Boston College Law Review

Volume 59 | Issue 4 Article 6

4-26-2018

Correcting Correctional Suicide: Qualified Immunity and the Hurdles to Comprehensive Inmate Suicide Prevention

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CORRECTING CORRECTIONAL SUICIDE: QUALIFIED IMMUNITY AND THE HURDLES TO COMPREHENSIVE INMATE SUICIDE PREVENTION

Abstract: Suicide is the leading cause of death in U.S. jails, and the second leading cause of death in U.S. prisons. Suicidal behavior among inmates largely stems from the custodial environment and inmates' difficulties coping with incarceration. Unfortunately, many correctional facilities lack the comprehensive suicide prevention policies necessary to reduce inmate suicides. Under the qualified immunity doctrine, current law also shields correctional authorities from liability for failure to implement adequate suicide prevention programs in their facilities. As a result, corrections officials lack incentive to enhance their efforts toward reducing inmate suicides, and families of inmate suicide victims have limited opportunities to seek justice. This Note argues that in order to reduce inmate suicides and ensure the safety and health of incarcerated individuals, the federal government should condition funding to state and local correctional facilities on their implementation of reasonable and effective suicide prevention protocols.

INTRODUCTION

Christopher Barkes lived in Wilmington, Delaware and worked at the Pepsi Bottling Company.[1] He and his wife, Karen, had two daughters: Alexandra and Brittany.[2] Barkes's life took a turn in 1997, when he killed two individuals in a drunk driving accident.[3] He pled guilty to two counts of second-degree vehicular homicide, and was sentenced to two years in prison followed by an extended period of probation.[4] The accident deeply affected Barkes, who subsequently suffered from overdoses, alcoholism, post-traumatic stress disorder, and bipolar disorder.[5] He also attempted suicide four times: once in 1997, in 2003, and twice in September of 2004.[6]

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[1] *Christopher J. Barkes Obituary*, DEL. ONLINE (Nov. 17, 2004), http://www.legacy.com/obituaries/delawareonline/obituary.aspx?page=lifestory&pid=146151850 [https://perma.cc/ZUC2-RR3H].

[2] *See* Barkes v. First Corr. Med., Inc. (*Barkes II*), 766 F.3d 307, 310 (3d. Cir. 2014), *rev'd*, 135 S. Ct. 2042 (2015).

[3] *See* Complaint at 3, *Barkes II*, 766 F.3d 307 (No. 12-3074).

[4] *Id.*

[5] *Barkes II*, 766 F.3d at 310–11; Complaint, *supra* note 3, at 3.

[6] *Barkes II*, 766 F.3d at 310–11.

On November 13, 2004, law enforcement officials arrested Barkes for violating his probation sentence for a domestic abuse incident.[7] Upon arrest, officials took him to the Howard R. Young Correctional Institution ("HRYCI") in Wilmington, Delaware, where a contract nurse gave him a medical evaluation at intake.[8] Barkes told the nurse that he had a history of psychiatric treatment and that he was on medications for bipolar disorder and depression.[9] He also disclosed his attempted suicide in 2003, but indicated that he was not currently thinking about killing himself.[10] Based on those responses, the nurse gave Barkes a routine referral to mental health services but did not initiate any special suicide prevention measures.[11] Correctional staff then placed Barkes alone in a cell in the booking and receiving area of HRYCI.[12]

Later that day, Barkes called his wife and told her that he "[couldn't] live [that] way anymore," and that he was going to kill himself.[13] His wife did not inform the Delaware Department of Correction of the conversation, thinking that her husband would be safe in the facility, given that state officials and his probation officer knew about his prior suicide attempts.[14] The next morning, correctional staff found Barkes dead, hanging by a sheet from a steel partition in the ceiling of his cell.[15]

In February of 2006, Barkes's wife and two daughters filed a complaint on behalf of Barkes against Stanley Taylor, then-Delaware Commissioner of Correction, and Raphael Williams, then-Warden of HRYCI.[16] Their claim was based on 42 U.S.C. § 1983, commonly known as Section 1983, which allows an individual to sue government officials for depriving him or her of a constitutional right, privilege, or immunity, and to seek damages or other relief.[17] The com-

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[7] *Id.* Barkes had violated his probation by loitering. Complaint, *supra* note 3, at 4.

[8] *Barkes II*, 766 F.3d at 311. The contract nurse was employed by First Correctional Medical, a private contractor hired to provide medical services at the HRYCI. *Id.*

[9] *Id.* at 314; Taylor v. Barkes (*Barkes III*), 135 S. Ct. 2042, 2043 (2015); Brief for Respondents in Opposition at 4, *Barkes III*, 135 S. Ct. 2042 (No. 14-939).

[10] *Barkes III*, 125 S. Ct. at 2043. Barkes did not disclose his suicide attempts in 1997 or 2004. *Id.*

[11] *Id.* An example of a suicide prevention measure used at the HRYCI is placement on Psychiatric Close Observation, Level II, which entails giving inmates suicide gowns (smocks made of heavy material that is difficult to tear) and requiring staff to check on the inmates every fifteen minutes. *Barkes II*, 766 F.3d at 311–12; Lindsay M. Hayes, *Suicide Prevention in Correctional Facilities: Reflections and Next Steps*, 36 INT'L J. L. & PSYCHIATRY 188, 189 (2013) (explaining what a safety smock is).

[12] *Barkes II*, 766 F.3d at 311.

[13] *Id.*

[14] *Id.*; Brief for Respondents in Opposition, *supra* note 9, at 6.

[15] *Barkes II*, 766 F.3d at 312.

[16] *Id.* at 310, 314.

[17] 42 U.S.C. § 1983 (2012); *Barkes III*, 125 S. Ct. at 2043; *see* Michael C. Dorf, *Supreme Court Jail Suicide Case Illustrates the Breadth of Qualified Immunity*, VERDICT (June 3, 2015), https://verdict.justia.com/2015/06/03/supreme-court-jail-suicide-case-illustrates-the-breadth-of-qualified-immunity [https://perma.cc/L8TF-457E] (explaining the language of 42 U.S.C. § 1983 and referring to the statute as "Section 1983"). The first sentence of 42 U.S.C. § 1983 states: "Every person who,

plaint alleged that Taylor and Williams violated Barkes's Eighth Amendment right against cruel and unusual punishment by their deliberate indifference to Barkes's serious medical needs, including failure to supervise and monitor First Correction Medical ("FCM"), the private contractor providing medical treatment at the HRYCI.[18] The plaintiffs specifically pointed to evidence that the contract nurse was a licensed practical nurse, rather than a qualified mental health professional, and argued that she was less qualified to evaluate inmates for mental health issues, such as suicide risk.[19] They also contended that FCM's suicide prevention screening practices relied on outdated guidelines by the National Commission on Correctional Healthcare, that FCM lacked access to Barkes's probation records containing information about his history of mental health problems, and that FCM was intentionally understaffing HRYCI in order to increase profits.[20]

Taylor and Williams moved for summary judgment, arguing that as government officials they were entitled to qualified immunity, and therefore were not liable for Barkes's death.[21] The United States District Court for the District of Delaware denied the motion, and the United States Court of Appeals for the Third Circuit affirmed.[22] The Third Circuit held that Taylor and Williams were

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under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable." 42 U.S.C. § 1983. The plaintiffs also filed state claims for wrongful death and survival actions. Complaint, *supra* note 3, at 8–9.

[18] U.S. CONST. amend. VIII ("Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."); *Barkes III*, 135 S. Ct. at 2043.

[19] *Barkes II*, 766 F.3d at 330. Qualified mental health professionals includes psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who are legally authorized to evaluate and treat patients with mental health needs because of their education, credentials, and experience. Hayes, *supra* note 11, at 191.

[20] *Barkes II*, 766 F.3d at 330–31.

[21] *Barkes III*, 135 S. Ct. at 2043. Government officials are not held liable for their actions unless those actions violate a right that is "clearly established" in the law at the time of the conduct. Reichle v. Howards, 566 U.S. 658, 664 (2012).

[22] *Barkes III*, 135 S. Ct. at 2042–43. The Barkes family filed its complaint against Taylor and Williams on February 16, 2006, in the United States District Court for the District of Delaware, and summary judgment was granted to Taylor and Williams. *Barkes II*, 766 F.3d at 314. The Barkeses filed an appeal, which was dismissed by a stipulation of both parties on July 9, 2008. *Id.* While that appeal was pending, the district court conducted a hearing on the Barkes family's motion for default judgment. *Id.* at 315. The court ruled in favor of the Barkeses at that hearing, and the family filed a first amended complaint on June 13, 2008. *Id.* Taylor and Williams moved to strike the amended complaint, arguing that the claims asserted had already been dismissed previously on summary judgment. *Id.* Although the district court granted the motion to strike, it also allowed the Barkes family to file a second amended complaint as long as it did not repeat the claims from the previous complaint. *Id.* The Barkeses filed a second amended complaint on April 9, 2009, which was dismissed, and then a

not entitled to qualified immunity because Barkes had suffered a deprivation of his constitutional right under the Eighth Amendment to proper implementation of adequate suicide prevention protocols, and this right was clearly established at the time of the alleged misconduct.[23] Taylor and Williams then petitioned for certiorari.[24]

In 2015, the United States Supreme Court reversed the Third Circuit's decision, holding that the qualified immunity doctrine protected the commissioner and warden from the Barkes family's claim.[25] Rather than request an oral argument to consider whether any constitutional rights were violated in Barkes's case, or to clarify the scope for supervisory liability and the standard for qualified immunity, the Court simply filed a short, per curiam opinion dismissing the claim.[26] The Court reasoned that there was no violation of clearly established law because none of its prior decisions established a right to proper implementation of adequate suicide prevention protocols, or even discussed suicide screening or prevention protocols.[27] Therefore, the Court concluded that the officials were entitled to qualified immunity.[28]

The Supreme Court's ruling in *Taylor v. Barkes* leaves inmates with no guarantee to suicide prevention measures.[29] Suicide has caused the majority of

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third amended complaint on April 22, 2010, in which they included an Eighth Amendment claim. *Id.* Taylor and Williams filed a motion to dismiss the third amended complaint on May 6, 2010, which was denied. *Id.* Both parties then filed cross-motions for summary judgment, at which point Taylor and Williams invoked qualified immunity for the first time. *Id.* The district court denied both motions for summary judgment, and the Barkeses filed an appeal with the Court of Appeals for the Third Circuit. *Id.* The Court of Appeals reviewed the case pursuant to the collateral order doctrine, which allows the review of orders denying qualified immunity at summary judgment when the denial turns on questions of law. *Id.* at 315–16.

[23] *Barkes II*, 766 F.3d at 327–28.

[24] *Barkes III*, 135 S. Ct. at 2044.

[25] *Id.* at 2045.

[26] *Id.* at 2043–44; *see* Lisa Soronen, *Prison Officials Get Qualified Immunity in Inmate Suicide*, NAT'L CONF. ST. LEGISLATURES BLOG (June 5, 2015), http://www.ncsl.org/blog/2015/06/05/prison-officials-get-qualified-immunity-in-inmate-suicide.aspx [https://perma.cc/72CE-KHJV] (discussing the Supreme Court's refusal to hear oral argument in Barkes's case). A per curiam opinion is an unsigned opinion written on behalf of the entire court. *Glossary of Legal Terms*, SCOTUSBLOG (Mar. 10, 2018), http://www.scotusblog.com/reference/educational-resources/glossary-of-legal-terms/ [https://perma.cc/NSB8-VPR8]. Supervisory liability refers to the personal liability of a government official whose subordinate acts in violation of an individual's constitutional rights. *See Barkes II*, 766 F.3d at 316. Supervisory liability may attach if the subordinate "established and maintained a policy, practice or custom which directly caused [the] constitutional harm" or if the supervisor "participated in violating the plaintiff's rights, directed others to violate them, or, as the person in charge, had knowledge of and acquiesced" in the unconstitutional act. *Id.* (alteration in original) (quoting A.M. *ex rel.* J.M.K. v. Luzerne Cty. Juvenile Det. Ctr., 372 F.3d 572, 586 (3d Cir. 2004)). Claims regarding a supervisor's failure to do something—such as train, discipline, or supervise—fall into the subcategory of policy or practice liability. *Id.* The Court declined to rule on the issue of supervisory liability and only reversed on qualified immunity. *See Barkes III*, 135 S. Ct. at 2043.

[27] *Barkes III*, 135 S. Ct. at 2044.

[28] *Id.* at 2045.

[29] *See* Dorf, *supra* note 17.

deaths in local jails in America each year between 2000 and 2014.[30] The number of suicides in local jails rose 13% between 2013 and 2014, from 328 suicides to 372.[31] In 2014, the suicide rate in local jails was fifty per 100,000 inmates, which has been the highest suicide rate among local jails since 2000.[32] In 2014, 7% of all deaths in state prisons were the result of suicides—the largest percentage of deaths in state prisons due to suicide since 2001.[33] In 2006, the suicide rate in detention facilities—where individuals are detained for more than forty-eight hours, but less than two years—was thirty-six deaths per every 100,000 inmates, which is approximately three times greater than that in the general non-incarcerated population.[34] The slow progress in inmate suicide prevention is attributable to a lack of comprehensive suicide prevention policies in correctional

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[30] *See* BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, MORTALITY IN LOCAL JAILS, 2000–2014—STATISTICAL TABLES 5 (2016), https://www.bjs.gov/content/pub/pdf/mlj0014st.pdf [https://perma.cc/BQ3R-6B2B] (showing that suicide was the leading cause of death in local jails between 2000–2014, when considering all the illnesses as separate causes of death); BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, MORTALITY IN LOCAL JAILS AND STATE PRISONS, 2000–2013—STATISTICAL TABLES 1 (2015), https://www.bjs.gov/content/pub/pdf/mljsp0013st.pdf [https://perma.cc/A3FA-WHHW] (stating that since 2000, suicide has been the leading cause of death in local jails each year). In response to the suicide of a former inmate in Texas, Sandra Bland, the Huffington Post gathered data from news reports, press releases, official records, and phone calls to compile an unofficial database of inmate deaths in jails and police lockups between July 13, 2015, and July 13, 2016. *Since Sandra*, HUFFINGTON POST (July 20, 2016), http://data.huffingtonpost.com/2016/jail-deaths [https://perma.cc/X4MX-QX4G]. According to the database, there were 256 inmate suicides in jails and police lockups across all fifty states between July 13, 2015 and July 13, 2016. *Id.* (to retrieve the data on suicide, scroll down to "Jail Deaths Database," find the dropdown list titled "Cause of death," and select "Suicide/Apparent Suicide"). The Huffington Post states that the numbers in the database are likely lower than the actual numbers, because many states do not collect data on inmate mortality, some agencies did not respond to requests for information, and deaths in smaller jails are not always made public. *Id.* Suicide is more prevalent in local jails than in state prisons, where various types of illness are the leading causes of death, and suicide is the next leading cause of death. *See* MORTALITY IN LOCAL JAILS AND STATE PRISONS, 2000–2013, *supra*, at 1, 20 (stating that suicide has been the leading cause of death in local jails since 2000, and showing that in state prisons, the number of deaths due to various illnesses caused the majority of deaths but that suicide was still the next leading cause of death after some of these illnesses). The rate of suicide in state prisons, however, still remains greater than that in the general non-incarcerated population. NAT'L INST. OF CORR., U.S. DEP'T OF JUSTICE, NATIONAL STUDY OF JAIL SUICIDE: 20 YEARS LATER 2 (2010), https://s3.amazonaws.com/static.nicic.gov/Library/024308.pdf [https://perma.cc/X9LL-WX76]. Some reasons for the higher rate of suicide in local jails are the initial shock of confinement, the fact that jails have less information on inmates upon arrival, and because prison policies are under greater scrutiny by accreditors. Maurice Chammah & Tom Meagher, *Why Jails Have More Suicides Than Prisons*, MARSHALL PROJECT (Aug. 4, 2015), https://www.themarshallproject.org/2015/08/04/why-jails-have-more-suicides-than-prisons#.IZUCfRuiE [https://perma.cc/A23Y-N9AE].

[31] MORTALITY IN LOCAL JAILS, 2000–2014, *supra* note 30, at 1.

[32] *Id.* at 2.

[33] BUREAU OF JUSTICE STATISTICS U.S. DEP'T OF JUSTICE, MORTALITY IN STATE PRISONS, 2001–2014—STATISTICAL TABLES 1 (2016), https://www.bjs.gov/content/pub/pdf/msp0114st.pdf [https://perma.cc/G7FT-HWJZ].

[34] NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at 2, 45.

facilities across the United States.[35] Such policies should be legally required in all correctional facilities in order to reduce the rate of suicide in jails and prisons across the country.[36]

Because the Supreme Court in *Taylor v. Barkes* declined to recognize that an inmate's right to effective suicide prevention measures is clearly established, officials at correctional facilities are protected from liability by qualified immunity even if their suicide prevention measures are flawed.[37] This immunity exists even if the defective suicide prevention protocols are directly linked to an increase in inmate suicide at their correctional facilities.[38] Correctional officials at a facility that has no suicide prevention protocols may still avoid liability for inmate suicide deaths under the doctrine of qualified immunity.[39] The *Barkes* holding has left families of inmate suicide victims with few avenues for retribution.[40]

This Note examines the status of the law regarding correctional liability for defective suicide prevention protocols, and the importance of ensuring the implementation of comprehensive suicide prevention policies in order to reduce inmate suicide.[41] Part I discusses the qualified immunity doctrine, and how it has shielded correctional officers from liability in inmate suicide cases.[42] Part II explains the necessary components of an effective suicide prevention strategy, the current state of suicide prevention programming in jails, and the reasons why inadequate programming has led to an increase in inmate suicide.[43] Finally, to provide greater protection to inmates at risk of suicide, Part III recommends that the federal government condition correctional funding for state and local governments on their implementation of reasonable and effective suicide prevention programs in their correctional facilities.[44]

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[35] *See generally* Hayes, *supra* note 11 (describing the antiquated views of correctional leaders regarding what it takes to prevent inmate suicides and recommending guidelines for improvement).

[36] *See generally id.* (same); Annette Hanson, *Correctional Suicide: Has Progress Ended?*, 38 J. AM. ACAD. PSYCHIATRY & L. ONLINE 6, 6 (2010), http://jaapl.org/content/jaapl/38/1/6.full.pdf [https://perma.cc/ZC8Y-2HB3] (suggesting that progress in preventing inmate suicides is declining and that current correctional suicide prevention measures should be updated and improved).

[37] Dorf, *supra* note 17.

[38] *See id.* (discussing the Supreme Court's decision in *Taylor v. Barkes* to extend immunity to the jail officials, despite the possibility that the jail's suicide prevention measures were defective and therefore led to the failure to prevent Barkes's death).

[39] *Id.*

[40] *See id.* (noting that the Supreme Court's dismissal of Section 1983 actions on qualified immunity grounds prevents any meaningful analysis of whether a plaintiff's constitutional rights were actually violated, thereby creating a barrier for future plaintiffs). *See generally Barkes III*, 135 S. Ct. 2042 (finding that Taylor and Williams were entitled to qualified immunity, without discussing whether Barkes's constitutional rights were violated).

[41] *See infra* notes 45–261 and accompanying text.

[42] *See infra* notes 45–101 and accompanying text.

[43] *See infra* notes 102–194 and accompanying text.

[44] *See infra* notes 195–261 and accompanying text.

I. CORRECTIONAL LIABILITY FOR DEFECTIVE SUICIDE PREVENTION PROTOCOLS

Inmate suicide is largely attributable to the lack of comprehensive suicide prevention protocols in jails and prisons.[45] Unfortunately, because of the current law's treatment of government officials, families of inmate suicide victims have limited means for retribution, and correctional facilities have little incentive to pursue change.[46] Government officials in inmate suicide cases—namely, correctional leaders and officers—are protected under the doctrine of qualified immunity, which shields them from liability so long as their actions did not violate an inmate's constitutional right that was clearly established at the time of the alleged improper conduct.[47] Section A discusses the origins of the qualified immunity doctrine and the development of the "clearly established" standard.[48] Section B examines how the qualified immunity doctrine has been applied to correctional suicide cases.[49]

A. Qualified Immunity and the "Clearly Established" Standard

The qualified immunity doctrine—a doctrine established by common law—allows government officials, including correctional officers, to avoid civil damages liability as long the conduct in question did not violate a statutory or constitutional right that was clearly established at the time of the incident.[50] The doctrine of qualified immunity balances the need to hold public officials accountable for abuses of power, and the government's interest in protecting officials from harassment, distraction, and liability when they perform their duties in a reasonable manner.[51] Qualified immunity also ensures that officials are on notice of what actions could be considered as unlawful conduct within their duties.[52] A variety of both state and federal government officials

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[45] *See* Hayes, *supra* note 11, at 188 (describing the antiquated views of correctional leaders regarding what it takes to prevent inmate suicides and recommending guidelines for improvement).

[46] *See* Dorf, *supra* note 17 (describing how the qualified immunity doctrine shields corrections officials from liability even when their facilities do not take adequate inmate suicide prevention measures).

[47] *See Reichle*, 566 U.S. at 664 (defining qualified immunity); Soronen, *supra* note 26 (explaining that the corrections officials in *Taylor v. Barkes* received qualified immunity).

[48] *See infra* notes 50–81 and accompanying text.

[49] *See infra* notes 82–101 and accompanying text.

[50] *See Reichle*, 566 U.S. at 664 (defining qualified immunity); Dorf, *supra* note 17 (explaining that the qualified immunity doctrine is one of several limitations placed by the Supreme Court on 42 U.S.C. § 1983 actions). Although government officials use qualified immunity as a defense in actions stemming from 42 U.S.C. § 1983, the qualified immunity doctrine is not explicitly mentioned in the text of the statute; rather, the doctrine has been developed by the Supreme Court. *See* Dorf, *supra* note 17 (same).

[51] Pearson v. Callahan, 555 U.S. 223, 231 (2009).

[52] *Id.* at 244 (quoting Hope v. Pelzer, 536 U.S. 730, 739 (2002)).

enjoy qualified immunity, including prison guards, school officials, health care providers, welfare administrators, and government employers.[53]

One of the first qualified immunity cases before the United States Supreme Court was *Pierson v. Ray*, which involved an action based on 42 U.S.C. § 1983 against police officers who had arrested several individuals for violating a Mississippi statute that was later declared unconstitutional.[54] The Supreme Court held that although common law did not give police officers complete immunity from liability, existing case law did shield an officer from liability when he or she acted according to a statute that at the time, he or she reasonably believed was valid, but that was later found to be unconstitutional.[55]

Following *Pierson*, two cases—*Scheuer v. Rhodes* and *Wood v. Strickland*—contributed significantly to the development of the law of qualified immunity.[56] In these cases, the Supreme Court developed the concept of immunity for public officials and clarified its scope.[57] In *Scheuer*, the Court rejected the idea of giving government officials absolute immunity, and instead defined a standard of qualified immunity involving both objective and subjective components.[58] The Court held that objectively, there must be reasonable grounds

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[53] John C. Jeffries, Jr., *What's Wrong with Qualified Immunity?*, 62 FLA. L. REV. 851, 851 (2010).

[54] Pierson v. Ray, 386 U.S. 547, 549–50 (1967); Chaim Saiman, *Interpreting Immunity*, 7 U. PA. J. CONST. L. 1155, 1159 (2005) (explaining that *Pierson* was the first qualified immunity case before the Supreme Court). The police officers had arrested several white and African American clergymen who attempted to use segregated facilities at a bus terminal in Jackson, Mississippi, under a Mississippi statute that prohibited individuals from congregating in a public place and refusing to leave when ordered by law enforcement. *Pierson*, 386 U.S. at 548–49.

[55] *Pierson*, 386 U.S. at 555.

[56] Wood v. Strickland, 420 U.S. 308, 309–10 (1975) (involving a lawsuit by public school students against their school administrators who suspended them); Scheuer v. Rhodes, 416 U.S. 232, 234, 235 (1974) (analyzing whether Ohio's governor was accountable for his misuse of the National Guard); John C. Williams, *Qualifying Qualified Immunity*, 65 VAND. L. REV. 1295, 1299 (2012) (explaining that the origins of the qualified immunity doctrine were in *Wood* and *Scheuer*). In *Scheuer*, the representatives of the estates of three deceased students, who had been attending Kent State University, sued the governor of Ohio, members of the National Guard, and the president of Kent State University for intentionally and recklessly deploying the National Guard on the Kent State University campus, resulting in the students' deaths. *Scheuer*, 416 U.S. at 234, 235. In *Wood*, the school administrators had expelled the two high school students for violating a school regulation that prohibited the use or possession of alcohol at school or school activities. *Wood*, 420 U.S. at 310.

[57] *See Wood*, 420 U.S. at 322 (holding that a school board member is not protected from liability if he knew or reasonably should have known that his actions, taken as part of his official duties, would violate a student's constitutional rights, or if he maliciously intended to violate a student's constitutional rights through his actions); *Scheuer*, 416 U.S. at 247–48 (holding that qualified immunity is available to government officials in the executive branch, subject to variation depending on the scope of their discretion and responsibilities, and that officials must have a reasonable belief and good faith basis for their actions in order to invoke immunity).

[58] *See Scheuer*, 416 U.S. at 243, 247–48 (finding that qualified immunity does not provide government officers with absolute immunity in lawsuits based on 42 U.S.C. § 1983, and that in order for qualified immunity to apply, officers must have both a reasonable belief and good faith basis for the conduct in question); Williams, *supra* note 56, at 1300–01 (noting that the Court in *Scheuer* rejected

for the accused officer's belief that the conduct was lawful at the time of the act, and considering all of the circumstances surrounding the instance; from a subjective standpoint, the officer must have also acted in good faith with the law on the books at the time of the incident.[59] In order to satisfy the threshold requirement for qualified immunity, the Court ruled that an officer must meet both the objective and subjective aspects of the inquiry.[60] The Court also held that qualified immunity is available to officers in the executive branch of government, but that the scope of immunity would vary depending on the officer's responsibilities and ability to exercise discretion.[61]

In *Wood*, the Court reiterated that a court must consider both the objective and subjective elements discussed above when determining whether qualified immunity is available to a government official.[62] Unlike in *Scheuer*, however, where the objective aspect of the inquiry focused on the reasonable belief of the officer at the time of the incident, the Court in *Wood* narrowed the focus of the objective inquiry to the government officials' knowledge of the law.[63] Therefore, under *Scheuer* and *Wood*, government officials in the executive branch were protected by qualified immunity if they satisfied both the objective and subjective aspects of the inquiry—that is, if the official in question reasonably lacked knowledge that his or her conduct would violate a constitutional right, and acted in good faith on that knowledge.[64]

Seven years later, in *Harlow v. Fitzgerald*, the Supreme Court considered the type of immunity that should be available to senior aides and advisers to the President.[65] In deciding this issue, the Court eliminated the subjective element of the qualified immunity test, in favor of a purely objective test similar to the one set forth in *Wood*.[66] The Court held that in general, government offi-

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the idea of absolute immunity and found that in order for the qualified immunity defense to be successful, both objective and subjective factors must be present).

[59] *See Scheuer*, 416 U.S. at 247–48 (holding that in order for qualified immunity to apply, officers must have both a reasonable belief and good faith basis for the conduct in question); Williams, *supra* note 56, at 1300–301 (explaining that in *Scheuer*, the Court's qualified immunity analysis involved both objective and subjective factors).

[60] *See Scheuer*, 416 U.S. at 247–48 (same); Williams, *supra* note 56, at 1300–01 (same).

[61] *Scheuer*, 416 U.S. at 247.

[62] *Wood*, 420 U.S. at 321.

[63] *See id.* at 322 (holding that in the context of school discipline, a school board member may be liable for an action if he knew, or reasonably should have known, that the action would violate the constitutional rights of the student affected, or if he acted with the intent to deprive students of their rights); *Scheuer*, 416 U.S. at 247 (holding that in order for qualified immunity to apply, officers must have both a reasonable belief and good faith basis for the conduct in question); Williams, *supra* note 56, at 1301 (noting the distinction between *Wood* and *Scheuer*).

[64] *Wood*, 420 U.S. at 322; *Scheuer*, 416 U.S. at 247–48.

[65] Harlow v. Fitzgerald, 457 U.S. 800, 802 (1982).

[66] *See id.* at 818 (holding that government officers performing discretionary duties are generally not liable for actions that do not violate clearly established statutory or constitutional rights that a reasonable person would have known); *Wood*, 420 U.S. at 322 (holding that in the context of school

cials with responsibilities requiring discretion are free from liability, as long as they do not "violate clearly established statutory or constitutional rights of which a reasonable person would have known."[67] *Harlow* made it more difficult for plaintiffs to bring allegations of constitutional violations to trial, because conducting an objective analysis of the state of the law made it easier for a court to dismiss a claim at summary judgment; as such, *Harlow* limited the opportunity for plaintiffs to argue the intent of the accused government official within open court.[68] The new test was also problematic because of the difficulty of defining the nature of a "clearly established" right under the law.[69] As Justice Powell mentioned in his dissent in *Wood*, it is dangerous to expect all government officials to know whether a right is clear or settled, as even courts disagree and change positions over time.[70]

The Supreme Court clarified what satisfies a "clearly established" right in the 1987 case *Anderson v. Creighton*.[71] In his opinion for the majority, Justice Antonin Scalia explained that for a right to be "clearly established," it must be particularized, and not overly general or abstract.[72] According to Justice Scalia, "the contours of the right must be sufficiently clear," putting a reasonable official on notice that his or her conduct violates that right.[73] Justice Scalia also added that although the "clearly established" standard does not require a plaintiff to demonstrate that the accused official's specific act was unlawful at the

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discipline, a school board member may be liable for an action if he knew, or reasonably should have known, that the action would violate the constitutional rights of the student affected, or if he acted with the intent to deprive students of their rights); Williams, *supra* note 56, at 1302 (noting the similarity between the objective tests in *Harlow* and *Wood*).

[67] *Harlow*, 457 U.S. at 818. The court reasoned that relying on the objective reasonableness of an official's conduct based on clearly established law would "avoid excessive disruption of government and permit the resolution of many insubstantial claims on summary judgment." *Id.*

[68] *See* Williams, *supra* note 56, at 1303 (arguing that *Harlow* restricted plaintiffs from bringing allegations of constitutional violations to trial).

[69] *See Harlow*, 457 U.S. at 818 (explaining the "clearly established" standard); *Wood*, 420 U.S. at 329 (Powell, J., concurring in part and dissenting in part) ("One need only look to the decisions of this Court—to our reversals, our recognition of evolving concepts, and our five-to-four splits—to recognize the hazard of even informed prophecy as to what are 'unquestioned constitutional rights.'").

[70] *Wood*, 420 U.S. at 329.

[71] *See* Anderson v. Creighton, 483 U.S. 635, 637, 641 (1987) (analyzing federal law enforcement officers' warrantless search of a home, which they claimed was justified on the grounds of "exigent circumstances"). An exigent circumstance, sometimes also referred to as an "urgent need," arises when law enforcement officers face a need requiring them to obtain a warrant without delay. Dorman v. United States, 435 F.2d 385, 392 (D.C. Cir. 1970). Some factors to be considered when determining whether an exigent circumstance existed are the seriousness of the offense, whether the suspect was armed, and the likelihood of the suspect escaping if not promptly apprehended. *Id.* at 392–93.

[72] *Anderson*, 483 U.S. at 640.

[73] *Id.* Applying these principles to the case, the majority held that qualified immunity was available to the officers for their warrantless search of a third party's home in search of fugitives. *Id.* at 646. The majority explained that in light of clearly established law, the officers could have reasonably believed that there was an exigent circumstance and that their warrantless search of the home was proper. *Id.* at 641.

time it was carried out, it does mean that the unlawfulness of the action must have been "apparent," in view of prior case law.[74] Because of *Anderson*, qualified immunity is available to government officials unless their conduct violates an established constitutional right, *and* at the time of the act, they reasonably knew that existing case law prohibited their specific conduct.[75]

Although the *Anderson* decision currently provides courts with a definition of "clearly established," this definition is blurry.[76] How factually similar does a prior case need to be in order for a plaintiff to be able to use it to argue that a clearly established right exists?[77] This blurriness also enables defendants to avoid liability by taking advantage of minor ambiguities in case law.[78]

Qualified immunity, as defined by the case law discussed above, is available to government officials in the executive branch so long as the official in question did not knowingly violate a clearly established constitutional right by his or her conduct.[79] Whether or not a right is clearly established depends on a court's view of the clarity of existing case law, including whether there is consensus among the Courts of Appeals.[80] Correctional officers have also benefit-

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[74] *Id.*

[75] *Id.*

[76] Charles R. Wilson, *"Location, Location, Location": Recent Developments in the Qualified Immunity Defense*, 57 N.Y.U. ANN. SURV. AM. L. 445, 454–55 (2000) (explaining that a clearly established right must be one that is described with some particularity in order to put government officials on notice, and describing that definition of clearly established law as "blurry").

[77] *See id.* at 455 (explaining that the blurry definition of clearly established law allows courts to choose whether to apply a narrow or broad definition of "clearly established," and that this choice is what determines the outcome of a case).

[78] Dorf, *supra* note 17. For example, in *Safford Unified School District No. 1 v. Redding*, the Supreme Court concluded that the school officials in question were entitled to qualified immunity, even though the officials violated a thirteen-year-old middle school student's Fourth Amendment right against unreasonable searches when they subjected her to a strip search. 557 U.S. 364, 368 (2009). The Court found that the strip search, which involved a search of a student's bra and underpants for school-banned drugs, was not justified under the Fourth Amendment and the reasonableness test for school searches established in *New Jersey v. T.L.O. See id.* at 369, 375–77 (quoting New Jersey v. T.L.O., 469 U.S. 325, 341–42 (1984)); *see also* U.S. CONST. amend. IV. The Court concluded, however, that the right against an unreasonable school search was not clear enough from prior case law to have put the officials on notice that their conduct was unlawful. *Safford*, 557 U.S. at 378–79. The Court reasoned that the circuit courts had come to divergent conclusions regarding the reasonable scope of school strip searches, and that this difference in opinion rendered the right against unreasonable school searches not sufficiently clear. *Id.* The court pointed to *Williams v. Ellington*, where the United States Court of Appeals for the Sixth Circuit upheld a strip search of a high school student for a drug, without any suspicion that drugs were hidden next to her body, and *Thomas v. Roberts*, where the United States Court of Appeals for the Eleventh Circuit granted qualified immunity to a teacher and police officer who conducted a group strip search of a fifth grade class when looking for a missing twenty-six dollars. *Id.* at 378. The court also quoted the Eleventh Circuit in *Jenkins v. Talladega City Board of Education*, which found that the numerous interpretations of *T.L.O.* among courts, along with the variety of possible school settings in which these cases could occur, entitled the officials to qualified immunity. *Id.*; Jenkins v. Talladega City Bd. of Ed., 115 F.3d 821, 828 (11th Cir. 1997).

[79] *Harlow*, 457 U.S. at 818; *Wood*, 420 U.S. at 321–22; *Scheuer*, 416 U.S. at 247–48.

[80] *Safford*, 557 U.S. at 378–79; *Anderson*, 483 U.S. at 640.

ed from the qualified immunity defense when sued by family members seeking to impose liability for harms suffered by inmates.[81]

B. Qualified Immunity in Inmate Suicide Cases

Case law demonstrates that prison officials violate the Eighth Amendment's Cruel and Unusual Punishment clause when they are deliberately indifferent to a substantial risk of serious harm to an inmate.[82] In *Farmer v. Brennan*, the Supreme Court defined the term "deliberate indifference," by holding that a prison official may be held liable under the Eighth Amendment for depriving an inmate of humane treatment in confinement only if he or she knows that the inmate faces "a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it."[83] In so holding, the Court relied on its previous decisions, which had established that deliberate indifference involved something between two extremes: negligence and the purposeful causing of harm through acts or omissions.[84] The Court also looked to prior cases decided by the Courts of Appeals, which frequently compared deliberate indifference to recklessness.[85]

Failure to implement adequate suicide prevention policies, however, is not considered an act of deliberate indifference, and the courts have not deemed the right to adequate suicide prevention policies as a "clearly established" right.[86] In *Taylor v. Barkes*, the Barkes family argued that the failure of the HRYCI warden and commissioner to supervise their contract medical workers amounted to deliberate indifference that resulted in Barkes's suicide.[87] Still, the Supreme Court dismissed the claim because of qualified immunity,

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[81] *See generally* Taylor v. Barkes (*Barkes III*), 135 S. Ct. 2042 (2015) (holding that correctional officers were entitled to qualified immunity in a case where the family of a former inmate who committed suicide filed a lawsuit based on 42 U.S.C. § 1983); Miller v. Harbaugh, 698 F.3d 956 (7th Cir. 2012) (holding that state officials were entitled to qualified immunity in a case where the mother of a juvenile inmate filed a lawsuit based on 42 U.S.C. § 1983).

[82] *See* Farmer v. Brennan, 511 U.S. 825, 834 (1993) (explaining that in the context of prison conditions, prison officials violate the Eighth Amendment when their "state of mind is one of 'deliberate indifference' to inmate health and safety").

[83] *Id.* at 847.

[84] *Id.* at 836.

[85] *Id.* (citing LaMarca v. Turner, 995 F.2d 1526, 1535 (11th Cir. 1993); Manarite v. City of Springfield, 957 F.2d 953, 957 (1st Cir. 1992); McGill v. Duckworth, 944 F.2d 344, 347 (7th Cir. 1991); Redman v. Cty. of San Diego, 942 F.2d 1435, 1443 (9th Cir. 1991); Miltier v. Beorn, 896 F.2d 848, 851–52 (4th Cir. 1990); Martin v. White, 742 F.2d 469, 474 (8th Cir. 1984)).

[86] *See Barkes III*, 135 S. Ct. at 2044–45 (finding that even if the facility's suicide screening and prevention measures were deficient, the officials were not violating any clearly established rights, and therefore qualified immunity applied); *Miller*, 698 F.3d at 964–65 (holding that the facility's placement of mentally ill inmates in cells with bunk beds did not amount to deliberate indifference, and that even if it did, the law was not clearly established enough to overcome qualified immunity).

[87] Barkes v. First Corr. Med., Inc. (*Barkes II*), 766 F.3d 307, 314 (3d. Cir. 2014), *rev'd*, 135 S. Ct. 2042 (2015).

reasoning that the right to proper implementation of adequate suicide prevention protocols was not clearly established at the time of Barkes's death.[88] The Court explained that, at the time of Barkes's suicide, there were no existing cases that would have made it clear to the officers that they were overseeing a correctional system that violated the Constitution.[89] The Court also noted that no decision of the Court had ever even discussed suicide screening or prevention protocols.[90] As such, the Court did not consider failure to provide adequate suicide prevention protocols to be a deliberate indifference to an inmate's constitutional rights.[91]

Another recent case with a similar outcome is *Miller v. Harbaugh*, decided by the United States Court of Appeals for the Seventh Circuit.[92] Jamal Miller was sixteen years old when he hung himself from the top bunk of his bed while incarcerated at the Illinois Youth Center ("IYC") St. Charles.[93] His mother sued a number of state officials, including the acting director of the Illinois' Department of Juvenile Justice at the time of Jamal's death, and the IYC St. Charles superintendent, for deliberate indifference to Jamal's serious mental illness, in violation of his Eighth and Fourteenth Amendment rights.[94] Specifically, her claims focused on the officials' adoption of certain living policies, including the use of bunk beds in the rooms of potentially suicidal inmates when history demonstrated that inmates used bunk beds to commit suicide, and there was evidence that single beds were available.[95] The Seventh Circuit ruled that the officials were entitled to qualified immunity, reasoning that where an inmate does not appear to be on the verge of suicide, but merely mentally disturbed as Jamal was, the law as it stood at the time did not clearly require corrections personnel to take further action.[96] Furthermore, the court stated that even if the decision to house mentally ill inmates in rooms with

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[88] *Barkes III*, 135 S. Ct. at 2044–45. The Supreme Court, in its per curiam opinion, dismissed the Barkes family's claim, holding that that the warden and commissioner were entitled to qualified immunity. *Id.* In doing so, the Court did not deny that that there was evidence that Barkes's constitutional right to be free from cruel and unusual punishment was violated. *See id.* at 2044 (noting the Third Circuit's findings as to the facility's inadequate supervision of its medical services contractor). The Court even acknowledged evidence of the contract nurse's failure to comply with the screening standards required under contract, evidence that the nurse did not have access to Barkes's probation records that shed light on his mental health history, and evidence that the medical contractor had been short-staffing the facility in order to increase profits. *Id.*

[89] *Id.* at 2045.

[90] *Id.* at 2044.

[91] *See id.* at 2044–45 (reversing the Third Circuit's decision, which stated that the jail officials violated Barkes's Eighth Amendment right to proper implementation of comprehensive suicide prevention measures).

[92] *Miller*, 698 F.3d at 964–65.

[93] *Id.* at 957, 959.

[94] *Id.*

[95] *Id.* at 960–61.

[96] *Id.* at 963.

bunk beds did amount to deliberate indifference, an inmate's right to be housed in safe conditions was not a clearly established right, and therefore qualified immunity still applied.[97]

Cases like *Barkes* and *Miller* highlight the reasons why jails and prisons should have and enforce adequate suicide prevention protocols.[98] Under current law, inmates do not have a right to adequate suicide prevention protocols, because courts do not consider prison officials' failure to implement these protocols to be deliberate indifference to a substantial risk of harm to inmates.[99] Furthermore, even if correctional facilities have constitutionally defective suicide prevention policies or no policies at all, the officers within the facilities are still protected from liability under the doctrine of qualified immunity.[100] As a result, inmates have no guarantee to a custodial environment in which their mental health needs are adequately addressed, and the families of inmate suicide victims are thus left with limited opportunities to recover damages.[101]

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[97] *Id.* at 964.

[98] *See supra* notes 87–97 and accompanying text (summarizing *Barkes* and *Miller*, two cases in which the Supreme Court shielded correctional leaders from liability even though their failure to implement effective suicide prevention measures contributed to the deaths of two inmates).

[99] *See Barkes III*, 135 S. Ct. at 2044–45 (reversing the Third Circuit's decision, which stated that the jail officials violated Barkes's Eighth Amendment right to proper implementation of comprehensive suicide prevention measures); *Miller*, 698 F.3d at 964 (finding that the facility's failure to properly house a suicidal inmate did not amount to deliberate indifference).

[100] *See Barkes III*, 135 S. Ct. at 2045 (finding that even if the facility's suicide screening and prevention measures were deficient, the officials were not violating any clearly established rights, and therefore qualified immunity applied); Dorf, *supra* note 17 (suggesting that the Court's decision in *Barkes* shields correctional leaders from liability even if their facilities fail to implement any suicide prevention measures whatsoever). Although qualified immunity does not protect government officials against suits for injunctive relief, a combination of judge-made doctrines and statutory obstacles severely limit the availability of injunctive relief for inmates or families of deceased suicidal inmates seeking an improvement of correctional policies. Dorf, *supra* note 17. For example, in *Farmer v. Brennan*, the Supreme Court narrowed the definition of deliberate indifference, holding that a prison official may only be held liable under the Eighth Amendment if he or she "knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." 511 U.S. at 847; *see* Lori Whitten, *Legal Liability Trends for Correctional Suicides*, NAT'L INST. OF CORR. (July 16, 2012), http://community.nicic.gov/blogs/mentalhealth/archive/2012/07/16/legal-liability-trends-for-correctional-suicides.aspx [https://perma.cc/RUB3-9TPF] (explaining how *Farmer* narrowed the definition of deliberate indifference, making it more difficult for inmates and their families to prevail against correctional authorities in suicide-related lawsuits). Also, the Prison Litigation Reform Act creates additional obstacles by eliminating the ability of the courts to waive filings fees for indigent inmates, and only allowing inmates to be placed on a monthly payment plan. William C. Collins, *Bumps in the Road to the Courthouse: The Supreme Court and the Prison Litigation Reform Act*, 24 PACE L. REV. 651, 669 (2004).

[101] Dorf, *supra* note 17.

II. THE INMATE SUICIDE CRISIS AND A NEED FOR ENHANCED CORRECTIONAL SUICIDE PREVENTION EFFORTS

The most recent statistics on inmate suicide show that suicide has been the leading cause of death in local jails, and has been the second leading cause in state prisons.[102] A variety of factors, both internal and external to an inmate, contribute to suicidal behavior.[103] These factors include isolation from family, loss of control, the shock of confinement, and being in an authoritarian environment.[104] Despite the high rate of suicide in jails and prisons, courts seldom hold correctional authorities liable for inmate suicides or deficient suicide prevention policies in correctional facilities.[105] Section A discusses the common reasons for inmate suicide.[106] Section B outlines some basic strategies for effective inmate suicide prevention recommended by correctional and mental health experts.[107] Section C analyzes the current state of suicide prevention programming in correctional facilities across the country.[108] Finally, Section D explores the reasons why correctional facilities are falling short of the standards needed for effective inmate suicide prevention.[109]

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[102] *See* MORTALITY IN LOCAL JAILS AND STATE PRISONS, 2000–2013, *supra* note 30, at 1 (stating that since 2000, suicide has been the leading cause of death in local jails); MORTALITY IN STATE PRISONS, 2001–2014, *supra* note 33, at 1 (explaining that suicides accounted for seven percent of all deaths in state prisons in 2014, the highest percentage of prison suicides since 2001). The overall decrease in inmate suicides over the years is largely due to enhanced research and understanding of jail suicides. *See* NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at xiii. In 2000, Congress passed the Death in Custody Reporting Act, and it required every state that received prison construction funding to report "on a quarterly basis, information regarding the death of any person who is in the process of arrest, is en route to be incarcerated, or is incarcerated at a municipal or county jail, State prison, or other local or State correctional facility . . . ." *Id.* at 4–5; Death in Custody Reporting Act of 2000, Pub. L. No. 106–297, 114 Stat. 1045. Although the inmate suicide rate has decreased overall in the last twenty years, recent statistics suggest that progress in preventing inmate suicide is diminishing, and the need for change persists. *See* Hanson, *supra* note 36, at 6 ("[R]ecent data from the Bureau of Justice Statistics suggest that we may be reaching a point of diminishing progress in suicide prevention.").

[103] *See* NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at 1 (explaining that the jail environment and inmates' experience of a crisis are the two main causes of jail suicide).

[104] *Id.*

[105] *See* Dorf, *supra* note 17 (discussing how the qualified immunity doctrine shields correctional leaders from liability for failure to implement suicide prevention measures); Whitten, *supra* note 100 (explaining how the Supreme Court's decision in *Farmer v. Brennan* narrowed the definition of deliberate indifference, making it more difficult for inmates and their families to prevail against correctional authorities in suicide-related lawsuits).

[106] *See infra* notes 110–126 and accompanying text.

[107] *See infra* notes 127–152 and accompanying text.

[108] *See infra* notes 153–172 and accompanying text.

[109] *See infra* notes 173–194 and accompanying text.

A. The Main Causes of Inmate Suicide

Experts in mental health and corrections have identified the primary causes of jail suicide.[110] One of their key conclusions is that the jail environment tends to promote suicidal behavior.[111] For example, inmates often face isolation, uncertainty about the future, shame, and dehumanization—sentiments that have serious negative impacts on mental health and encourage suicidal behavior.[112] Additionally, because jails often house individuals who have never before been incarcerated, being in custody can have a traumatic effect on these inmates.[113] Experts call this experience the "shock of confinement," which involves trauma that causes mental and emotional breakdown and leads to suicide.[114] Another factor that frequently contributes to inmate suicide in jails is the experience of a crisis while in custody, such as severe guilt or shame over the charges that an inmate is facing, or an approaching court date.[115] These experiences create severe stress and anxiety, and consequently, result in suicidal behavior.[116]

Often, jail inmates simply have trouble coping with the difficulties of confinement.[117] Many of them are disconnected from friends and family, have trouble getting along with corrections officers and fellow inmates, face legal hurdles, and experience physical and emotional breakdown.[118] These stressful experiences also contribute to an inmate's suicidal ideation, attempt, and completion.[119]

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[110] *See* NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at 1.

[111] *Id.* Inmates experience various forms of stress, such as shock, fear, isolation, shame, and dehumanization, which often times lead to suicidal ideation. *Id.*

[112] *Id.* In 2000, Joseph Scott Rehrig committed suicide while incarcerated at the Wake County Jail in Raleigh, North Carolina for kidnapping and sexually assaulting a thirteen-year-old boy. NAT'L CTR. ON INSTS. & ALTS., JAIL SUICIDE/MENTAL HEALTH UPDATE 1 (Summer 2007), http://www.ncianet.org/wp-content/uploads/2011/06/sp_update_2007_summer.pdf [https://perma.cc/7FKX-2MHU] [hereinafter JAIL SUICIDE/MENTAL HEALTH UPDATE (Summer 2007)]. Rehrig had no prior record, and when arrested and questioned by the police, he had appeared downcast and embarrassed, saying that he had never committed any crime like that before. *Id.*

[113] *See* Chammah & Meagher, *supra* note 30 (explaining that one reason why jails have more suicides than prisons is that jail inmates are often facing incarceration for the first time and experience shock).

[114] *See id.* (same); Martin Kaste, *The 'Shock of Confinement': The Grim Reality of Suicide in Jail*, NPR (July 27, 2015), http://www.npr.org/2015/07/27/426742309/the-shock-of-confinement-the-grim-reality-of-suicide-in-jail [https://perma.cc/P5G6-WTMV] (describing the "shock of confinement" and the traumatic effect that first-time incarceration can have on individuals).

[115] NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at 1.

[116] *See id.* (explaining that the stress of confinement can lead an inmate to an emotional breaking point, which often precipitates suicide). In 2007, Charles Nixon, an inmate in the Southwick County Jail in Massachusetts committed suicide in his cell after being arrested for carrying a concealed weapon and menacing by stalking. JAIL SUICIDE/MENTAL HEALTH UPDATE (Summer 2007), *supra* note 112, at 6. Correctional staff had described him during his first few days in jail as anxious about his nearing court date and deeply concerned about the well-being of his wife and young son. *Id.* at 6–7.

[117] NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at 1.

[118] *Id.*

[119] *See id.*

Although the rate of suicide in prisons is lower than it is in jails, it is still greater than the rate of suicide in the general non-incarcerated population, and is the second leading cause of death in state prisons, after various types of illnesses.[120] Although prison suicide victims face some of the same difficulties as jail suicide victims—such as loss of freedom and isolation—there are additional factors that contribute to suicidal behavior that are unique to prison inmates.[121] For example, research suggests that more suicides occur in maximum and supermaximum security prisons than medium or minimum-security prisons, because the maximum-security environment, which often involves single-cell or other types of punitive housing and limited opportunities for contact with the outside community, increases the likelihood of psychological distress and suicidal ideation.[122] Because inmates in maximum-security prisons are deprived of personal security, autonomy, and liberty, they are more prone to aggression, anxiety, depression, and suicide.[123]

As research demonstrates, various factors precipitate inmate suicide, and these factors relate to both an inmate's own emotional and mental health, as well as an inmate's experience while incarcerated.[124] The consequences of these factors worsen when jails and prisons do not have adequate suicide prevention protocols to address inmate experiences that lead to suicide.[125] Therefore, effective suicide prevention programs are necessary to ensure that inmates receive the resources they need to maintain their safety and health while incarcerated.[126]

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[120] *Id.* at 2; MORTALITY IN STATE PRISONS, 2001–2014, *supra* note 33, at 4. The leading causes of death in prisons are various illnesses, including cancer, heart disease, liver disease, AIDS-related illnesses, and respiratory diseases. MORTALITY IN STATE PRISONS, 2001–2014, *supra* note 33, at 4.

[121] *See generally* Meredith Huey Dye, *Deprivation, Importation, and Prison Suicide: Combined Effects of Institutional Conditions and Inmate Composition*, 38 J. CRIM. JUST. 796 (2010), http://www.sciencedirect.com/science/article/pii/S0047235210001194 [https://perma.cc/BA4J-4YMQ] (discussing the causes of suicide in prisons). Prison inmates, unlike jail inmates, are typically convicted of more serious crimes, have had prior experience with the criminal justice system, and serve longer sentences. Radley Balko, *A Primer on Jailhouse Suicides*, WASH. POST (July 17, 2015), https://www.washingtonpost.com/news/the-watch/wp/2015/07/17/a-primer-on-jailhouse-suicides/?utm_term=.23323ea9c449 [https://perma.cc/H7MS-BBYR]; Kaste, *supra* note 114.

[122] Dye, *supra* note 121, at 797–98, 803–04.

[123] *Id.* at 797.

[124] *See* NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at 1 (explaining that the jail environment and inmates' experience of a crisis are the two main causes of jail suicide).

[125] *See id.* at 54 (explaining the need for comprehensive suicide prevention services to address the needs of mentally ill inmates).

[126] *See id.* (same); UNIV. OF TEX. SCH. OF LAW, PREVENTABLE TRAGEDIES: HOW TO REDUCE MENTAL HEALTH-RELATED DEATHS IN TEXAS JAILS 10 (Nov. 2016), https://law.utexas.edu/wp-content/uploads/sites/11/2016/11/2016-11-CVRC-Preventable-Tragedies.pdf [https://perma.cc/X4L9-J5UG] (describing how jails in Texas have failed to adequately screen, house, observe, and treat mentally ill inmates, leading to inmate suicides).

B. Effective Suicide Prevention Programming

Creating a comprehensive and effective inmate suicide prevention program requires dedication and effort from every division and staff member in a correctional facility.[127] The use of appropriate methods and strategies recommended by experts in the correctional mental health field can provide support to troubled inmates and prevent inmate suicides.[128] Unfortunately, the majority of prisons do not provide such programs for its inmates.[129]

Agencies engaged in correctional research and policymaking agree that there are several critical components to an effective custodial suicide prevention program.[130] Staff training, intake and ongoing screenings, and supervision are just a few measures that jails and prisons should be taking to ensure that they have comprehensive suicide prevention policy programs in place.[131] These efforts can have far-reaching impacts in reducing inmate suicides, which in many instances are foreseeable and preventable.[132]

Suicides usually take place in inmate housing units, during times when mental health staff is not monitoring the inmates.[133] Therefore, correctional staff should receive suicide prevention training, and should clearly understand the mental history of their inmates, in order to prevent these incidents.[134] The National Center on Institutions and Alternatives ("NCIA") recommends that correctional staff who have regular contact with inmates receive eight hours of initial suicide prevention training and two hours of refresher training each

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[127] *See* GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS WITHIN JAILS AND PRISONS, NAT'L CTR. ON INSTS. & ALTS. 3 (revised July 2017), https://www.ncchc.org/filebin/Resources/Suicide-Prevention-2017.pdf [https://perma.cc/3TEE-5Z5H] (advocating for a multidisciplinary approach to inmate suicide prevention).

[128] *See generally id.* (outlining several critical components of an effective inmate suicide prevention strategy).

[129] *See* NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at 41 (noting that although the majority of facilities surveyed in the study had written suicide prevention protocols, most of these policies failed to incorporate the critical components of an effective suicide prevention strategy).

[130] *See* GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS, *supra* note 127, at 1–5; Hayes, *supra* note 11, at 189–93; NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at 33–41; PREVENTABLE TRAGEDIES, *supra* note 126, at 47–53; RAND CORP. PRIORITY CRIMINAL JUSTICE NEEDS INITIATIVE, CARING FOR THOSE IN CUSTODY: IDENTIFYING HIGH-PRIORITY NEEDS TO REDUCE MORTALITY IN CORRECTIONAL FACILITIES 9–12 (2017), https://www.rand.org/content/dam/rand/pubs/research_reports/RR1900/RR1967/RAND_RR1967.pdf [https://perma.cc/7VNW-GNFM].

[131] *See* Hayes, *supra* note 11, at 193.

[132] *Id.*

[133] NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at 34–35. For example, Charles Nixon, who was an inmate in the Southwick County Jail in Massachusetts, was found hanging from a bed sheet in his cell at least forty-five minutes after he was last observed by correctional staff. JAIL SUICIDE/MENTAL HEALTH UPDATE (Summer 2007), *supra* note 112, at 6. According to one of the jail's officers, Nixon was not placed on suicide watch because he had received psychiatric treatment at a local hospital for suicidal ideation several days earlier, and was released by the hospital. *Id.* at 7.

[134] GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS, *supra* note 127, at 1.

year.[135] All training should be meaningful and aimed at reducing suicides.[136] Trainings should also incorporate timely and reliable information that addresses current problems, rather than simply achieve the bare minimum in order to comply with an accreditation standard.[137] Because suicide prevention requires collaboration between correctional officers and mental health professionals, training should be conducted in a live, interactive setting, rather than through video or webinar.[138]

Intake screening and ongoing assessments are also critical to an effective suicide prevention program.[139] Because inmates can become suicidal at any point during their sentence, and often experience their first episode of mental illness after incarceration, screening should be a continuous process.[140] Furthermore, research shows that approximately two-thirds of all suicide victims communicate their intent some time before death.[141] Therefore, inmate evaluations should be ongoing and include a variety of inquiries, including any history of suicidal thoughts or attempts, current plans of suicide, prior mental health treatment, suicide risk during prior confinement, and opinions of the arresting or transporting officers that the inmate is suicidal.[142] Finally, the determination that an inmate is no longer suicidal and can be released from suicide precautions must only be made by a qualified mental health professional ("QMHP")—a licensed, masters-level or above clinician—after a comprehensive risk assessment.[143]

Proper levels of observation and management can also reduce the likelihood of suicide.[144] Mental health professionals recommend two levels of supervision for inmates.[145] The first is close observation of an inmate who is not

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[135] *Id.* The National Center on Institutions and Alternatives is a non-profit organization that conducts research and training on jail suicide, and provides materials and resources to assist correctional professionals and their facilities. NAT'L CTR. ON INSTS. & ALTS., PROGRAMS AND SERVICES (2015), http://www.ncianet.org/wp-content/uploads/2015/03/About-NCIA.pdf [https://perma.cc/ZL62-9H76].

[136] Hayes, *supra* note 11, at 190.

[137] *Id.*

[138] *Id.*

[139] *Id.* at 189–90.

[140] *Id.* When it comes to screening, it is important to note that staff should not rely solely an inmate's statements during a screening, even if they deny suicidal thoughts, because there are various reasons why an inmate would not want to disclose their intention to commit suicide, such as not wanting correctional staff to prevent him or her from actually committing the suicide. *Id.* at 189. Correctional staff should also pay close attention to the inmate's behavior, actions, and/or behavioral history. *Id.* at 190.

[141] GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS, *supra* note 127, at 1.

[142] *Id.* at 2; Hayes, *supra* note 11, at 189–90.

[143] Hayes, *supra* note 11, at 191. According to national standards, a QMHP would include a psychiatrist, psychologist, psychiatric social worker, psychiatric nurse, and others who have the legally required education, credentials, and experience permitting them to evaluate and care for the mental health needs of patients. *Id.*

[144] GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS, *supra* note 127, at 4.

[145] *Id.*

actually suicidal, but who has expressed suicidal thoughts, has a recent prior history of self-harm, or behaves in ways that demonstrate a potential for suicide.[146] Inmates under this level of supervision should be housed in protrusion-free cells and observed at staggered intervals every ten minutes or less.[147] The second level of supervision is constant observation, intended for inmates who are actively suicidal—those threatening or engaging in suicidal behavior.[148] Correctional staff should observe such inmates continuously.[149] In addition to observing suicidal inmates, mental health staff should also assess and interact with such inmates on a daily basis.[150] Finally, inmates on suicide watch should have individual treatment plans developed by mental health staff in conjunction with correctional personnel.[151] These plans should discuss the signs, symptoms, and circumstances that often lead to suicidal behavior, advise on how to help inmates overcome suicidal thoughts, and suggest actions that the inmate and correctional staff can take if suicidal ideation reoccurs.[152]

C. The Current State of Suicide Prevention Programming

Despite consensus among researchers about the need for comprehensive suicide prevention programming in prisons and jails, the vast majority of current custodial suicide monitoring and prevention policies are not adequate in preventing inmate suicide.[153] According to a 2005–2006 national study of jail suicide, only 7.5% of suicide victims in the facilities participating in the study were on suicide precautions when they committed suicide.[154] Although the

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[146] *Id.*

[147] *Id.* A protrusion is an anchoring device that inmates use to hang from in order to commit suicide. *See id.* (describing different types of protrusions and devices for hanging).

[148] *Id.*

[149] *Id.*

[150] *Id.*

[151] *Id.*

[152] *Id.* Between 1985 and 1987, New York State developed the "Crisis Service Model," which was "a multifaceted initiative designed to facilitate the identification, referral and treatment of inmates who were suicidal and/or seriously mentally ill." NAT'L CTR. ON INSTS. & ALTS., JAIL SUICIDE/MENTAL HEALTH UPDATE 2 (Summer 2005), http://www.ncianet.org/wp-content/uploads/2011/06/sp_update_2005_summer.pdf [https://perma.cc/N4TL-JK9B] [hereinafter JAIL SUICIDE/MENTAL HEALTH UPDATE (Summer 2005)]. Specifically, the Crisis Service Model brought local jails and mental health programs into partnership to address the needs of mentally ill and suicidal inmates. *Id.* In 1984, before the Crisis Service Model was implemented, there were thirty-two inmate suicides among all of New York State's county and police department jails. *Id.* at 4. In 2004, that number dropped to fifteen inmate suicides. *Id.*

[153] *See* Hanson, *supra* note 36, at 8; Hayes, *supra* note 11, at 193.

[154] NATIONAL STUDY ON JAIL SUICIDE, *supra* note 30, at 27. Note that the percentage is for both holding facilities (where inmates are detained for seventy-two hours or less) and detention facilities (where inmates are detained for over seventy-two hours). *Id.* From 2005 to2006, there were a total of 564 reported jail suicides. *See* MORTALITY IN LOCAL JAILS, 2000–2014, *supra* note 30, at 5. It appears that the failure to identify and adequately supervise suicidal inmates continues to be a problem. *See* Jesse Bogan, *Man Hung in Cell for Hours at St. Louis Lockup While Guards Streamed Netflix*, ST.

same study showed that approximately 77% of the facilities had implemented an intake screening process to evaluate suicide risk in inmates, only 27.4% verified whether an inmate had ever been on suicide precautions during any prior confinement in the same facility.[155] Additionally, only about 31% of facilities surveyed arresting and/or transporting officers on their concerns about the mental health of newly admitted inmates.[156]

In addition to employing qualified and competent mental health professionals, preventing inmate suicide also requires adequate training for correctional staff.[157] Roughly 62% of the respondents in the 2005–2006 study disclosed that they provided suicide prevention training to at least 90% of their correctional staff.[158] Of the respondents who reported having suicide training, however, 75% conducted trainings only once a year, whereas the remaining 25% coordinated trainings biennially or on a pre-service basis.[159] The majority (69%) of reported suicide-prevention trainings offered by the facilities in the study were two hours or less in length; only 6% of the training programs were eight-hours long.[160]

Safe housing is another important aspect of inmate suicide prevention.[161] Because hanging is the most common method of inmate suicide—roughly 93%, according to the study mentioned above—correctional facilities with adequate suicide prevention measures should ensure that the cells of suicidal inmates do not contain obvious protrusions and are located close to correctional

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LOUIS POST-DISPATCH (Apr. 26, 2017), http://www.stltoday.com/news/local/crime-and-courts/man-hung-in-cell-for-hours-at-st-louis-lockup/article_198d0a9c-21f1-545a-b08e-622929aed169.html [https://perma.cc/KG2H-83ZW] (detailing the circumstances surrounding the death of David Garceau, a former inmate at the St. Louis Community Release Center who, despite having issues with mental health and drug abuse, was placed in a segregated unit and hung himself and laid dead in his cell for ten hours while guards on duty watched television and browsed the internet); Dan Kane & David Raynor, *51 NC Jail Inmates Have Died in Past Five Years After Poor Supervision from Jailers*, NEWS & OBSERVER (updated Aug. 15, 2017), http://www.newsobserver.com/news/local/crime/article164829912.html [https://perma.cc/FMM3-UDNM] (describing the events leading up to the death of Emily Jean Call, a former inmate in North Carolina's Wilkes County Jail who had cut her wrists two weeks before her death and expressed to detention officers that she was depressed wanted to kill herself, but nonetheless went unwatched for more than an hour and eventually hung herself in a bathroom in a common area of the facility).

[155] NATIONAL STUDY ON JAIL SUICIDE, *supra* note 30, at 33.

[156] *Id.* at 34.

[157] Hayes, *supra* note 11, at 190.

[158] NATIONAL STUDY ON JAIL SUICIDE, *supra* note 30, at 35.

[159] *Id.* In one instance, a booking officer confessed that he did not receive any training on how to conduct a proper intake screening or what questions to ask a newly admitted inmate. Hayes, *supra* note 11, at 190–91.

[160] NATIONAL STUDY ON JAIL SUICIDE, *supra* note 30, at 35.

[161] *See id.* at 38 (explaining the importance of safe housing in jails, given the prevalence of inmate suicides due to hanging).

personnel.[162] As of 2005–2006, however, only 32% of facilities from the earlier-mentioned study reported having policies that involved assigning suicidal inmates to safe, suicide-resistant, and protrusion-free cells.[163]

In addition, the NCIA and the National Institute of Corrections ("NIC") recommend that every suicide and suicide attempt requiring hospitalization be examined through a morbidity-mortality review process in order to determine if the incident was preventable.[164] The review should include all relevant information, including the circumstances surrounding the incident, the victim's medical or mental health information, factors that contributed to the suicide, and recommendations for policy, procedural, or other changes.[165] A 2005–2006 report on inmate suicide demonstrated however, that the majority—63%—of respondents in the study stated that they did not conduct a mortality-morbidity review after an inmate suicide.[166] Those who did conduct reviews either did not mention any precipitating factors, or pointed to triggers such as a recent conviction or sentence, loss of a loved one, fear of being transferred to a long-term prison, or lack of visits from family members as causes for the suicides.[167]

According to the NIC, although 85% of holding and detention facilities in its report had suicide prevention policies in writing, only 20% of those written policies encompassed all of the components of an effective suicide prevention program.[168] These facts and statistics reveal the deficiencies in suicide prevention that permeate correctional facilities throughout the United States.[169] These deficiencies explain why the rate of suicide in jails and prisons is increasing,

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[162] *Id.* at 38, 44. In 2015, former Texas inmate Sandra Bland committed suicide by hanging herself from the bathroom privacy partition of her cell, using a plastic garbage bag provided by the facility—a common method of inmate suicide. Debbie Nathan, *What Happened to Sandra Bland?*, NATION (Apr. 21, 2016), https://www.thenation.com/article/what-happened-to-sandra-bland/ [https://perma.cc/SW9U-X8Q9].

[163] NATIONAL STUDY ON JAIL SUICIDE, *supra* note 30, at 38–39.

[164] *Id.* at 39. The morbidity-mortality review process is separate from formal investigations to determine the cause of death of inmates. *Id.*

[165] *Id.*

[166] *Id.*

[167] *Id.* In 2015, Guy Duffy, a former inmate at the Essex County Jail in Massachusetts, hung himself in his cell just barely two weeks into his thirty-day sentence for an animal cruelty charge. Jenifer McKim & Shaz Sajadi, *'They Left Him Everything to Hang Himself,'* BOS. GLOBE (May 6, 2017), https://www.bostonglobe.com/metro/2017/05/06/they-left-him-everything-hang-himself/KVbjAopCsOsPVZ3y2StGSN/story.html [https://perma.cc/VBU5-SLUY]. The facility's mortality review of Duffy's death concluded that staff "responded appropriately" in his case, but failed to explain why Duffy was placed in a segregation unit despite the fact that he exhibited "mental health issues." *Id.*

[168] NATIONAL STUDY ON JAIL SUICIDE, *supra* note 30, at 41. Additionally, although 93% of participants in the NIC study reported having suicide-watch protocols, only 2% provided constant observation as an option. *Id.* at 37.

[169] *See id.* at 37–41 (presenting data on correctional facilities' implementation of various suicide prevention strategies, and finding that these statistics show an overall lack of comprehensive inmate suicide prevention programming).

and why further suicide prevention reform by correctional facilities is required.[170] As one psychologist and suicide expert said, "The style [of suicide] can be readily seen, and there are steps we can take to stop suicide, if we know where to look."[171] Correctional leaders must enhance their efforts to reduce inmate suicides, which are preventable if the appropriate methods and strategies are implemented.[172]

D. Why Correctional Facilities Are Falling Short in Preventing Inmate Suicide

There are several explanations for the inadequate suicide prevention programming in today's correctional facilities.[173] First, facilities struggle to prevent the suicide of an inmate who is difficult to recognize as being at risk for self-harm.[174] Although certain suicide prevention measures have become popular in facilities throughout the country, these measures only focus on inmates who have already been determined as suicidal risks.[175] Identifying suicidal inmates on an ongoing basis is important because an increasing number of suicides among inmates are "clean" suicides—suicides among prisoners with no prior psychiatric history.[176] Current suicide prevention efforts focus only on identifying and preventing deaths of inmates with known mental illnesses, but many inmates experience their first mental health crisis only after incarceration.[177] Therefore, these suicide prevention efforts fail to recognize inmates who develop suicidal ideations after they have been incarcerated.[178]

Another obstacle to effective inmate suicide prevention is correction officials' negative attitudes toward prevention.[179] Statements like, "[i]f someone really wants to kill themselves there's generally nothing you can do about it" and "[w]e did everything we could to prevent this death, but he showed no signs of suicidal behavior" are often made following an inmate suicide, and before any meaningful attempt to understand the incident.[180] As one jail com-

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[170] *See id.* (same).

[171] Hayes, *supra* note 11, at 193.

[172] *See id.* (stating that progress in correctional suicide prevention is still attainable if the right strategies are implemented).

[173] *See infra* notes 174–191 and accompanying text (explaining several key reasons for the lack of comprehensive suicide prevention programming in facilities).

[174] Hayes, *supra* note 11, at 189. These are inmates that deny being suicidal, and may even sign contracts with their facilities' medical staff saying that they will not engage in self harm in order to be released from suicide precautions, but whose actions and history show otherwise. *Id.*

[175] *Id.* Examples of these popular measures include the use of "suicide-resistant" cells, closed-circuit television for inmate supervision, and inmate companions. *Id.*

[176] Hanson, *supra* note 36, at 7–8.

[177] *Id.*

[178] *Id.*

[179] Hayes, *supra* note 11, at 193.

[180] *Id.*

mander stated, "[w]hen you begin to use excuses to justify a bad outcome, whether it be low staffing levels, inadequate funding, physical plant concerns, etc., issues we struggle with each day, you lack the philosophy that even one death is not acceptable." The commander added that if facilities tolerate even just a few deaths, then they have "already lost the battle."[181]

Additionally, many facilities across the United States have not yet embraced the goal of preventing inmate suicides.[182] For example, one jail facility implemented a fee-for-service program for health care services, including a ten-dollar charge for inmates to request release from suicide watch.[183] In another example, a nurse asked an inmate during an intake screening if he was suicidal, and when the inmate answered in the affirmative, the nurse replied, "[i]f you tell me you're suicidal, we're going to have to strip you of all your clothes and house you in a bare cell." [184] The inmate then replied that he was not suicidal.[185] Negative attitudes have contributed to the idea that deaths in prison are inevitable, and have thus prevented correctional facilities from developing meaningful suicide prevention efforts.[186]

Finally, the increasing costs of mental health care also contribute to inadequate inmate suicide prevention measures.[187] For example, in 2007, jails in Broward County, Florida spent $130 a day on an inmate with mental illness, as opposed to just $80 on an inmate with no mental illness.[188] In 2003, Texas prisons spent between $30,000 and $50,000 annually on each of its mentally ill inmates, as compared to about $22,000 annually on non-mentally ill inmates.[189] In 2002, the Ohio Clark County Jail spent more on psychiatric medi-

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[181] *Id.*

[182] *See id.* at 189 (explaining that providing services to mentally ill inmates is often not a priority for correctional leaders, and that the focus of inmate suicide prevention is often on implementing "quick fixes," rather than on the more important goals of identifying and treating suicidal inmates).

[183] *Id.* at 193. The fee for being released from suicide watch was later eliminated, after the jail was investigated by the Civil Rights Division of the U.S. Department of Justices. *Id.* Still, inmates are often charged fees for various aspects of life in confinement, including medical visits, phone calls, and work release programs. Laura I. Appleman, *Nickel and Dimed into Incarceration: Cash-Register Justice in the Criminal System*, 57 B.C. L. REV. 1483, 1501–02 (2016).

[184] Hayes, *supra* note 11, at 193.

[185] *Id.*

[186] *Id.*

[187] *See* Hanson, *supra* note 36, at 7. In particular, funding is necessary in order to attract and retain mental health staff in correctional facilities, and purchase technology and equipment that will facilitate suicide prevention measures. *See* CARING FOR THOSE IN CUSTODY, *supra* note 130, at 12 (explaining the importance of funding to attract and retain mental health personnel in jails, as well as the growing need for technology and equipment to reduce inmate suicides).

[188] TREATMENT ADVOCACY CTR., HOW MANY INDIVIDUALS WITH SERIOUS MENTAL ILLNESS ARE IN JAILS AND PRISONS? (Nov. 2014), http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how%20many%20individuals%20with%20serious%20mental%20illness%20are%20in%20jails%20and%20prisons%20final.pdf [https://perma.cc/WFW4-V2PJ].

[189] *Id.*

cation than on food for inmates.[190] Given the costliness of mental health care in jails and prisons, states have little incentive to invest in mental health and suicide prevention efforts.[191]

There is a severe lack of effective and comprehensive suicide prevention programming across the United States; as a result, suicide has become a leading cause of death among inmates.[192] Families of inmates struggle against current case law to hold correctional facilities liable for inmate suicide deaths, and thus, correctional facilities have little incentive to implement change.[193] Therefore, in order to protect suicidal inmates, it is vital that the federal government incentivize adequate suicide prevention in correctional facilities.[194]

III. ENDING THE INMATE SUICIDE CRISIS

Suicide is one of the leading causes of death for inmates across the United States; these deaths however, are preventable.[195] Comprehensive suicide prevention programs can be effective in eliminating, or at least significantly reducing, inmate suicides.[196] Unfortunately, the majority of prisons and jails do not employ effective suicide prevention programs.[197] Because correctional officers are currently protected from liability for inmate suicide under the doctrine of qualified immunity, the need for effective suicide prevention programming is even more crucial; inmates and their families have no viable options for justice when such programs fail.[198] As such, the federal government

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[190] *Id.*

[191] *See id.* In Worcester, Massachusetts, correctional officials have attempted to implement new suicide prevention measures, but struggled with a lack of funding. McKim & Sajadi, *supra* note 167. According to the superintendent of the Worcester County Jail and House of Correction, the facility's $45 million budget is not even enough to pay for basic costs, let alone to improve mental health services. *Id.*

[192] *See supra* notes 153–172 and accompanying text (outlining the current state of suicide prevention programming across the states).

[193] *See* Dorf, *supra* note 17 (explaining how the Supreme Court's holding in *Taylor v. Barkes* prevents families of inmate suicide victims from seeking retribution).

[194] *See infra* notes 195–261 and accompanying text.

[195] *See* Hayes, *supra* note 11, at 193 (explaining that inmate suicides are preventable if the correct prevention measures are implemented); MORTALITY IN LOCAL JAILS, 2000–2014, *supra* note 30, at 5 (showing that suicide was the leading cause of death in local jails between 2000–2014, when considering all the illnesses as separate causes of death); MORTALITY IN STATE PRISONS, 2001–2014, *supra* note 33, at 4 (showing that suicide was a leading cause of death in state prisons between 2000–2014).

[196] *See* Hayes, *supra* note 11, at 188–89 (explaining that inmate suicide can be further reduced with the appropriate practices).

[197] NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at vii.

[198] *See* Taylor v. Barkes, 135 S. Ct. 2042, 2044 (2015) (holding that qualified immunity applied to correctional officers despite the fact that their failure to implement adequate suicide prevention measures may have caused the death of a suicidal inmate); Dorf, *supra* note 17 (explaining that families of inmate suicide victims have limited means to achieve justice because of the holding in *Taylor v. Barkes*).

must intervene to ensure protection for suicidal inmates.[199] Specifically, the U.S. Department of Justice (DOJ) should revise its Justice Assistance Grant ("JAG") Program to condition state and local government correctional funding on the implementation of comprehensive suicide prevention programs in their prisons and jails.[200] The DOJ should also list inmate suicide prevention as an area of emphasis on its JAG application form, to encourage jurisdictions to invest more resources in preventing correctional suicide.[201] Finally, the DOJ should establish discretionary grant opportunities through which state and local agencies can apply for additional funding to support their inmate suicide prevention programs, and encourage their implementation and enforcement.[202]

A. Elements of a Comprehensive Suicide Prevention Program

Although there is no single formula for an effective inmate suicide prevention program, correctional mental health experts recommend certain protocols that should be implemented in jails and prisons in order to prevent inmate suicides.[203] These protocols should be dictated on paper and enforced in practice.[204] At a minimum, state and local correctional facilities should implement the suicide prevention strategies that are in place at the Orange County Sheriff's Department ("OCSD"), as such policies have effectively reduced the prevalence of inmate suicides.[205]

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[199] *See infra* notes 231–261 and accompanying text. This section will focus on the reform of state prisons and local jails, and not federal prisons, as there are significantly fewer inmates in the latter (in 2014, there were approximately 1,264,300 inmates in state prison and 750,100 in local jails, but only 169,500 in federal prisons). *See* MORTALITY IN LOCAL JAILS, 2000–2014, *supra* note 30, at 25; MORTALITY IN STATE PRISONS, 2001–2014, *supra* note 33, at 18. Also, note that in forty-four states, jails are operated by the local government, and in six states, jails and prisons are jointly operated by the state government. NAT'L CONFERENCE OF STATE LEGISLATURES, MANAGING CORRECTIONS COSTS 8 (Feb. 2014), http://www.ncsl.org/documents/cj/managingcorrectionscosts.pdf [https://perma.cc/5UST-6SSR].

[200] *See infra* notes 231–244 and accompanying text.

[201] *See infra* notes 245–249 and accompanying text. The 2017 JAG state application form contained a list of "BJA Areas of Emphasis"—areas of justice reform in which state and local governments applying for the JAG Program were encouraged to invest with their funding awards. BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, EDWARD BYRNE MEMORIAL JUSTICE ASSISTANCE GRANT PROGRAM FY 2017 STATE SOLICITATION 10–11 (2017), https://www.bja.gov/Funding/JAGState17.pdf [https://perma.cc/Q7C3-L86R] [hereinafter JAG 2017 STATE SOLICITATION].

[202] *See supra* notes 250–261 and accompanying text. A discretionary grant is awarded by the Department of Justice to a state or local agency in order for that agency to implement a specific type of justice-related program. *OJP Grant Process*, OFF. JUST. PROGRAMS (Mar. 11, 2018), https://ojp.gov/funding/Apply/GrantProcess.htm [https://perma.cc/3M25-3WE4].

[203] *See supra* note 130 and accompanying text.

[204] *See* NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at 40–41 (explaining the importance of written suicide prevention protocols, but also questioning the quality of those protocols in today's correctional facilities).

[205] *See* NAT'L CTR. ON INSTS. & ALTS., JAIL SUICIDE/MENTAL HEALTH UPDATE 1–6 (Fall 2005), http://www.ncianet.org/wp-content/uploads/2011/06/sp_update_2005_fall.pdf [https://perma.cc/XPL6-QZ7E] [hereinafter JAIL SUICIDE/MENTAL HEALTH UPDATE (Fall 2005)] (highlighting news from

One important element of the OCSD inmate suicide prevention program that all correctional facilities must implement into their own programs involves the process of intake screenings.[206] Intake screenings at facilities should be detailed—with comprehensive questions regarding an inmate's prior mental health and medical treatment, and questions to elicit indications of emotional stability—in order to reveal an inmate's suicide risk and/or other mental health issues.[207] Effective screenings require that a qualified mental health professional ("QMHP")—a licensed, masters-level or above clinician such as a psychiatrist, psychologist, psychiatric social worker, or psychiatric nurse—be responsible for conducting such screenings.[208] Additionally, correctional facilities should adopt the OCSD's strategy, which requires mental health staff to place at-risk inmates under suicide precautions that are tailored to the inmates'

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around the country about jail suicide rates and new initiatives taken by facilities to improve suicide prevention measures). The Orange County Sheriff's Department ("OCSD") administers five jail facilities in Orange County, California, and is the eleventh largest jail system in the United States and the second largest system in California. *Id.* at 1. As of August 2005, the Orange County jail system had an average population of over 6,500 inmates. *Id.* Between 1995 and 2004, the OCSD jail system had over 660,000 admissions, but only four inmate suicides. *Id.* During this period, the suicide rate among all five OCSD facilities was only 7.7 deaths per 100,000 inmates. *Id.* At the time of the report, the OCSD system had the lowest inmate suicide rate across the largest county jails in California, and a rate far lower than the average across jails within the state. *Id.* Its success in preventing inmate suicides is attributable to the approach implemented by its prior Assistant Sheriff for Jail Operations, John "Rocky" Hewitt, and his successor, Kim Markuson, who replaced Hewitt in 2003. *Id.* at 2. Hewitt and Markuson made it a priority to prevent jail suicides and ensure that the jail staff was serious about their jobs and the mental health of the inmates. *Id.* Markuson continued Hewitt's legacy, making sure that there was a clear expectation within the department that everyone was responsible for preventing jail suicides, and encouraging close relationships between correction officers and the medical and mental health staff. *Id.*

[206] *See id.* at 2 (describing the intake process at the OCSD, which includes a basic suicide risk inquiry, a review of the inmate's mental health history, the ability to refer an inmate to a mental health staff member who is stationed in the intake area); Hayes, *supra* note 11, at 193.

[207] *See* GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS, *supra* note 127, at 2 (providing a list of intake screening questions). Specifically, the National Center for Institutions and Alternatives recommends the following questions, which may be included in the routine medical screening form, or in a separate form:

> Was the inmate a medical, mental health, or suicide risk during any prior contact or confinement in this facility? Does the arresting or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates the inmate is a medical, mental health, or suicide risk now? Has the inmate ever attempted suicide? Has the inmate ever considered suicide? Is the inmate now being treated or has he/she ever been treated for mental health or emotional problems? Has the inmate recently experienced a significant loss (e.g., relationship, death of family member or close friend, job)? Has a family member or close friend of the inmate ever attempted or committed suicide? Does the inmate feel there is nothing to look forward to in the immediate future (expressing helplessness or hopelessness)? Is the inmate thinking of hurting or killing himself/herself?

Id.

[208] *See* Hayes, *supra* note 11, at 191 (explaining the importance of QMHPs in the intake process).

individual needs.[209] In particular, mental health staff should monitor inmates placed on suicide precautions according to their level of suicide risk, and should house such inmates in suicide-resistant cells that are located near mental, medical, or other staff—for example, high-risk inmates should receive around the clock monitoring by trained medical staff, whereas low-risk inmates should receive only periodical monitoring that is staggered in ten minute intervals.[210] A QMHP should also be responsible for authorizing the removal of inmates from suicide precautions, and ensuring that inmates who are released from suicide precautions are reassessed periodically throughout their confinement, to address any recurring suicidal ideations.[211]

Perhaps one of the biggest reasons for the OCSD's success in inmate suicide prevention is that its correctional officers receive extensive suicide prevention training.[212] Thus, new correctional staff at jails and prisons should be required to attend at least two hours of suicide prevention training before they begin their employment, as well as an advanced training during their first year on duty that is at least four hours long.[213] All current and new correctional officers and correctional mental health personnel should also receive quarterly in-service suicide prevention training, and veteran sheriffs should undergo

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[209] JAIL SUICIDE/MENTAL HEALTH UPDATE (Fall 2005), *supra* note 205, at 2. Inmates placed on suicide precautions receive supervision from both correctional officers and nursing staff at staggered thirty-minute intervals, thereby ensuring that each inmate is seen by either an officer or nurse every fifteen minutes. *Id.* at 3. Other precautions include requiring the inmate to wear a safety gown, or housing the inmate in a safety cell. *Id.* at 2. Once an inmate's level of suicide risk has returned to a safely manageable level and the inmate is transferred out of a mental health unit, the OCSD inmate continues to receive mental health services according to clinical recommendations. *Id.* at 3.

[210] *See* GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS, *supra* note 127, at 3–4. Suicidal inmates should be housed in cells that are free of protrusions, such as those from clothing hooks, towel racks, or certain light fixtures. *Id.* at 3. The cell doors of suicidal inmates should contain clear panels, allowing for unobstructed observation of the inmate. *Id.* Some facilities use heavy gauge Lexan clear panels. *Id.*

[211] *See* Hayes, *supra* note 11, at 189–90. In one local jail facility, mental health professionals briefly screen inmates with a history of mental illness or suicide risk after they attend a court hearing, as many suicides occur close to a court hearing. *Id.* In other jurisdictions, inmates arrested for murder, domestic violence, child molestation, or highly publicized cases require additional layers of assessment. *Id.*

[212] *See* JAIL SUICIDE/MENTAL HEALTH UPDATE (Fall 2005), *supra* note 205, at 4 (explaining the types of training offered to OCSD correctional staff).

[213] *See id.* (explaining that OCSD correctional staff receive two hours of suicide prevention training before the start of employment and four hours of advanced training during the first year on the job). Walking around and interacting with inmates is key to reducing the chance of an incident, including a suicide attempt. *Id.* at 3–4. Therefore, the OCSD encourages correctional officers to maintain continuous movement in the housing areas, and dialogue with inmates in their housing units. *Id.* at 3. In addition, all correctional staff are required to carry a pocket-sized laminated card containing potential high-risk warning signs for suicidal behavior. *Id.* at 4. The cards are not only informational but are also symbolic, and reinforce the administration's message that suicides will not be tolerated. *Id.*

supplemental training at least once a year.[214] Such training should be conducted in-person in an interactive environment, and at a minimum, educate correctional staff on appropriate screening methods, identifying warning signs of suicidal ideation, and emergency response strategies.[215]

Another key component of the OCSD's suicide prevention program is the multidisciplinary team approach, where correctional, medical, and mental health staff all work together to address the medical needs of inmates.[216] Correctional facilities must therefore also cultivate collaboration and teamwork, by requiring representatives of the three disciplines to meet regularly to discuss cases requiring immediate attention, as well as ongoing systemic issues.[217] As with the OCSD, correctional facilities should develop a system of checks and balances to ensure that each department within a facility is doing its part to prevent inmate suicides.[218] At the OCSD, the suicide prevention process begins when an arresting officer alerts booking personnel of a potentially at-risk inmate, or when a medical professional identifies a problem with an inmate during an intake.[219] The process continues when correctional staff in the housing units refer potentially suicidal inmates to mental health staff members, who then perform suicide risk assessments on the inmates.[220] There is an understanding among all the OCSD staff that although everyone in a given facility

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[214] *See id.* at 4 (explaining that OCSD correctional staff receive quarterly in-service training on suicide prevention and that more experienced staff members also receive refresher training at least once a year). At the OCSD, these supplemental trainings often occur before the holidays, when inmates experience increased feelings of despondency or anger, and are more prone to suicidal behavior. *Id.* Following these trainings, deputies make referrals to mental health staff more often. *Id.*

[215] *See* GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS, *supra* note 127, at 1; Hayes, *supra* note 11, at 190.

[216] *See* JAIL SUICIDE/MENTAL HEALTH UPDATE (Fall 2005), *supra* note 205, at 5. The Orange County Adult Correctional Health Services, which provides mental health services at the OCSD's five correctional facilities, states the following on its website:

> Adult Correctional Health Services (ACHS) provides a wide range of psychiatric and crisis intervention services to the inmates in the Orange County Jail System: Evaluation/assessment of all inmates referred during the triage process; Crisis intervention to ameliorate symptoms of psychiatric/psychological decompensation; Medication evaluation and prescription of psychotropic medication where indicated; Collateral contacts with Sheriff's Department, Criminal Justice System, Mental Health professionals, families, and friends for the purpose of effective continuing care during incarceration; Group Therapy; Care coordination services for linkage, referral to community mental health services and discharge planning for post custody treatment service; Coordination with Long Term Care for psychiatric hospitalization as appropriate . . . .

Adult Correctional Health Services—What We Do, ORANGE COUNTY HEALTH CARE AGENCY (Mar. 10, 2018), http://www.ochealthinfo.com/about/chs/achs [https://perma.cc/FFD9-5Z8J].

[217] *See* JAIL SUICIDE/MENTAL HEALTH UPDATE (Fall 2005), *supra* note 205, at 5 (describing the OCSD's practice of holding weekly meetings between correctional staff from different disciplines).

[218] *See id.* (describing the OCSD's effective system of checks and balances).

[219] *Id.*

[220] *Id.*

has separate duties and functions, the responsibility for preventing suicides is shared, and it takes a team to prevent inmate deaths; this dedication to inmate suicide prevention must be fostered in all correctional facilities.[221]

Finally, the OCSD takes seriously each inmate death that occurs, and revises its policies and procedures to address the causes of inmate deaths.[222] Similarly, correctional facilities should submit every completed inmate suicide or suicide attempt to morbidity-mortality review.[223] An outside agency should conduct the review in order for the process to be handled in a neutral manner.[224] The review should also "include a critical inquiry of the circumstances surrounding the incident, procedures relevant to the incident, all relevant training that involved staff received, pertinent medical and mental health services or reports involving the victim, precipitating factors that may have led to the suicide."[225] Finally, it is important for the reviewing agency to explore potential recommendations for policy, operational, or other changes to reduce the likelihood of another inmate suicide.[226]

Together, the policies and procedures described above constitute a comprehensive suicide prevention strategy that will be effective in reducing the number of inmate suicides in both state and local correctional facilities.[227] Inmate suicides are demonstrably preventable, but such prevention requires an intentional effort on the part of correctional leaders, correctional medical staff, and even government leaders.[228] Correctional systems modeled after the OCSD, in which a comprehensive range of suicide prevention strategies are

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[221] *See id.* (describing the OCSD staff's sense of responsibility for inmate deaths).

[222] *See id.* at 6 (describing the OCSD's administrative review process following a critical incident). Following each of the four inmate suicides that occurred in OCSD facilities between 1990 and 1996, the OCSD conducted an administrative review that included recommendations "for change in policy, training, physical plant, medical or mental health services, and operational procedures." *Id.* For example, in February 1990, an inmate in the OCSD's Central Women's Jail chose to remain alone in her dormitory unit while other inmates went to dinner, and during that time, she hung herself from a fixed metal rod in the shower area. *Id.* Following the incident, the OCSD replaced all fixed shower rods with breakaway rods, and revised its policies to prohibit any inmate from remaining alone in a dormitory unit. *Id.*

[223] *See id.* (describing the OCSD's administrative review process following a critical incident); GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS, *supra* note 127, at 5 (stating the importance of a morbidity-mortality review process); NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at 39 (stating the importance of a morbidity-mortality review process).

[224] *See* GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS, *supra* note 127, at 5 (stating the importance of a morbidity-mortality review process).

[225] NATIONAL STUDY OF JAIL SUICIDE, *supra* note 30, at 39.

[226] *Id.*

[227] *See supra* notes 203–226 and accompanying text.

[228] *See* Hayes, *supra* note 11, at 193 (explaining that inmate suicides are preventable); *supra* notes 203–226 and accompanying text (describing the key elements of an effective suicide prevention program and the need for involvement by both correctional and mental health staff); *infra* notes 231–261 and accompanying text (suggesting that the federal government can help reduce inmate suicides by improving their criminal justice funding programs).

implemented, are likely to have greater success in reducing inmate suicides.[229] In order to incentivize state and local correctional facilities to implement the above-discussed inmate suicide prevention strategies, the federal government should revise its primary grant program for state and local criminal justice operations—JAG—to condition such grant funding on the implementation of comprehensive suicide prevention programs, and provide additional discretionary grants for correctional suicide prevention purposes.[230]

B. Incentivizing Inmate Suicide Prevention Reform by Modifying the Federal Justice Assistance Grant Program Requirements and Forms

The Edward Byrne Memorial JAG Program, administered by the Bureau of Justice Assistance ("BJA"), is the primary source of federal funding for state and local criminal justice initiatives.[231] JAG funds may be used to provide resources, such as training or equipment, for any of the following criminal justice purposes: (i) law enforcement; (ii) prosecution and court; (iii) prevention and education; (iv) corrections and community corrections; (v) drug treatment and enforcement; (vi) planning, evaluation, and technology improvement; (vii) crime victim and witnesses; and (viii) mental health programs.[232] Any state or local government that meets the JAG eligibility requirements may submit an application for JAG funds, which must include a description of the program to which the funds will be allocated, and a budgeting worksheet detailing how the JAG funds will be used to implement the program.[233] The award process starts

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[229] *See* JAIL SUICIDE/MENTAL HEALTH UPDATE (Fall 2005), *supra* note 205, at 1–6 (describing the OCSD's suicide prevention programming).

[230] *See infra* notes 231–261 and accompanying text.

[231] BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, JUSTICE ASSISTANCE GRANT PROGRAM ACTIVITY REPORT 1 (2016), https://www.bja.gov/programs/JAG-Activity-Report-Sept-2016_508.pdf [https://perma.cc/MJ9E-5Z4B] [hereinafter JAG ACTIVITY REPORT]. The program is authorized by statute. 42 U.S.C. § 3751 (2012); BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, EDWARD BYRNE MEMORIAL JUSTICE ASSISTANCE GRANT (JAG) PROGRAM FREQUENTLY ASKED QUESTIONS (FAQS) 1 (Aug. 2017), https://www.bja.gov/Funding/JAGFAQ.pdf [https://perma.cc/SGE5-WKFA] [hereinafter JAG FAQ]. In 2016, approximately $275 million of JAG funds were awarded to various states and U.S. territories. BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, JUSTICE ASSISTANCE GRANT PROGRAM TECHNICAL REPORT 1 (2016), https://www.bjs.gov/content/pub/pdf/jagp16.pdf [https://perma.cc/6MJ5-VBQE] [hereinafter JAG TECHNICAL REPORT]. Of that amount, approximately $181 million went to state governments, $86 million went to local governments, and $7 million went to U.S. territories and the District of Columbia. *Id.* The BJA is a component of the U.S. Department of Justice's Office of Justice Programs. *About the Bureau of Justice Assistance*, BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE (Mar. 10, 2018), https://www.bja.gov/About/index.html [https://perma.cc/68LS-S3HX].

[232] JAG 2017 STATE SOLICITATION, *supra* note 201, at 5.

[233] *Id.* at 16. All fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, Guam, and American Samoa are eligible to apply for JAG State awards. JAG FAQ, *supra* note 231, at 1. JAG Local awards are available to local governments listed on the JAG webpage. *Id.* In every state or U.S. territory, the governor or chief executive officer must appoint an agency, known as the State Administering Agency (SAA) to apply for and

with a calculation prepared by the Bureau of Justice Statistics, which creates an initial allocation of funds to all fifty states and U.S. territories, based on each jurisdiction's share of the nation's violent crime and overall population.[234] Every state and U.S. territory is entitled to a minimum of 0.25 percent of the total JAG allocation, regardless of population or crime average; if a state or U.S. territory's initial allocation exceeds the minimum amount, it receives the minimum award in addition to an award based on its share of violent crime and population.[235] States receiving JAG funds are then required to set aside forty percent of those funds to be allocated to local governments.[236] Local jurisdictions are then awarded funding based on a calculation of their three-year crime averages.[237]

The JAG Program application form for both state and local governments outlines several requirements, including a requirement that all applicants comply with applicable federal laws; additional requirements exist for certain other programs as well.[238] For example, the 2017 application form for state solicitation provides that applicants requesting JAG funds to purchase body-worn camera equipment must certify that the agency using that equipment has implemented policies and procedures regarding "equipment usage, data storage and access, privacy considerations, training, etc."[239] In order to incentivize inmate suicide prevention reform in state and local correctional facilities, the BJA should modify the JAG Program application requirements to similarly include a suicide prevention protocol prerequisite for applicants who are seeking JAG funds for correctional purposes.[240]

The suicide prevention protocol prerequisite would effectively condition correctional JAG funds on the implementation of comprehensive suicide pre-

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administer the JAG funds. *State Administering Agencies*, NAT'L CRIM. JUST. ASS'N, https://www.ncja.org/ncja/policy/about-saas [https://perma.cc/AS6Q-ZF5X]. In New York, the SAA is the New York State Division of Criminal Justice Services. *State Criminal Justice Profile: New York*, BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE (Mar. 10, 2018), https://bjafactsheets.iir.com/State/NY [https://perma.cc/9V6X-2TG9].

[234] JAG TECHNICAL REPORT, *supra* note 231, at 2.

[235] *Id.*; *see* 42 U.S.C. § 3755(a) (providing the allocation formula).

[236] 42 U.S.C. § 3755(b); JAG TECHNICAL REPORT, *supra* note 231, at 3. This sixty-forty percent split does not apply to the District of Columbia or any of the U.S. territories. JAG TECHNICAL REPORT, *supra* note 231, at 3.

[237] JAG TECHNICAL REPORT, *supra* note 231, at 3. For JAG purposes, units of local government include towns, townships, villages, parishes, cities, counties, boroughs, and other subdivisions of a state. JAG FAQ, *supra* note 231, at 1. In some states, district attorneys or parish sheriffs may also be considered units of local government. *Id.*

[238] BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, EDWARD BYRNE MEMORIAL JUSTICE ASSISTANCE GRANT PROGRAM FY 2017 LOCAL SOLICITATION 6–9 (2017), https://www.bja.gov/Funding/JAGState17.pdf [https://perma.cc/UG2A-X5MY] [hereinafter JAG 2017 LOCAL SOLICITATION]; JAG 2017 STATE SOLICITATION, *supra* note 201, at 6–10.

[239] JAG 2017 STATE SOLICITATION, *supra* note 201, at 6.

[240] *See id.* (describing prerequisites for certain uses of JAG funds).

vention policies in the facilities that will be using the funds.[241] State and local governments who can demonstrate that effective suicide prevention programs—i.e. programs that implement the above-discussed policies and procedures—are utilized by their correctional facilities, will meet the suicide prevention prerequisite necessary to receive correctional JAG funding.[242] State and local governments who fail to demonstrate that their suicide prevention programs meet the standards previously discussed will not receive JAG correctional funding.[243] Given the rising costs of maintaining a corrections facility, this prerequisite would give JAG applicants seeking correctional funding a stronger incentive to implement suicide prevention protocols, thereby affording enhanced protection to inmates at risk of suicide in their jurisdictions.[244]

In addition to adding this prerequisite for correctional funding requests, the BJA should also draw attention to the need for correctional suicide prevention programming on future JAG Program application forms.[245] In the 2017 JAG Program state and local application forms, the BJA included a section entitled "BJA Areas of Emphasis."[246] Under this portion of the form in the state application, the BJA listed several prevalent criminal justice issues, and encouraged state and local recipients of JAG funds to increase resources and

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[241] *See id.* (same).

[242] *See id.* (same); *supra* notes 203–230 and accompanying text (discussing the components of an effective suicide prevention scheme).

[243] *See* JAG 2017 STATE SOLICITATION, *supra* note 201, at 6–8 (listing preconditions for using JAG funds in certain areas of criminal justice programming). The Department of Justice requires recipients of its grants, including JAG, to submit financial reports detailing the expenditures and outstanding bills for a project that is covered by grant funding. OFFICE OF JUSTICE PROGRAMS, U.S. DEP'T OF JUSTICE, 2015 DOJ GRANTS FINANCIAL GUIDE 120, https://www.justice.gov/ovw/file/892031/download [https://perma.cc/9ZGZ-KEYY]. These reports must be submitted online through the Grants Management System (GMS), no later than thirty days after the last day of each quarter of the project. *Id.* at 120–21. If the report is not submitted by the deadline, the GMS will prevent withdrawal of funds through the Grants Payment Request System. *Id.* at 121. In addition to financial reports, the DOJ requires grant recipients to submit progress/program reports describing the activities of an ongoing plan or project. *Id.* at 123. Progress/program reports should be submitted annually or semi-annually, depending on the type of award, through the GMS. *Id.* Additionally, applicants requesting JAG funding for purchasing body-worn camera equipment are required to submit a signed certification stating that law enforcement agencies receiving the equipment have implemented written "mandatory wear" policies. JAG FAQ, *supra* note 231, at 11.

[244] PEW CHARITABLE TRS., STATE PRISON HEALTH CARE SPENDING 19 (July 2014), http://www.pewtrusts.org/~/media/assets/2014/07/stateprisonhealthcarespendingreport.pdf [https://perma.cc/ZV7U-YXZR]. In 2015, grantees across the country allocated approximately 6% of their JAG awards toward corrections and community corrections programs, which was the third program area to which grantees invested the most JAG funds. JAG ACTIVITY REPORT, *supra* note 231, at 2. Law enforcement and prosecution, courts, and public defense were the top two program areas where grantees allocated JAG funding, with 64.2% for law enforcement and 9.9% for prosecution, courts, and public defense. *Id.*

[245] *See* JAG 2017 STATE SOLICITATION, *supra* note 201, at 10–11 (listing the "BJA Areas of Emphasis").

[246] JAG 2017 LOCAL SOLICITATION, *supra* note 238, at 9–10; JAG 2017 STATE SOLICITATION, *supra* note 201, at 10–11.

reform towards those areas.[247] In 2017, the priority areas listed were: (i) reducing gun violence; (ii) national incident-based reporting system; (iii) officer safety and wellness; (iv) border security; and (v) collaborative prosecution.[248] In order to encourage greater attention and investment towards inmate suicide prevention reform, the BJA should add correctional suicide prevention programming to the list of JAG priority areas in future JAG Program application forms; as such, state and local governments will be aware that the federal government is willing to support improvement on this issue.[249]

C. The Department of Justice Should Create a Discretionary Grant Program That Supports Inmate Suicide Prevention Reform

In addition to offering broad-based criminal justice grants through the JAG Program, the DOJ should also create new discretionary grant opportunities specifically addressing the issue of inmate suicide.[250] Discretionary grants awarded by the DOJ's Office of Justice Programs are grants for state or local governments to use in addressing specific justice issues, and are often awarded on a competitive basis.[251] Discretionary grants aimed at inmate suicide prevention would offer state and local governments additional incentives and resources to pursue that type of reform in their jurisdictions.[252]

For example, the BJA had an application available in early 2017 for a competitive grant that would support the implementation of the Prison Rape Elimination Act ("PREA") to reduce sexual abuse and harassment in a local correctional system.[253] The application form included details on what the recipient of the grant would be expected to implement with the grant money, as well as a timeline according to which different phases of the project should be executed.[254] It outlined expectations for the planning phase of the project—such as identifying local confinement facilities in need of support to initiate PREA standards—and the implementation phase, including the introduction of sexual abuse victim support services.[255]

Similarly, the BJA should create a discretionary grant program for state or local correctional facilities that are in need of additional support to implement

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[247] JAG 2017 STATE SOLICITATION, *supra* note 201, at 10–11.

[248] *Id.*

[249] *See id.* (listing the BJA "Areas of Emphasis").

[250] *See OJP Grant Process*, *supra* note 202 (explaining what a discretionary grant is).

[251] *Id.*

[252] *See id.* (explaining what a discretionary grant is).

[253] BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, PREA PROGRAM: STRATEGIC SUPPORT FOR PREA IMPLEMENTATION IN LOCAL CONFINEMENT FACILITIES NATIONWIDE 4 (2017), https://www.bja.gov/Funding/PREA17.pdf [https://perma.cc/LZ4F-DAY3] [hereinafter PREA PROGRAM].

[254] *Id.* at 6–11.

[255] *Id.*

effective inmate suicide prevention measures.[256] As with the PREA grant, the inmate suicide prevention grant should include specific goals and objectives that the recipient agency would be required to fulfill.[257] These goals and objectives should focus on the key components of effective inmate suicide prevention that have already been mentioned: (i) intake screenings containing a mental health and suicide risk component, and continuing assessments of suicide risk, both conducted by qualified mental health professionals; (ii) initial and annual in-person suicide prevention trainings for correctional and mental health staff; (iii) collaboration between correctional and mental health staff, cultivated through joint meetings to discuss recent suicide incidents and issues; (iv) proper levels of observation by correctional officers for inmates at risk of suicide; (v) safe and suicide-resistant housing for at-risk inmates; (vi) prompt and appropriate intervention by correctional officers upon discovery of an inmate who has attempted suicide; and (vii) multidisciplinary morbidity-mortality reviews after each inmate suicide incident.[258]

Adequate funding is essential in every jurisdiction to maintain and improve a correctional system.[259] Therefore, the above-mentioned modifications and additions to the DOJ's JAG and other grant programs will encourage state and local governments to address the problem of inmate suicide, and will likely lead to an increase in the prevalence of comprehensive inmate suicide prevention programs across the nation.[260] With the essential suicide prevention strategies in place, jails and prisons will have what it takes to prevent someone like Christopher Barkes from taking his or her own life.[261]

CONCLUSION

Inmate suicide is one of the most pressing issues in correctional systems nationwide, because it is the leading cause of death in local jails and the second leading cause of death in state prisons. For a number of reasons, including the costliness of mental healthcare and complacency regarding inmate deaths, many correctional facilities do not have the comprehensive range of inmate suicide prevention programs that mental health experts recommend in order to reduce inmate suicides. Additionally, because of the qualified immunity doc-

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[256] *See OJP Grant Process*, *supra* note 202. *See generally* PREA PROGRAM, *supra* note 253 (offering a grant application for the purposes of implementing PREA standards in correctional facilities).

[257] *See* PREA PROGRAM, *supra* note 253, at 6–11.

[258] *See supra* notes 203–230 and accompanying text.

[259] *See* Hanson, *supra* note 36, at 7; STATE PRISON HEALTH CARE SPENDING, *supra* note 244, at 19 (showing a peak in correctional healthcare spending in 2009 at $8.2 billion, and a slightly lower amount of $7.7 billion in 2011).

[260] *See* Hanson, *supra* note 36, at 7; STATE PRISON HEALTH CARE SPENDING, *supra* note 244.

[261] *See supra* notes 203–230 and accompanying text.

trine, correctional authorities are shielded from liability even when their failure to implement suicide prevention measures results in an inmate death.

To address the lack of progress in inmate suicide prevention, the federal government should intervene by incentivizing enhanced efforts by state and local governments nationwide toward inmate suicide prevention reform. The U.S. Department of Justice (DOJ) should require state and local governments who request funding for correctional purposes through the Justice Assistance Grant ("JAG") Program to have comprehensive suicide prevention programs in effect in their jurisdictions' correctional facilities. The DOJ should also encourage JAG applicants to spend their funding on inmate suicide prevention reform, by including the issue on its list of areas of emphasis on future JAG application forms. Finally, the DOJ should establish new discretionary grants that offer additional funds to state and local agencies to support their implementation of comprehensive inmate suicide prevention program in jails and prisons.

An effective corrections system should aim at rehabilitating the lives of those who have become involved in the criminal justice system, so that they can rejoin their communities and flourish in them. This cannot happen if jails and prisons are places where inmates are left to fall prey to their environment and to their own mental illnesses. Therefore, inmate suicide prevention efforts are essential to the function and operation of a successful corrections system, and should be encouraged, supported, and urged in the most effective ways possible. Only then can a corrections system truly be engaged in restorative efforts.

VENUS CHUI