

A PORTRAIT OF SUICIDES IN TEXAS JAILS: *Who is at Risk and How Do We Stop It?*

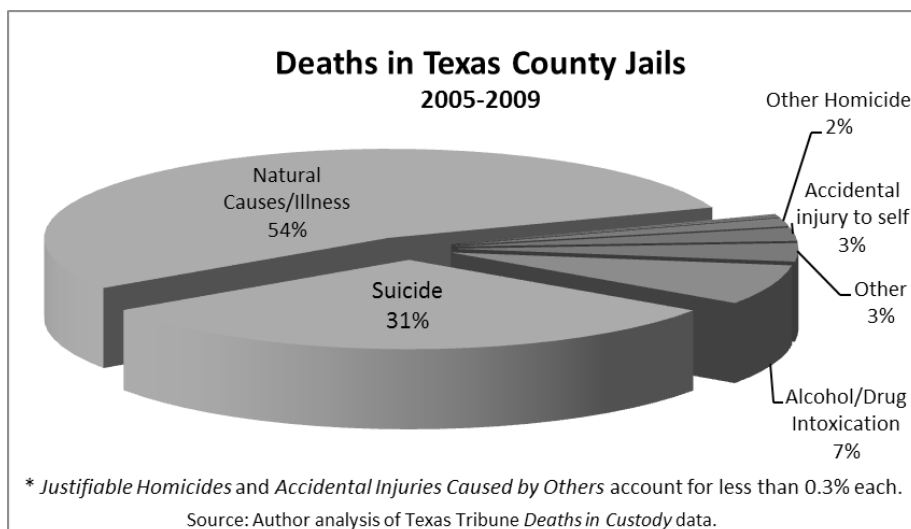
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SUICIDE IS THE SECOND LEADING cause of death in Texas prisons and jails. Only natural causes claim more inmate lives under custody each year. Of the roughly 200 inmate deaths annually in Texas, nearly a quarter is the result of suicide. For county jails in Texas, the proportion is even higher: 31 percent of jail deaths are suicides, whereas suicides comprise only 21 percent of prison deaths (Figure 1).¹

This discrepancy between prisons and jails is not altogether surprising. Because jails house inmates for shorter periods of time, it is reasonable to expect

Figure 1



that natural causes will account for a smaller proportion of deaths, while suicides will account for a larger proportion, when compared to prison deaths.

The question then is how do suicide *rates* in jail compare with suicide rates in prison, or elsewhere? When standardized per 100,000 inmates, jail suicides happen at more than three times the rate of suicide in state prisons, national studies find.² Even after adjusting for differences associated with age, gender, and ethnicity, suicide is the only cause of death that occurs at a higher rate in local jails than in the U.S. general population.³ In fact, a comprehensive study on jail suicide by leading correctional suicides expert Lindsay Hayes suggests this rate of jail suicide is as much as three times the rate in the general population.⁴

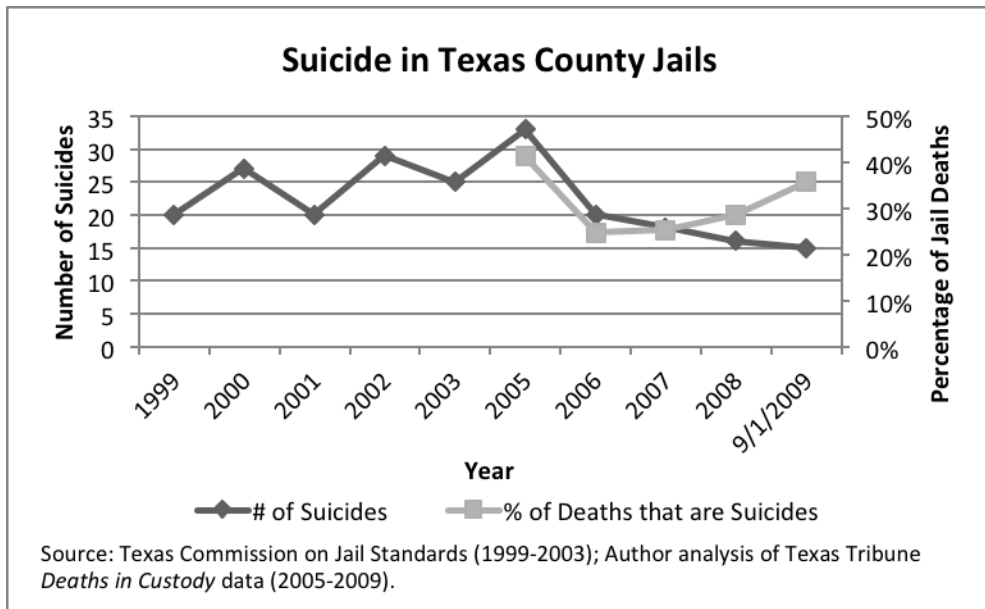
Given the disproportionate incidence of suicide in county jails, this report seeks to understand who is most at-risk in Texas jails, specifically, and what can be done to reduce the rate and number of suicides. To address these questions, this report presents the findings of an original analysis using data obtained through the *Texas Tribune* in 2010. This dataset reflects all deaths in custody in Texas between January 1, 2005, and September 1, 2009, and was collected by state and local agencies in accordance with reporting requirements under the Deaths in Custody Reporting Program (DCRP), run by the Bureau of Justice Statistics (BJS). Detailed information on methodology can be found at the end of this report.

THE TEXAS HISTORY

Over the past several decades, national trends have been encouraging: jail suicide rates have fallen sharply since data collection efforts began in the early 1980s. In 1983, suicides were the leading cause of jail mortality, accounting for some 55 percent of all U.S. jail deaths. By 1993, natural causes had surpassed suicide as the most common cause of death in local jails.⁵ Suicide rates continued to tumble, and by 2000 suicides accounted for roughly one-third of jail deaths. In 2007, they slipped further to just 26 percent.⁶

Whether Texas follows the national trend is unclear. In real numbers, suicides have fallen precipitously from their peak of 33 in 2005 (Figure 2). However, as a percentage of all jail deaths, suicides have been on the rise since 2006, climbing from 25 percent to 36 percent in just three years. This data point suggests that although suicides have fallen in real numbers, natural deaths have fallen at an even faster rate, giving the appearance of an increase in suicides. This increase makes sense in the context of a general downward trend in mortality rates for jails across the nation.⁷ Several more years of data will be necessary to ascertain whether recent trend lines are indicative of a substantive shift in the cause of jail deaths or the result of something more random.

Figure 2



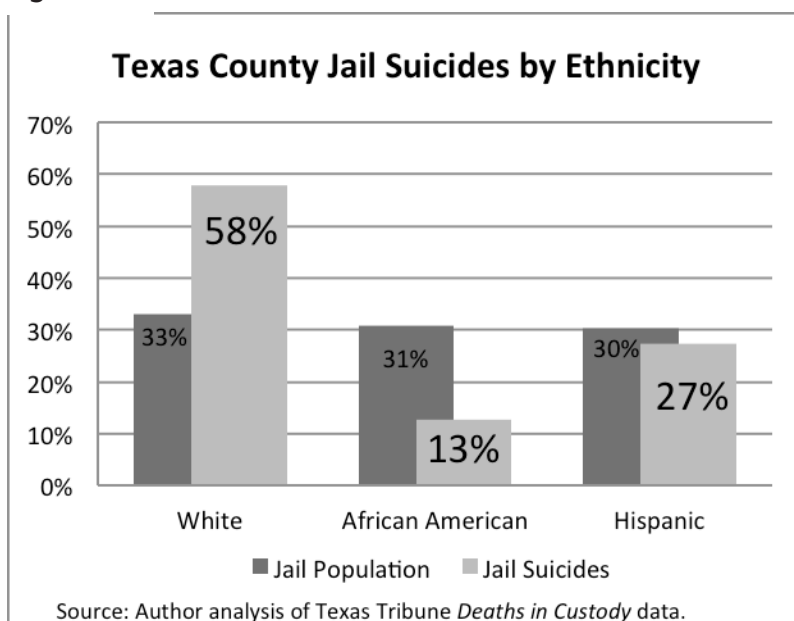
SUICIDE VICTIM CHARACTERISTICS

Naturally, not all inmates or facilities present the same risk for suicide. This brief seeks to highlight characteristics of those populations most at-risk in hopes of furthering attempts at early identification and risk management. Compared with other inmates who died in custody, jail suicide victims were disproportionately white and young. They were more likely to be violent offenders, have more charges, and die within the first month of confinement.

AGE

Texas jail suicide victims had a median age of 33, while those who died from other causes in Texas jails had a median age of 46. Inmates ages 25 to 34 were most at-risk, accounting for over 37 percent of jail suicides. This age group, however, is also the largest segment of the jail population (32 percent). The similarities of these proportions suggest that this group is committing suicide at a rate only slightly higher than expected.⁸

Several studies point to evidence suggesting that the risk of jail suicide grows with age. When standardized against the average daily population and the number of people in each age bracket, older inmates appear to present the highest suicide risk. While inmates ages 18 to 24 have a suicide rate of 31 per 100,000, inmates ages 55 and older commit suicide at a rate more than double that amount (72 suicides per 100,000 inmates). With each older age bracket, the rate of suicide climbs steadily.⁹

Figure 3

ETHNICITY

Jail suicide victims were overwhelmingly white; white inmates accounted for 58 percent of Texas jail suicides despite representing only one-third of the Texas jail population (Figure 3). African-American jail suicides, by contrast, were less common, accounting for only 13 percent of jail suicides despite African-Americans representing 31 percent of the jail population. Hispanics committed suicide at a rate roughly equal to their proportion of the jail population.¹⁰

Other research substantiates the disproportionate incidence of suicide among white inmates, which appears even more dramatic in national trends, where some 70 percent of jail suicide victims are white.¹¹ A separate study found that white jail inmates were six times more likely to commit suicide than African-Americans and three times more likely than Hispanics.¹² Suicide rates by ethnicity in the U.S. general population also show a higher rate of suicide for whites; however, that rate is only double that of other ethnicities. Jail appears to magnify the already existing racial difference in suicide rates.¹³

GENDER

Ninety-three percent of Texas jail suicide victims were male. Of the 102 suicides, only 7 victims were women. This disproportionate incidence of male suicide holds nationally even after standardizing for jail gender population differences.¹⁴

OFFENSE TYPE

Violent offenders were most likely to commit suicide, accounting for more than 43 percent of jail suicides, despite representing only a quarter of the jail inmate population and 29 percent of other jail deaths.¹⁵ By contrast, property offenders

were at relatively low risk of death in Texas jails. Despite making up roughly 25 percent of the jail population, property offenders accounted for only 13 percent of the suicides and 8 percent of other jail deaths. Of all the offense types, only drug offenders were less likely to die as a result of suicide than by some other means. Drug offenders made up 26 percent of jail suicides but 38 percent of other jail deaths. Still, this group committed suicide in proportion to its size in the jail population, where drug offenders make up about a quarter of all inmates.¹⁶

These trends are echoed by national research on jail deaths in custody, where violent offenders commit suicide at three times the rate of nonviolent offenders, and drug offenders have the lowest suicide rate of all offender groups.¹⁷

National studies also suggest violent offenders are not a homogenous group when it comes to suicide risk. Offenders held on charges for kidnapping, rape, and homicide have the highest rates of suicide, while offenders held for other sexual assaults, assaults, and robbery commit suicide at a substantially lower rate.¹⁸

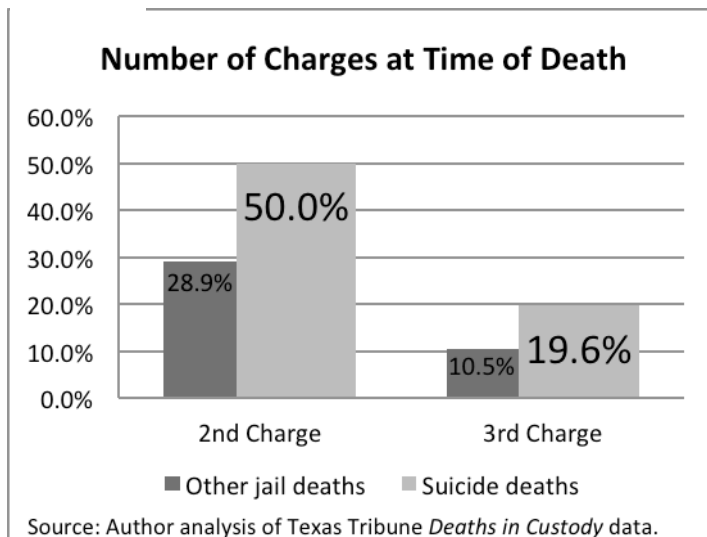
CHARGES AT TIME OF DEATH

Half of those committing suicide in jail had two charges and 20 percent had three (Figure 4). These percentages are dramatically out of line with other jail deaths, where only 29 percent had two charges and 11 percent had three.

TIME SINCE ADMISSION

Of inmates who committed suicide, there was a median of almost 11 days in a Texas jail before the act. The shortest time frame was two hours and the longest was about fourteen and a half months. Almost 18 percent of suicides happened within the first 24 hours of admittance, and 42 percent happened within the first week. Two-thirds of jail suicides took place within a month of admission to the jail.

Figure 4



To put these timeframes in context, it is useful to understand how long an inmate typically spends in jail. For the majority of jurisdictions, the average length of stay in county jails is between ten and twenty-five days. Bexar County jail, for example, had an average length of stay of twenty-one days in 2005.¹⁹ Smaller jails tend to have shorter stays. This suggests that while jail suicides do tend to happen within the first several weeks, most inmates are only *staying* several weeks. As a result, time since admission may be of little use in determining where to focus prevention efforts.

Conventional wisdom for suicide prevention rests on the idea that jail suicides happen shortly after admittance. Indeed, standard recommendations have long advised that preventative resources be frontloaded within the first week of an inmate's stay. There is some precedent for this belief, as studies from the mid-1980s show half of all jail suicides occurring within 24 hours of admission.²⁰ Since that time, however, trends have changed. Based on jail suicide data from 1999 to 2003, the Texas Commission on Jail Standards (TCJS) has written that suicides appear to be an "action of opportunity" rather than anything that can be predicted by length of time since admission.²¹ Experts behind other recent research express similar sentiments and caution against relaxing suicide precautions too early.²²

FACILITY CHARACTERISTICS

Like inmates themselves, not all jail facilities or housing assignments appear to present the same risk for suicide. Smaller jails and single cell housing assignments introduce a higher degree of danger for inmates already at risk of suicide.

JAIL SIZE

Eighty county sheriff's departments had at least one jail suicide from 2005 to September of 2009; 174 had none. Not surprisingly, high-population urban areas recorded more jail suicides in absolute numbers. The Bexar County sheriff's department logged the most, with seven jail suicides over the nearly five-year period. El Paso County had the next largest total with five, followed by Dallas County and Travis County, with four each. The scarcity of suicides for any single county suggests that, while suicides do account for a substantial proportion of jail deaths, they are still relatively rare occurrences for any one facility. Indeed, more than 80 percent of jails nationwide report no deaths in custody each year, and over the eight-year period from 2000 to 2007, 42 percent of U.S. jails reported no deaths.²³

To understand why some jails have a higher incidence of suicide than others, it is necessary to look at the *rate* of suicide in jails of different sizes. Numerous studies suggest that, when standardized by average daily population, the nation's smallest jails have a suicide rate more than six times the rate in the nation's largest jails.²⁴ Jail size and suicide rates, it turns out, are closely related throughout the entire range of jail sizes: as jail size increases, suicide rate falls.

Most jails in Texas are small. In 2006, 112, or nearly half of Texas's jail jurisdictions, held less than fifty inmates.²⁵ Despite the prevalence of small jail

jurisdictions, these facilities housed only 3.4 percent of the state jail population. Statistically, these inmates were significantly more at risk of suicide than the 58 percent housed in large jurisdictions of 1,000 or more inmates.²⁶ Part of the reason, no doubt, lies in the dearth of staff suicide-risk assessment training and counseling services offered by smaller jails. Nationally, only 54 percent of the smallest jails had staff suicide risk-assessment training compared to 91 percent of the largest jails. Similarly, only 41 percent of small jails offered counseling services, compared with 93 percent of large jails.²⁷

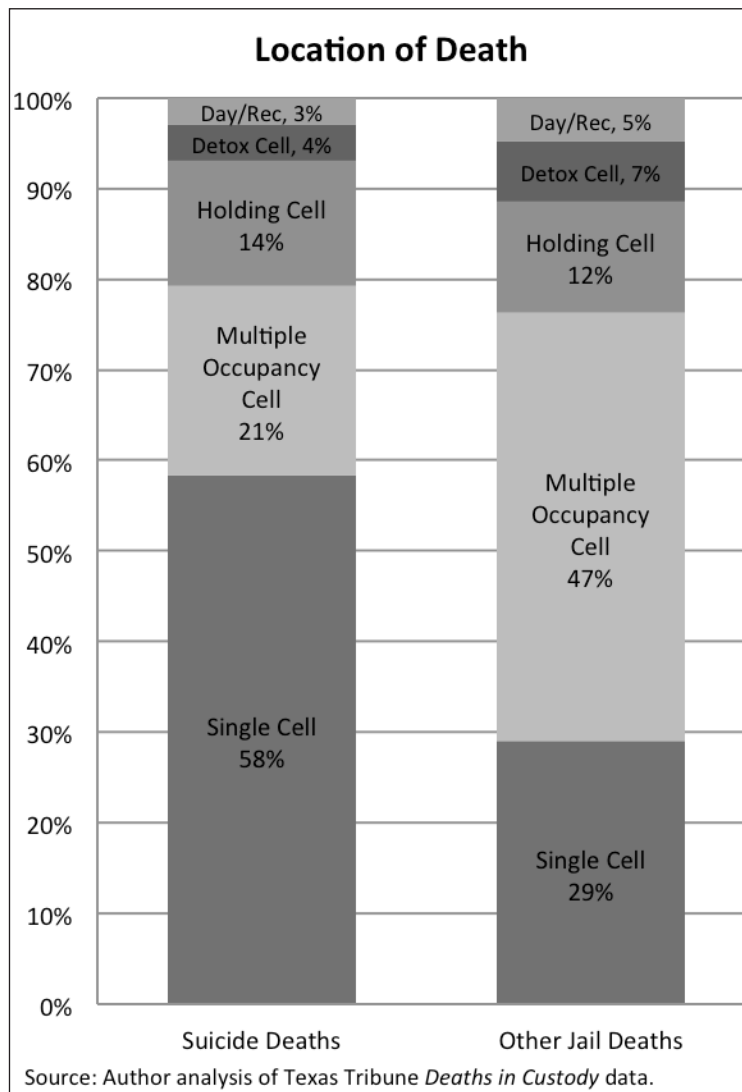
LOCATION OF DEATH

Compared with other jail deaths, suicide victims were twice as likely to be housed in a single cell when the incident occurred (Figure 5). While only 29 percent of other jails deaths occurred with single cell inmates, 58 percent of suicide deaths occurred with single cell inmates, 58 percent of suicide victims were housed in a single cell. Multiple occupancy housing appears negatively correlated with jail suicide, suggesting its potential use as a preventative tool. Only 21 percent of jail suicides occurred in multiple occupancy cells, compared with nearly half of other jail deaths taking place in multiple occupancy housing.

METHOD OF SUICIDE

Hanging or strangulation is the dominant method of suicide in Texas county jails. Of the 102 suicides that occurred between 2005 and September of 2009, over 87 percent happened by hanging or strangulation. Drug overdoses and incidents involving

Figure 5



knives or cutting instruments were the next most common, accounting for 5 percent and 4 percent of suicides, respectively.

INMATE TO STAFF RATIO

To the extent that a larger staff translates into more supervision and lower rates of suicide, a lower inmate to staff ratio is considered preferable. In 2006, Texas averaged 3.5 inmates per jail staff member. This was slightly higher than the national average of 3.3 inmates per staff member, but slightly lower than the average of 3.6 for southern states. Texas then, does not appear to differ substantially from other states in terms of staffing levels.²⁸

PREDICTIVE MODELING FOR AT-RISK INMATES

The dataset used in this report includes considerable information on each custodial death, allowing predictive modeling to shed light on particular characteristics that make an inmate at risk, statistically, for suicide in Texas county jails. The results of correlation and regression analyses point to several factors that can be linked to jail suicides. However, as discussed later in this section, these predictive profiles are inadequate as a prevention tool and should be treated as limited in their explanatory capacity.²⁹ The results of these analyses are included as tables in the appendix of this report.

The central findings of correlation and regression analyses echo many of the relationships seen elsewhere. Correlation matrices suggest suicide victims tend to be younger and spend less time in jail prior to death when compared against other jail deaths. They tend to be held in a single cell more often, have more charges, be violent offenders, and be white. They tend *not* to be drug offenders or have entry behavior that is medical in nature. But what these models do not say is perhaps just as important as what they do. Entry behavior is often referenced in suicide prevention literature as a key indicator of risk. However in both correlation and regression analyses, intoxicated or behavior indicative of mental illness upon entry did not appear to be a factor in predicting jail suicides.³⁰ Inmates displaying these characteristics were just as likely to die of other causes as to die as a result of suicide.

Regression modeling on the cause of death in Texas county jails finds some degree of predictability for suicide, given certain characteristics. Roughly 28 percent of the variability in suicide incidents can be explained by just five factors: age, white ethnicity, the number of charges an inmate is facing, whether they exhibit medically related entry behavior, and whether they are being held in a single cell.³¹ This suggests that knowing nothing more than a few categorical factors is enough to have some degree of knowledge as to whether an inmate is at risk. Table 1 combines the key findings from both correlation and regression analyses with conclusions reached earlier in this report.

Table 1 Summary of Risk Characteristics for Texas Jail Suicides		
At-Risk Inmate Characteristics 1. Inmate is age 25 to 34. 2. Inmate is white. 3. Inmate has multiple charges. 4. Inmate is a violent offender.	Other At-Risk Considerations 1. Small jails. 2. Single cell housing.	Low-Risk Characteristics 1. Large jails. 2. Multiple cell housing. 3. Inmate is African-American. 4. Inmate is a drug offender. 5. Inmate exhibits medically related entry behavior.

LIMITATIONS OF RESEARCH

Even if an inmate were to exhibit all of the at-risk characteristics and be held under all of the at-risk environmental conditions, the chance that he or she would commit suicide is extremely low. All things considered, suicides are relatively rare events for any one jail. Consider the Bexar County jail, which over the course of 2005 to 2009 logged more suicides than any other jail in the state, with a total of seven. This facility houses an average daily population of 4,000 inmates.³² At any given time, several hundred inmates may fit the at-risk profile for suicide, yet the vast majority of them will not commit suicide.

Understanding the triggers for inmate suicide is challenging, as they vary greatly from inmate to inmate. Suicides are often spontaneous and notoriously difficult to forecast. Clearly the categorical predictors in this study are only a handful of pieces in a much larger puzzle. Some stressors may come from the jail environment itself where isolation, loss of control, conflict with other inmates or staff, frustration with legal proceedings, or distress and shame over incarceration may flare suicidal tendencies.

Still other causal variables lie outside of the state's involvement. Roughly half of all jail inmates grew up in single-parent households. Half have a family member who has been incarcerated. Many have suffered from past physical or sexual abuse, and nearly seven in ten have substance abuse problems.³³ Family troubles, loss of employment, mental health issues, and a host of other factors may be driving the decision to commit suicide. For all these reasons, many of those who study correctional suicides in pursuit of practical predictive profiles, including the TCJS, Lindsay Hayes, and others, are wary of placing too much faith in the forecasting capacity of a few demographic variables.³⁴ This reluctance, however, is not to say that preventative measures cannot be taken. The next section attempts to distill and adapt a number of suicide-prevention practices for use in Texas county jails.

RECOMMENDATIONS

Nearly everyone has a stake in suicide prevention. For counties, prevention means avoiding litigation and bad press. For communities and families, prevention means saving lives. Jail suicide literature is dense with recommendations; some have already been adopted in Texas, and others may prove helpful to future prevention efforts. As the independent agency tasked with jail oversight, the TCJS has done much to address jail suicides in the past several decades. Apart from conducting regular, unannounced inspections for jail compliance with mandatory standards, the agency requires a written plan from county jails detailing mental health/suicide-prevention training, identification, reporting, and other procedures. Taken together, these efforts might be credited for much of the reduction in suicide over the past few decades. Still, more can be done. The following is a list of policy recommendations for suicide prevention that should be incorporated into the commission's standards for jail compliance or otherwise facilitated by TCJS:

The Intake Screening for Suicide, Medical, and Mental Impairments should be conducted by a qualified mental health professional or specially trained correctional staff member. Inmates who screen those at risk for suicide should be referred to a mental health professional for further evaluation and treatment.³⁵

National research reveals only 37 percent of suicide victims had been assessed by a qualified mental health professional prior to committing suicide.³⁶ Thorough screenings by trained staff and expedient referral procedures are critical to prevention efforts, and should be written into the required suicide prevention plan of each jail.

Mental health services should be available to jail inmates twenty-hour hours a day, seven days a week. Where full-time mental health staffing is impractical, written arrangements should exist with local mental health facilities for providing emergency mental health care.³⁷

In Texas, only 11 percent of jails have a mental health professional assigned to the facility.³⁸ Jails should be required to demonstrate that sufficient access to mental health services exists within the facility through a detailed description of staffing and contracted service provision in the written suicide prevention plan.

The Commission on Jail Standards should require mandatory training sessions on suicide prevention for county correctional staff.

Currently, TCJS offers training on suicide prevention as part of its optional inmate classification training.³⁹ Instead, suicide prevention training should be required in the form of a meaningful, stand-alone workshop provided at regular intervals to *all* corrections staff.

Jails should avoid detaining inmates at risk of suicide in isolated areas that exacerbate the potential for suicide.

Most suicides occur in special housing units where inmates are alone.⁴⁰ By contrast, few suicides occur in the presence of others, and only 8 percent happen while an inmate is under suicide watch.⁴¹ Wise housing placement then, is critical to sound prevention policy. An inmate's suicide risk should determine housing placement and observation level through a rubric similar to the following:

1. *Actively Suicidal*: Should be housed in a suicide-resistant cell under constant watch. Paper gowns should be substituted for clothing, with blankets and sheets removed. A mental health professional should visit multiple times per day.
2. *At-risk*: Should be housed in suicide-resistant cells under close observation at staggered intervals not to exceed 15 minutes. Meaningful interaction, not just observation from staff, is critical for inmates at this stage.
3. *Low risk*: Should be housed in multiple-occupancy cells or high-traffic areas under normal observation. The presence of other people acts as an implicit prevention mechanism for low-risk inmates.⁴²

The TCJS should continually monitor the number of suicides occurring in each Texas jail and reevaluate compliance in high-incidence jails. TCJS should also provide troubled jails with referrals to suicide prevention experts to identify problematic policies and practices.

In 2009, six inmates committed suicide in the Bexar County jail—a total of more than three times the national average.⁴³ In 2010, another five inmates committed suicide, followed by another three in 2011. Finally, in late 2011, Bexar County sought outside assistance in the form of a suicide prevention expert.⁴⁴ TCJS should be vigilant in tracking suicides and taking the necessary steps to address ineffective policies before avoidable suicides occur.

The following recommendations are less suited to oversight and regulation by TCJS. Nonetheless, they should be viewed as an outline for combatting suicide more generally:

Increase communication and interaction to avoid preventable suicides.⁴⁵

- Between jail staff and mental health staff.
- Between arresting officer and jail staff.
- Between jail staff and inmates.⁴⁶

—Increase awareness and procedures for addressing high-risk periods, such as the days preceding and following a court appearance, anniversaries, and admission into segregation.⁴⁷

—The BJS Deaths in Custody Reporting Program should expand its reporting requirements to include:

Whether an inmate was identified as at risk of suicide, to understand the degree to which intake screenings are identifying suicide victims. There are different policy implications, depending on whether we are failing at identification or failing at prevention.

More information on the detention status of suicide victims. Suicide literature suggests suicide profiles differ between pretrial and sentenced inmates.⁴⁸ For sentenced inmates, knowing the length of sentence and proximity of death date to sentencing date would be helpful to determine the role of sentencing in inducing suicidal behavior.

A handful of practices repeatedly crop up in jail suicide literature as approaches to avoid. The following is a list of things jails should *not* do:

—Jails should not rely on video surveillance as a means of monitoring at-risk inmates.

—Correctional suicide experts, the World Health Organization, TCJS, and jails themselves are in full consensus that video surveillance cannot and should not be a substitute for human observation when it comes to suicide prevention.⁴⁹

—Jails should not relax suicide watch after intake, or after the first week.

—Suicide prevention is an ongoing task. Experts caution that intake screenings, while crucial to the prevention process, only provide a snapshot of the inmate at a single point in time and may not catch latent suicidal tendencies that could flare under future stressors.⁵⁰ Research suggests that suicide is an act of opportunity and that staff should be trained to recognize the signs at any time.⁵¹

CONCLUSION

Over the past several decades, Texas has made great strides in reducing the number of suicides occurring in county jails. The problem, however, is far from solved. Jail suicide rates continue to outpace rates in prison and in the U.S. general population at a ratio of three to one. Texas jail suicide victims tend to be white, have more charges, and be violent offenders. They are held disproportionately in single cells and small jails. Prevention efforts would benefit from an increased presence of mental health staff and mandatory prevention training for correctional staff. The TCJS should also implement improved standards for housing at-risk inmates.

The Deaths in Custody Reporting Program should expand reporting requirements to include more information on intake screenings and inmate detention status. Over time, with improved reporting requirements and additional steps toward prevention, future research will contribute to a better understanding of precisely who is at risk and what can be done to help.

METHODOLOGY

The original dataset used in this report was obtained through an open records request from the *Texas Tribune* in 2010 and contains all deaths in custody occurring in Texas between January 1, 2005, and September 1, 2009. Deaths in custody are reported under law to the Texas Attorney General and to the Bureau of Justice Statistics as part of the nationwide Deaths in Custody Reporting Program (DCRP). In its original format, this dataset includes all inmate death records from state prison systems, state juvenile correctional authorities, local jail jurisdictions, and deaths occurring during the process of arrest.⁵²

For purposes of this report, the original dataset was distilled to include only deaths occurring within state prison and county jail facilities. Federal prisons and municipal jails are excluded. Deaths occurring under the jurisdiction of county jails and state penitentiaries but that did not take place within jail or prison walls are also excluded. As such, deaths occurring in correctional/rehabilitation facilities, in custody of a peace officer subsequent to arrest, or in hospital/infirmaries are excluded.

After excising these cases, the analysis included 928 deaths in custody occurring between January 1, 2005, and September 1, 2009. Of these, 598 occurred in state prisons, and 330 occurred in county jails. The bulk of this report focuses on the 330 cases occurring within county jails.

TECHNICAL APPENDIX

Table 2 Correlation Analysis with Texas Jail Suicide		
	<i>Variable</i>	<i>R</i>
Positive	Age	-0.37
	Number of Days in Jail	-0.09
	Held in a Single Cell	0.28
	Number of Charges	0.20
	Violent Charge(s)	0.14
Negative	White	0.14
	Entry Behavior: Medical	-0.30
No Relationship	Drug Charges	-0.12
	Entry Behavior: Intoxicated	-0.02
No Relationship	Entry Behavior: Mental	0.00
Note: This analysis uses the standard correlation coefficient, or Pearson's <i>r</i> , as a measure of linear dependence between two variables on a scale from -1 to +1, inclusive.		

Table 3 Regression Analysis Predicting Suicide as the Cause of Death in Texas County Jails		
R Square	0.283	
Adjusted R Square	0.272	
Significance F	9.84E-22	
Observations	330	
	<i>Coefficient</i>	<i>P-Value</i>
Age	-0.10	1.57E-08
Ethnicity: White	0.156	0.0004
Number of Charges	0.089	0.0040
Entry Behavior: Medical	0.264	1.76E-06
Held in a Single Cell	0.203	1.08E-05

NOTES

1. Unless otherwise noted, all statistics in this report come from the author's analysis of Bureau of Justice Statistics data collected under the Deaths in Custody Reporting Program.
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3. Noonan, Margaret. "Mortality in Local Jails, 2000-2007," NCJ 222988 (Washington, DC: United States Department of Justice, Bureau of Justice Statistics, July 2010): 1.
4. Hayes, Lindsay M. "National Study of Jail Suicide: 20 Years Later," NIC 024308 (U.S. Department of Justice, National Institute of Corrections, April 2010): 7.
5. Mumola, 1.
6. Bureau of Justice Statistics, "Deaths in Custody: Local Jail Deaths 2000-2007, Statistical Tables," table 2.
7. Mumola, 2; Noonan, 1.
8. James, Doris J., "Profile of Jail Inmates, 2002," NCJ 201932 (Washington, DC: United States Department of Justice, Bureau of Justice Statistics, 2004): 2.
9. Bureau of Justice Statistics, "Deaths in Custody," table 11; Mumola, 5; Noonan, 8.
10. United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, "Annual Survey of Jails: Jail-Level Data," Ann Arbor, MI: Inter-university Consortium for Political and Social Research (ICPSR), 2011. [Filtered by Race and State (44)].
11. Bureau of Justice Statistics, "Deaths in Custody," table 10.
12. Mumola, 6.
13. Noonan, 12
14. Mumola, 5.
15. James, 3.
16. James, 3.
17. Mumola, 7.
18. Mumola, 7; Noonan, 10.
19. Bexar County, prepared by Carter Goble Associates in association with Saldana Architects and HOK, "Bexar County Detention Master Plan Update," February 27, 2007, 3-6.
20. Hayes, "National Study of Jail Suicide: 20 Years Later," 20.
21. Texas Commission on Jail Standards, "House Bill 1660 Report to the Texas Legislature," 7.

22. Hayes, Lindsay M., "Jail Suicide Prevention Seminar," National Center of Institutions and Alternatives, for the New Mexico Association of Counties, March 2011, 9.
23. Noonan, 1.
24. Noonan 1; Mumola, 5.
25. Stephan, James, and Georgette Walsh, "Census of Jail Facilities, 2006," (Washington, DC: United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, December 2011): 14.
26. Stephan, 19; Noonan, 5.
27. Noonan, 5.
28. Stephan, 25.
29. It should be noted that correlation and regression analyses are hampered by their inability to compare against the jail population at large. All jail suicide predictive capabilities are interpretable only in relation to other jail deaths. A more useful model in a policy and operational context would evaluate suicide risk in relation to the jail population at large.
30. Todd, Heather, "Suicide Watch: Sheriffs and County Jail Staff Learn How to Detect and Prevent Inmate Suicides," *County Magazine* 13, no. 3 (May/June 2001).
31. As seen elsewhere, younger age, white ethnicity, having more charges, and being held in a single cell are positively associated with suicide. Medically related entry behavior is negatively associated with suicide; this can best be interpreted to mean inmates displaying medical problems at entry are more at risk of dying by other means than by suicide.
32. Bexar County, 3–8.
33. Karberg, Jennifer, "Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002," NCJ 209588, (Washington, DC: United States Department of Justice, Bureau of Justice Statistics, July 2005): 1, 4; James, 10.
34. Bureau of Justice Statistics, "House Bill 1660 Report," 4; Hayes, "National Study of Jail Suicide," 4.
35. American Bar Association, *ABA Standards for Criminal Justice: Treatment of Prisoners*, 3rd ed. (Washington, DC: American Bar Association, 2011).
36. Hayes, "Jail Suicide Prevention Seminar," 4.
37. Mental Health America, "Position Statement 56: Mental Health Treatment in Correctional Facilities," June 13, 2010.
38. Texas Commission on Jail Standards, "House Bill 1660 Report," 36.
39. *Ibid.*, 35.
40. Hayes, "Understanding Suicide Prevention in Correctional Facilities," 13; Todd, 2.

41. Hayes, "National Study of Jail Suicide: 20 Years Later," xii.
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46. Hayes, "National Study of Jail Suicide; 20 Years Later," 38, 50.
47. Hayes, "National Study of Jail Suicide; 20 Years Later," 49.
48. "Preventing Suicide, A Resource for Prison Officers," 6.
49. Todd, 2; "Preventing Suicide, A Resource for Prison Officers," 10; Hayes, "National Study of Jail Suicide; 20 Years Later", 37; House Bill 1660 Report to the Texas Legislature, 40.
50. Hayes, "Understanding Suicide Prevention in Correctional Facilities," 27; "Preventing Suicide, A Resource for Prison Officers," 9.
51. House Bill 1660 Report to the Texas Legislature, 7.
52. "Deaths in Custody Reporting Program: Methodology," United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, accessed March 8, 2012.