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The Survivability Hierarchy Behind Bars: Themes, Reforms, and Prevention Program Evaluations in Washington State Jail Suicides

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The Survivability Hierarchy Behind Bars:

Themes, Reforms, and Prevention Program Evaluations in Washington State Jail Suicides

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ABSTRACT

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Across jails nationwide, suicide remains the leading cause of death. Suicide has been the leading cause of death for U.S. jail inmates for over 40 years. In Washington State, suicide accounts for 47% of all jail fatalities while incarcerated. To address this critical issue, the U.S. Justice Department set best practices for jails to follow for suicide prevention programs in 1989. Yet, these best practices have not reduced the disproportionate rate of jail suicides. Far from a decrease, suicide deaths for jail inmates rose 13% in the last 20 years. This dissertation involved three methods of analysis for this critical issue. First, a thematic analysis was conducted on all suicide jail death records in Washington State from 2004 to 2021. Second, a dataset of 29 Washington State jails' suicide prevention and training policies was evaluated. These policies were scored according to their adherence to the best practices for jail suicide prevention. Scores were correlated with jail-specific suicide rates (in deaths per 100,000 residents) to determine whether best practice adherence was associated with disproportionately low suicide rates. Finally, a narrative analysis was conducted on project-wide themes. Results suggested that though many factors in best practices were associated with individual jail suicides, best practice adherence was not actually associated with jails' suicide rate on a systemic level. Implications from these results include problems with implementing on-the-books policy by correctional staff, and the possibility that current best practices, nearly 35 years old, may no longer be the most effective components of jail suicide prevention.

DECLARATION

I, Rocky B. Marks, the principal author, state that I did not receive any funding for this research. No agency or organization was involved in the planning or organization of this dissertation. Data was partially provided by the Columbia Legal Center with permission; however, that agency had no role in the planning or analysis of the current dissertation. Thus, there are no conflicts of interest to declare.

CHAPTER I – INTRODUCTION

By a wide margin, the United States has the highest incarceration rate in the world. Almost every state, taken as its own country, would have a higher incarceration rate per capita than virtually any independent democracy on Earth (Prison Policy Initiative, 2021). Amidst this population of incarcerated persons, suicide remains the leading cause of death in jails[1] representing over one-third of all deaths behind bars. On one specific day in June of 2019, more than half of all jails housing more than 1,000 people reported at least one death by suicide (Bureau of Justice Statistics, 2021). Controversies following high-profile deaths by suicide, such as those following the deaths of Sandra Bland, Cachin Anderson, Billy Slagle, and Jeffrey Epstein, have also led to calls for reform from judges, senators, and congressional staff (Cohen & Eckert, 2019).

Despite these calls for reform and more than a quarter of a decade of research on comprehensive correctional suicide prevention, there has been little major progress in terms of systemic change. Far from a decrease, suicide deaths for jail inmates have risen 13% since the turn of the 21st century. Though comprehensive best practices exist, setting in place many recommendations for effective suicide prevention in jails, national surveys of jail programs found that only 20% of jails have utilized more than half of these best practices and only 10% have utilized all of them (Hayes, 2012). Most jails nationwide were found to ignore one of the most fundamental procedure of conducting of a mortality review following a suicide in custody (Vera Project, 2018). Psychologists and clinicians who work within the correctional system

[1] An important term of distinction for this dissertation and field of research relates to the difference between 'jails' and 'prisons.' They are often used interchangeably but are actually two different types of custody. When someone is arrested for a crime, they are taken to be booked at a jail, where they will be held until they can be tried for the charge that they are facing. If the person has a history of fleeing, or if the charges that they are facing are very serious, then they will be held without the option of bail. This means they will wait in jail until their trial. Otherwise, a predetermined amount of bail will be set based on the nature of the crime. If an individual is able to post a portion of that money, they will be able to leave jail. A prison is where that individual will be sentenced to serve out their time if found guilty at their trial. Thus, jails are short-term facilities meant to hold persons before their trial. In most states, sentences under 1 year will be served out in jail. Prisons are long-term incarceration facilities.

must find and address the gaps that have contributed to the rise in forensic suicidality. To identify these faults, it is crucial to have a comprehensive understanding of the factors contributing to this issue and how they have developed over time.

Background

Many factors contribute to the elevated rates of suicide facing those incarcerated within jails. These include overcrowding, limited healthcare options, lack of financial and social support, and the "shock of confinement," the term describing the sudden shift to the reality of incarceration. From the moment a person is restrained and locked into the back of a police cruiser, to the moment they are booked into jail, they become disincorporated from mainstream society, losing control over personal property, social support systems, and autonomy and agency over their life course (Fazel et al., 2017; Goss et al., 2002; Marks et al., 2020; Wilson, 2019). When paired together with hopelessness about one's future, the conditions are set for unpredictable and fluctuating levels of suicide risk. However, not every person is entering custody at equivalent risk of suicide; some individuals are intersectionally vulnerable to dangerous levels of suicide risk behind bars.

Some have argued that systemic oppression on the grounds of race, socioeconomic status, availability of insurance, housing status, and other marginalized identities play into both the lack of available mental health treatment and the propensity for marginalized people to be targeted by strict policing and substandard court defenses leading to incarceration en masse (Greenberg & Rosenheck, 2008; Hawthorne et al., 2012). Once in custody, their risk of suicide rapidly increases, as past research has found that the highest risk of suicide death occurs within the first 24-48 hours (Hayes, 2010; Wilson et al., 2019; Marks et al., 2020). Additionally, an individual's

mental health history places them at differing levels of risk, as many find themselves jailed due to untreated psychopathology.

Past research has argued the starkly elevated suicide rate in American jails is a direct consequence of the "Great Migration." This term describes the process in which individuals were forced out of mental institutions as they closed en masse in the 1980s. With little effective scaffolding for treatment, these individuals migrated to the justice system, which some have argued have become, in large effect, mental health holding facilities (Felthous, 2011; Frühwald & Frottier, 2005; Torrey, 1995). Jail administrators themselves have decried this system, with the National Sheriff's Association (2015) releasing a statement to emphasize, "Sheriffs and wardens are not the nation's psychologists. We have decided that as a society, let's just warehouse the mentally ill in a jail, which is neither equipped for, nor trained, to handle or be able to be the most efficient or effective at solving the problem. The failure is that these individuals are being put in a criminal environment for mental illness." (NSA, 2015)

Those in jails are five times more likely to be living with a mental health condition when compared to the general populace. Any given American individual living with serious mental illness is three times more likely to be in a jail or prison rather than in any sort of treatment center (Aufderheide, 2014). Behind bars, 77% of those who engaged in suicidal behavior were found to have been living with serious mental illness. Those who were living with a mental health issue in jail were over five times more likely to engage in initial and repeated suicidal behavior (Cain & Ellison, 2022; Goss et al., 2002). Over three-fifths of those who die by suicide while incarcerated in jail were living with a mental illness before their untimely deaths (Hawthorne et al., 2012). This pattern speaks to a grim realization that many jail suicides are those who have failed to either access or benefit from mental health treatment.

There is a critical need to understand jail suicide prevention on an individual and systemic level to understand these changes and direct potentially life-saving reforms. This dissertation aims to determine whether best practices in jail suicide prevention are still effective at preventing suicide in jails, and if they are not, where reforms could be made.

Washington State Jails

Washington's jail system is unique. Within the state, the past 50 years have seen a staggering 362% increase in the number of persons incarcerated within jails. Compare this to California, the state with the highest jail population in the nation, which grew by 180% over the same period. Were Washington State its own country, only seven countries in the world would have a higher rate of growth over the same period (Bureau of Justice Statistics, 2020; Vera Project, 2018). The jail population numbers just under 10,000 people, two-thirds of whom are pretrial and not yet convicted of any crime. Of the state's population, 5% is currently within the jail system. Like many other states, BIPOC individuals are overrepresented in the jail population. To name just one example, in the state of Washington, Black individuals account for roughly 5% of the state population, but over 12% of the state's jail population. Far from a metropolitan issue, the highest rate of jail incarceration occurs in rural counties such as Lincoln, Garfield, and Cowlitz (Green, 2020; National Institute of Corrections, 2019).

Despite the progressive politics Washington State is known for, its policing and incarceration laws are unquestionably strict, which plays a large role in the disproportionate rate of suicide in jails. In fact, most jails did not have any form of suicide screening, assessment, or treatment policy until 2002. At that time, independent researchers hired by a review committee for King County Jail, who found that over three-fourths of those who had attempted suicide had an untreated mental health condition, compared to 15% of those in the general jail population

(Goss et al., 2002). The reforms King County Jail took in response to this report soon spread to other jails within the state, showcasing that although the State's correctional system can be strict, it is amenable to change in light of research findings. Recently, the Office of the Corrections Ombuds (2021) conducted an independent review of jail policies. They warned that the State's mismanagement of jail mental health care, as well as the state's facilities overuse of psychologically stressful disciplinary punishment such as lengthy stays in solitary confinement, have resulted in the State's elevated jail suicide rate. They further warned that this rate will only increase in the future. Currently, there is little to no information available about the quality, use, or frequency of suicide prevention programs within the state's 58 jails. This segmentation of information only serves to impede reform efforts.

Existing Research on Suicide in Jails

Past research has allowed insight into some of the common themes involved in correctional suicidality. Inmates who died by suicide while awaiting trial in jail were most commonly younger, often between the ages of 20 to 25 years old, and typically unmarried male first-time offenders charged with a nonviolent drug offense (Blaauw et al., 2005; Konrad et al., 2007; Winter, 2003). Frank & Aguirre (2013) conducted a meta-synthesis of qualitative jail suicide studies and found three overarching categories, a) mental health issues such as depression, psychosis, prior suicide attempts, and religious beliefs; b) environmental factors, such as problems with jail staff, losing employment, or issues relating to court appearances; and c) issues of social support, such as with family or with other inmates. In quotes from incarcerated persons on what themes motivated their suicidal behavior, inmates shared about untreated mental illness, being at the mercy of guards and other prisoners, feeling humiliated and alone, wanting to scare or traumatize correctional staff who were cruel to them, and carrying secret hopes that

someone would come to save them. Among suicide attempters, hopelessness, loneliness, shame, guilt, isolation, and paranoia were consistent themes that drove incarcerated persons to engage in suicidal behavior (Suto & Arnaut, 2010). Incarcerated persons have been shown to respond well to participating in research on suicide prevention, and they have responded favorably to changes in suicide prevention programs motivated by research, exhibiting that these incarcerated persons want their voices to be heard by psychologists, clinicians, and administrators, as well (Hemming et al., 2021).

Suicide Prevention Programs in Jails

Much of the modern infrastructure around suicide prevention programs in correctional settings was built after a series of national studies by Lindsay Hayes, the pre-eminent researcher in this field. These studies established the starkly elevated rate of suicide deaths among jail inmates (Hayes, 1983; Hayes, 1989). Following the second report, Hayes and the National Commission on Correctional Health Care (NCCHC) set best practices for suicide prevention programs for jails and prisons. These programs were initially slow to catch on, especially in smaller jails that could not logistically afford some of the resources required. Widespread adoption of these practices became more commonplace after a landmark decision by the Michigan Court of Appeals established that jails could be liable for hefty civil suits if their suicide prevention programs were found to be deficient in the event an incarcerated person died by suicide (*Williams v Mehra, 186 F.3d 635*).

The foundation of Hayes and the NCCHC's standards were built upon 11 core components that needed to be integrated into any suicide prevention program; these include Identification, Training, Assessment, Monitoring, Housing, Referral, Communication, Intervention, Notification, Reporting, and Review. See Appendix A for a detailed breakdown of

each component and examples of each in action. In more recent years, the NCCHC pledged to adopt a Zero Suicide initiative by 2025 (NCCHC & AFSP, 2019), incorporating some of the most well-supported suicide assessment programs such as the Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2012) and Chronological Assessment of Suicide Events (CASE, Shea, 2009). Through incorporating modern suicide theories, screening tools, and knowledge of risk factors, the recommended suicide prevention policy and program recommendations are still anchored in those same 11 components established over three decades earlier.

While there are logistical factors, such as facility liability or correctional staff stress, that make the adoption of these best practices desirable for any jail administrator, they are voluntary. Jail suicide prevention is neither restricted nor enforced by any sort of licensing or review board. Each jail is free to choose whether these standards should be followed. Although this latitude allows each jail the maneuverability to adopt suicide prevention practices that are more responsive to their particular incarcerated population, the reality is that it creates a hierarchy of jail environments that are simply more survivable than others. Often, the jails with the fewest resources end up as the least survivable jails, often in the most disenfranchised and intersectionally vulnerable communities.

Past research has found the strength and versatility of each facility's suicide prevention program are tied to those same suicidal inmates' ratings of each jail's survivability, respect for their dignity, and consideration of their rights (Knoll, 2010). Systematic reviews have shown that poorer suicide prevention programs, as well as facilities with a reduced mental health presence or more sparsely trained staff, are directly related to increases in the rates of suicidal behavior and suicide death (Pompili et al., 2009). While best practices for jail suicide prevention are dynamic

and comprehensive, their inability to halt the growth of death by suicide behind bars speaks to troubling overarching questions: are there gaps in the implementation of these best practices? Are there issues in the training that teaches them? Or are there more serious issues in the foundational knowledge that these best practices are built on? To answer these questions, multiple levels of access may provide insight. One of the most informative being investigations at the facility and state level, examining commonalities among suicide prevention programs drafted within particular regions. However, the individual-level factors also provide insight, and to build the foundation of those themes, we may look to theories of suicidality as a guide.

Relevant Theory

Integrated Motivational-Volition Theory

The Integrated Motivational Volitional Theory (IMVT; O'Connor and Kirtley, 2018) conceptualizes the development of suicidality into three distinct phases. The first of which is the threat-to-self phase, in which an interaction between diathesis, environment, and life events sets the stage for the development and advancement of suicidality. Next, the motivational phase occurs when social defeat, humiliation, and hopelessness lead to the development of threat-to-self factors such as entrapment, in which the individual feels like they are at their lowest, and that the future holds little to no promise for them. At this point, the individual begins to develop suicidal ideation and an intent to die by suicide. They start to develop a plan and think through the logistics of dying by suicide. Finally, suicidal behavior emerges in the volitional phase when factors, such as access to means, impulsivity, physical pain sensitivity, and fearlessness about death rise to their peak. In this phase, acquired capability, exposure to others' suicidal behaviors, detailed suicide plans, and cognitive rehearsal of death facilitate the transition from suicidal ideation into suicidal behavior. Among suicide theories, the IMVT may uniquely explain

components such as humiliation, social defeat, and hopelessness that may be linked to the jail experience. Past research has investigated components of the IMVT in prison samples, such as those that found that hopelessness, social defeat, and entrapment were associated with the development of suicidal ideation and behavior (Chapman et al., 2005; Simlot et al., 2014; Slade & Edelmann, 2014). However, this dissertation will be the first explicit application of the IMVT in its entirety to a forensic sample, and further still, the first to investigate the theory when applied to jail suicides. In so doing, I am to examine factors relevant to jail suicides on an individual level in a correctional environment, as these factors should inform policy decisions.

Present Study

The present study uses multiple methods of analysis that are all intended to answer the question, 'Where are the points of access and reform in jail suicide prevention?' This is a wider-scope question, however, and the more direct intent of the project is to examine whether jail suicide prevention practices are still effective at reducing the suicide rate, and if not, what factors should be considered for reform. The purpose is that the analysis should direct progress in curbing further loss of life to preventable suicide. Using this framework, this dissertation will examine three levels of analysis, each with an increasingly broad scope. First, individual-level factors will be analyzed through a qualitative analysis of suicide decedent death records. Next, jail-level factors will be analyzed through program evaluations of suicide prevention policy. Finally, statewide-level themes will be analyzed through a mixed methods approach and a combined thematic analysis.

Aim and Hypothesis 1 – Individual-Level Themes

Using a sample of all jail suicide death records from 2004 to the present day, I conducted an exploratory qualitative thematic analysis of common factors and themes underlying death by

suicide. These death records were coded for their applicability to the IMVT. Specifically, codes which support the each of the three phases of the IMVT will be found; Appendix B contains all possible themes which could be coded for within this dataset under the IMVT framework. These themes should support whether unique drivers of suicide exist in the correctional environment which policy should be effectively attenuating. The IMVT may be uniquely set to explain some of the relevant social drivers of suicide in jail settings due to the greater emphasis on social defeat, humiliation, and entrapment components when compared to other suicide theory. Further, should results of the study support the need for reform, these themes may provide valuable insight to the areas in which suicide prevention efforts should target. Expected themes that there will be thematic support for the IMVT to find common drivers of suicide in jail settings.

Aim and Hypothesis 2 – Jail-Level Analysis

Next, analysis for jail-specific factors relevant to suicidality will be conducted. First, individual death records from the *Gone But Not Forgotten* dataset will be coded for both explicit mentions of Best Practice Criteria that is followed, and explicit mention of Lack of Best Practices that were followed. An example of this latter set of codes could be discrepancies in the frequency of suicide check-ins while an incarcerated person is on suicide watch, or remarks about suicide that were not referred to mental health services. This will allow a degree of insight into the preventability of each death by suicide, which will be integrated into the final analytical method. Next, a program evaluation was conducted on jail suicide prevention policy and training materials, which were provided by over half of all jails in Washington State. These policies will be coded by two independent raters who analyzed the provided policy or training materials based on whether they explicitly mentioned or included each of the 11 core suicide prevention criteria first outlined by Hayes and the NCCHC in 1989 (See Appendix A). These results were analyzed

to assess best practice adherence in Washington State jails. For the best practice and lack of best practice codes, expected themes are that there will be more codes for jails that have problematic best practice criteria than those that have codes for correctly implementing best practice criteria. This would suggest that best practices are still effective, yet there may be issues in implementation. An adjoined theme I expect to find is that most jails with problematic criteria will have those same criteria reflected in policy. That is, many jails will fail to follow criteria that is actually reflected in their policy materials. For the policy-coded data, I hypothesize that due to a lack of enforceability behind these best practices, more than half of the jails will meet less than 50% of these criteria.

Aims and Hypothesis 3 – Statewide-Level Analysis

Finally, I combined these two methods of analysis, comparing individual death records with available suicide prevention policies by facility. Each facility will be explored for its best practice criteria score, and themes that emerged among suicide deaths that have occurred within that facility. This mapping will help examine whether best practice adherence results in fewer deaths by suicide for each jail in the dataset. Furthermore, jails with higher best practice scores should have fewer deaths with codes for Lack of Best Practices Followed, such as unanswered requests for help, lack of comprehensive means restriction, or inconsistent reports of safety and wellness checks. In addition, each jail will be assigned a suicide rate per 100,000 residents, based on the number of deaths by suicide over the average daily population of that jail. In sum, I hypothesize that jails with high best practice adherence will have a lower jail suicide rate, jails with low best practice adherence will have a higher suicide rate, and jails with high best practice adherence should have few, if any, decedent themes related to Lack of Best Practices Followed.

The present study seeks to highlight the factors that are most contributing to the critical problem of incarcerated suicides within state jails. By using a mixed methods approach, this dissertation hopes to find crucial commonalities underlying these suicides. In using a program evaluation approach, this dissertation endeavors to find state-level gaps in the justice system. In so doing, these analyses can direct the attention of clinicians, administrators, and concerned citizens toward how we can best build systemic reform efforts. Finally, this study seeks to ask about the viability of best practices within correctional systems to ask whether the rising tide of jail suicides points to a problem with implementation, training, or a more troubling issue with the practices themselves. Specifically, I make one central hypothesis and one adjoined hypothesis for this dissertation. I hypothesize best practice adherence will be correlated with jail suicide rates. This would suggest that best practices are still effective at controlling jail suicides, yet the key issue preventing their effectiveness is a lack of implementation.

CHAPTER II – METHOD

As any issues with jail suicide prevention are complex, multilayered, and with many stakeholders, this dissertation will use analyze data at three different levels of increasing scope. Each is intended to tackle the central construct of suicidality within the jail system. To improve the veracity of the results, this dissertation was conducted under the Standards for Reporting Qualitative Research (SRQR; O'Brien et al., 2014), a set of 19 standards for high-quality qualitative research. See Appendix C for a full checklist of SRQR quality criteria and their respective sections within this dissertation.

Positionality Statement

One of the most distinctive characteristics of the SRQR involves the disclosure of researcher characteristics that may affect the research questions, methods, results, or transferability. After all, in qualitative research, the researcher is the instrument. As a fifth-year doctoral student from a research team focused on studying suicide, my attention is often drawn to stories of suicide, hopelessness, and pain. A variety of characteristics pushed me to this dissertation, from my long-held desire to work within the sphere of forensic psychology, to my time talking with incarcerated women in the yard of the Washington Corrections Center for Women, whom my high school physical education class would pass on our daily walks. Additionally, my experiences also shape my interaction with this material, from the frustrations my mother would share during her time as a Social Program Coordinator working at Skagit County Jail while growing up, to a distant family friend's death by suicide while in jail for drug charges during my adolescence. These experiences draw me to empathize with the incarcerated person, the individuals enmeshed in the correctional system, above and beyond the needs and concerns of jail administrators. Thus, I may be more likely to interpret the story of an incarcerated individual as the victim of systemic faults, which ultimately led to their death, rather than as a perpetrator or a tragic yet unforeseeable case. Additionally, I am a post-positivist, which is to say that I do believe there is some common truth underlying each case of jail suicidality, rather than a constructivist interpretation that may frame each suicide as distinct and irreproducible. I believe that by studying suicide deaths in the past, the information gained can be used to prevent suicides in the future.

Individual Level Analysis

The first approach is a thematic analysis of individual death records for all jail deaths in Washington State since 2004.

Sample, Ethical Issues, & Researcher Characteristics

This analysis used the records gathered for Columbia Legal Service's report *Gone but Not Forgotten: The Untold Story of Washington State's Jail Deaths (2019),* a comprehensive dataset containing official mortality record reviews filed by the State (n = 213). In addition, this record has been supplanted with details provided through psychological autopsies of family members, descriptions from other incarcerated persons, and news stories of the deaths, where applicable. As this record contains deaths by homicide, overdoses, withdrawal/detoxification, illness, use of force, or unknown causes, only the records deemed to be suicides were retained for analysis (n = 90; 42%). It is noteworthy that these records contain information which is not gathered or edited by myself. Thus, they may contain the biases or interpretations of the original staff who gathered them.

Table 1 and Table 2 contain demographic statistics for this data.

Table 1. Jail Suicide Death Demographic Statistics

Demographic	*n*	Percentage (N = 90)
Biological Sex		
Male	74	82.2%
Female	16	17.8%
Race/Ethnicity		
African American/Black	7	7.9%
Asian	1	1.1%
Latinx	3	3.4%
Native American	4	4.5%
Pacific Islander	2	2.2%

White	47	52.8%
Unknown Race/Ethnicity	25	28.1%
Jail (County or City)		
Jail I (*County*)	9	10.10%
Jail II (*County*)	9	10.10%
Jail III (*County*)	5	5.60%
Jail IV (*County*)	5	5.60%
Jail V (*County*)	7	7..9%
Jail VI (*County*)	16	18%
Jail VIII (*County*)	4	4.50%
Jail IX (*County*)	4	4.50%
Jail X (*County*)	3	3.40%
Jail XI (*County*)	4	4.50%
Jail XII (*County*)	2	2.20%
Jail XIII (*County*)	3	3.40%
Jail XIV (*County*)	3	3.40%
Jail XIX(*County*)	2	2.20%
Jail XV (*County*)	1	1.10%
Jail XVI (*County*)	1	1.10%
Jail XVII (*County*)	2	2.20%
Jail XVIII (*County*)	1	1.10%
Jail XX (*County*)	1	1.10%
Jail XXVII (*County*)	2	2.20%
Jail XXVIII (*County*)	1	1.10%
Jail XXXIII (*City*)	2	2.20%
Jail XXXIV (*City*)	1	1.10%
Jail XXXV (*City*)	1	1.10%

Table 2. Demographic Statistics on Jail Suicide Death Charge/Reason for Incarceration

Charge	*n*	Percentage (*N* = 90)	RCW: Violent (V) or Nonviolent (N)
Arson	1	1.1%	N
Assault 1	3	3.4%	V
Assault 2	7	7.9%	V
Assault 3	1	1.1%	N
Assault 4	6	6.7%	N
Burglary	5	5.6%	N
Child Molestation	1	1.1%	V
Child Rape	5	5.6%	V

Criminal Trespassing	1	1.1%	N
Delivery of Controlled Substance	1	1.1%	N
DOC Detainer	1	1.1%	N
Drug	3	3.4%	N
DUI	4	4.5%	N
Domestic Violence	10	11.2%	N
Failure to Register as a Sex Offender	1	1.1%	N
Federal Detainer	1	1.1%	N
Felony Bench Warrant	1	1.1%	N
Felony Harassment	1	1.1%	N
Intoxicated Assault	1	1.1%	V
Kidnapping	1	1.1%	V
Murder	1	1.1%	V
Property and Retail Theft	1	1.1%	N
Prostitution	1	1.1%	N
Rape	3	3.4%	V
Robbery	2	2.2%	V
Stolen Car	1	1.1%	N
Theft	6	6.7%	N
Unknown	17	19.1%	N
Warrant Hold	2	2.2%	N
Violent vs. Nonviolent Crimes			
Violent	24	26.6%	-
Nonviolent	66	73.4%	-

Note: RCW stands for Revised Code of Washington, a compilation of Washington State's in-effect laws.

The final sample contained a wide range of ages, from ages 18 to 82 ($\bar{x}$ = 37.1, *SD* = 10.7). Additionally, there was a wide range of variability for how many days an individual was incarcerated until they died by suicide, from mere minutes to just under 3 years ($\bar{x}$ = 58.4, *M* = 5, *SD* = 152.7). The majority of the dataset was comprised of individuals classified as biologically male (*n* = 74; 82.2%). The remaining subset consisted of individuals classified as biologically female (*n* = 16, 17.8%). Just over half the dataset was listed as White (*n* = 47; 52.8%), followed by an Unknown Ethnicity category (*n* = 25; 28.1%) and African American (*n* = 7; 7.9%). The number of suicide deaths in individual facilities varied greatly, with Jail VI (*n* = 16; 18%), Jail I

(*n* = 9; 10.1%), and Jail II *(n* = 9; 10.1%) carrying the greatest number of jail suicides. Among specific charges, with the exception of an Unknown Charges classifier (*n* = 17; 19.1%), individuals who were facing charges of domestic violence had the greatest number of suicides (*n* = 10; 11.2%), followed by those charged with Assault II (*n* = 7; 7.9%). Under Washington State law (*RCW 9.94A.030*), the majority of charges among those who died by suicide in jail were related to nonviolent crimes (*n* = 47; 52.8%), as opposed to charges for violent crimes (*n* = 25; 28.1%), or unknown charges (*n* = 17; 19.1%).

Ethically, the dataset does contain identifying information within it, such as full names or dates of death. However, as this information does not provide additional insight into the research question, and more importantly, out of respect for the decedents and their families, this information will not be reprinted. Instead, a coding structure will be used where each person is referred to by their specific jail code (see Jail-Level Analysis) and the order in which they died chronologically. For example, if Jail I had nine deaths by suicide and themes were pulled from the third person to die at that jail in chronological order, they would be referred to as [Jail I – Person #3].

Data Analytic Method & Techniques to Enhance Trustworthiness

This thematic analysis was conducted using *Atlas.ti*, a premier software for processing qualitative research. Using this software, content from these death records will be coded and synthesized into themes with supporting quotes. One of the additional boons of using *Atlas.ti* is that this program raises ease of access for triangulation, or the coding of the same dataset through multiple members, each with their own perspective. It does so by exporting codes and project files that are easy to use between members. Within this dataset, each of the samples is triangulated by a different independent coder as well as myself. The dataset involving death

records was subject to reliability coding by a colleague from the same research team that I belong to. That is, she reviewed codes that I had assigned, and based on her knowledge and perspective, removed codes that did not appear to make sense, or added codes where I may have missed them. The jail-level dataset involving policy codes was completely coded by an independent second rater, an undergraduate Research Assistant from my research team with the primary scores from this dataset being an average between each of the two raters. The presence of multiple viewpoints for each of these datasets increases the trustworthiness of the final dissertation results.

These codes were generated through process coding to pattern, classify, and reorganize themes that exist within the dataset (Saldana, 2011). *A priori* themes related to components of suicide theory, specifically the IMVT, as listed in Appendix B. Finally, miscellaneous codes were also assigned. These were codes without direct *a priori* parallels in the IMVT or the Best Practice criteria, but appeared to be common enough to be noteworthy.

Jail-Level Analysis

The next method of analysis was chosen as it allowed for facility-level and state-level views on suicide prevention programs. Specifically, this dissertation utilized a particular type of program evaluation termed a policy analysis, which is an important analysis used in economics, sociology, and public health, yet often used in psychology as well (Hayden, 2006; Heckman, 2010; Kingdon, 1984; Weimer & Vining, 2017).

Sample Characteristics & Materials

The sample used for this methodology is two-fold. First, the same dataset of death records from the individual-level analysis (the *Gone but Not Forgotten* data) was analyzed for codes related to best practices. Expected themes related to the 11 core components of suicide

prevention programs. Thus, codes were assigned whenever a specific criterion was mentioned as being followed or deficient, according to definitions outlined in Appendix A. For example, if a death mentioned that staff implemented life-saving measures such as CPR or utilizing an AED during suicidal behavior, they would be coded for implementing the best practice of Intervention. If a death record mentioned staff did not check on a suicidal individual regularly, they would be coded for Lack of Monitoring.

Next, jail-level policy was analyzed through an original dataset of suicide prevention policies and training materials for 32 of Washington's 58 county and city jails (55%). This dataset was gathered from December of 2019 through November of 2023. My specific hypothesis was that fewer than 50% of jails would meet fewer than half of the criteria, as operationalized by the mean score for best practice adherence being lower than 50%; this hypothesis was made according Hager's (1996) model for qualitative analysis hypotheses. For this dissertation, Washington State jail commissioners, correctional staff, or Sheriff's departments for 54 city and county jails were contacted. Two tribal jails did not have contact information available, and two jails were currently closed during the study's period. All jails were requested to provide their suicide prevention written policy materials and staff training programs. Specifically, they were asked for written policies on suicide prevention programs or training such as memos, written training materials, employee manuals, and public or private policy materials. They were explicitly asked to provide written directives meant to define a jail's suicide prevention process. Finally, I asked for any suicide prevention training materials that were not written, such as slideshows or videos as well. These requests were not direct and did not explicitly refer to materials under a specific title as the heterogeneity of how jails refer to these documents might confuse. Within responses received, similar written suicide prevention

policy was referred to as ‘suicide prevention policy,’ ‘suicide directives,’ ‘mandated staff regulations on suicide,’ ‘zero suicide policy,’ ‘crisis policy,’ ‘crisis management systems’ and more, justifying the vagueness of the request language used.

Additionally, many jails provided a variety of materials from electronic records to PowerPoint slideshows, web portals, brochures, leaflets, notecards, pictures of written policies posted on staff boards, and in one case, a complete training video for new staff on a DVD. Some facilities provided records of suicide decedents they had kept, which were excluded as they contained identifying information and thus fell outside of the bounds of this study. Of the 55 facilities surveyed, 27 responded and 2 indicated that they had no suicide prevention programs. 25 of those that responded were in county jails, as opposed to city jails. Three county jails did not wish to provide materials for this study. Excluding those jails that refused, this dataset included all jails with larger than 100 beds within the State of Washington, with most remaining jails being city-based jails with fewer than 50 beds or tribal jails that did not have many staff. As such, the dataset, which contained the most populous half of the State’s jails, was considered to be an effective and representative sample of Washington State jails.

An additional ethical consideration related to the identification of specific jails by name. This dissertation contains analysis which could be quite critical of these jails. Though policy materials fall under the domain of public records, all jails provided materials willingly and may have done so without specific knowledge that these materials may be scrutinized as part of this research. However, more importantly, criticism of specific jails does not fulfill the central aims and hypotheses of this dissertation, which primarily serves to analyze factors relevant to jail suicidality from multiple perspectives for reform efforts, and in addition, analyzing the implementation and effectiveness of best practices for all jails in the state. The solution chosen is

that each jail will be coded according to population size, which should help to protect jails. Some administrators may find information which could be critical of these policies to be useful for the purposes of improvement or analysis, and if so, a key for decoding results and de-identified materials by can be supplied at my email, footnoted below[2].

Data Analytic Plan

From this sample of suicide prevention policy, two independent coders generated codes based on whether each jail explicitly referred to each one of Hayes and the NCCHC's foundational 11 core suicide prevention components which are: Identification, Training, Assessment, Monitoring, Housing, Referral, Communication, Intervention, Notification, Reporting, and Review. For example, a jail which had all criteria except that that failed to specifically mention suicide-specific cell blocks or housing units would be docked one out of 11 available points to generate their score, receiving a 10/11 total score. These policies were coded on their adherence to 11 best practice criteria. Within this dataset, scoring criteria was as follows:

- A facility was given a full point (1) if they met all of the core components of a particular factor of best practices.
- A facility scored three-quarters of a point (.75) if they met most of the core components but had some small imperfections in how that facility chose to implement that best practice criteria; an example could be if a jail notifies the warden, the coroner, and other administrative bodies in the event of a suicide death, but not the family of the decedent specifically, as is recommended in best practices.
- A half point (.5) if parts of the best practice factor were present but there were notable deficiencies in the implementation of that factor. An example would be that staff are

[2] Please reach out for a key to identify specific results at marksj2@spu.edu

trained in suicide prevention when they are hired but are not given annual refreshers, as is recommended.

- A quarter-point (.25) if the best practice factor was represented in policy but with such noteworthy flaws or shortcomings in this factor that the effectiveness of this criteria would be limited. An example would be if checks are conducted on the safety of individuals on suicide watch every hour, as opposed to the recommended 15-minute maximum.
- Zero points if the best practice criterion was absent.

These points were then summed for a total score for each jail. Each facility could score up to an 11, which would indicate perfect adherence to best practices. Facilities that denied having any suicide prevention policy were scored as zeroes. Facilities that declined to participate were given an N/A rating. Further, a miscellaneous category for policy details that are noteworthy or unusual are kept to fulfill the aim of directing reform efforts.

Statewide-Level Analysis

Data Analytic Plan

For the final method of analysis, the qualitative themes from each facility's jail suicides were combined with scores and themes from the program evaluation. This was done to examine whether higher scores from the policy analysis result in fewer jail suicides, or if facilities with notably high scores still have elevated rates of jail suicidality. This was conducted through a mixed methods approach. First, I calculated each jail's mean suicide rate per 100,000 residents for 2014 through 2023 for parity with the policy data, using the following calculation taken from the World Health Organization's suicide mortality rate guidelines (WHO, 2015):

$$Suicide\ Rate = \left(\frac{Mean\ suicide\ deaths}{Mean\ average\ daily\ population}\right) * 100{,}000$$

This suicide rate per 100,000 residents was then analyzed using correlations to examine whether the facility's suicide prevention score is correlated with their suicide rate. Further, to rule out possible alternative variable explanations, I also examined the correlations between the jail suicide rate and jail population size, as well as between jail suicide rates and suicide rates in the general population for each facility's county or city. Next, a thematic summary was conducted comparing components of suicide prevention between jails and common codes. This was conducted through an Applied Thematic Analysis, a framework used to analyze policy and program related outcomes, recommended to reduce bias in qualitative analysis (Mackieson et al., 2019). This framework involves the separation of Thematic results into three levels: the first involves jail-specific themes, whereas the second level analyzes all-jail themes. The third and final level involves the analysis of whole-project themes and their implications when compared to existing research and practice, as covered in the Discussion section. The results were discussed considering the central questions relating to nodes of access and systematic reform for clinicians and citizens.

CHAPTER III - RESULTS

Individual-Level Results

This analysis related to themes of the IMVT, best practices, and miscellaneous *in vivo* codes from a large dataset of all Washington State jail suicides from 2014 to 2023. This dataset was triangulated with an independent reliability coder, who reviewed codes to ensure the applicability and acceptability of the codes assigned.

Integrated Motivational-Volitional Theory

The IMVT is separated into three separate phases of escalating suicide drivers. That is, factors that motivate the development and progression from suicidal thoughts to suicidal behaviors and, ultimately, death by suicide. These progress from the Threat-to-Self phase to the Motivational phase, and finally to the Volitional Phase. In total, 60% of the death records had at least one code supporting the IMVT. 28.8% were coded for one phase of the IMVT, whereas 31.1% were coded for two or more phases. Codes for each phase are summarized below:

Threat-to-Self Phase. The Threat-to-Self Phase, which is theorized to be when suicidal thoughts begin to form, build, and coalesce, Of the three domains of the IMVT, there were the fewest codes for Threat-To-Self risk factors (n = 21; 23.3%). There was, however, thematic support for some factors, including Social Problem-Solving Deficits (n = 7; 7.7%). This factor refers to a tendency to react to social problems in impulsive, emotionally reactive, and ineffective ways. Some quotations for this factor are excerpted below:

"[Jail V – Person #6] was booked into the jail and had multiple issues with the guards, violence and uncooperativeness leading to things like placing him in a padded cell, stitches in the head, and being pepper-sprayed."

"[Jail XII – Person #2] was involved in a fight on the day of his death with another inmate. He was then placed in a private cell. He was found hanging from his bed frame."

"Prior to her death, [Jail VI – Person #1] made several calls to her ex-boyfriend, threatening that if he didn't bail her out, she would kill herself."

Support also existed for the factor of Entrapment (n = 7; 7.7%). As mentioned above, entrapment refers to the state of being which occurs with the combination of social defeat, hopelessness, and humiliation:

"[Jail V – Person #3] was diagnosed with conduct disorder, ADHD, borderline traits with a history of major depression … he had a long list of prior suicide attempts and thoughts. One of his constant symptoms included self-mutilation and impulsive behavior. He was arrested for trying to commit suicide by lighting fire all around him. He was booked on charges of arson but [the] arresting officer said he was suicidal … during his months in jail he was having gang-related troubles that caused many assaults on him and others to occur from pressures … he also indicated that he was scared since all the gang members in his unit were calling him a snitch since he agreed to 21 months in prison. He indicated that they told him he would never get out of prison alive. He made a call and had been crying/observed as very depressed post-call. … Supposedly only about 30 minutes later he was found hanging and pronounced dead at 2224."

"There's a suggestion in the record that he got news that he might be facing a long prison sentence from his attorney and then he committed suicide quickly thereafter."

"[Jail XIII – Person #2] found unresponsive in a suicide cell in Jail XIII. [Jail XIII – Person #2] was disowned by his family due to his four counts of child rape and [he] was a Type 1 diabetic. He wanted

to induce a diabetic coma and thus refused food and water and medication for 5 days until he was found unresponsive. Jail staff and his lawyer were all aware of his thoughts about suicide. His lawyer indicated that he did not try to stop him."

"It seems his desire for suicide came from his multiple allegations and reports of his sexual child abuse within the past months and years. There was much suspicion that he had issues with child sex crimes in addition to his previous incarcerations for level arrests."

Some support also existed for the factor of Suicide-Adjacent Rumination (*n* = 3; 3.3%). This factor referred to when an individual was described as ruminating on a thought or belief, such that they could not stop thinking about it before their death by suicide. Quotes exemplifying this theme are below:

"He submitted [messages] to the chaplain indicating that he was having doubts in his mind that would not go away."

"He claimed that he was not only fighting with [his partner] but also his 'inner demons.'"

"A note to his mother was found in his cell indicating that he just kept thinking of killing himself."

Motivational Phase. The Motivational phase refers to the stage in which ideational urges begin to coalesce into form, spurred on by pre-existing risk factors from the Threat-to-Self phase. Problems and stress begin to build, and the individual is unsuccessful with, or does not attempt alternative means of coping. Intent to die is thus formed. The Motivational Phase had the greatest

number of applicable codes (*n* = 53; 58.8%). Of these, three factors were especially prevalent within the death records. The most common theme in this phase related to Thwarted Belongingess (*n* = 24; 26.6%). This factor refers to interruptions in a person's social context. A common component under this code related to isolation, which unique to the jail context, could either be self-imposed (*n* = 3) or imposed by correctional staff (*n* = 21). Quotes supporting this code are excerpted below:

"[Jail XI – Person #2] was found hanging in her isolation/solitary cell."

"He was placed in lockdown with no hour break due to using foul language with an officer. He was found hanging in his cell."

"Told others that he was feeling depressed and [had] been seen by mental health care, in segregated housing at the time of suicide."

"Its unclear the specifics, but prior to her death, [Jail VI – Person #1] was moved into 48 hour isolation."

"Complained about solitary."

Prior suicidal ideation (*n* = 18; 20%) was a common factor within this phase. Quotes from this factor are excerpted below:

"Lastly, someone who had previously lived with [Jail VIII – Person #3] claimed that they removed all the guns from their home because he had threatened to kill himself."

"He had a long history of suicide attempts, had answered yes to suicidal [questions] at booking, and had made numerous comments about killing himself during his arrest."

"She claimed before committing suicide, 'I should just hang myself.'"

"On [date], he told the mental health professional staffs that he wanted to 'kill himself.' He continued to express suicidal statements numerous times in the months that followed."

Many decedents also had indications of impaired social support (n = 10; 11.1%) as well. This factor refers to explicit mention of unmet social needs:

"Numerous reports indicated that he was suicidal and constantly asking staff to get a cell mate to help him deal with being in the hole."

"He had previously begged his mom to bail him out and stated if she didn't he would commit suicide."

"He called his father multiple times to ask him to bail him out, mortgage the house, or do anything to help. He explained to his father that he was vomiting, freezing, shaking, etc. [Jail I – Person #11] was found hanging in his cell at around 2058 hours."

"Phone calls from the jail between [Jail VIII– Person #1] and possibly his family, two women were on the phone trying to convince him not to commit suicide and that they are not able to let the kids talk to him because otherwise they will be taken away."

Additionally, themes relating to perceived burdensomeness, or the belief that one is a bother or an inconvenience to those around them, were noted (n = 4; 4.4%):

"Prior to the hanging he had submitted a [request message] requesting a Bible, glasses, and a request to say a prayer. He left a suicide note for his family apologizing for everything."

"[Jail I– Person #1] was found hanging by a TV chord [sic] in her single cell at Jail I County corrections despite giving no evidence of wanting to commit suicide … Her cellmate confided that [Jail I – Person #1] had asked if the child in the car she hit was alright."

Volitional Phase. The Volitional phase refers to the stage in which risk factors produce the enactment of suicidal behaviors. Of the three stages of the IMVT, this phase was the second most well-supported within the dataset (n = 47; 52.2%). Past Suicidal Behavior (n = 20; 22.2%) was the most common factor associated with this phase, occurring in just over a fifth of all suicide deaths in the dataset. Quotes indicating prior suicidal behaviors include:

"[Jail IX – Person #2]'s father and mother adamantly claim that they told the arresting officers that their son was suicidal and his history shows multiple suicide attempts … he was housed in a cell alone and hung himself by the top bunk."

"He had a long history of depression and suicide attempts."

"Died after jumping from hospital window after multiple suicide attempts by hanging and jumping off second tier at Jail VI."

"In addition, a worker who claimed to have seen [Jail VIII – Person #6] many times said that he had tried to commit suicide 10-11 times previously."

In addition, one factor within this phase that was presented in the data was Planning (*n* = 14; 15.5%). This refers to explicit plans for engaging in suicidal behavior involving a chosen or identified means:

"She informed medical staff that she was "stir crazy" and threatened that 'If you don't get me out I will end up hanging myself with [a] sheet. … On the 9th, she was found hanging in her cell, not breathing, and aid was dispatched to assist her … she was pronounced dead at Jail VI."

"He had been found cutting [his] wrists [a] month before and [officers] recovered a suicide note from his pocket and [he] had said he was feeling depressed [one] day before [his] suicide. He was infracted for cutting himself."

"She claimed before committing suicide 'I should just hang myself.' … [Jail XVII – Person #2] was found unresponsive hanging in her cell in Jail XVII."

"When he was found, he had been hanging from a light fixture and had jammed the cell door shut so staff was not able to enter the cell quickly."

"[Jail II – Person #1] was found dead two days after a murder conviction. Incident Reports indicated he was found with medication in his cell that he had been storing. Media report believed he was pretending to take prescription medication in order to store [a] dose big enough to be fatal."

Another factor related to this phase that was supported in the dataset related to Physical Pain Sensitivity (*n* = 8; 8.8%). This refers to exposure to physically painful experiences. With enough of these experiences, one's sensitivity to physical pain is reduced, indicating an increased risk of death by suicide:

"During his arrest he had indicated that he just purchased the marijuana for his unhealed leg injury he was also seen for."

"Hurt self after finding out that [he was] facing another charge."

"In addition, [Jail VI – Person #1]'s daughter said her mother was a drug user and has always been suicidal, she said [her mother] attempted suicide in the past and that her wrists would show the scars."

Additionally, Access to Means was another important factor within this phase (n = 4; 4.4%). This refers to being simply able to access and use whatever method the individual wishes to use to end their life. In a jail setting, this access is usually ardently restricted. However, within the dataset, support for this factor did exist:

"He was found in his cell with a plastic bag over his head secured with a bed sheet."

"[Jail II – Person #7] was booked with a pre-existing medical condition that required him to have a dialysis port in his arm as well as bi-polar affective disorder … three days after being taken off suicide watch he activated the emergency call button in his cell and was found with blood squirting out of his arm. He died in the hospital from blood loss."

In Vivo Codes

During coding, several themes emerged which did not have direct parallel under the IMVT, best practice criteria, yet seemed relevant to the individual-level aims of supporting efforts at elucidating jail-specific drivers of suicide for reform. These themes were coded to increase insight into unique suicide risk factors for individuals within jails. Miscellaneous *in vivo* codes were found for many entries within the dataset (n = 49; 54.4%).

A common theme that arose in *in vivo* codes related to substance use (n = 21; 23.3%). This code was applied when: a) substances were involved in the incarcerated persons charges, b) the incarcerated person was mentioned to be undergoing withdrawal symptoms during incarceration, or c) the incarcerated person used substances while within the jail, either for recreational use for intentional overdose as a means of death by suicide. Quotes supporting this code are excerpted below:

"Prior to his death, claims indicate that he was neglected the proper treatment and medical attention for withdrawal of narcotic use and [suicidality]."

"Other inmates thought her to be on methamphetamine while committing suicide."

"Committed suicide within two days of being arrested. Made threats about withdrawal and needing to get out of jail."

"During this trial, jail staff searched his cell looking for stolen evidence and about a week before his death, found what they thought was heroin in his cell."

"Autopsy indicated that cause of death was due to hanging with toxicology showing drugs in his system."

"He admitted to using heroin and methamphetamines during booking."

An additional theme related to aggression and conflict (*n* = 16; 17.7%). This code was applied when aggression was displayed behaviorally. This could be related to an incarcerated person's charges, aggressive behavior with other incarcerated peers, or aggression during conflict with correctional staff. Some excerpts include:

"[Jail V – Person #1] was booked into the jail and had multiple issues with the guards, violence, and uncooperativeness leading to things like placing him in a padded cell, stitches in the head, and being pepper sprayed."

"He was placed in isolation apparently for 'mental health problems' and violence towards the corrections staff at Jail VI."

"[Jail V – Person #2] was moved to isolation/solitary due to 'antisocial behavior.'"

"He had many domestic violence and assault charges and he had threatened to kill his girlfriend in the heat of an argument."

"He was placed in a lockdown with no hour break due to using foul language with an officer."

Another *in vivo* theme that was supported within the dataset related to diathesis, or biological risk factors (*n* = 13; 14.4%). This refers to both chronic and acute health problems, which can increase an individual's risk of death by suicide. Within this dataset, this code was applied when individuals were mentioned to have either a health condition which was causing current symptoms of note, or if the individual was experiencing noteworthy physiological symptoms without a clear etiology prior to death by suicide. Some quotes which support this code are outlined below:

"Upon booking, she also stated that she had ovarian cancer but was not taking her medication at that time and only did take it sometimes."

"[Jail II – Person #4] was booked with a pre-existing medical condition that required him to have a dialysis port in his arm as well as bi-polar affective disorder."

"He called his father multiple times to ask him to bail him out, mortgage the house, or do anything to help. He explained to his father that he was vomiting, freezing, shaking, , etc."

"[Jail XVII – Person #2] seemed to be sleeping semi-irregularly or strangely before she was found dead."

Within this dataset, multiple codes made explicit note of the assertion that no prior signs of suicidality existed prior to these individuals' death by suicide (*n* = 8; 8.8%). This code was

applied to any death record where it is overtly denied that this individual had any indication of suicide risk, with supporting quotes documented below:

"[Jail XVII – Person #3] found unresponsive hanging in her cell in Jail XVII. There were no previous signs of suicide leading up to this."

"Was found hanging by a TV cord in her single cell at Jail I County Corrections despite giving no evidence of wanting to commit suicide."

"Upon his booking, [Jail VIII – Person #3] indicated no signs that he was suicidal."

"While [Jail X – Person #2] had no signs of being suicidal, he was extremely drunk and belligerent."

Another code which may be unique to forensic contexts related to targeted harassment (*n* = 4; 4.4%). This code was applied to records which indicated that the incarcerated person was experiencing social conflict by peers or staff in which they were victimized. Quotes supporting this code are outlined below:

"[Jail VI – Person #9] reported being raped by his cellmate. An official case was made after he called [the Prison Rape Elimination Act agency] the day before he committed suicide."

"He was booked into a cell with seven other inmates where some sort of fight broke out, but [he] insisted he just fell."

"During his months in jail he was having gang-related troubles that caused many assaults on him and others to occur from pressures."

"He said that he was not currently suicidal but he was concerned about being placed in the general population for the sex offenses he was being booked on."

One additional code related to religious concerns (n = 3; 4.2%) a code applied when individuals' death records mentioned some form of religious contact prior to their death. Quotes supporting this code are documented below:

"After meeting with a chaplain he hung himself in his cell."

"He submitted kites to the chaplain indicating that he was having doubts in his mind that won't go away and was questioning about God."

"Prior to the hanging he submitted a kite requesting a Bible, glasses, and a request to say a prayer."

Jail-Level Results

The next arm of the study had two methods of analysis. The first related to codes from death records highlighting trends wherein best practices were either explicitly mentioned to be followed, or those where best practices were problematically implemented.

Best Practice Codes

Within this dataset, support existed within these mortality records which suggested the presence or absence of several of the 11 best practice criteria. The number of records that contained some mention of best practice criteria being followed (n = 44; 48%) slightly

outnumbered instances where explicit mention was made of deficiencies in best practice procedure (*n* = 43; 47%). These were not mutually exclusive conditions; several records (*n* = 22; 24.4% of total records; 51% of those with best practice codes) had at least one instance where best practice criteria were both followed and other areas where best practices were problematically implemented.

Among the best practice criteria followed, the three most common criteria explicitly mentioned were Identification (*n* = 18), Monitoring (*n* = 13), and Intervention (*n* = 10). Some quotes which support the implementation of best practice procedures are excerpted below:

"Jail intake says that she was pregnant and had mental health issues and was marked for suicide risk. Yes [on an intake form] was also marked for concerns that Corrections staff needs to be away [sic] of [by the arresting officer.]"

"He told others that [he] was feeling depressed and [had] been seen by mental health care, in segregation at time of suicide."

"There was only about 15-20 minutes between the time [Jail I – Person #1] was checked on and when she was found hanging. Jail I County Corrections initiated life saving measures immediately … all staff at Jail I County Corrections were said to have completed regular procedures to help avoid the death of [Jail I – Person #1]."

"They found [Jail XVI – Person #1] hanging in his cell, so they immediately took him down and began to perform CPR, chest compressions, and [attached] an Automated External Defibrillator."

"Died by hanging in Jail IX, but had been on suicide watch."

There was also support for the lack of following certain best-practice criteria within death records. This could mean that the best practice criteria were either problematically implemented (e.g., for monitoring, having interval checks which exceeded every 15 minutes for suicidal inmates, for identification, having someone remark that they were suicidal at intake but then they were not placed on suicide watch, etc.), or the criteria were not mentioned to be followed in circumstances where it should have been. The most common of these problematic best practice components were Lack of Monitoring (n = 20; 39%), Lack of Referral (n = 10; 21.9%), and Lack of Communication (n = 6; 14.6%). In addition, three (7%) entries were coded for administrative issues in policy implementation that did not have direct parallels under the best practice criteria; these were related to two instances of faulty medication administration by nursing staff and one instance of faulty records keeping in drug screening prior to overdose suicide. Some of the quotes exemplifying deficiencies in best practice implementation are excerpted below:

"He was booked answering 'yes' to 6 questions on the suicide questionnaire. Protocol was to notify shift supervisor immediately but the [Seargent] on duty denied ever receiving anything and the original copy [of the form] was never found. He was housed in a cell alone and hung himself by the top bunk."

"[Jail VI – Person #1] made several suicidal statements during booking into Jail VI. He died sometime between 1215 [hours] and 1648 [hours] due to high levels of prescription medication. Was ruled a suicide. During this time he was never fully checked on, just assumed to have been sleeping despite being scheduled for a diabetic visit with medical and an hour out of cell. Correctional officer who was supposed to check on his [sic] took his unresponsiveness as an answer instead of actually checking."

"His death was ruled a suicide and not further investigated. There was uncertainty about whether correct security checks hours prior to his death were being made as they were not correctly recorded but these worries were dismissed by the investigator."

"Prior to [Jail VI – Person #2]'s death, his wife called the jail multiple times and sent in a formal complaint noting that one [staff member] had the ability and records/documents to move [Jail VI – Person #2] to a hospital due to previous suicide attempts but [that staff member] would not take the time to look at or consider [Jail VI – Person #2]medical records. … During the time leading up to his suicide, [Jail VI – Person #2] was moved from a highly monitored cell to a less frequently monitored cell where he was not checked on for two hours, which was then thought to have prompted his eventual suicide."

"Investigators say they believe he was saving medications which would indicate [the] medical nurse was not watching him take his full dose. They also failed to strip search him upon his return to jail which could have also been his way to bring drugs in."

"Booking information indicated that he was depressed but he was not placed on suicide watch. Other inmates expressed concerns to [the Seargent] that [Jail II – Person #7] was suicidal and did not speak good English."

"Her fellow inmate [name withheld] checked on her many times until she found her not breathing, she then pressed the 'Correctional Officer Help Button' in cell 2 where she had no response. She then tried cell 3 and did not get a response."

"Died due to asphyxiation/lack of oxygen while in the booking area. Was unmonitored."

Next, this level of analysis included a policy analysis conducted on suicide prevention policy for half of all Washington State jails. As mentioned above, this dataset was triangulated with a different coder who worked independently from myself utilizing a similar codebook to the best practice criteria descriptions in Appendix A. Interrater reliability was assessed through a kappa value (κ). Our initial agreement for these ratings was moderate (κ = .543). however, upon discussion, it became clear that we had differed in ratings of a common practice for most jails in the sample (discussed in more detail below); specifically, this related to a large number of jails that shared the same practice of implementing mandatory suicide prevention training upon hire, but not mandating annual trainings nor specifying the amount of time that these trainings should take. We discussed the matter until reaching a shared rating on this practice, at which point the interrater reliability was again assessed and fell into the substantial agreement range (κ = .758). Appendix D contains all ratings for each jail from myself, the independent rater, and our mean scores for each best practice criterion.

During coding, it became clear that many of the entries shared striking similarities and were in many ways identical. Upon investigation, over half of the jails surveyed (*n* = 18; 66.6%) contracted their policies through Lexipol (https://www.lexipol.com/), a company that provides policy and training materials for law enforcement, fire and rescue, emergency services, local government, corrections, and more. This company sells subscription-based services that provide policies for various governmental and public service agencies. Some jails (*n* = 6; 33.3% of all Lexipol policies) made noteworthy adjustments to existing Lexipol policies, though they still used the company's template. The remaining jails (*n* = 12; 66.6% of all Lexipol policies) more or less utilized an unaltered version of Lexipol's policies. These policy programs contained numerous suicide screening and prevention procedures. Lexipol policies tended to have a notably

higher mean best practice criteria score ($\bar{x}$ = 9.19, *SD* = 3.38) with a narrower range (5.5 – 10.38) when compared to the jails that used original policy documents (*n* = 8; 27.6%) which had lower average scores ($\bar{x}$ = 7.95, *SD* = 4.72) and a wider range (2 – 11). The remaining five jails (*n* = 5; 17%) had no score due to a lack of either suicide prevention programs or policy materials, or refusal to participate in this arm of the study. Notably, Lexipol jails had deficiencies in the Training and Notification components which were common deductions from best practice scores across all jails who used these templates. Additionally, jails in the upper and lower ends of the best practice criteria score, including the jails closest to a perfect score (Jail I and Jail VII), did not use Lexipol policies. Appendix D and Appendix E both contain information regarding which jails used Lexipol policies.

Some jails did have unusual or idiosyncratic policies which were highlighted during coding. Appendix E contains all miscellaneous noteworthy codes and their corresponding facilities.

Applied Thematic Analysis

Jail-Level Themes

Jails with problematic implementation. A variety of jails were coded due to having a problematic implementation of best practices, as mentioned in death records. The most prevalent jails to have incidents coded for deficient best practices for an incarcerated person's suicide were Jail II, with five deaths mentioning a lack of monitoring, referral, communication, and training, and Jail VI, with four deaths mentioning a lack of monitoring, training, referral, and assessment. In addition, at similar rates were Jail I, with three deaths mentioning a lack of monitoring and communication, Jail V, with three deaths mentioning a lack of monitoring and referral, and Jail VIII, with three deaths mentioning a lack of referral and monitoring. Aside from one exception,

all jails were explicitly mentioned to have problems implementing components of best practices that they did have in their policy. That is, though each jail's policy may have had, for example, monitoring criteria that met or exceeded best practices, they still had a death where a lack of sufficient monitoring played a role in that person's suicide. The one exception to this was in Jail VI, which had problems with its training component, and at least one death where the lack of staff training was explicitly mentioned.

For the jails with the greatest number of problematic suicide deaths, the jail suicide rate also revealed interesting trends. Three of the top five jails flagged for problematic deaths were three of the top four most populous jails in the state (Jail I, Jail II, and Jail V, in descending order.) These jails all had suicide rates (43.9, 47.6, and 60.2 deaths per 100,000 residents, respectively) which were roughly similar to the national jail suicide rate of 49 deaths per 100,000 persons (BJS, 2020). This national jail suicide rate is just under three and a half times the national general population suicide rate (14.1 deaths per 100,000 residents; CDC, 2021) However, Jail VIII and Jail VI, the other two jails in this sample, had jail death rates that were more discrepant. Jail VIII had a death rate 1.8 times the national jail suicide average, and over five and a quarter times as large as the general suicide rate in Jail VIII's county. This effect was even more pronounced in Jail VI's county. Jail VI had a suicide rate that was more than five times greater than the national jail suicide average, and over fifteen and a half times greater than the suicide rate in Jail VI's county.

Among specific jails included in the dataset, the largest suicide death rate was for Jail XXVII, with a suicide rate of 900.9 deaths per 100,000 persons, over 18 times the national jail suicide rate average. However, Jail XXVII had two suicide deaths over the reporting period, though it was the fifth smallest jail in the dataset, housing only 37 persons. As such, this rate

may be inflated by the lower sample size. The next highest jail suicide rate in the dataset was at Jail XVII, which had a daily bed population of 154 persons and a death rate of 324.6 deaths per 100,000 residents. This is over six and a half times the national jail suicide rate and over 17 and a quarter times greater than Jail XVII's county suicide rate. Jail XVII was also notable as it had the second-lowest score for best practice adherence for jails that participated by sending materials to be included in the dataset.

Jails with positive policy implementation. As mentioned above, slightly more jails had codes of following some component of best practices even though the individual in question died by suicide. Within the dataset, several jails had specific mentions of multiple components of best practices followed; the jail with the greatest number of components followed in death records was Jail I, with records mentioning monitoring, communication, identification, training, and intervention. In addition, Jail V, with communication, referral, monitoring, and housing, as well as Jail VI, with housing, referral, intervention, and identification. These are noteworthy as they are also three of the five jails with the greatest number of problematic best practice implementation codes, as mentioned above. Jail XIV and Jail IX were two jails mentioned to follow best practice criteria in death records (with referral and identification and monitoring and housing, respectively), noteworthy as there was no mention of either of these jails having problematic implementation of best practices. This was not shared with jails mentioned to have deficiencies in best practices in death records; that is to say, no jail was mentioned to have more than one problematic best practice that did not at least have at least one mention of how they followed best practices faithfully. Also noteworthy for the jail mentioned to have followed the greatest number of best practice criteria, Jail I, was the only jail with a perfect score on best

practice adherence and the lowest jail suicide rate in the dataset, despite being the jail with the highest population in the state.

Statewide-Level Results

This analysis began with calculating individual jail suicide rates for the period of 2014 through 2020 for policy parity. Table 3 has each jail's suicide rate during this period, if applicable, as well as the suicide rate within the county or city where the jail is located.

Table 3. Suicide Prevention Policy Program Evaluation Scores

Jail (County or City)	***Mean Suicide Prevention Score***	***Criteria Met***	***Problematic Criteria***	***Jail Population***	***Jail Suicide Rate****	***General Pop. Suicide Rate****
Jail I (*County*)	11/11	*[ALL]*		1,906	43.5	11.9
Jail II (*County*)	9.5/11	*ID, AS, HO, RF, CO, IN, RP, RV*	*TR, MO, HO*	1,051	47.6	18.7
Jail III (*County*)	N/A	-	-	897	92.9	19.6
Jail IV (*County*)	10/11	*ID, AS, MO, HO, RF, CO, IN, RP, RV*	*TR, NO*	887	93.6	14.6
Jail V (*County*)	9.25/11	*AS, MO, HO, RF, CO, IN, RP, RV*	*ID, TR, NO*	831	60.2	14
Jail VI (*County*)	9.875/11	*ID, MO, HO, RF, CO, IN, RP, RV*	*TR, AS, NO*	668	254.5	16.4
Jail VII (*County*)	10.75/11	*ID, TR, AS, MO, HO, RF, CO, IN, RP, RV*	*NO*	581	-	11.9
Jail VIII (*County*)	8.75/11	*ID, AS, MO, RF, CO, IN, RF, RP*	*TR, HO, NO*	573	87.3	16.5
Jail IX (*County*)	N/A	-	-	444	150.15	16.1
Jail X (*County*)	9/11	*ID, AS, MO, RF, CO, IN, RP, RV*	*TR, HO, NO*	417	79.1	17.7
Jail XI (*County*)	2/11	*RF*	*ID, TR, AS, MO, HO, CO, IN, NO, RP, RV*	321	155.8	16.3
Jail XII (*County*)	9.375/11	*ID, AS, HO, RF, CO, IN, RP, RV*	*TR, MO, NO*	256	66.4	20.1
Jail XIII (*County*)	9.75/11	*ID, AS, MO, HO, RF, CO, IN, RP, RV*	*TR, NO*	231	142.9	17.1
Jail XIV (*County*)	10/11	*ID, AS, MO, HO, RF, CO, IN, RP, RV*	*TR, NO*	204	-	19.2
Jail XIX(*County*)	10/11	*ID, AS, MO, HO, RF, CO, IN, RP, RV*	*TR, NO*	114	289.5	18.4

Jail XV (*County*)	0/11		*[ALL]*	182	93.4	9.8
Jail XVI (*County*)	10/11	*ID, AS, HO, RF, CO, IN, NO, RP, RV*	*TR, MO*	181	94	11.8
Jail XVII (*County*)	3/11	*MO, HO, IN*	*ID, TR, AS, RF, CO, NO, RP, RV*	154	324.6	18.8
Jail XVIII (*County*)	7/11	*ID, AS, HO, RP, RV*	*TR, MO, RF, CO, IN, NO*	116	-	23.7
Jail XX (*County*)	8.75/11	*MO, HO, RF, IN, RP, RV*	*ID, TR, CO, NO,*	100	166.6	18.3
Jail XXI (*County*)	10/11	*ID, AS, MO, HO, RF, IN, RP, RV*	*TR, CO, NO*	67	-	15.6
Jail XXII (*County*)	10.375/11	*ID, AS, MO, HO, RF, CO, IN, RP, RV*	*TR, NO*	57	-	25.6
Jail XXIII (*County*)	9/11	*ID, AS, MO, HO, CO, IN, RP, RV*	*TR, RF, NO*	54	-	17.9
Jail XXIV (*City*)	7/11	*ID, MO, HO, CO, IN*	*TR, AS, RF, NO, RP, RV*	49	-	-
Jail XXV (*County*)	10/11	*ID, AS, MO, HO, RF, CO, IN, RP, RV*	*TR, NO*	41	-	29.8
Jail XXVI (*County*)	10/11	*ID, AS, MO, HO, RF, CO, IN, RP, RV*	*TR, NO*	38	-	19.4
Jail XXVII (*County*)	N/A	-	-	37	900.9	14.3
Jail XXVIII (*County*)	0/11		*[ALL]*	35	-	13.9
Jail XXVIX (*County*)	0/11		*[ALL]*	29	-	54.8
Jail XXX (*County*)	10/11	*ID, AS, MO, HO, RF, CO, IN, RP, RV*	*TR, NO*	26	-	<10
Jail XXXI (*City*)	5.5/11	*AS, MO, HO, RP*	*ID,TR,RF,CO,IN, NO,RV*	13	-	20.5
Jail XXXII (*County*)	0/11		*[ALL]*	6	-	<6

*Note: * = denotes a rate of suicide deaths per 100,000 residents. Rates were calculated from mean values from 2014 through 2020 for policy parity. Blank values indicate the absence of suicide data. Criteria met were drawn from an average of both coders scores. Problematic criteria were those given any score less than one, which may include deficiencies or absences of the criteria measured. ID = Identification; TR = Training; AS = Assessment; MO = Monitoring; HO = Housing; RF = Referral; CO = Communication; IN = Intervention; NO = Notification; RP = Reporting; RV = Review. Data for general population suicide rates by county was pulled from the Washington State Department of Health 2018 publication, accessible here: https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/971-025-ActionAllianceSuicidePrevention2018.pdf*

Correlations were then conducted to examine the relationship between best practice adherence and jail-specific suicide rates. First, assumptions for correlations were checked. The variable of mean suicide prevention best practice adherence scores was not overtly kurtotic (-.499) but did show evidence of skew (-1.099). A significant Shapiro-Wilk's test (.732, p = <.001) suggested that this variable significantly differed from a normal distribution. The same was true of the variable of jail suicide rate was not kurtotic (.223) but did appear skewed (-1.165) and a significant Shapiro-Wilks (.814, p = .013) suggested non-normality of the data. Similarly, the general population suicide rate for Washington state counties was skewed (-2.869) and kurtotic (-11.633) with a Shapiro-Wilks suggesting non-normality (.728, p = <.001). Finally, the average daily population of the jail for the data period showed evidence of skew (2.3) and kurtosis (6.294) and a significant Shapiro-Wilks (.717, p = <.001) as well. All variables examined did not have normal distributions, and thus correlations were conducted through Kendall's Tau to account for the non-parametric nature of the variables.

Table 4 contains the correlation for mean suicide prevention best practice adherence score and jail suicide rate.

Table 4. Correlations between Suicide Prevention Score and Suicide Rate

Jail (*County or City*)	Mean Suicide Prevention BPA Score	Jail Suicide Rate*
Jail I (*County*)	11/111	43.5
Jail II (*County*)	9.5/11	47.6
Jail III (*County*)	N/A	92.9
Jail IV (*County*)	10/11	93.6
Jail V (*County*)	9.25/11	60.2
Jail VI (*County*)	9.875/11	254.5
Jail VII (*County*)	10.75/11	-
Jail VIII (*County*)	8.75/11	87.3
Jail IX (*County*)	N/A	150.15
Jail X (*County*)	9/11	79.1
Jail XI (*County*)	2/11	155.8
Jail XII (*County*)	9.375/11	66.4

Jail XIII (*County*)	9.75/11	142.9
Jail XIV (*County*)	10/11	-
Jail XV (*County*)	0/11	93.4
Jail XVI (*County*)	10/11	94
Jail XVII (*County*)	3/11	324.6
Jail XVIII (*County*)	7/11	-
Jail XIX (*County*)	10/11	289.5
Jail XX (*County*)	8.75/11	166.6
Jail XXI (*County*)	10/11	-
Jail XXII (*County*)	10.375/11	-
Jail XXIII (*County*)	9/11	-
Jail XXIV (*City*)	7/11	-
Jail XXV (*County*)	10/11	-
Jail XXVI (*County*)	10/11	-
Jail XXVII (*County*)	N/A	900.9
Jail XXVIII (*County*)	0/11	155.8
Jail XXVIX (*County*)	0/11	-
Jail XXX (*County*)	10/11	-
Jail XXXI (*City*)	5.5/11	-
Jail XXXII (*County*)	0/11	-
Total τ	.107	
p	.584	

Note: BPA refers to Best Practice Adherence ratings. Correlation was conducted through Kendall's Tau due to non-normal distributions within all variables.

The correlation coefficient indicated a weak ($\tau = .107$) and non-significant correlation ($p = .584$) between these two variables. Figure 1 contains a scatterplot of this correlation.

Figure 1. Correlation Scatterplot Jail Suicide Rate and Jail Suicide Prevention Best Practice Adherence

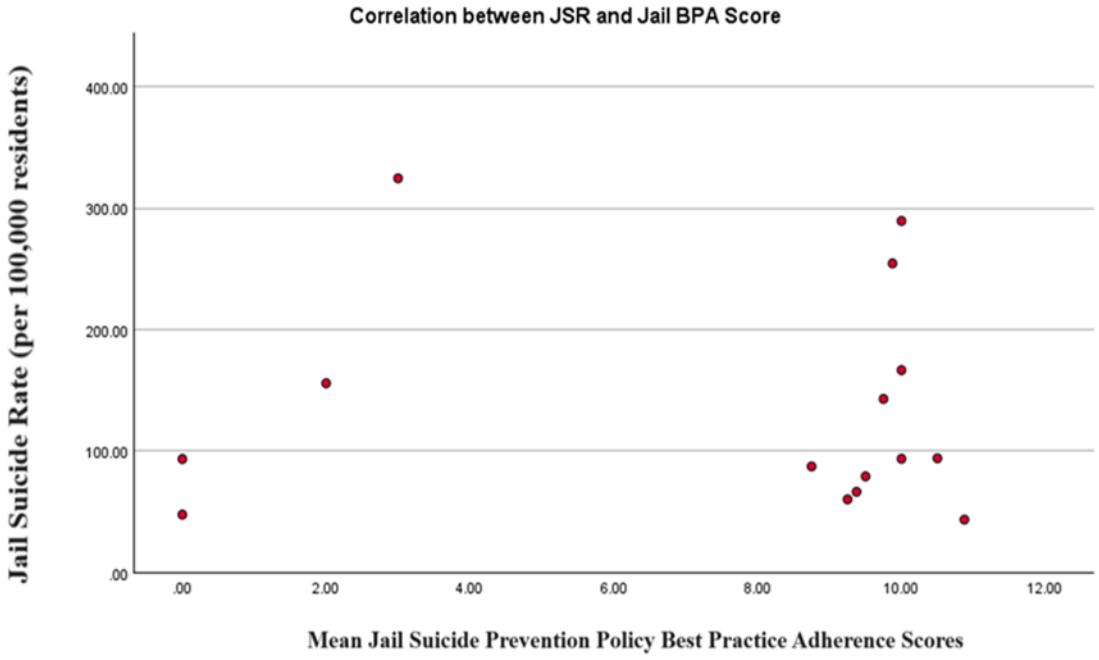

Table 5 contains further correlations between other variables to establish whether third-variable explanations existed in the dataset.

Table 5. Correlation Table for Mean Suicide Prevention BPA Score, Jail Suicide Rate, Jail Population, and General Population Suicide Rate

Variables Correlated	Correlation Coefficient (Kendall's τ)	*p*
MSPBPA Score x Jail Suicide Rate	.107	.584
MSPBPA Score x Jail Population Size	.206	.128
Jail Suicide Rate x Jail Population	-.524	.061
Jail Suicide Rate x GSPR	-.377	008*

*Note: MSPBPA = Mean Suicide Prevention Best Practice Adherence score; GSPR = General Population Suicide Rate. * = p < .05*

First, the relationship between mean suicide prevention best practice adherence score and jail population size was also weak ($\tau = .206$) and nonsignificant ($p = .128$), suggesting against the possibility that larger jails had corresponding better quality suicide prevention programs. Next, the relationship between jail suicide rate and jail population size had a strong ($\tau = -.524$) yet nonsignificant ($p = .061$) negative relationship, largely suggesting against the possibility that larger jails would necessarily have higher suicide rates. Finally, a significant negative correlation existed between the jail suicide rate and the general population suicide rate ($\tau = -.377$; $p = .008$). That is, as the jail suicide rate increases, the general population suicide rate for the county the jail was located in would tend to decrease. This is consistent with the findings from the Individual-Level Analysis, which found that prior suicidality was the most commonly supported component of the IMVT codes.

Applied Thematic Analysis

Statewide-Level Themes

The most common instance of problematic best practice criteria in available death records is related to monitoring. Often, death records mentioned that individuals were checked on far less frequently than best practice criteria, and often less often than jail policy required that they should be. Some records indicated that jails would assert that they had monitored incarcerated people as often as they should have, yet incarcerated peers would assert that they had not. Some jails also found persons dead while they were on suicide watch with no ability to tell how long they had been dead. This is despite all but five jails having full criteria met for monitoring components within their policy. One explanation for this discrepancy between monitoring practices being one of the most commonly met criteria and yet the most commonly sourced programmatic deficiency in suicide deaths could be a lack of implementation. Simply put,

monitoring incarcerated persons at risk of suicide at least every 15 minutes is one of, if not the most, labor-intensive part of effective suicide prevention programs. This is because this component involves a comprehensive check by floor staff four times an hour for every inmate considered to be at risk. Prior research has argued that this component is one that is least likely to be effectively implemented in a jail setting (Hayes, 1997); In this dissertation's dataset as well as those in existing literature, the lack of effective monitoring had been directly linked to deaths by suicide.

The next leading theme of best practices associated with death by suicide is related to improper referral of suicidal persons to therapeutic services. In many samples, incarcerated persons would make suicidal statements, but these warning signs did not result in effective or timely therapeutic intervention. Some individuals would enter custody making suicidal statements; however, they were not given referrals to mental health providers. This is troubling as research suggests that access to various therapeutic services reduces the suicide rate within jails (Winicov, 2019). This lack of referral to mental health services may sometimes be linked to human error, but the more troubling implication is that smaller jails do not have access to the resources to retain or contract effective treatment providers. At one jail, I spoke with a Sheriff who wished to remain anonymous when requesting records. He stated that he pays for the mental health service providers for his jail out of his own paycheck. He remarked that he felt these services were critical and thus emphasized them but reported frustration that no official channels existed to secure these funds. Indeed, within this dataset, though this correlation was not significant, a moderate negative correlation coefficient indicated a general trend of larger jails having more well-controlled suicide rates. One potential explanation for this could be the lack of

available resources for treatment in smaller jails, resulting in jails that do not have the funding or staffing to provide effective services.

Finally, the most prevalent theme in available death records for suicide decedents revolved around isolation for suicidal persons. While this isolation was occasionally self-imposed, much more often, this was an isolation imposed upon the incarcerated person by the jail. Many death records had similar themes wherein a suicidal individual would be placed in solitary confinement or segregated cells when suicide risk was indicated. Some death records indicated incarcerated person begging or pleading with jail staff for social contact before they died. This is largely due to the way that correctional institutions conceptualize suicidality, which does not make distinctions between risk of suicide and other forms of risk, such as risk for violence (Favril et al., 2017; Vera Project, 2018). Multiple jails within the dataset had specific instructions within policy that even if an incarcerated person was actively dying by suicide, correctional staff should not intervene until another officer can accompany them into the cell for officer safety. This showcases how jails conceptualize risk, no matter which kind, as a variable to be controlled rather than treated. As other research has highlighted, this represents an issue as while restrictive, isolated housing may allow for the physical restriction of safety, it also exacerbates the drivers of suicide, such as social disconnection or lack of purposeful activity (Favril, 2021). In that sense, restrictive and isolating housing for incarcerated persons on suicide watch may be analogous to putting a band-aid over a splinter. Far from a conceptual issue, in prison populations, single-celled incarcerated persons were at over four hundred times greater risk for death by suicide than those incarcerated persons in double cells (Reeves & Tamburello, 2014).

As covered above, best practices for suicide prevention coalesced in 1989. At the time they were implemented, they were massively successful at stabilizing the suicide rate. As such, the best practices defined in Hayes' seminal articles have become the backbone of suicide prevention policy in corrections for nearly 35 years. Some evidence from the current dissertation suggests that, at the very least, the ability of the best practices to effectively control the jail suicide rate has stalled in recent years. A more direct interpretation may be that these best practices have become outdated. This is consistent with existing research which has argued for stalled progress on this issue, wherein the capacity for jail administrations to assess and intervene in preventing suicide deaths has decreased in recent years (Hanson, 2010). To begin, while problems in implementation of these best practices could be drawn from the dataset as documented above, it is still noteworthy that more jails were found to be following best practices than those that were found to have problematic implementation of these practices in death records. The average best practice adherence score was 71% or 7.8 of the maximum total score of 11. The majority of jails within the sample utilized Lexipol policies, which had an even higher mean score of 83.5% or 9.19 of the maximum total score of 11. However, the suicide rate in jail settings has continued to rise. In Washington State in particular, only two jails out of the included 29 in this study had a suicide rate below the national average. Two conclusions from these trends are that best practices within the state are followed more often than they are not, and the suicide rate has continued to rise in spite of this.

Another noteworthy theme within this project relates to the vulnerability inherent in the population that is entering the correctional system. The significant negative correlation between the jail suicide rate and the general population suicide rate has a troubling implication; that is, individuals who are at greatest risk of suicide may be being arrested rather than treated. Once

arrested, they are placed in an environment with very little protective factors and often die by suicide. The more individuals die by suicide in a jail, the lower the suicide rate outside of that jail tended to be. This is also consistent with death records, which had stories of individuals incarcerated for their suicidal behavior. Some individuals were written to have remarked to family and loved ones that they would kill themselves if they remained in jail. Nearly a quarter of the suicide deaths in jail had a history of suicidality or suicidal behavior in the days preceding their deaths. These are people that may have been treated, and ultimately may have survived, if outside of the jail environment.

CHAPTER IV - DISCUSSION

The aims of this dissertation were to highlight factors relevant to jail suicidality to inform efforts at reform, and to examine whether best practices in jail suicide prevention were still effective at managing jail suicide rates. In the individual-level analysis, expected themes were that support would be found for codes and themes that support the applicability of the IMVT for jail suicides. At many stages in the death record review, themes unique to the IMVT, such as entrapment, social defeat, diathesis, and access to means were written about among those who had died by suicide. Greater support was found for factors relating to the Motivational and Volitional phases. Each stage generated 17, 53, and 47 codes respectively, in order of progression along the IMVT. That is, there seemed to be more applicability for the IMVT in the stages where suicidal ideation begins to intensify, and in the critical stages in which thoughts of suicide transition to serious and life-threatening behaviors. In total, 75.5% of the sample generated at least one code, with a relatively even split of those who generated codes only relating to one stage of the IMVT (41.1%) and those who generated codes for multiple stages of the IMVT (34.4%). This suggests against the possibility that a few individuals were generating most of the codes within the dataset. Some *in vivo* codes also included factors relevant to suicidality in jail settings. The most common supported themes altogether related to prior suicidal ideation, past suicidal behavior, substance use, aggression and conflict, impaired social support, planning, physical pain sensitivity, hopelessness, and targeted harassment. These largely align with results from existing literature, which found that protective custody (i.e., isolated housing), substance use issues, hopelessness, exposure to violence, and aggression and conflict were found to be the most acute risk factors for death by suicide in jails (Cain & Ellison, 2022; Schaefer et al., 2016; Smith et al., 2016; Stoliker & Abderhalden 2021). Unique to this study are

the factors of planning, impaired social support, and targeted harassment. Taken together, these findings support the applicability to suicide theory to exploring the unique risk factors associated with suicidality in correctional settings. Further, clinicians may find it useful to employ specific therapeutic techniques or programmatic interventions aimed at attenuating these risk factors. These could include substance use treatment, greater exposure to group activities, group therapy, or social skills courses. Potential reforms to attend to these relevant factors are discussed further below.

Themes were also found in the jail-level analysis. First, in individual death records, expected themes were that that there will be more codes for jails that have problematic best practice criteria than those that have codes for correctly implementing best practice criteria. This was not supported. 44 codes were found for jails that correctly implemented best practices leading up to, and during, individual deaths by suicide, which was one more than codes mentioning problematic implementation of best practices. As discussed below in the statewide-level analysis, this may mean that issues relating to the rising rate of correctional suicide may go beyond jails simply not implementing best practices. The second hypothesis was that due to a lack of enforceability behind best practice criteria, more than half of the jails in Washington State would meet less than 50% of the criteria. This hypothesis was not supported by the data. Only five jails of the 29 included met fewer than half of the criteria. Among the entire dataset, the total average score for best practice criteria just under 71% of the total score. Were the initial hypothesis to be supported, we would expect this average to be under half. This average contrasts with national reports, which suggested that the majority of jails followed fewer than only 20% of best practice criteria. (Hayes, 2012). This could suggest that jails in Washington State are, in general, more adherent to best practice criteria than the national average. However,

an important point of consideration relates to another national trend for police and public entity policy since the Hayes study in 2012 was published: the widespread adoption of Lexipol policies for jails and prisons. Within the current dataset, over half of all policies were supplied by Lexipol. This is much lower than the rates found in the sparsely available research on this company. In California, for comparison, 95% of all jails and prisons utilize Lexipol policy (Fowler, 2018). Lexipol, on its website, reports that it oversaw legislation and regulatory changes for over 10,000 laws, and it similarly supplies policy to over 2 million public safety and government professionals. Ultimately, within our dataset, Lexipol policies were beneficial in terms of raising the average best practice adherence score. Though no Lexipol policies were rated as perfect scores, Lexipol policies had higher overall average best practice scores than jails that did not use Lexipol policies. However, several concerns have been argued in response to the explosion of Lexipol policy adoption in the U.S. Namely, that Lexipol is a for-profit agency that orients its policy largely to mitigate liability on behalf of the agency, rather than prioritizing safety on behalf of the incarcerated person (Eagly & Schwartz, 2019). Further, there is almost a total lack of transparency regarding the effectiveness or use of Lexipol policy in public safety matters; almost no original research examines the formation or utility of these policies. Finally, Lexipol policies have been argued to be most beneficial for smaller jails and agencies that do not have the resources to develop original policies, but simply purchasing a Lexipol does not ensure that the jail has the resources to carry those policies out (Eagly & Schwartz, 2019). Some aspects that are standard in Lexipol policy, such as reviews of inmates by a licensed mental health care provider within 48 hours of admission, might be reflected in policy yet not in practice. Further research is critically needed to ensure that these suicide prevention policies, representing the majority of such policies for jails in this state and beyond, work to effectively prevent suicide

and do not artificially inflate best practice adherence from an outside perspective. An adjoined hypothesis was also that more populous counties, due to receiving greater state resources, will have suicide prevention policy that better incorporates current best practices. This hypothesis was also largely unsupported. There was no significant correlation between jail population size and best practice adherence scores. The only caveat is that the largest jail within this dataset had the only perfect score, and the two largest jails in the dataset had the only suicide rates below the national average.

Finally, the statewide-level analysis had one central and one adjoined hypothesis. The first was that was that jails with high best practice adherence scores would have fewer jail suicides, and the converse as well; that jails with low scores would have corresponding higher rates of jail suicides. This hypothesis was not supported. As covered more extensively in the project-wide themes section, this correlation was weak and nonsignificant. The adjoined hypothesis was that more than 50% of jails with death records implicating problematic implementation of best practice criteria should have followed the criteria named; that is, the problematic best practice mentioned was one that, were the jail to adhere perfectly to policy, should have been followed. This hypothesis was supported; just one of the 43 deaths by suicide which mentioned problems in implementing best practices mentioned best practices that the jail did not actually have in their policy manual. Taken together, there are several possible explanations. First, there may be significant problems in implementing policy. Staff may either not tend to follow best practices when interacting with suicidal incarcerated persons, or they may do so with low adherence. This could be due to the demands which best practices tend to impose on floor staff, it could be due to poor quality training, or difficulties in creating accessible procedures for this policy to be followed in the event of an emergency. Another possibility is

that, though problems with implementation may exist, it may be that policy materials are generally not reflective of actual procedures. With the advent of Lexipol policy becoming widespread, and jail policy primarily being written to avoid liability and litigation, it may be that these policy materials do not reflect the lived reality for correctional staff and are merely 'on-the-books.' A final possible explanation relates to the best practices themselves. Though problems with implementation invariably exist, given the lack of a relationship between best practices scores and the fact that more jails had deaths which followed best practices than those that did not, it may be that best practices are no longer effective at managing suicide risk. This could be due to the changing role of correctional systems as places which inter mentally ill individuals, or it could be due to heavier restrictions on social drivers of suicide like those relevant in the IMVT-supported individual-level analysis. Though many potential explanations have arisen, it is clear that reforms in jail suicide prevention are sorely needed.

To explore the potential ramifications of the findings from this dissertation, I return to the central question it was written to address.

Where are the nodes of access and reform in the jail suicide prevention system?

Though the results from this dissertation suggest deep and troubling issues in correctional suicide reform, there are inroads towards new and exciting reforms that are backed by research. Appendix E also contains miscellaneous policies relevant to suicide prevention which are noteworthy. These include many potentially exciting and relevant practices that could be considered for jails that are considering additions to their suicide prevention program.

Potential Reforms

Regarding difficulties in effective monitoring due to the challenge of regular checks not exceeding every 15 minutes, some have argued that even this 15-minute target represents a

compromise to administration and staffing. That is, Felthous (1994) posited that even 15-minute increments are not ideal due to the plain fact that death by suicide can occur much faster than 15 minutes. Continuous observation and monitoring should be the ideal circumstance to prevent death by suicide. Neither, however, is electronic surveillance (e.g., closed circuit security cameras, etc.) recommended due to how many gaps these systems have in effective prevention. However, continuous monitoring by a person would require staffing which may not be feasible at most jails. A potential area of reform could be the implementation and development of peer-based monitoring. In these programs, incarcerated peers are utilized as continuous and effective suicide monitors, whether incentivized by compensation or volunteer services. Available research suggests that peer-based monitoring significantly reduced the length and number of suicide watches within a prison setting (Junker et al., 2005). This program also increases social contact during suicide watch, which is otherwise an isolating experience; this is particularly relevant given that isolation was the most common theme found in death records for this dissertation. These considerations make peer monitoring an ideal solution for administrators, incarcerated persons, and their peers as well.

Another potential flaw with a corresponding potential for reform lies in the disproportionate level of access some jails have for therapeutic services. For jails that do not have readily available therapeutic services, legislation may have the ability to earmark funds specifically for this purpose. Further, communication between jails that have found effective interventions to normalize their suicide prevention rate should be shared between jails. Insular practices in jail communication may afford variability in how jails operate their suicide prevention and mental health resources, but this benefit does not outweigh the risks in having suboptimal suicide prevention programs. Finally, similar to peer monitoring, peer interventions

have been shown to be both effective and affordable methods of managing suicide risk. Peer support programs have been found to be tenable and effective in managing suicide risk within prison settings (Hall & Gabor, 2004). A specific framework that could be implemented is the Prevention of Suicide in Prisons (PROSPER; Pratt et al., 2016), which has been found to be effective in correctional settings at reducing self-harm, suicide watch admissions, and suicidal ideation among incarcerated persons. This framework allows for the delivery by ex-incarcerated persons who have lived experience with suicidal thoughts while incarcerated. This is beneficial not just from a peer support perspective, but also a potential area of opportunity for ex-incarcerated persons to gain employment that would not exclude them due to a criminal record.

For isolative and restrictive housing for individuals who indicate suicidality, two jails within the dataset (Jail VII & Jail XVIII) indicated that they either plan to, or currently implement, cellmates for individuals who are on suicide restrictions. Specific recommendations supported by this project would include many practical changes for jail administrators to make to phenomenologically separate suicide risk procedure from violence risk. These changes, supported by this dissertation, include mandatory cellmates for suicidal individuals, initiation of continuous peer-based monitoring, lack of possession restriction, and immediate referral for mental health services. These could be peer-based counseling services, or referral to mental health service providers trained in evidence-based brief suicide prevention modalities. One example could be building crisis response plans (C-RP; Bryan et al., 2018) or using techniques from Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP; Stanley et al., 2009). These changes represent practical considerations for the underlying problem: current best practices do not prescribe specific benchmarks for suicide prevention procedures, nor do they account for integration of social contact. In effect, current procedure is risk management until the

desire to die by suicide abates naturally. Future research should continue to examine ways to increase, rather than decrease, social contact, meaningful behaviors, and drivers of suicide in those at risk.

Wider systems-level reforms are more complex but are still achievable. As noted above, many jail administrators maintain that they are not the nation's mental health providers but instead fulfill a function that is closer to crime and punishment; they contend that their function of housing America's mentally ill population is one that they were given, rather than one they are designed for. This is not an incorrect assertion to make. If we as a society have decided that we can live with disproportionate policing of the mentally ill and socioeconomically disadvantaged, then two options are available to us to reduce suicidality which results from these conflicting contextual realities. First, we might support legislation which allows for funding and expansion for existing service models for correctional health care, including mental health care. One particular avenue for this involves expanding the primary care behavioral health model to correctional facilities (Rich et al., 2014); similar reforms have been found to reduce recidivism rates overall for patients who receive this care (Kennedy-Hendricks et al., 2016). The second option involves deferring these individuals away from the correctional system and diverting them into programs designed to increase stability. For example, some programs, such as the Los Angeles County Office of Diversion and Re-entry's Supportive Housing Program (Hunter & Scherling, 2019) deferred pre-trial detainees (i.e., people who would otherwise be in jail) with a supporting socioeconomic need or behavioral health issue with mental health services and supported housing. At 6 months, 91% of individuals still had housing stability, and recidivism was lowered to just 14% over 1 year. Similar initiatives were supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), which supported three Jail XVI-funded

programs designed to divert individuals with mental health needs away from the criminal justice system. Early diversion programs are effective suicide prevention programs, as they divert individuals with mental health needs away from a correctional environment which amplifies the drivers of suicide. They are also cost saving measures, as diverting individuals with mental health conditions out of the legal system has consistently proven a substantial savings effort; some research has shown that each individual with mental health concerns diverted out of the justice system saves just under $3,000 in taxpayer money per year (ACLU, 2017; Cowell et al., 2013) Finally, larger sweeping reforms such as the NCCHC's pledge to adopt a Zero Suicide framework that incorporates treatment (CAMS; Jobes, 2012) and assessment (CASE, Shea, 2009) specifically for suicidality (NCCHC & AFSP, 2019) represent exciting prospects of suicide-centric reforms. However, it is worth noting that for this latter reform effort, the largest operable piece of this program relates to trainings and materials offered to officers and qualified mental health professionals. Reform efforts must also target jails with fewer resources that do not have adequate staffing or referral services to enact them. In addition, such reform efforts should also incentivize jails to spend the time and effort to implement these resources. In all, effective systemic reform will require the support of both legislators and researchers, both of which are responsive to informed public support. Public support can be curried by integration with mental health awareness organizations or special interest groups, such as NAMI or AFSP. This argument towards reducing systemic discrimination in the legal system towards mental health issues, such as suicidality, can be brought to events through tabling, or debated in public forums. This support can translate into resources with the introduction of public state bills to earmark funds, were the public to vote in support of them. Specific targets for this funding should be

towards jails or correctional mental health contractors. Public support could also be directed towards a state bill to introduce diversion statutes specific to mental health defenses.

It is not hyperbolic to state that the most critical issue to be addressed to save lives in jail settings going forward relates to modernization of best practices. These potential reforms represent inroads; however, a more extensive and complete reconsideration of best practices appears to be called for. The original best practices were founded through a collaborative effort involving Hayes and the NCCHC in 1989, before systems were in place to capture national data trends. In the modern era, multiple agencies, including the Bureau of Justice Statistics, the NCCHC, the Department of Justice, the National Institute of Corrections and the U.S. Marshall's Service all collect and present data relating to correctional suicide on a national scale. There are systems in place which make this task much more feasible than it was when the best practices were formed.

Strengths, Limitations, & Future Directions

This dissertation had multiple strengths unique to its design. Despite the fact that we live in the nation with the greatest number of incarcerated people in the world, the struggles of the inmate are not often heard in academia, and there is scant little research that examines systematic reform of jail suicide prevention. While some attention has been given to jail suicide liability (Daniel, 2021), assessment (Marzano et al., 2016), and treatment (Daigle et al., 2007), there is a lack of research examining this issue from a thematic and policy perspective. In so doing, the problem of jail suicidality is framed as something for psychologists and clinicians to handle alone, which is patently untrue; jail suicidality is a systemic issue. From correctional staff, to police, to clinicians, to incarcerated persons and their families, there are a multitude of parties that need communication in order to ensure the existential safety of people as they move through

the justice system. Policy, simply put, is that communication; it is how these parties work together to achieve that goal. This dissertation was conducted at multiple levels to answer systemic and policy questions and provide commentary on reform at both an individual and statewide level. Additionally, for this project, I used standards of quality reporting for qualitative research, including techniques to enhance trustworthiness in the results. The analyses also included death records, which is noteworthy for suicide research. Simply put, much research on suicide studies samples that have either had suicidal ideation, or those who have engaged in suicidal behavior but did not die from it. Past research has suggested that though there is much overlap between the two groups, there are some risk factors unique to those that die by suicide (Gvion & Levi-Belz, 2018; May & Klonsky, 2016). This argument is supported by suicide theory, which has unique risk factors for those that progress to lethal suicidal behavior (e.g., acquired capability for suicide, the volitional phase of the IMVT, etc.). As such, it is noteworthy that this study includes records and themes from suicide decedents.

Some important limitations of this dissertation should be noted. One of the largest is the absence of inmate perspectives in this research. As this dissertation concerns death records, I do not incorporate the perspective of living inmates, and as this voice is such a lynchpin of comprehensive reform, further research will be necessary before any of the recommendations from the dissertation should be enacted. An additional limitation is that our final sample comprises only half of Washington State's many jails. Many of the jails that did not respond to requests for materials are small, containing under 40 beds, and are largely city jails in rural areas. Additionally, three state jails refused to participate. As this project was conducted via voluntary participation requests and not through a formal filing via the Freedom of Information Act, these requests were honored, and these jails are not scored for best practice criteria. Though our final

sample contains the largest and most diverse jails in Washington State, it is important to acknowledge that this project does not include every jail in the state. Another limitation relates to the equation used to calculate the suicide rate per 100,000 individuals. It utilizes daily population as the denominator, meaning that like many other statistics, small sample sizes are prone to have disproportionately large figures. As such, for the smallest jails in the sample, the suicide rate may appear inflated due to the small population. Finally, inherent with any qualitative analysis, there is a degree of researcher bias that may influence the interpretation of results. Though the SRQR attempts to include aspects that attenuate this bias, such as the positionality statement for the researcher, that only points out where potential biases may lie. It is not the same as removing them or controlling for them in the analyses proper. This partiality is also reflected in the death record materials gathered from a third-party agency, which have their own biases in the information that they collect and the framing that they use. I utilized these records for analysis but did not correct for the bias which may have been reflected in these records.

In summary, jail suicidality can often be a case of extremes. In the United States, suicide is the leading cause of death for jail inmates. To my knowledge, those in jail are one of the very few groups in the nation where suicide the leading cause of death, much less the number one cause of death for four decades or more. The disproportionate rate of suicide deaths in jail settings has many theoretical causal factors; these include the clash between the corrections framework and treatment needs of the population, to the cultural and social consequences we have imposed on aspects of crime and punishment. The direness of the disproportionate rate of suicide is met by an even more significant challenge in the general populace: the ‘why-should-we-care’ mentality. It is not an uncommon view in the United States to assert that it is voluntary to commit a crime, and therefore, it is superfluous to spend time, effort, and most importantly

resources, on keeping “criminals” safe and alive. This apathetic paradigm can be partially reflected in the research literature, as though incredible research has investigated this issue from multiple perspectives, best practices codified more than three decades years ago have remained unchallenged since then even as suicide rates continue to rise.

Above and beyond the fact that jails mostly consist of individuals not yet convicted of any crime, this viewpoint is not tenable with the reality of our correctional system: that we have created a system where mental health symptoms (e.g., substance abuse, impulsivity, etc.) are criminalized, that we tend to jail those most socioeconomically disenfranchised, and that our nation’s mentally ill are three times more likely to be behind bars than in treatment. This is reflected within this study, which found that as the county’s general suicide rate decreased, the jail suicide rate increased. This suggests that those who are suicidal were being incarcerated, where they died by suicide, rather than receiving treatment. Individual-level analysis also supported that the jail environment did not directly contribute to the formation of suicidal ideation, but more commonly intensified previously existing suicidal thoughts. So, more plainly put, whether or not someone is charged with a crime is irrelevant to why we as a society should care if they’re suicidal in jail, we should care because that is where our mentally ill get placed, where a hugely disproportionate rate are killing themselves. If we are aware where our society’s most vulnerable persons are ending up, we have an absolute responsibility to ensure our best efforts are put forth to, at the very least, keep them safe and alive. The current framework needs reforms, some programmatic and some foundational, to make that a reality. Whether that is in the form of new programs aimed at stabilization and reducing recidivism instead of incarceration, or whether that be in the form of new, widespread research efforts to modernize best practices, there is one key conclusion: nothing can be done without groundswell. The answer to the

question of where the nodes of access for suicide prevention reform are multiple: in supporting new legislation, in supporting research aimed to address systemic obstacles, and in creating popular support to raise awareness of these issues and combat cultural apathy. Through comprehensive reform and committed action as psychologists, clinicians, administrators, corrections staff, and concerned citizens, we can deconstruct the suicide survivability hierarchy and stop putting our most vulnerable at the lowest rung.

APPENDIX A - Hayes and the NCCHC's Best Practice Standards for Jail Suicide Prevention

Core Suicide Prevention Component	Definition	What Might This Look Like?
Identification	Sometimes called Screening. Upon admittance, many individuals are vulnerable to suicidal thoughts due to loss of control, hopelessness, or shame. This risk level may shift very quickly.	At the time of admittance, identification/screening should seek out: • known history of suicide risk, • substance abuse issues, • current mental status, • historical medical and mental health information, • recent losses/trauma, history of suicide, • current threats or plans to die by suicide, • information from the arresting officer.
Training	Jail staff who routinely contact/interact with incarcerated persons should receive a minimum of eight hours of initial training in suicide prevention, as well as two hours of refresher training thereafter.	Formalized training covering: • mindset about suicide prevention, • tenets of suicide prevention, relevant statistics, and research, • training on how the correctional facility environment is conducive to suicidal behavior, • warning signs, • screening and assessment, • safety planning, • risk and protective factors, • how to recognize risk even if the individual denies it, • policies in place, and • liability issues. Refresher courses should cover the same topics and include: • notifications of any changes regarding the facility's suicide prevention program, and • discussion of recent suicidal behavior or suicide deaths in the facility.
Assessment	Individuals should be assessed by a qualified mental health professional to determine the level of suicide risk that the individual presents at the time of the assessment. This assessment should, at a minimum, include recommendations about the level of risk, the degree of suicide precautions that should be taken, and whether the individual should be transferred to an inpatient mental health program. Individuals should also be checked periodically for changes in their level of risk, adhering to a schedule.	Formalized measures of suicide risk screening (e.g. SITBI, SAD PERSONS, BHS, etc) administered by a mental health professional, done at first admittance, after significant life events, and periodically according to a schedule. Some form of report with mental health information available and easy to access.

Monitoring	Ensuring that there are systems for constant monitoring and observation, allowing ease of access in under four minutes. The frequency and duration of 'check-ins' should be determined by a qualified mental health professional, but never exceed 10 minutes.	• Proximity to guard stations, • Regular 10-minute in-person checks by a guard, • Closed-circuit televisions and security cameras.
Housing	Individuals at elevated risk of suicidality or self-harm should have, at best, special housing that allows for the best protection of these individuals. At a minimum, there should be additional safety precautions taken in the cells of those at risk for suicide. Additionally, it is recommended that these aren't segregated cells, as social interactions are so critical.	Cell safety measures such as: • Restriction of private property to enact means restriction, • Beds that are anchored to the wall, • Untie-able bedsheets, • Clear doors, • Proximity to guard stations, • The 'suicide smock' – is a short, rough tunic that cannot be tied to hang oneself.
Referral	If the incarcerated person requests mental health assessment, resources, or help, then there should be a system wherein any jail staff can know the proper channels for referral to mental health services.	• Mandated training on the importance of referrals, • and written and documented filings of requests for services. • Incarcerated individuals should be able to request services from any staff member.
Communication	Communication between other departments of the correctional facility. Ongoing assessments, which include any observations from staff or formal evaluations conducted by clinicians, should be communicated between all departments in a documentable fashion. Situational information (e.g. bad news, adjudication, etc.) should be shared among disciplines for effective suicide prevention.	The arresting officer should communicate pertinent info to jail staff. Jail staff should communicate mental health concerns, and concerns of self-harm and suicidality to a multidisciplinary team of program coordinators, qualified mental health clinicians, and religious services.

Intervention	Staff should be trained in life-saving interventions and basic medical responses. There should be available equipment easily accessible. Staff should never assume that the victim is dead before intervention. All individuals who attempt should receive immediate intervention and assessment by mental health staff	• Mandated first aid training.
		• Mandated CPR training.
		• First aid kits, containing:
		  ○ pocket masks,
		  ○ rescue tool for cutting ligatures or makeshift nooses,
		  ○ bandages,
		  ○ antiseptic,
		  ○ tourniquets,
		  ○ and other materials.

Notification	The policy and procedures should address notification of the chain of command, all appropriate outside authorities, and the victim's family.	Instructions for staff on how to get in contact with family members to notify them of the suicidal behavior or death by suicide, and available information about chain-of-command/outside agency notifications
Reporting	The facility should have a written policy and defined procedures for the reporting of all suicidal behavior or suicide deaths. Staff who came into contact with the individual before the incident should provide a written statement regarding their full knowledge of the individual and the incident.	Written, posted material, available to every staff member easily and accessibly, regarding the standard order of operations. The full policy should treat suicidal behavior with the same level of severity as death by suicide.
Review	A system for the review of serious suicide attempts and death by suicide. Appropriate support is given to staff and other incarcerated	An inquiry after death that reports circumstances leading up to and at the time of the event, training of involved staff that is relevant, services/reports involving the

persons, given that these deaths can be incredibly stressful.	victim's medical and mental health, and recommendations regarding the physical environment, staff training

APPENDIX B - Factors Relevant to Each Phase of the Integrated Motivational-Volitional Theory (IMVT) of Suicidality

Phases of the IMVT

Threat-to-Self Phase		Motivational Phase		Volitional Phase	
Factor	Definition	**Factor**	Definition	**Factor**	Definition
Social Problem-Solving Deficits	A tendency to react to social problems in impulsive, emotionally reactive, and ineffective ways	**Thwarted Belongingness**	The belief that one does not belong to an important social group; the feeling that one is an outcast	**Access to Means**	Having access to whatever preferred method of death by suicide is selected.
Suicide-Specific Rumination	A repetitive mental fixation, particularly on one's suicidal thoughts, intentions, and plans	**Perceived Burdensomeness**	The belief that one is a bother or an inconvenience to those around them.	**Planning**	Explicit plans for methods, timetable, or other objective factors in one's death by suicide.
Memory Biases	Fixations on negative aspects of memory; particularly strong memories are connected to negative emotions.	**Lack of Future-Oriented Thinking**	Thinking patterns which seem 'locked' in either the present moment or the past. Little in the way of goals, problem solving attitudes, etc.	**Exposure to Suicide**	Suicide deaths in one's environment, whether directly (e.g., suicide death of a known person) or indirectly (e.g., suicide death of a famous person).
Impaired Coping	Lack of effective coping skills	**Impaired Social Support**	Unmet social needs; a social support network either may not exist or may provide inadequate social/practical resources.	**Impulsivity**	The tendency to make decisions quickly and without fully considering consequences.
Entrapment	A state of being which arises when one experiences social defeat (e.g., a loss of social status), hopelessness, and humiliation.	**Impaired Resilience**	Impairments in one's ability to resist emotionally-aversive thoughts or emotions, or the intensification of otherwise manageable negative	**Physical Pain Sensitivity**	One's threshold for considering an event physically painful. In suicidality, this threshold is heightened, meaning one is less sensitive to

		internal reactions.		pain than before.
	Impaired Goal Regulation	The ability for one to set, and feel closer to achieving, reasonable goals. Impairments mean that one is unable to believe that they are progressing towards their goals.	**Fearlessness About Death**	Lack of fear or aversiveness around thoughts of death and mortality.
	Prior Suicidal Ideation	Thoughts around suicide	**Past Suicidal Behavior**	Prior instances of suicidal behavior (e.g., what was previously termed a suicide attempt.)

Note: Definitions are drawn from O'Conner & Kirtley (2018).

APPENDIX C - Standards of Reporting Qualitative Research (SRQR) Checklist

SRQR Item	Response and Page Number
1. Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	[p. 1] The title of this project, *The Survivability Hierarchy Behind Bars: Themes, Reforms, and Prevention Program Evaluations in Washington State Jail Suicides*, highlights thematic analysis and program evaluations as the principle approaches to analyze data.
2. Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	[p.5] The abstract includes background, purpose, methods, results, and brief conclusions.
3. Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	[p. 17] The Present Study section includes the following problem statement after a background review of the significance of the problem: "The present study uses multiple methods of analysis that are all intended to answer the question, 'Where are the points of access and reform in jail suicide prevention?'"
4. Purpose or research question - Purpose of the study and specific objectives or questions	[p.17 – 20] Outlined in the 'Aims and Hypotheses' section.
5. Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	[p. 22 – 24] Covered in support of the program evaluation and thematic analysis sections. Additionally, epistemological view of the lead author is included in the research paradigm statement in this section.
6. Context - Setting/site and salient contextual factors; rationale**	[p. 5 – 17] Explained in the introduction. Salient contextual factors are given particularly in page 16 & 17, which discusses these factors in the context of suicide theory.

7. Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	[p. 22-23; 24-25] Covered in the Sample Characteristics section for each of the two samples.
8. Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	[p. 22-23; 24-25] Covered in the Sample Characteristics section for each of the two samples.
9. Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	[p. 22-23; 24-25] Also covered in the Sample Characteristics section for each of the two samples.
10. Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	[p.21-22] Covered under the Sample and Study Characteristics section, as well as in Appendix A, as well as Table 1, 2, and 3
11. Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	[p. 22-23; 24-25] Also covered in the Sample Characteristics section for each of the two samples. Data integrity is covered on page 22, in particular.
12. Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	[p. 22-23; 24-25] Also covered in the Sample Characteristics section for each of the two samples. Positionality statements were given on page 22.
13. Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	[p. 23 – 24] Covered in the Techniques to increase trustworthiness section. Triangulation was most appropriate for this study due the study's population (decedents & policy) precluding member checking, and the

	large number of codes and themes making an audit trail unwieldy.
14. Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	[p. 48 – 54; 60-61; 67] Thematic analysis in Statewide-Level and the Discussion section both contain sections which report interpretations and themes in respect to prior research and theory.
15. Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	[p. 29 - 45] The Individual-Level Results section contains direct quotes from death records, which provides evidence for analytic conclusions.
16. Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	[p. 48-54; 55-61] The Statewide-Level Themes and discussion section both contain direct relation for conclusions to existing research and theory. The discussion in particular includes challenges to earlier scholarship, scope of application, and identification of unique contribution to scholarship in the field of jail suicide prevention.
17. Limitations - Trustworthiness and limitations of findings	[p. 62-63] Trustworthiness (i.e., strengths) and limitations are listed in this section.
18. Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	[p. 4] In the Declaration section.
19. Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	[p. 4] In the Declaration section.

APPENDIX D - Full Suicide Prevention Best Practice Adherence Scores by Jail

Best Practice Criteria

Jail	Identification			Training			Assessment			Monitoring			Housing			Referral		
	#1	#2	M	#1	#2	#1	#2	M	#1	#2	#1	#2	M	#1	#2	#1	#2	M
Jail I (*County*)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Jail II[†] (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	0.5	0.5	0.5	1	1	1	1	1	1
Jail III (*County*)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Jail IV[†] (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	1	1	1	1	1	1	1	1	1
Jail V (*County*)	0.75	0.75	0.75	0.5	0.5	0.5	1	1	1	1	1	1	1	1	1	1	1	1
Jail VI (*County*)	1	1	1	0.75	1	0.88	0.5	1	0.75	1	1	1	1	1	1	1	1	1
Jail VII (*County*)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Jail VIII (*County*)	1	1	1	0	0	0	1	1	1	1	1	1	1	0	0.5	1	1	1
Jail IX (*County*)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Jail X (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	1	1	1	0	0	0	1	1	1
Jail XI (*County*)	0.5	0.5	0.5	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1
Jail XII[†] (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	0.75	0.5	0.63	1	1	1	1	1	1
Jail XIII[†] (*County*)	1	1	1	0.5	1	0.75	1	1	1	1	1	1	1	1	1	1	1	1

Jail XIV† (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	1	1	1	1	1	1	1	1	1
Jail XV (*County*)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	-	0
Jail XVI† (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	0.5	0.5	0.5	1	1	1	1	1	1
Jail XVII (*County*)	0	0	0	0	0	0	0	0	0	1	1	1	1	1	1	0	0	0
Jail XVIII† (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	0.5	0.5	0.5	1	1	1	0	0	0
Jail XIX† (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	1	1	1	1	1	1	1	1	1
Jail XX† (*County*)	0.75	0.75	0.75	0.5	0.5	0.5	1	1	1	1	1	1	1	1	1	1	1	1
Jail XXI† (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	1	1	1	1	1	1	1	1	1
Jail XXII† (*County*)	1	1	1	0.75	1	0.88	1	1	1	1	1	1	1	1	1	1	1	1
Jail XXIII† (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	1	1	1	1	1	1	0	0	0
Jail XXIV† (*City*)	1	1	1	0	0	0	0	0	0	1	1	1	1	1	1	0	1	.5
Jail XXV† (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	1	1	1	1	1	1	1	1	1
Jail XXVI† (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	1	1	1	1	1	1	1	1	1

Jail XXVII (*County)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Jail XXVIII (*County*)	-	-	0	-	-	0	-	-	0	-	-	0	-	-	0	-	-	0
Jail XXVIX (*County*)	-	-	0	-	-	0	-	-	0	-	-	0	-	-	0	-	-	0
Jail XXX† (*County*)	1	1	1	0.5	0.5	0.5	1	1	1	1	1	1	1	1	1	1	1	1
Jail XXXI† (*City*)	0.5	0.5	0.5	0	0	0	1	1	1	1	1	1	1	1	1	0	0	0
Jail XXXII (*County*)	-	-	0	-	-	0	-	-	0	-	-	0	-	-	0	-	-	0

	Best Practice Criteria														
Jail	Communication			Intervention			Notification			Reporting			Review		
	#1	#2	M	#1	#2	M	#1	#2	M	#1	#2	M	#1	#2	M
Jail I (*County*)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Jail II† (*County*)	1	1	1	1	1	1	.5	.5	.5	1	1	1	1	1	1
Jail III (*County*)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Jail IV† (*County*)	1	1	1	1	1	1	.5	.5	.5	1	1	1	1	1	1

Jail V (*County*)	1	1	1	1	1	1	0	0	0	1	1	1	1	1	1
Jail VI (*County*)	1	1	1	1	1	1	.5	0	.25	1	1	1	1	1	1
Jail VII (*County*)	1	1	1	1	1	1	1	.5	.75	1	1	1	1	1	1
Jail VIII (*County*)	1	1	1	1	1	1	0	.5	.25	1	1	1	1	1	1
Jail IX (*County*)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Jail X (*County*)	1	1	1	.5	.5	.5	1	1	1	1	1	1	1	1	1
Jail XI (*County*)	.5	.5	.5	0	0	0	0	0	0	0	0	0	0	0	0
Jail XII† (*County*)	1	1	1	1	1	1	0	.5	.25	1	1	1	1	1	1
Jail XIII† (*County*)	1	1	1	1	1	1	.5	.5	.5	1	1	1	1	0	.5
Jail XIV† (*County*)	1	1	1	1	1	1	.5	.5	.5	1	1	1	1	1	1
Jail XV (*County*)	-	-	0	-	-	0	-	-	0	-	-	0	-	-	0
Jail XVI† (*County*)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Jail XVII (*County*)	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0
Jail XVIII† (*County*)	.5	.5	.5	0	0	0	.5	.5	.5	1	1	1	1	1	1
Jail XIX† (*County*)	1	1	1	1	1	1	.5	.5	.5	1	1	1	1	1	1
Jail XX† (*County*)	0	0	0	1	1	1	.5	.5	.5	1	1	1	1	1	1

Jail XXI† (*County*)	0.75	1	.88	1	1	1	.75	.5	.63	1	1	1	1	1	1
Jail XXII† (*County*)	1	1	1	1	1	1	.5	.5	.5	1	1	1	1	1	1
Jail XXIII† (*County*)	1	1	1	1	1	1	.5	.5	.5	1	1	1	1	1	1
Jail XXIV† (*City*)	1	1	1	1	1	1	.5	.5	.5	.5	.5	.5	0	1	.5
Jail XXV† (*County*)	1	1	1	1	1	1	.5	.5	.5	1	1	1	1	1	1
Jail XXVI† (*County*)	1	1	1	1	1	1	.5	.5	.5	1	1	1	1	1	1
Jail XXVII (*County)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Jail XXVIII (*County*)	-	-	0	-	-	0	-	-	0	-	-	0	-	-	0
Jail XXVIX (*County*)	-	-	0	-	-	0	-	-	0	-	-	0	-	-	0
Jail XXX† (*County*)	1	1	1	1	1	1	.5	.5	.5	1	1	1	1	1	1
Jail XXXI† (*City*)	0	0	0	.5	.5	.5	.5	.5	.5	1	1	1	0	0	0
Jail XXXII (*County*)	-	-	0	-	-	0	-	-	0	-	-	0	-	-	0

Note: #1 and #2 to the individual entries for each coder. M refers to the mean rating for each criteria by both coders. † = Indicates a jail that uses Lexipol policy

APPENDIX E - Miscellaneous and Noteworthy Policy for Washington State Jail Suicide Prevention Policies

Jail	Miscellaneous Comments on Materials Provided
Jail I (*County*)	"Jail original. Mock drill, suicide attempt review committee, arresting officer provides info of suicidality during booking. Only assigned perfect score." "Suicide prevention and psychiatric referrals."
Jail II (*County*)	"Lexipol policy. Temporary custody on holding which allows for diversion of people with a severe mental disorder or 'those that are or may be contemplating suicide' to a designated medical or county mental health facility. Specific mention of arresting deputy inquiring about suicide and being responsible for communication of suicidality to the proper channels."
Jail III (*County*)	N/A
Jail IV (*County*)	"Lexipol policy."
Jail V (*County*)	"Jail original. Unique risk classification system where any inmate is considered moderate risk at admission.. Additionally, they have a circle system - circle of black foam placed on the door of an actively suicidal inmate not yet cleared by a designated mental health professional. Yellow circle for inmates cleared but still considered at risk - treated as actively suicidal. Suicide referral information in the inmate welcome packet."
Jail VI (*County*)	"Jail original. Excellent training. Mentions 66% of all hanging jail suicides done with bedding."
Jail VII (*County*)	"Jail original. Info from arresting officers. Housing reviewed every 24 hours by qualified professional for suicide watch. Reassessed within 24 hours of being discharged from suicide watch. With approval, individuals who are suicidal are provided a cellmate while on watch."
Jail VIII (*County*)	"Jail original. Notable - The jail has a policy that inmates will be flagged for a behavioral/mental health review on intake if they have a past 12-month history of being on 15 minute watch. Evaluations by mental health staff can be done by telephone. Also monitoring is specifically instructed to monitor signs of life and document them."
Jail IX (*County*)	N/A

Jail X (*County*)	"Jail original. Note about leaving the cell of a person engaging in suicidal behavior undisturbed after intervention. (e.g., don't sweep for notes, other means, etc.). Clearly name the criteria and their parallels in their policy. Short, 4 pages, but still hits many best practice criteria."
Jail XI (*County*)	"Jail original. Only really discusses protocol for suicide attempts."
Jail XII (*County*)	"Lexipol policy. Unusual facts from initial hiring staff training regarding suicidal inmates - 30% use bunks as anchor, almost 50% had seen counselor in last 3 days. Only 7.5% were on watch."
Jail XIII (*County*)	"Lexipol policy."
Jail XIV (*County*)	"Lexipol. They call their suicide watch 'Heightened Awareness', which is unusual."
Jail XIX(*County*)	"Lexipol with added materials/changes."
Jail XV (*County*)	N/A
Jail XVI (*County*)	"Lexipol policy."
Jail XVII (*County*)	"Jail original. Covers only watch and suicidal behavior."
Jail XVIII (*County*)	"Lexipol. Training suggests that they place suicide inmates with a cellmate - Not reflected in policy. Uses structured screener - C-SSRS. Also DBT Resources in intake hiring packet for staff."
Jail XX (County)	"Lexipol. Standard part of new staff training involves reading a digest written/presented by Lindsay Hayes. Tests on suicidality and training scenarios at hiring to pass the initial training."
Jail XXI (*County*)	"Lexipol. Psych Autopsy by psychologist post-mortem. Suicide prevention team (reviews by warden, sheriff, qualified health professionals, etc.) conducted annually. Qualified mental health professional observation every 5 hours for individuals on suicide watch."
Jail XXII (*County*)	"Lexipol policy. Lindsay Hayes training manual; great training but not all components are reflected in policy, which is Lexipol." "Lots of detail in training manual!"
Jail XXIII (*County*)	"Lexipol policy."
Jail XXIV (*City*)	"Lexipol policy."

Jail XXV (County)	"Lexipol. Suicide review team made of physicians, mental health workers, and higher-level administrators who conduct annual reviews of environment, attempts, and policy."
Jail XXVI (*County*)	"Lexipol. Jail Suicide Team. Qualified health care professional monitors recommended every 5 hours for individuals on suicide watch. Psychological autopsy conducted by psychologist post-suicide."
Jail XXVII (*County*)	N/A
Jail XXVIII (*County*)	N/A
Jail XXVIX (*County*)	N/A
Jail XXX (*County*)	"Lexipol policy. Notes on use of TASER indicates tasing inmates at imminent risk is outlined in policy; same with Electronic Restraint Devices (stun guns, stun cuffs, etc.)"
Jail XXXI (*City*)	"Lexipol policy."
Jail XXXII (*County*)	N/A

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