in correctional settings, it is quite noticeable that there is much more litigation involving suicide in jail than suicide in prisons.73 The difference between the number of jail suicide litigation cases and prison suicide litigation cases can be explained by two main factors.74 One factor is that there are far more suicides in jails than in prisons.75 The second factor is that jail inmates are more likely than prison inmates to have a support system outside of the jail who are willing to bring a claim against the state.76 Regardless of the numbers, many of the decisions in jail suicide litigation can be, and have been, used as precedent in prison suicide litigation.77

A. Section 1983 Claims

In order for a plaintiff to bring a successful 1983 civil rights claim against a defendant, the plaintiff must demonstrate that the defendant deprived a person of “any rights, privileges, or immunities secured by the

68 Coleman, No. Civ S-90-0520 LKK JFM P at 47.
71 Id. at 104.
72 Collins, supra note 36 at 60.
73 Id.
74 Id.
75 Id.
76 Id.
77 Hanser, supra note 1 at 464.
In the case *Estelle v. Gamble*, the Supreme Court held that “deliberate indifference by prison personnel to a prisoner's serious illness or injury constitutes cruel and unusual punishment contravene[s] the Eighth Amendment,” making such actions answerable to a section 1983 claim. The ruling in *Estelle* has resulted in Eighth Amendment claims of inadequate medical care becoming the most common type of allegation filed in suits involving prison suicide. For a prison suicide case to be successful, a plaintiff must show that the inmate had a serious medical need and that the medical care given to the suicide victim was so inadequate as to be considered deliberately indifferent.

When *Estelle* was decided, the term “deliberate indifference” was not defined. As case law developed, lower courts began to develop criteria for plaintiffs to show in order to prove that a corrections officer was deliberately indifferent. Common themes included that defendants had: “(1) reckless knowledge of; (2) suicidal danger personal to the victim; and (3) failed to undertake reasonable preventative measures.” Courts also adopted a subjective definition to measure the definition of reckless knowledge, making it extremely difficult for plaintiffs to show deliberate indifference.

In 1994, the Supreme Court decided *Farmer v. Brennan*. While this case did not directly deal with suicide, the court addressed the standard of deliberate indifference which has been applied to prison suicide cases. In *Farmer*, the court affirmed what lower courts had been saying about a subjective actual knowledge standard, making this the official standard plaintiffs must meet to prevail on a section 1983 claim. For a plaintiff to meet the subjective actual knowledge standard, they must show that prison personnel were both “aware of the facts from which the inference can be drawn that a substantial risk of serious harm exists, and he must also draw on the inference.” This standard is similar to the standard for criminal

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79 429 U.S. at 104.
80 Hanser, supra note 1 at 460.
81 Id.
83 Hanser, supra note 1 at 460.
84 Id. at 461.
85 Id.
86 Id.
88 Id.
89 Id. at 861.
90 Id. at 837.
recklessness.\textsuperscript{91} Fact-finders may find that a prison official “subjectively knew of the substantial risk of harm by circumstantial evidence” or “from the very fact that the risk was obvious.”\textsuperscript{92} However, because “a prison official may show that the obvious escaped him,” the Supreme Court has warned courts that evidence of an obvious risk does not definitively establish an inference that a prison official was subjectively aware of the substantial risk of harm.\textsuperscript{93} As a result of this standard, inadequate training can be an effective defense against liability claims.\textsuperscript{94} The idea is that if the guards did not know what to look for, or what to do in the event a risk was detected, prison guards could not have been deliberately indifferent.\textsuperscript{95}

Today, plaintiffs must establish three elements to show deliberate indifference in a prison suicide case: “(1) the detainee had a ‘particular vulnerability’ to suicide, (2) the custodial officer or officers knew or should have known of that vulnerability, and (3) those officers ‘acted with reckless indifference’ to the detainee’s particular vulnerability.”\textsuperscript{96} Reckless indifference is the same standard as deliberate indifference.\textsuperscript{97} Basically, in order to prove liability, plaintiffs have the burden of proving that the defendant “[knew] of, and disregard[ed] an excessive risk to the inmate’s health or safety.”\textsuperscript{98} Defendant’s knowledge of a prisoner’s particular vulnerability to suicide can be established by one of many ways. The plaintiff can show knowledge of the vulnerability when defendant had actual knowledge of “an obviously serious suicide threat, a history of suicide attempts, or a psychiatric diagnosis identifying suicidal propensities.”\textsuperscript{99}

Since Farmer, corrections officials have typically used one of three defenses to defeat section 1983 claims: the official was not aware of the facts indicating that the particular inmate was at risk; the official was aware of the facts, but believed that the risk either did not exist or was not serious; or that officials in fact did provide an adequate response to the risk.\textsuperscript{100}

\begin{thebibliography}{99}
\bibitem{91} Hanser, supra note 1 at 474-475.
\bibitem{93} Id.
\bibitem{94} Id.
\bibitem{95} Hanser, supra note 1 at 466.
\bibitem{96} Id.
\bibitem{98} Colburn v. Upper Darby Township, 946 F.2d 1017, 1023 (1991).
\bibitem{100} Id. (citing Colburn, 946 F.2d at 1025 n.1).
\end{thebibliography}
1. Officials were not aware of the facts indicating that the particular inmate was in danger.

   In order for officials to be liable under a section 1983 claim, plaintiffs must show that officials were aware of the facts indicating that the inmate was in danger of suicide. If officials can show that they were not aware of any risk for the particular inmate, even in spite of evidence indicating that there is a general risk for suicide in their facility, liability can be avoided. In the case Frake v. City of Chicago, inmate Frake committed suicide by hanging while in a police lockup, and his family sued the city under section 1983. In this case, the family argued that the “history of suicides in the Chicago detention facilities” combined with the fact that the city places inmates “alone in cells with horizontal cross bars” shows that the city of Chicago is deliberately indifferent. In a seven year period, there were twenty completed suicides and 163 attempts by hanging. In spite of the fact that the administration was aware of the risk of suicide by hanging in the facilities, the court found that because there was no evidence that Frake himself was suicidal, his family failed to prove their claim.

   Another example of an unsuccessful section 1983 claim is House v. City of Macomb. In this case, plaintiffs presented evidence that officials and jail personnel should have known House was suicidal due to her bipolar disorder and attempted suicide days before the attempted suicide that is the cause of this complaint. However, summary judgment for the defense was granted because there was not sufficient evidence to show that officers and jail personnel who came into contact with the suicide victim knew she was suicidal, plaintiffs could not prove that the defendant’s had drawn on the inference necessary for them to know House was suicidal, as required in Farmer.

2. Officials were aware of the facts indicating that the particular inmate was at risk, but did not believe the risk actually existed, or was actually serious.

   When jail or prison personnel know of facts that indicate an inmate is a

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101 210 F.3d 779 (2000).
102 Id. at 782
103 Id.
104 Id.
106 Id. at 854.
107 Id. at 850-853.
108 Id. at 854.
109 511 U.S. at 837.
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suicide risk, but do not take the risk seriously, or do not believe that the risk actually exists, liability can be avoided. In the case Boncher v. Brown County, the court granted summary judgment to jail officials in a section 1983 claim because the evidence was insufficient to show that the jail officials showed deliberate indifference to an inmate’s suicide risk by failing to adequately train employees.\(^{110}\) The plaintiffs presented evidence that intake officers were not trained adequately to assess suicide risk, and were using a defective checklist in determining suicide risk for new inmates.\(^{111}\) The defense argued that the intake officers believed the defendant to be joking, which is why they did not take the suicide threat seriously, even though they knew Boncher had previously attempted suicide.\(^{112}\) The court did not believe sufficient training would have helped the intake officers determine whether or not Boncher was joking, so granted summary judgment.\(^{113}\) Forty-five minutes after Boncher “joked” about committing suicide and was placed into a cell, he hung himself with a bed sheet.\(^{114}\)

3. The officials provided an adequate response to the risk.

If prison officials know about the risk of suicide to an inmate, take that risk seriously, and the inmate still commits suicide, no liability will be found. In some cases, this is quite reasonable, but in others nobody is held liable for a death that could have been easily prevented. In the case Williams v. Mehra, Williams hoarded pills and attempted to overdose.\(^{115}\) This attempt was not successful.\(^{116}\) Williams was switched to liquid medication in order to prevent pill hoarding, and was made to attend additional therapy.\(^{117}\) Williams’s condition improved.\(^{118}\) A short time later, Williams was again prescribed pills but was forced to take them in a pill line, which is designed to prevent hoarding.\(^{119}\) In spite of the pill line, Williams still managed to hoard his pills and took his own life about two months after being put back on the pills.\(^{120}\)

In a less understandable case, Serafin v. City of Johnstown, prison

\(^{110}\) 272 F.3d 484, 488 (2001).
\(^{111}\) Id. at 487.
\(^{112}\) Id. at 485.
\(^{113}\) Id. at 488.
\(^{114}\) Id. at 485.
\(^{115}\) 186 F.3d 685, 688 (1999).
\(^{116}\) Id.
\(^{117}\) Id.
\(^{118}\) Id.
\(^{119}\) Id.
\(^{120}\) Id.
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officials avoided liability for failing to adequately monitor a prisoner on suicide watch. In this case, prisoner Serafin was placed on suicide watch, and an untrained clerk who had other duties to perform while simultaneously monitoring Serafin through a closed-circuit monitor, failed to intervene in Serafin’s suicide. The city had a policy of having clerks, while performing their regular job functions, periodically check on suicidal inmates. The clerks were untrained in how to handle suicide watch or what to do in the case of an attempt, these clerks were just told to “monitor intoxicated pretrial detainees at risk for suicide” in addition to performing normal job duties. The court found that this did not constitute deliberate indifference and affirmed summary judgment granted to the defendants.

The success of these three defenses illustrates that even if plaintiffs have evidence that prison personnel were aware of information indicating that an inmate was suicidal, it may not be enough to win a case. Under today’s system, it is a rare thing for a plaintiff to win a section 1983 claim against a prison for not adequately protecting an inmate from suicide. This reality has stunted positive prison reform.

B. Tort Claims

In 1994, the Supreme Court held in Farmer that the Eighth Amendment places on prison officials a duty to ensure that inmates receive adequate medical care. This same decision also reaffirmed that prison officials must take reasonable measures to ensure the safety of inmates. As mentioned previously, the Farmer decision did not directly deal with prison suicides, but had important implications for these types of cases. Plaintiffs are able to bring a tort suit against prison officials who failed to protect an inmate from suicide if the self inflicted injury was reasonably

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122 Id. at 215.
123 Id.
124 Id.
125 Id. at 216.
126 Farmer, 511 U.S. at 122.
127 Shevon L. Scarsafe, “Deliberate Indifference” or Not: That is the Question in the Third Circuit Jail Suicide Case of Woloszyn v. Lawrence County 51 Vill. L. Rev. 1133, 1136 (2003).
128 Collins, supra note 36 at 61.
129 511 U.S. at 832.
130 Id. (citing Hudson v. Palmer, 486 U.S. 517, 526-527 (1984)).
foreseeable.\textsuperscript{131} However, prison officials are not liable when prisoners inflict harm upon themselves, including committing suicide, unless the self inflicted injury was reasonably foreseeable by that official.\textsuperscript{132} Foreseeability can be proved when the suicide is shown to have been probable in light of ordinary care.\textsuperscript{133} This is an easier standard to prove than the standard in section 1983 claims.\textsuperscript{134}

In tort cases, in order to establish liability for negligence against a defendant, the plaintiff must establish four things: “(1) The defendant owed a duty to the plaintiff; (2) the duty was breached; (3) the breach was the proximate cause of the plaintiff’s injury; and (4) the plaintiff sustained damages.”\textsuperscript{135} Numerous cases establish that prison and jail officials have a duty to protect suicidal prisoners against the risk of self-inflicted harm.\textsuperscript{136} A major stumbling block with tort claims in prison suicide cases is the fact that most states provide qualified immunity for state organizations, officials, and employees.\textsuperscript{137}

In the case \textit{Middlebrooks v. Bibb County}, Middlebrooks committed suicide while being held in county lockup, and his father brought a tort claim against the county and several jail administrators and employees.\textsuperscript{138} In granting summary judgment for the defendants, the court noted that in Georgia, a public officer or employee may only be personally liable for acts that are “ministerial,” or “simple, absolute, and definite” and are performed negligently or with malice or intent to harm.\textsuperscript{139} In this case, the court found that training, supervision, and adoption of policies regarding suicidal inmates was discretionary rather than ministerial, so the defendants were entitled to qualified immunity unless their conduct was malicious.\textsuperscript{140}

In the case \textit{Forgan v. Howard County, Tex.} the family of now deceased inmate Forgan sued the county and various jail officers under tort claims in Texas.\textsuperscript{141} In granting summary judgment on grounds of qualified immunity for the tort claim, the court noted that in Texas, a Texas governmental unit is immune from torts unless the legislature waived immunity.\textsuperscript{142} The Texas legislature has a limited waiver of immunity for “personal injury or death so
caused by a condition or use of tangible personal or real property…”\textsuperscript{143} In this situation, the inmate hung himself with a pair of “non-defective” trousers, and thus does not qualify for the limited waiver of immunity.\textsuperscript{144}

While some plaintiffs may benefit from the ability to bring a tort suit against prison officials, most states provide prison officials with qualified immunity.\textsuperscript{145} While a discussion of individual state laws surrounding qualified immunity is outside the scope of this paper, it should be noted that an overwhelming majority of courts in this country apply immunity to officials unless limited circumstances apply.\textsuperscript{146} Plaintiffs in states with stringent qualified immunity provisions for these officials have section 1983 claims as their sole remedy for the untimely death of a loved one.\textsuperscript{147}

VI. UNIFORM POLICIES AND PROCEDURES IN PRISONS SHOULD BE MANDATED TO CURTAIL SUICIDE IN PRISONS

Prisons with successful suicide prevention programs in place typically have several components to their written policies, including training, screening, housing and levels of supervision, intervention, and review.\textsuperscript{148} These prisons mark their success with long periods of time without any suicides.\textsuperscript{149} In this section, I will explore five areas believed to be critically important to the successful prevention of suicide in correctional settings: Training; Intake and Periodic Screening; Supervision and Housing of Prisoners on Suicide Watch; Record Keeping, Incident Reporting and Investigation; and Incentives for Prison Personnel.

A. Training

The first step in reducing prison suicide is to require comprehensive training for prison staff. Training for prison guards should be a primary focus because guards are the ones who deal with inmates on a daily basis.\textsuperscript{150} Suicide attempts generally occur in housing units, where guards, rather than medical staff, control the environment.\textsuperscript{151} Training is especially important in the face of prison overcrowding. Overcrowding poses increased safety risks

\begin{footnotes}
\item[143] Id. (citing Tex. Civ. Prac. & Rem. Code §101.021(2)).
\item[144] Id.
\item[145] Collins, supra note 36 at 64.
\item[146] 60 A.L.R. 2d 1198.
\item[147] Collins, supra note 36 at 64.
\item[148] Hayes Guide, supra note 35 at 34.
\item[149] Id.
\item[150] Hayes Key Ingredients, supra note 21 at 261-262.
\item[151] Id. at 262.
\end{footnotes}
for both prison guards and inmates, making adequate training essential for prison guards to prevent suicide.

Guards should be provided with training that educates them about the risk factors of suicide, the typical profile of a suicidal prisoner, including the times when inmates are most at risk, warning signs and symptoms, and what to do in the event that a suicide threat or attempt occurs. Additionally, all prison employees with regular contact with prisoners should be provided with basic medical training that educates them about what to do during a suicide attempt. Research indicates that hanging is the most common method of prison suicide. Because hangings are so common, at a minimum prison employees should be educated on how to handle a hanging victim until medical professionals arrive.

The possibility of staged suicide attempts by prisoners in order to manipulate the system, gain access to better living conditions or sleeping pills places guards in a difficult position. While I could find no examples of prisoners staging suicide attempts in their cells in order to escape, guards must keep security concerns in mind so as to prevent possible harm to themselves or an escape. Guards are faced with conflicting goals: to protect the safety of one’s self and the institution from a manipulative prisoner, and to protect the inmate from himself. In situations where guards believe the suicide threat or attempt is a fake, established protocol should still be to take the threat or attempt seriously. Regardless of the intention of the inmate, suicide attempts can result in death and ignored suicide threats can escalate into increasingly dangerous behavior. Inmates who are faking suicidal behavior are still crying out for help, and thus require psychological resources.

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152 Federal Bureau of Prisons Oversight, Hearing Before the Subcommittee on Crime, Terrorism, and Homeland Security of the Committee on the Judiciary House of Representatives 111th Cong. 12 (2009) (statement of Harley G. Lappin, Director, Federal Bureau of Prisons, U.S. DOJ; “Correctional administrators agree that crowded prisons result in greater tension, frustration and anger among the inmate population, which leads to conflicts and violence.”).

153 Id.
154 Id.

156 Id. at 11.
157 Id.
158 Id.
159 Id.
160 Id.
1. Intake Screening

Although screening for suicidal tendencies at intake is not constitutionally required, something as simple as a few questions on a self-reporting intake questionnaire can help medical staff at a prison in determining how to treat inmates. Medical professionals disagree as to which factors can be used to predict suicidal behavior, but research on prison and jail suicides has identified several factors useful in predicting the suicidal behavior of inmates. Factors indicative of suicidal tendencies include: intoxication, emotional state, family history of suicide, recent losses significant to the inmate, incarceration history, strength of any support system outside of the prison, stressors, history of mental illness, and previous suicide attempts. Research has also indicated that at least two-thirds of suicide victims will communicate their suicidal thoughts prior to attempting suicide, so there is a chance an inmate may indicate on his self-reporting questionnaire any suicidal thoughts.

Ideally, the intake process will involve a self-reporting questionnaire and some one-on-one time between an inmate and a medical professional where the professional reviews the medical records of the new inmate and discusses responses on the questionnaire. Based on this meeting, the medical professional can determine at what interval the inmate should be screened for mental and other health needs. Currently, intake procedures at many facilities are far from ideal. In Michigan, four inmates reported being kept overnight in only underwear for refusing to answer a question about suicide during an intake interview. In California, the Coleman court found that California prisons “lacked all of the basic, essentially common sense, components of a minimally adequate prison mental health care delivery system,” which includes adequate screening of inmates.

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161 Belchner v. Oliver, 898 F.2d 32, 34 (1990) (“The general right of pretrial detainees to receive basic medical care does not place on jail officials the responsibility to screen every detainee for suicidal tendencies.”).
162 Hayes Guide, supra note 35 at 19 (“The key to identifying potentially suicidal behavior in prison inmates is through inquiry during intake screening/assessment…”).
163 Id.
164 Id.
165 Id.
Sometimes, California inmates are removed from the intake process and do not receive an intake screening or any medical care until weeks after arrival at the prison facility.\(^{169}\) Also, prisoners in California\(^{170}\) have a complete lack of privacy during intake screening, which according to a court expert “virtually ensures that an adequate exam will not be done.”\(^{171}\)

Practically speaking, due to the sheer volume of inmates entering a prison on a given day, one-on-one meetings with medical staff may not be possible during intake at an overcrowded facility. Since suicide in prisons typically occurs some time after initial incarceration,\(^{172}\) an acceptable time frame for the first screening for suicide may be allowable for low-risk inmates, as determined by health professionals. Once overcrowding in prisons has been reduced or eliminated, medical staff may have a realistic chance at screening inmates on the day of their entry into the prison facility.

2. Screening at Intervals

Screening inmates at regular intervals is critical because prison suicides most often occur once a prisoner has been incarcerated for some time.\(^{173}\) Prison mental health staff should screen individuals at intervals determined during their initial intake screening, and update the screening recommendation after each meeting with an inmate. In addition to screening at regular intervals, screening should be mandatory after certain life events because certain life stressors can increase propensity for suicidal behavior.\(^{174}\) If a prisoner is going through a divorce, had a death in the family, gets placed in or taken out of administrative segregation, is being threatened or victimized by other inmates, or has a negative status change of an appeal or other legal proceeding their personal risk for suicide will likely be elevated.\(^{175}\) In order for mental health staff to learn when a prisoner is experiencing a life stressor, the prison should encourage prisoners to ask for help and the prison should also reach out to family members and encourage them to report warning signs to prison officials. It would also be ideal for prison mental health staff to ask the family members of inmates if the inmate or any family member of the inmate has previously attempted or


\(^{170}\) *Id.* at 19 (“prisoners undergo an examination by a physician at which up to three prisoners are interviewed and examined simultaneously with no individual protection of the prisoner’s privacy”).

\(^{171}\) *Id.*


\(^{173}\) *Id.*

\(^{174}\) Hayes Guide, *supra* note 35 at 96-97 (Hayes lists several stress factors in Appendix D that can increase an inmate’s potential for suicide).

\(^{175}\) *Id.*
completed a suicide attempt since this is one factor that indicates whether or not a person has suicidal tendencies.\(^\text{176}\)

In overcrowded prisons, prison guards have so many prisoners to look after that it is impractical to rely solely on the observations of these guards. For this reason, screening at intervals in overcrowded prisons becomes vitally important. As prisoners succumb to the stressors of the overcrowded environment, mental health care becomes increasingly important. Currently, in California, the system is understaffed with medical personnel, and the medical personnel California prisons have on staff are often poorly trained.\(^\text{177}\) To make matters worse, the medical records system is in shambles, making adequate medical care practically impossible.\(^\text{178}\) Records are slow to arrive to the inmate’s new prison after a transfer, and in some cases missing altogether.\(^\text{179}\)

While California has been ordered to remedy these problems, California has insisted on fighting the court orders all the way to the United States Supreme Court, which is currently deciding whether or not California must comply with the court orders. California’s system will not improve by ignoring court orders, and even if California wins its Supreme Court case, the Eighth Amendment rights of prisoners will still be violated because of the lack of adequate medical and mental health care.

\section*{C. Supervision and Housing of Prisoners on Suicide Watch}

Monitoring of inmates should be based on the level of risk as determined by mental health professionals. Supervision of inmates should range from no mental health supervision needed, to meeting with a counselor at a set interval, to constant supervision. Additionally, because the majority of suicides occur in the late evening hours or on the weekends,\(^\text{180}\) ideally a suicide counselor should be on call twenty-four hours a day, seven days a week.

To every extent possible, inmates should not be housed in isolated or segregated settings.\(^\text{181}\) Most prison suicides occur in isolated or segregated settings to begin with,\(^\text{182}\) so placement of a suicidal prisoner in the general population, mental health unit, or infirmary is preferable to isolation.\(^\text{183}\) “Social and environmental isolation is never an appropriate consequence [of

\begin{thebibliography}{99}
\bibitem{176} Hayes Key Ingredients, \textit{supra} note 21 at 262.
\bibitem{177} \textit{Plata}, No. C01-1351 TEH at 5-10.
\bibitem{178} \textit{Id.} at 21.
\bibitem{179} \textit{Id.} at 20-21.
\bibitem{180} \textit{Id.}.
\bibitem{181} \textit{Id.} at 262-263.
\bibitem{182} World Health Organization, \textit{supra} note 55 at 10.
\bibitem{183} Hayes Key Ingredients, \textit{supra} note 21 at 263.
\end{thebibliography}
acts of self-harm or attempted suicide] as it undoubtedly worsens emotional state, hinders problem-solving and can increase the risk for life-threatening behavior.”\textsuperscript{184} Additionally, restraints should only be used in extreme circumstances, where the inmate cannot be prevented from harming himself any other way.\textsuperscript{185} Any use of restraints should be a measure of last resort, carefully monitored, and limited to a maximum time.\textsuperscript{186}

When a mental health professional determines that a prisoner is at risk for suicide, tear proof clothing and bedding should be provided. Most prisoners commit suicide by hanging themselves with clothing, sheets, or towels.\textsuperscript{187} Complete removal of inmates clothing should be forbidden.\textsuperscript{188} Courts have held that prisoners do not have to involuntarily expose their genitals to the opposite sex when not reasonably necessary,\textsuperscript{189} and being left naked in an observation cell for days can result in being seen by the opposite sex. This can be psychologically damaging to prisoners.\textsuperscript{190} Ideally, the inmate will also be housed in a cell with no place to hang from,\textsuperscript{191} but overcrowding in prisons limits the availability of appropriate cells. In addition, liquid medication should be administered instead of pills whenever possible to reduce the threat of pill hoarding and overdoses.\textsuperscript{192}

\textbf{D. Record-Keeping, Incident Reporting and Investigation}

Organized record keeping, incident reporting and investigative systems are critical so prison employees can learn from mistakes, prevent suicides from occurring in the future, and provide a meaningful way to measure the success of suicide prevention initiatives. One of the most common problems in the delivery of mental health services in prisons is record-keeping.\textsuperscript{193} Record keeping is essential to medical and mental health care of inmates because treatment is often handled by more than one individual and in order to ensure continuity of care, each professional must be aware of the patient’s history and ongoing issues and treatments.\textsuperscript{194} In an overcrowded

\textsuperscript{184} Raymond Bonner, \textit{supra} note 57 at 7-8.
\textsuperscript{185} Hayes Key Ingredients, \textit{supra} note 21 at 263.
\textsuperscript{186} World Health Organization, \textit{supra} note 55 at 10.
\textsuperscript{187} \textit{Id}.
\textsuperscript{188} Hayes Key Ingredients, \textit{supra} note 21 at 263.
\textsuperscript{190} Lee, 641 F.2d at 1119.
\textsuperscript{191} World Health Organization, \textit{supra} note 55 at 10.
\textsuperscript{192} Michael Puisis, Clinical Practice in Correctional Medicine 313 (Elsevier Health Sciences 2006).
\textsuperscript{193} Clarence J. Sundrum, Monitoring the Quality and Utilization of Mental Health Services in Correctional Institutions 7 U. D.C. L. Rev. 163, 166 (2003).
\textsuperscript{194} \textit{Id}. at 167
system, this can be difficult because of the sheer case load. For the same reason, organized record keeping is that much more important. In chronically overcrowded prisons in California, the record keeping system in most facilities is “either in shambles or nonexistent.”195 ‘Organization’ of files in some facilities consists of stacks of files one to eight feet high in no apparent order.196 This coupled with inadequate medical staffing is a recipe for disaster.197

If an inmate is successful in committing suicide, an investigation should immediately follow. Prison personnel should focus on recreating the events leading up to the suicide, identifying warning signs that were missed or improperly addressed, assessing the response of the medical staff, and amend prison policies and training as necessary to ensure the same mistake is not made again.198

E. Increased Incentives for Prison Personnel

Prison guards interact with inmates on a daily basis, and are often the ones who will notice suicidal behavior or to whom an inmate will communicate suicidal thoughts. Strategies for achieving employee cooperation include a “sanction-based command-and-control model” and a “self-regulatory approach” that hones in on the ethical motivations of employees.199 Both methods can be effective in motivating employees, but research has shown that the self-regulatory strategies are generally more influential.200

The command-and-control model focuses on the concerns and goals of employees; this model takes advantage of the idea that people follow rules because of the costs or benefits associated with following those rules.201 The idea is that if prison employees are told to abide by the policies and procedures of a suicide watch policy or they will face discipline, the employees will be more likely to become engaged in complying with those policies and procedures. Moreover, if prison employees are educated about the potential legal liability that acting negligently or showing deliberate indifference to a prisoner exhibiting suicidal behavior can bring, in theory they will be more likely to report suicidal behavior to mental health professionals rather than regarding such behavior as manipulative.

195 *Plata*, No. C01-1351 TEH at 20.
196 *Id.* at 20-21.
197 *Id.* at 5-10.
199 *Id.*
200 *Id.* at 1287-88.
201 *Id.* at 1289-90.
The self regulatory approach uses the ethical values of employees to motivate them to follow organizational policies and procedures.\textsuperscript{202} The values that are the most important with this approach are those that are related to and developed while on the job.\textsuperscript{203} This approach could be problematic in the sense that inmates do not have a reputation for treating prison guards well\textsuperscript{204} and vice versa.\textsuperscript{205} This is one reason that adequate training of prison guards is crucial to the success of prison suicide prevention policies. Educating prison guards about mental illness and suicide in addition to providing appropriate incentives is one formula for encouraging active participation in suicide prevention activities.

Communication is another key factor in motivating employees to comply with rules.\textsuperscript{206} Communication about organizational rules, plans, goals, and the reasons for these rules, plans, and goals should be frequent.\textsuperscript{207} Additionally, something as simple as a sign posted in the break room or entrance to the prison that says “XX days since last suicide” would not only be a constant reminder to prison employees that a major goal of the prison is to prevent suicides, but would also give employees a sense of accomplishment as the number of days ticks upward. Offering rewards to prison employees if the sign reaches 30 days, 60 days, 90 days, etc. is one way to motivate prison employees to pay attention to warning signs, keep a closer eye on inmates on suicide watch, and take immediate action if a suicide attempt occurs.

Perhaps the most important way to motivate prison officials and employees to take inmate suicide prevention seriously is to provide families of suicide victims with a realistic remedy to sue prison employees who fail to prevent suicide. Section 1983 civil rights claims were once the most effective vehicle for instituting positive changes in the United States corrections system.\textsuperscript{208} Section 1983 prison suicide cases have become nearly impossible to win which has snuffed out most of the power of such a claim.\textsuperscript{209} Tort claims could have the potential to incite reform, but

\begin{itemize}
\item \textsuperscript{202} \textit{Id.} at 1290.
\item \textsuperscript{203} \textit{Id.}
\item \textsuperscript{204} William N. Elliot, Power and Control Tactics Employed by Prison Inmates – A Case Study 70 Fed. Probation 45 (2006) (“many correctional employees have been victimized by [the predation of inmates].”).
\item \textsuperscript{205} Andrea Jacobs, Prison Power Corrupts Absolutely: Exploring the Phenomenon of Prison Guard Brutality and the Need to Develop a System of Accountability 41 Cal. W. L. Rev. 277 (2004) (“inmate abuse is a common problem in prisons and jails across the country.”).
\item \textsuperscript{206} Leslie I. Messman, Motivating Employees in the Legal Workplace 23 Colo. Law. 1261, 1263 (1994).
\item \textsuperscript{207} \textit{Id.}
\item \textsuperscript{208} Collins, \textit{supra} note 36 at 61.
\item \textsuperscript{209} Scarafile, \textit{supra} note 124 at 1136.
\end{itemize}
practically speaking it is not as likely.\textsuperscript{210} Many tort suits are blocked because of qualified immunity,\textsuperscript{211} and in cases where a tort claim can be brought, courts cannot enter injunctions mandating improvements to suicide policies and procedures.\textsuperscript{212} While qualified immunity has the important benefit of “limiting social costs of civil rights claims against public officials,”\textsuperscript{213} it is arguable that preventing suicide has a greater social benefit. If limiting immunity in tort claims involving prisoner suicide helps to prevent unnecessary death, immunity should be limited.

In order to permit courts to once again become a vehicle for reform in the area of prison suicide, I propose that changes to the section 1983 standard of liability should be made so that a correctional facility’s failure to train employees on suicide policies and procedures no longer results in escaping liability. If a prison fails to train personnel on effective suicide prevention policies and procedures, the institution should be liable to the families of inmates who commit suicide. If a prison provides adequate training to its employees, but an employee fails to follow the procedures, the employee should be held responsible. Providing families of suicide victims with a remedy will give prisons an incentive to better protect inmates from suicide.

CONCLUSION

While overcrowding poses a substantial obstacle to effective suicide prevention in United States prisons, measures can still be taken to reduce the number of suicide victims in prisons. In order to achieve this goal, prisons need to implement comprehensive and written suicide prevention policies and procedures designed to train guards, gather relevant information from prisoners, handle suicidal behavior in a way that will help inmates through their crises, supervise and house inmates according to levels of risk and mental health needs, investigate and report successful suicides, and provide incentives for prison employees to comply with such policies and procedures. The legal system needs to once again empower courts to both provide a remedy for grieving families and to be a vehicle of reform for positive change in the area of prison suicide. The overcrowding crisis many prison systems in the United States are dealing with will complicate suicide prevention initiatives because of the additional stressors

\textsuperscript{210} Collins, \textit{supra} note 36 at 61.
\textsuperscript{211} \textit{Id.} at 84.
\textsuperscript{212} \textit{Id.} at 62.
placed on prisoners and the additional strain placed on the administrative functions of the prison, but it is nonetheless possible to reduce prison suicide rates in the face of overcrowding.

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