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ASSESSING SUICIDE and RISK BEHAVIORS in an INCARCERATED AMERICAN INDIAN POPULATION: INVESTIGATING CULTURALLY SENSITIVE RISK ASSESSMENT INSTRUMENTS and PROCEDURES in a BORDER JAIL

Final Report to the National Institute of Justice

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EXECUTIVE SUMMARY

In 1997, the administrator of a County Jail, located in the Northern Plains of the United States contacted these researchers with his concerns about the incidence of suicide behaviors occurring in that facility, particularly among the American Indian population. Seeking assistance in ensuring and where necessary, developing a best practices approach to suicide management in his facility, the administrator agreed to collaborate with researchers from the University of Kansas School of Social Welfare and the University of Colorado Health Sciences Center in designing and carrying out a study geared toward discovering and identifying two essential types of information. First, because the admission screening tool used in the County Jail to interview inmates at their intake into the jail facility was developed in New York and consequently embraced by this jail (and many other jails across the country) as its screening instrument, one research objective was to determine if that instrument was culturally appropriate for use with the County Jail population, particularly with the American Indian population. Second, the principle objective of the second year of this funded research was to determine whether the employment of different suicide screening protocols would make a difference in the responses of new detainees with regard to the likelihood of securing their honest reports of experiencing suicide ideation and it's associated risk factors.

The National Institute of Justice ultimately agreed to fund two years of research in this County Detention Center. The results are significant not only for their bearing on the research questions, but also for the questions they raise about this very fundamental practice of suicide risk screening in a pre-trial detention center. To date, the practice of screening detainees at the time of intake into a correctional facility – be it a lock-up; a pre-trial detention facility; or a prison facility – has been treated in the literature as a per se duty on the part of institutional managers. As will be addressed in the body of this report, this "duty" has been largely set upon these institutions by judges, lawyers, and expert consultants. The objective of this investigation was to move jail practitioners closer to an understanding of what is a good, if not best, practice in performing suicide risk assessments of detainees, based on actual practice evidence. Further, this inquiry was framed from an awareness of the cultural context in which jails are situated. Consequently, risk detection and prediction were explored among the dominant population admitted into the detention center, that consist of Caucasians, as well among as the detained dominant cultural minority population, who are American Indians.

The research protocols for each of the two years of this project called for the administration of surveys to new detainees and participation (both voluntary) and by longer-term inmates in focus groups.

Separate focus groups were held with male and female American Indian and non-Indian inmates, and with a coed group of officers as well. The researchers came to be known to jail staff as "the suicide ladies" – a euphemism taken as the mark of familiarity and cooperation between jail staff and the researchers. In this secure environment, officers share a common interest in the research and particularly in the efforts to learn something that might help them interdict in suicidal behavior in the detention facility.

The Relevance of the Data and Findings

Tribes that reside in the Northern Plains share many historical, governance, and cultural erosion similarities with tribes in other geographical settings, and parallel current socioeconomic conditions and contact with the criminal justice system. These shared characteristics suggest that many of the findings presented here may be relevant to other Indian populations;[i] however, local cultural symptoms, signs, and definitions of depressive-like experiences that may lead to suicide ideation are specific to tribes located in the Northern Plains. The findings particular to Indian inmates, therefore, should be considered within the culture and mores of Northern Plains' tribes.

Research Aims

The overall objective of this funded research was to address and fill in the gaps in the existing research literature by evaluating a popular suicidal ideation assessment tool, one commonly used within detention centers around the country, for its cultural sensitivity and to modify and, where appropriate, to improve the state, local, and tribal correctional agencies' ability to more effectively screen for suicide ideation among American Indian detainees. This endeavor involved exploring the connection between American Indian – Northern Plains culture and non-Indian inmates' responses to suicide screening questions as they are asked within this setting. **Specific objectives** of this research, by year, have been:

Year I

(1) To determine the prevalence rates of suicide ideation between American Indian and non-Indian jail populations.

(2) To examine concordance of the current screening tool used in the County Jail with other self-report measures of suicidal ideation and associated risk factors.

(3) Examine through focus groups, the cultural relevance of the current suicide risk screening tool and of the intervention methods employed in response to suicidal behavior within this particular jail setting.

(4) To develop measures of culture specific symptoms of suicide ideation that can be incorporated into a suicide screening protocol. And,

(5) To provide recommendations for culturally sensitive suicide ideation detection and intervention or treatment policy/ procedures in this detention setting.

The **hypotheses** of the first year endeavor were: **(1)** the prevalence of suicide ideation is higher among American Indian detainees than non-Indian detainees; and **(2)** culture plays an important role in identification of and intervention in suicide risk. The first year examined cultural and social factors influencing suicidal behavior among American Indian detainees.

Year II

The preliminary findings from the first year of research suggested a slightly modified path of inquiry for the proposed second year of research. Focus group data led to a consideration that inmates' experiences when being asked questions about suicide and mental illness at the time of intake and during incarceration vary according to the setting in which the questions are asked and who is asking the questions, i.e. who is administering the screening. Further, the importance of understanding how different methods and styles of screening administration influence the veracity of the responses an inmate gives to the suicide risk assessment questions was underscored by focus group feedback. Do screening questions alone produce a valid assessment? Does the screener's personal demeanor play a part in eliciting responses to the screening questions? Does the setting in which the questions are asked make a difference in terms of a detainee's comfort level when responding, thereby maximizing the predictive effects of the risk assessment? Does the manner in which the first suicide risk screening process is carried out have an affect on whether a particular inmate will seek mental health services later during his/her incarceration?

These questions provided the basis for **underlying assumptions and hypotheses** guiding the second year. Specifically, it was assumed that: **(1)** inmates of all races and ethnic backgrounds experience discomfort when asked directly about suicide ideation and mental health status through current screening measures; **(2)** reliable, valid, and effective suicide screening at intake is a matter of both the wording of questions being asked, and the manner or context in which they are asked; **(3)** relieving the inmate's discomfort during the screening process by utilizing culturally-respectful wording and conversation will lead to more personal comfort and disclosure of honest information from Indian detainees.

In essence, the overall goal for this second year of research was to determine if suicide screening questions alone produce a valid assessment. The specific objectives of this second year of research were:

(1) To identify, through the use of an experimental design, a suicide screening process that influences Northern Plains' detainees' comfort level in disclosure of suicidal ideation as well as future help seeking behavior and depression management within the jail setting; and

(2) To determine if the following make a difference in the detainee's comfort level for self-disclosure, management of depression, and future help seeking behavior:

a) The wording and format of screening questions as well as setting where screening takes place, and

b) The type of screener – current officer; indigenous officer; non-uniformed mental health professional.

The second year of study continued exploration into some of the key questions posed in the first year as well as its results. How does culture influence the experience of suicide ideation, the presentation of suicide symptoms, and the outcomes of suicide risk detection in this specific jail setting? Is the likelihood of honest self-disclosure about suicide ideation enhanced by the type of person asking them, the demeanor of the interviewer, the personal and professional characteristics of the interviewer, or some combination of these variables? How does the setting in which risk assessment questions are asked influence the truthfulness of the responses obtained? These key questions were addressed through a research methodology that once again included a combination of quantitative and qualitative methods.

Research Methodology

During the sampling period from October 1999 through January, 2000, all new prisoners who gave their informed consent were given a self-report survey after they had been interviewed using the NYSPSG questionnaire. Exclusion criteria included those that were not literate in the English language. For both years of the study, the research surveys sought demographic information. In addition, in the first year of study, the self-report survey also measured stress, anxiety, suicide ideation, hopelessness, loneliness, self/family suicidal behavior history, as well as risk factors for suicide ideation or behavior. As part of the first year data collection, the qualitative component of this research called for the convening of focus groups, stratified by American Indian and non-Indian status and by gender. The purpose of the focus groups, outlined in the consent forms signed by each participant, was to complete an item-by-item review of the NYSPSG and the jail's existing intake screening procedures.

The sampling period for the second year of research was initiated in October, 2000, and continued through May, 2001. Several sampling strategies were employed and these varied according to the intake

protocol used by the booking officer after s/he received specific training in the nature and purpose of the study and the protocol to be used during the data collection period. Data were collected by asking every inmate who was admitted into the jail to participate in the study by completing a "Feedback and Satisfaction Survey" after having been through the routine booking process during specific shifts and protocols: Control Group consisted of inmates booked in under normal procedures without any change to the assessment tool or process already in use in the jail; Group B consisted of new detainees screened in a *private area* of the booking section of the Detention Center by a *uniformed officer;* Group C consisted of all incoming inmates being screened by an *Indigenous (American Indian) officer* in the more *private* area of the jail; and Group D would have had incoming inmates *screened, in private,* by someone with a *credentialed mental health background;* Group E consisted of all incoming inmates being screened, in *private*, by a *non-uniformed Indigenous* (American Indian) person. Measurable outcome variables were included in a 15 minute self-report survey (38 items) consisting of demographics, comfort experience during booking and the screening process, self-efficacy management of depression, and demographics .

Systematic, semi-structured questioning of focus group participants during or after each of the experimental interventions has informed the final interpretation of the survey data. What was this screening procedure like? Did they feel comfortable answering the questions? Were their answers honest? What suggestions do they have for improvement?

Further, a focus group comprised of officers having primary responsibilities in the both the intake and housing areas of the jail was held. Again, a semi-structured questioning method which allowed for the pursuit of emerging themes was utilized. What were their perceptions of the different group processes of suicide screening? How comfortable do inmates appear to be during the screening interviews? Did the officers feel that they elicited honest answers through this process? Finally, observation provided direct personal researcher contact with the process and booking environment and allowed better understanding of the context in which this process takes place.

Data Management & Analyses

To protect confidentiality, all quantitative data were entered into a computer database using an assigned unique identifier. SPSS® for Windows Base 10.0 statistical software was used for data input, cleaning, and subsequent analyses. All qualitative data (audiotapes of focus groups or notes taken during observations and encounters) were entered into text data using first a word processing and then downloaded into Atlas^{ti} qualitative software.

Initial strategy for all quantitative data included descriptive parametric and nonparametric analyses (frequencies, standard deviations, proportional testing, chi-squares and t-tests as appropriate) to allow assessment of endorsement patterns for all measures first as total survey sample, then by race and in some cases, gender. Internal consistencies of all screening scales and measures were calculated (Cronbach's alpha). ***Year 1*** quantitative data analyses (for Specific Aim #2) included descriptives of our sample population. Next, rate calculations were done of the prevalence of suicide ideation *(Specific Aim #1)* by Indian and non-Indian using the SSI. For *Specific Aim #2,* calculation of percent agreement, kappa's, and sensitivity and specificity (criterion validity) compared endorsements of the NYSPSG and the Mental Health Survey. Qualitative analyses used basic a priori codes based on the NYSPSG items reviewed. This codebook expanded to important factors that surfaced during the discussions of suicide screening and protocol procedures (emerging codes). Special attention was paid to data regarding the cultural perceptions of the process, and the social and cultural contexts. These findings were synthesized by group, highlighting major themes and domains by inter- and intra cultural variation. *(Specific Aim #3 & #4).* ***Year 2*** data analytic strategies followed closely Year 1's.

Summary of Findings

Below we *highlight* the main results in a summary outline fashion. This list is not exhaustive.

- ***Characteristics of Jail Population***
  - There were significantly more female American Indians detained than nonIndian females.
  - The American Indian detainees were significantly older than nonIndian detainees.
  - The American Indians had significantly more alcohol-related charges.
  - The American Indians had significantly more un- or under-employment.
  - The American Indians had significantly more children than nonIndians.
  - The American Indians had significantly more prior arrests.
  - The American Indians had significantly more prior jail time.
  - The American Indians had significantly more prior hospitalization for alcohol problems.
  - The American Indians had significantly more prior six month service utilization.
  - All detainees experience significant life-time trauma which correlates highly with suicide ideation.
  - The American Indians (72%) practice traditional Indian beliefs "sometimes to a lot."

- ***Suicidal Ideation & Behavior***
  - Suicidal Ideation was 12% for both groups.
  - No significant differences were found between groups on suicide ideation.

- ***Risk Factors***
  - No significant differences were found on hopelessness, anxiety, social support, overall coping, and loneliness between groups.

- American Indians detainees experience less jail stress than nonIndian detainees.

❖ ***Concordance of NYSPSG & Validation Measures***
- Sensitivity was low on all concordance analyses.

❖ ***Focus Group Issues with Screening and Procedures***
- In terms of honest responses to screening questions, both Indian and non-Indian groups do not fully disclose.
- Both groups report concerns about relationship building, privacy, distrust, officer demeanor, confidentiality, and consequences as barriers to honest disclosure in suicide screening.
- Differences between groups were found in concepts of extended family, respect, and definitions of "mental health" and loss.
- Issues especially found important for the American Indian population are the longstanding and appropriate mistrust of system, culturally bound syndromes (i.e., ghost illness and externalization of cause of disorder), and need for Indian-specific programming and activities.

❖ ***Confirmation of Findings of First Year Through Quantitative Survey in Year 2***
- The American Indians show lower mean levels in honesty and comfort levels for disclosure than nonIndians.
- Honest disclosure was related to privacy, perceived officer concern and a trusting relationship.
- The American Indians report slightly higher confidence in handling depression after booking than nonIndians though not significant.

❖ ***Protocol Testing***
- The majority of all detainees recalled being questioned about physical health, mental health or emotional well-being, and use of drugs or alcohol.
- Screening protocols using civilians in a private setting or using an Indian screener show higher mean honest responses, comfort levels, and confidence in handling depression overall than when normal officer screening was done, though in some cases these findings did not reach a significant level.

Discussion & Conclusions

In terms of the prevalence rate of suicide ideation among all detainees, there were no significant differences between the American Indian detainees and the non-Indian detainees. An overall rate of 12% was ascertained; a rate lower than expected. It is important to view the inconsistent findings about inmates' truthfulness in responding to some of the questions on the NYSPSG questionnaire as well as the low sensitivity found with the instrument as evidence that this screening protocol alone cannot be relied upon to make a valid assessment of risk. Rather than see this as a measure of either the detainee's honesty or deception, it seems critical to view the inconsistent responses as being indicative of the variances between objective and subjective appraisals of the screening process. Though the results are not conclusive, indications from the second year of research suggest that, regardless of who asks the

questions, if they are asked in a private place and a trusting relationship has been developed though presumably undivided attention of the person who is asking them, the detainee is more likely to answer the questions honestly. This is an important finding, one which requires further investigation.

While it is tempting to disregard the NYSPSG as being insensitive in picking up particular emotional states within the American Indian culture, restraint is appropriate. The complex nature of intake processing – the personalities, procedures, timing, and context involved – mean that caution is required to avoid the summary exclusion of any one piece of the screening equation. Still, further research is warranted to determine the sensitivity of the NYSPSG that includes actual clinical assessment, particularly when used with culturally diverse populations residing in distinctive areas of the country.

There are central themes gleaned from focus groups that should inform future research and practice into suicide screening practices. Actual screening forms, like the NYSPSG, are commonly distributed at training forums which are sponsored by accreditation agencies and by technical assistance agencies such as the National Institute of Corrections. These procedures and practices have reflected a "one size fits all" approach, based on assumptions that risk assessment and risk prediction is a transcultural, transracial, and transecological/environmental phenomenon. Our focus group feedback indicates that this is not so. The American Indian participants pointed out many culture-specific, unique perspectives on and interpretations of these risk assessment practices such as concept of "mental health" as a White person's disease. Consequently, asking a questions about one's mental health history may be interpreted inconsistently and thus not have integrity as a predictive or assessment factor. Additionally in the American Indian community, who is "important" may be very different than one who would be considered important in a non-Indian community. This must be looked at as a potential misunderstanding that occurs in context: it is not that an officer or screener cannot hear who is important to an American Indian detainee, rather, it is the detainee's own personal sense of knowledge of that importance and the officers lack of the same knowledge that may lead to feelings of despair, isolation, being misunderstood. Similarly, concepts of "community" differ between Indian and non-Indian detainees. "Community" to an Indian detainee may mean something much wider – spatially and spiritually – than to others.

Repeated comments were heard from American Indian detainees about the personal discomfort that results from the perceived disrespect inherent in being asked direct, highly personal, and evocative questions about family history, suicide intent, and personal suicide history and behaviors. These reactions suggest that some adaptations can be made in the wording of the questions and reinforce what much of the mental health research literature has already established: that relationship is a (perhaps the) key variable

in establishing a helping relationship. Asking direct, intrusive questions when there is no sense of relationship between the interviewer and the detainee is likely to yield dishonest answers. Additionally, the negative wording of the screening questions further inhibited honest disclosures by conjuring up the memories of those who have died by suicide. Those memories, as mentioned earlier, can result in "ghosting illness" which then can be a causal link to suicidal acting out. When asked what kind of wording would be appropriate and more likely to yield truthful results, the Indian detainees suggested wording in more positive and future oriented terms would be more productive. Though for all inmates the questions and concerns about how information gained during the screening might later be used against them, about the consequences of truthful answers, i.e., being placed in a "oven mitt", "fishbowl", or "dress", and for the Indian detainees, the historical context of their experiences as oppressed people carries over at the booking desk. Questions about what stands to be lost for the American Indian detainee if s/he provides information, signs forms, and submits to the authority of this uniformed person are quite possibly at the fore. While they may not be acted upon in any hostile or demonstrative way, the act of deception is a passive method of registering one's objection. This is not a definitive assessment but is a phenomenon that must be explored further if culturally sensitive suicide (and mental health) risk assessment instruments and procedures are to be developed.

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[i] Duclos, C. W., Beals, J., Novins, D. K., Martin, C., Jewett, C. S., & Manson, S. M. (1998). Prevalence of common psychiatric disorders among American Indian adolescent detainees. *Journal of Child and Adolescent Psychiatry*. 37:866-873.

Assessing Suicide and Risk Behaviors in an Incarcerated American Indian Population: Investigating Culturally Sensitive Risk Assessment Instruments and Procedures in a Border Jail

ABSTRACT

Objective: To determine if a popular contemporary suicide risk assessment tool is culturally appropriate for use with American Indians admitted into a county jail facility which borders reservations and whether the employment of different suicide screening protocols makes a difference in the responses of detainees with regard to their giving honest reports of suicide ideation and related risk factors.

Methods: Data were gathered utilizing two self-report surveys and other jail documents to ascertain validation data as well as honesty and comfort level of screening protocols. Additionally, focus groups were convened to review item-level responses to the jail's current risk assessment tool as well as to assessment process issues.

Results: Prevalence of suicide ideation was the same across Indian and non-Indian groups; a rate lower than expected. Validity concordance was low in sensitivity for the suicide risk assessment screening tool, especially with American Indians. Focus group results point to nondisclosure of suicide ideation and other risk factors due to both the wording of the question and procedural and culturally specific issues. Timing of the assessment, wording of the assessment tool, establishment of a trusting relationship, and a concerned demeanor were found to increase honesty as well as comfort levels for full disclosure. Indian-specific concepts of community, mental health, loss, respect, ghost illness, as well as direct questioning of negatively framed concepts were found influential.

M. Severson & C. Duclos, Co-Principal Investigators
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Conclusions: There are many reasons why American Indian detainees hesitate to disclose suicide ideation and other personal information. Historical distrust of uniformed officers, multiple and complex histories of trauma, cultural mores and definitions around self-disclosure, the importance of relationship, and spirituality all have an impact on jail procedures that are the products of the dominant culture. Non-Indian detainees, however, also resist making honest self disclosures and voice interest in having a trusting and empathic interviewer as a pre-condition to their revealing personal information.

Research findings carry many implications for the public policy and regulatory demands currently made on detention centers, especially in areas where particular cultural groups are represented.

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Assessing Suicide and Risk Behaviors in an Incarcerated American Indian Population: Investigating Culturally Sensitive Risk Assessment Instruments and Procedures in a Border Jail

Final Report to the National Institute of Justice
(NIJ Research Award #1999-IJ-CX-0016)

I. INTRODUCTION

The Origin of these Studies

In 1997, the administrator of a County Jail[1] located in the Northern Plains of the United States, contacted these researchers with his concerns about the incidence of suicide behaviors occurring in that facility, particularly among the American Indian population. Seeking assistance in ensuring and where possible, developing a best practices approach to suicide management in his facility, the Administrator agreed to collaborate with researchers from the University of Kansas School of Social Welfare and the University of Colorado Health Sciences Center in designing and carrying out a study geared toward discovering and identifying two essential types of information. First, because the admission screening tool used in the County Jail to interview inmates at their intake into the jail facility was developed in New York and consequently embraced by this jail (and many other jails across the country) as its screening instrument, one research objective was to determine if that instrument was culturally appropriate for use with the County jail population, particularly with the American Indian population. Second, the principle objective of the second year of this funded research was to determine whether the employment of different suicide screening protocols would make a difference in the responses of new detainees with regard to the likelihood of securing their honest reports of experiencing suicide ideation and it's associated risk factors.

The National Institute of Justice ultimately agreed to fund two years of research in this County Detention Center. The results are significant not only for their bearing on the research questions, but also for the questions they raise about this very fundamental practice

of suicide risk screening in a pre-trial detention center. To date, the practice of screening detainees at the time of intake into a correctional facility – be it a lock-up; a pre-trial detention facility; or a prison facility – has been treated in the literature as a per se duty on the part of institutional managers. As will be addressed in the body of this report, this "duty" has been largely set upon these institutions by judges, lawyers, and expert consultants. The objective of this investigation was to move jail practitioners closer to an understanding of what is a good, if not best, practice in performing suicide risk assessments of detainees, based on actual practice evidence. Further, this inquiry was framed from an awareness of the cultural context in which jails are situated. Consequently, risk detection and prediction were explored among the dominant population admitted into the detention center, who are Caucasians, as well among as the detained dominant cultural minority population, who are American Indians.

Timeliness

The timing of this research can be characterized as serendipitous. Several events in the Detention Center itself, in the County community, in the state, and on the national front served to underscore the critical nature of this research.

First, the perception in the County Detention Center was that there was a very high rate of suicidal behavior among its American Indian inmate population. While in fact, in retrospect this phenomenon does not appear to be more prevalent in this jail than in many other places in the country, national statistics indicate that the rate of suicide among American Indians is two and one-half times that of non-Indians.[2] Still, during the course of designing and completing this study there were two completed suicides in the County Detention Center. Both were American Indian males who had been incarcerated for some time prior to their deaths. For these tragedies, the screening instrument and protocol used at intake had seemingly little relevance and relationship to their ultimate deaths.

At the local level, this city has not escaped federal scrutiny over the law enforcement practice of racial profiling. The mysterious and still unsolved murders of a number of American Indians along a creek in the city in a very short period of time brought the spotlight on the racial tensions that already existed within County. Complaints about law enforcement

practices and the efforts being made or not made toward solving these crimes were prominent in the local media, and they captured the attention of the Civil Rights Division of the U.S. Department of Justice. In March 2000, the Civil Rights Team released a substantive report finding that unfair treatment of Native Americans at different levels of the criminal justice system was indeed a problem in this city.[3] While the County Jail serves as a custodial institution and not as a law enforcement agency and its admission practices are unrelated to any sort of profiling behaviors, fallout from this report and other community events surely impacted the perception of the jail in the eyes of community members.

At the same time that this investigation ensued, the Sheriff of County, along with his administrators in the Sheriff's Office and the detention center, were lobbying to build another floor onto the existing detention center. Funding for this addition would come not solely from government and community support, but also from the contract housing of federal prisoners. Contracts were established between County and several federal agencies, including the Immigration and Naturalization Service and the Marshal's Service. Ultimately, plans for this vertical addition were scratched and an off-site location was secured for a work release center, thus clearing out valuable secure space in the jail. Further, at the present time plans are underway to expand the detention center by adding additional podular housing units.

In late 2000 and early 2001, certain city officials including the Administrator of the County Detention Center joined in with local Indigenous community leaders to initiate a process of healing within the community. Organized around various community work groups, a cross-section of County citizens came together to listen to the history of the American Indians living in the area in an attempt to understand the historical trauma and hurt experienced by these persons. While this healing process and community dialogue has slowed since that time, there exists considerable interest and hope that it will be sustained.

In the midst of the unfolding of these local and statewide events, as far as jail protocols are concerned, this research proceeded. Nothing like this research was known to be occurring anywhere else in the country. Over time, a lack of culturally based, culturally-sensitive research being carried out in pre-trial detention facilities, even though minorities of all colors and cultures are over-represented in jail populations, is evident. Noting this dearth of research in the broader social context, in Fall, 2001, the Surgeon General of the United

States issued the first ever report on culture and mental illness, and, along with recommendations for service provision to groups of people who have been historically ill-served by the country's mental health systems, he recommended that research initiatives which investigate the design and efficacy of culturally appropriate mental health services be pursued and funded.[4]

Also over time, despite changes in the laws that make some civil rights-based litigation by prisoners harder to file and win, jail suicide cases (generally survivor cases brought under theories of negligence and malpractice) are still common and the professional literature is replete with ideas about how to interdict in these events. Unfortunately, such interdiction has failed to address the unique cultural issues that are often at play in jail populations and detainee and inmates' behaviors.

Description of the Jail

The County Jail is located in the Northern Plains, and is situated within the center of the region in which the contemporary Plains Indian tribes reside. Approximately 45% of the yearly average of 8,800 intake bookings into the jail are American Indians. In 1996 over 75% of the documented suicide gestures in this facility involved an American Indian and the only completed suicide in the first quarter of 1997 was that of an American Indian male. These provocative numbers and facts led to the initiation of this research proposal and the subsequent funding of it.

The County Jail is houses persons arrested for misdemeanor and felony charges and, by contract, persons incarcerated under the jurisdiction of federal authorities (prisoners held on detainers for the United States Marshal's Office account for only one percent of the total population). As will be seen, while approximately 45% of those admitted into the jail are American Indian and the other 55% are primarily White, non-Indian, or of African-American, Hispanic, and Asian descent, generally 70% of those who stay any length of time in the jail are American Indian. These are often persons booked into the jail on nuisance and alcohol related charges. These details are presented in the demographic data provided in the following pages.

The research protocols for each of the two years of this project called for the administration of surveys to new detainees who provided their informed consent and the informed and voluntary participation by longer-term inmates in semi-structured focus groups. Separate focus groups were held with male and female American Indian and non-Indian inmates, and with a coed group of officers as well. In a rather unusual procedure, the latter focus group took place from 11:15 p.m. to 1:00 a.m. after these particular officers' shift.

The Relevance of the Data and Findings

Tribes that reside in the Northern Plains share many historical, governance, and cultural erosion similarities with tribes in other geographical settings, and parallel current socioeconomic conditions and contacts with the criminal justice system. These shared characteristics suggest that many of the findings presented here may be relevant to other Indian populations;[5] however, the local cultural symptoms, signs, and definitions of depressive-like experiences that may lead to suicide ideation that are described in this report are specific to the tribes located in the Northern Plains.

The findings particular to American Indian inmates, therefore, should be considered within the culture and mores of the Northern Plains tribes. As to the non-Indian inmates, it is important to consider the Northern Plains – a rural, rugged, somewhat barren environment that has historically depended on ranching and mining industries for its economic base and more recently has looked to tourism dollars to support state budgetary allocations. Therefore, the culture of the non-Indian inmates also limits the generalizability of the findings to jailed populations in a similar geographic area of the Northern Plains. This issue is more fully developed in the discussion and conclusions sections of this report.

II. RESEARCH QUESTIONS

Study Site

As noted above, this County Jail served as the study site for both years of this research. This particular jail site was deemed particularly appropriate because of its geographic location near reservation lands, the racial makeup – primarily American Indian – of its inmate population, and because of the jail administrator's enthusiasm for being a key part of this important research. The County Jail located in the Northern Plains is situated within the center of the region in which the contemporary Plains Indian tribes reside.

Discussions with Administrator revealed his and the agency's deep concerns about the nature and prevalence of suicidal behavior in the County Jail. Further, the concern that this behavior was more prevalent among American Indian inmates than those representing other cultural groups in the facility was clearly articulated and so consequently integrated into the research questions and methodology.

The **overall objective** of this funded research was to address and fill in the gaps in the existing research literature by evaluating a popular suicidal ideation assessment tool, one commonly used within detention centers around the country, for its cultural sensitivity and to modify and, where appropriate, to improve the state, local, and tribal correctional agencies' ability to more effectively screen for suicide ideation among American Indian detainees. This endeavor involved exploring the connection between American Indian – Northern Plains culture and non-Indian inmates' responses to suicide screening questions as they are asked within the jail setting. The **specific objectives** of this research, by year, have been:

Year I

(1) To determine the prevalence rates of suicide ideation within and between American Indian and non-Indian jail populations.

(2) To examine concordance of the current screening tool used in the County Jail with other self-report measures of suicidal ideation and associated risk factors.

(3) To examine through focus groups, the cultural relevance of the current suicide risk screening tool and of the intervention methods employed in response to suicidal behavior within this particular jail setting.

(4) To develop measures of culture specific symptoms of suicide ideation that can be incorporated into a suicide screening protocol. And,

(5) To provide recommendations for culturally sensitive suicide ideation detection and intervention or treatment policy/ procedures in this detention setting.

Hypotheses

The **hypotheses** of the first year of this research endeavor were: **(1)** The prevalence of suicide ideation is greater among American Indian detainees than non-Indian detainees; and **(2)** Culture plays an important role in identification of and intervention in suicide risk. The first year of study examined the cultural and social factors influencing suicidal behavior among American Indian detainees.

Research Questions

This study sought to fill the research gaps by investigating **key questions**: What is the prevalence of suicide ideation by culture? What role does culture play in the experience of suicide ideation, the presentation of suicide symptoms, and in the outcomes of suicide risk detection in this specific jail setting? What is the extent of suicidal ideation among American Indian males and females incarcerated in this jail? Are screening techniques as they are employed currently, culturally appropriate for these groups of American Indian inmates?

These key questions were addressed through a **research methodology** that included a combination of quantitative and qualitative methods used to explore and ultimately understand behavior cross-culturally. The methodology is more fully described below.

Year II

The preliminary findings from the first year of research suggested a slightly modified path of inquiry for the proposed second year of research. Focus group data led to a consideration that inmates' experiences when being asked questions about suicide and mental illness at the time of intake and during incarceration vary according to the setting in which the questions are asked and who is asking the questions, i.e. who is administering the screening. Further, the importance of understanding how different methods and styles of

screening administration influence the veracity of the responses an inmate gives to the suicide risk assessment questions was underscored by focus group feedback. Do screening questions alone produce a valid assessment? Does the screener's personal demeanor play a part in eliciting responses to the screening questions? Do the wording and delivery of the questions affect responses? Does the setting in which the questions are asked make a difference in terms of a detainee's comfort level when responding, thereby maximizing the predictive effects of the risk assessment? Does the manner in which the first suicide risk screening process is carried out have an affect on whether a particular inmate will seek mental health services later during his/her incarceration?

Underlying Assumptions

These questions provided the basis for the **underlying assumptions and hypotheses** guiding the second year of this research. Specifically, it was assumed that: **(1)** inmates of all races and ethnic backgrounds experience discomfort when asked directly about suicide ideation and mental health status through current screening measures; **(2)** reliable, valid, and effective suicide screening at intake is a matter of both the wording of questions being asked, and the manner or context in which they are asked; and, **(3)** relieving the inmate's discomfort during the screening process by utilizing culturally-respectful wording and conversation will lead to more personal comfort and disclosure of truthful information from Indian detainees.

In essence, the overall goal for this second year of research was to determine if suicide screening questions *alone* produce a valid assessment.

The ***specific objectives*** of this second year of research were:

(1) To identify, through the use of an experimental design, a suicide screening process that influences Northern Plains' detainees' comfort level in disclosure of suicidal ideation as well as future help seeking behavior and depression management within the jail setting; and

(2) To determine if the following make a difference in the detainee's comfort level for self-disclosure, management of depression, and future help seeking behavior:
a) The wording and format of screening questions as well as setting where screening takes place, and

b) The type of screener – current officer; indigenous officer; non-uniformed mental health professional.

Research Questions

The second year of study continued exploration into some of the key questions posed prior to the initiation of the first year investigation: What is the rate of suicide ideation by culture? How does culture influence the experience of suicide ideation, the presentation of suicide symptoms, and the outcomes of suicide risk detection in this specific jail setting? Other questions were raised as well: Is the likelihood of truthful self-disclosure about suicide ideation enhanced by the type and wording of questions asked, the type of person asking them, the demeanor of the interviewer, the personal and professional characteristics of the interviewer, or some combination of these variables? How does the physical and ambient setting in which risk assessment questions are asked influence the truthfulness of the responses obtained? These key questions were addressed through a research methodology that once again included a combination of quantitative and qualitative methods to explore and ultimately understand behavior cross-culturally.

III. REVIEW OF THE RELEVANT LITERATURE

Jail Suicides

In the early and mid 1980s, as a result of the first major national jail suicide study, suicide was identified as being a major cause of death in jails.[6] For the years during which these national data were gathered, 1979, 1985, and 1986, there were, respectively, 419, 453, and 401 documented jail suicides in the United States. By some estimates, these and all jail deaths are thought to be both underreported and to constitute a suicide rate nine times that which is experienced in society at large. By other rationales, the prevalence rates of such deaths in jails when compared to suicides in the larger society are thought to be dramatically overstated and act against jail operations by imposing unsupported practice standards that are both impractical and impossible for jails to meet.

No matter the actual numbers, for a variety of reasons, incarcerated individuals are reportedly at particular risk for suicidal behavior[7]. Suicide behind bars has long been receiving attention because suicide is the second leading cause of inmate death in jail facilities.[8] Even more recent "official" (though admittedly not fully reliable) government reports of deaths in custody (e.g. 324 suicides in 1999) find that suicide remains the second leading cause of death in jails, after natural, but AIDS-excluded, causes.[9] There are consistent findings of a strong relationship between ethnicity and inmate self-destruction: White inmates are more prone to suicidal behavior than are their Black counterparts[10], and at least one researcher concludes that ethnicity is the single most powerful predictor of self-inflicted death.[11] Studies point to differences in cultural norms, the experience of psychological stress, individual coping skills, and institutional and interpersonal factors, which carry serious life saving implications for the identification, care, and management of persons of varying ethnic backgrounds incarcerated in American jails and prisons.

Suicides Among American Indians

Suicide among American Indians has been a topic of interest to social scientists, and numerous studies have examined this phenomenon.[12] Results indicate that mortality and morbidity associated with suicidal behavior among Indians, compared to non-Indians, are excessive and almost universal across tribes and regions. Though the perception that

American Indians commit suicide frequently in correctional settings is common, there have been no studies to date concerning suicide behavior specifically among American Indian jail detainees[13]. Further, though some research attention has been paid to the importance of profiling and labeling the status of persons who attempt and/or complete suicide while incarcerated[14] with the exception of commentary on the overrepresentation of African Americans in jails nationally, the literature is almost devoid of references to the possible roles ethnic and cultural factors play in the occurrence of jail suicide behavior. Further, although one study found that 88% of jails had an intake screening procedure and 79% had some suicide prevention programming[15], there is no published research detailing the investigation of the relationship between culture and ethnicity, suicide risk screening, and suicidal behavior. In addition, there are no known evaluations of the cultural competency of the suicidal ideation screening tools widely used in correctional settings.

As to jail procedures, though admission screening for suicide risk has been widely lauded as being the key to reducing the occurrence of suicide behavior in jails, there has been little focus on the environmental and humanistic conditions under which this screening occurs. What is the impact of the physical and ambient design of the intake area and / or of the personal demeanor of the booking screener on the respondent's propensity for truthfulness in self-disclosure?

Systemic Factors: Racism, Institutional Bias, Socio-Environmental Conditions

Though the over-representation of racial minorities in jails and prisons in the United States has been commented upon for many years, new emphases have been placed on studying the disproportionate impact of arrest and sentencing rates. Heightened concern about the insidious effects of racism within the criminal justice system has led to increased commentary from legitimized sources such as the President's Advisory Board on Race, which found a "lack of data and good research on the experience of ... Native Americans"[16]. After an extensive review of the existing literature, Alvarez and Bachman (1996) concluded that American Indians are among the most oppressed minority groups in this country, and are subjected to negative and degrading stereotypes that likely perpetuate and encourage discriminatory and adverse applications of the law against them.[17] Shoring up their assertion

are recent statistics which estimate that 1 in 25 American Indians age 18 or older is involved in the criminal justice system. This rate is 2.4 times the per capita rate of Whites; 9.3 times the per capita rate of Asians – in fact, in 1997, at a rate of 1,083 per 100,000 adults, American Indians had the highest incarceration rate of any racial group.[18]

Related to the possible discriminatory applications of the law are concerns about the status, treatment, and well being of racial minorities involved in the criminal justice system[19]. These concerns intersect and are to some extent crystallized in the detention setting, where inmate behaviors seem to be related to both risk and protective factors. Studies point to differences in cultural norms, psychological stress, individual coping skills, environmental conditions, and institutional and interpersonal factors, which carry serious life saving implications for the identification, care, and management of persons of varying ethnic backgrounds incarcerated in American jails and prisons. There appears to be a strong relationship between ethnicity and self-destructive behavior, a relationship growing stronger with time. Recent studies show that the rates of suicidal behavior for Black youths have increased over the last two decades with the gap between rates for White and Black youths narrowing.[20] For suicidal youth in general, risk factors include a sense of hopelessness; depression; family history of suicide; impulsive and aggressive behavior; social isolation; prior suicide attempts; and access to substances and the lethal methods to complete suicide.[21]

Further, related to cultural issues are environmental risk factors to which some hypothesize a correlation with both suicide rates and crime rates. Researchers indicate that community conditions such as "neighborhoods of concentrated disadvantage"[22] have more to do with the differential impact of arrest and conviction rates than does race alone. Suicide rates have been found to be inversely related to level of education and directly related to levels of residential instability, unemployment, lower levels of social integration and instability in social environments.[23] Complicating the picture, some researchers hypothesize that exposure to poverty, poor educational choices, and discrimination may actually serve as protective factors for minority youth, because their low expectations for the future paradoxically enhance their resiliency to suicide.[24]

These risk and protective factors have not been closely studied in the incarcerated population in general, and especially not in the incarcerated minority population in particular.

Amazingly, though much has been written about suicide behavior and risk for suicide as they appear in detention and correctional environments, almost nothing has been addressed with regard to the connections between culture, race, environment, and suicide. Some researchers have dismissed race as a factor simply because the majority of those known to have completed suicide in jails have been White.[25] However, when one views the detention center as one service provider (which provides, in part, for the safe and secure custody of those who might otherwise present a danger to society) within the context of a particular community of service providers, race, culture, and environment take on new meaning in jail suicide prevention endeavors. This notion that the jail is one service provider of many in a particular and unique community served as the ideological foundation for the first year of this research; this same notion carried over to guide this research in its second year of study.

IV. DESCRIPTION OF RESEARCH AND METHODOLOGY

Sample: Year 1

Admission Survey and Jail-Based Data. As part of its custodial mandate, this County Jail operates a 24-hour, daily intake / release processing center. Law enforcement officers from one of the many jurisdictions which house inmates in this facility are able to bring detainees into the jail at any time, day or night. In designing a sampling strategy, this important part of the Jail's operation was considered. In order to acquire the most reliable data, it was deemed important that survey administration occur within a short period of time after an inmate was admitted into the facility, immediately following completion of the facility's own admission requirements. In the normal course of intake screening in the County Jail, certain inmates whose intoxication levels made it either impossible or inadvisable for them to answer the routine screening questions were presumed to be unable to knowingly provide their consent to participate in this research. Consequently, if a detainee was identified at intake as one who, due to drug and / or alcohol ingestion, could not give reliable answers to the intake screening questions, he or she was likewise not asked to participate in the survey until sober and appropriately responsive.

In consultation with the Administrator of the County Jail, an original sampling strategy was proposed which included the sampling of new detainees brought into the facility throughout one and one-half security shifts (evening and midnights, 3:00 p.m. to 2:00 a.m.), seven days per week. A review of the jail's admission rates, which averaged approximately 25 intakes per day during the first year of data collection, and estimates of refusal rates, suggested that to obtain the desired sample strength, two months of data collection would be required. In an effort to respect the facility's needs to move inmates quickly through the booking process and into their initial assigned housing areas, consents to participate in the research could be sought and surveys provided either in the booking area or at the officers' work area located just outside of the initial housing units. Because shifts as well as officer assignments are not static and rotate on an every 8-12 week and daily, respectively, schedule, all officers and supervisors were briefed on the purpose and elements of the research and trained in appropriate procedures for seeking inmate consent to participate in the research, as

approved in the funding proposals and through the human subjects review process (see, Appendix A).[26]

Though not anticipated beforehand, fairly quickly after the study period was initiated, it became apparent that the timing protocol for eliciting subject participation was confusing to officers. Because of officer workload and the multiple tasks required of housing officers as they prepare to move a new detainee into a living unit, if an inmate was not asked to complete the survey while in the booking area, s/he was also not likely to be asked to do so once s/he arrived at the living unit. Further, because paperwork might not move contemporaneously with the inmate, it was a challenge for the housing unit officer to know whether the inmate had actually been admitted during the study hours of 3:00 p.m. to 2:00 a.m., or whether s/he was simply moved to the housing area during those hours.[27]

As a result of these unforeseen sampling challenges, procedures were changed and a new sampling protocol was developed and distributed to officers during shift briefing and training meetings. Under the new and final sampling strategy (see, Appendix B1) all inmates brought into the jail were given an explanation of the research and asked to sign the informed consent form (see, Appendix B2), which also explained the purpose of the study and the jail-based data which would be reviewed as part of the study, take the survey, and be provided a reasonably "private" but supervised space in the booking area where the survey could be completed. When a new detainee agreed to participate, s/he was given a pencil and a survey, and provided a private space in which to answer the survey questions (see, Appendix B3). Upon completion of the survey, the inmate was directed to place it into an envelope, seal the envelope, and return it to the officer with the consent form attached to it.

Rather than place a time limit on the sampling, the Administrator and shift supervisors agreed to allow for ongoing sampling until a sufficient number of subjects was obtained. Except for a four week period between December 14, 1999 and January 13, 2000, detainees coming into the jail were (to be) asked to participate in the study. In total, 701 detainees consented to completing the survey and to allowing the researchers to review other jail-based data, including the suicide screening form (the "New York Suicide Prevention Screening Guidelines" (NYSPSG) (see, Appendix B4) that they were required by jail protocol to complete when first entering into the detention center. Exclusion criteria

included those who were not proficient in reading and / or understanding the English language.

Focus Groups. As part of the first year data collection, the qualitative component of this research called for the convening of focus groups, stratified by American Indian and non-Indian status and by gender. The purpose of the focus groups, outlined in the consent forms signed by each participant (see, Appendix B5), was to complete an item-by-item review of the "New York Suicide Prevention Screening Guidelines" (NYSPSG) and the jail's existing intake screening procedures. A semi-structured focus group guide was used to structure the movement of each focus group, and emerging themes were allowed for by inviting participants to share related perceptions to each of the questions asked about the specific jail procedures and each specific question detailed on the NYSPSG (see, Appendix B6).

Potential participants for each focus group were contacted by the jail's mental health professional up to one week in advance of the actual group meeting. Those excluded from participation were non-English-speaking inmates. Participation was entirely voluntary and was not conditioned on their having any particular mental health or security status in the facility, except that inmates deemed to be at risk for violence and/or security breaches were excluded from consideration, consistent with the safety, security and classification responsibilities of the institution. No personal information was obtained from these participants nor were survey or intake data identified to any participant. Prior to the initiation of each focus group, inmates were given information detailing the nature and purpose of the focus group and the research as a whole, verbally and in writing, and asked to sign the informed consent document. Inmates who refused to provide their consent were returned, without comment or negative consequences, to their housing units prior to the start of the group. Once all remaining inmates provided their consent, the focus group proceeded. Again, the research protocol was reviewed according to the procedures for full Committee review established by the University of Kansas Committee on the Protection of Human Subjects as well as by the Jail Administration.

Sample – Year 2

The sampling period for the second year of research was initiated in October 2000, and continued through May 31, 2001. Several sampling strategies were employed and these varied according to the intake protocol used by the booking officer after s/he received specific training in the nature and purpose of the study and the protocol to be used during the data collection period (see, Appendix C1). In the initial months of the study period, using the jail's customary intake procedures, baseline data were collected by asking every inmate who was admitted into the jail to participate in the study by completing a "Feedback and Satisfaction Survey" (see, Appendix C2) after having been through the routine booking process. Officers explained and/or read the consent forms to new detainees and asked for their consent to voluntarily participate by completing a confidential "satisfaction survey" (see, Appendix C3). If they agreed to do so, the inmate was given a pencil and a survey, and provided a private space in which to answer the survey questions. Upon completion of the survey, the inmate was directed to place it into an envelope, seal the envelope, and return it to the officer with the consent form attached to it.

Sample – Years 1 and 2

For both years of research, the Indian sample consisted of Northern Plains Indians, specifically the Arikara, Assiniboine, Blackfeet, Cheyenne, Chippewa, Crow, Delaware, Gros Ventre, Hidatsa, Iowa, Kickapoo, Mandan, Omaha, Plains Ojibwa, Potawatomi, Sac and Fox, Lakota, Winnebago, and Wyandotte. Persons identifying themselves as not being of American Indian descent were also selected to participate under the same protocols, for comparison purposes. Because the County Jail houses adult inmates only, only those over the age of 18 (male & female) booked into the jail were eligible to participate during the specific data collection periods.

Instrumentation

Years 1 and 2

For the duration of this two-year research project, consistent with the sampling strategies described above and with jail procedures as they existed (and currently exist) at the

time, all male & female inmates over the age of 18 who were booked into the jail went through the customary booking procedure that included the administration of the "New York Suicide Prevention Screening Guidelines" (NYSPSG) questionnaire. This questionnaire is the suicide risk detection tool historically and currently being used in this detention center. During the sampling periods, all new prisoners who gave their informed consent were given a self-report survey after they had been interviewed using the NYSPSG questionnaire. For both years of the study, the research surveys sought demographic information. In addition, in the first year of study, the self-report survey also measured depression, stress, anxiety, suicide ideation, hopelessness, and self/family suicidal behavior history. In the second year, the self-report survey sought to measure the detainee's responsiveness to the NYSPSG questionnaire in terms of their truthfulness in responding. Other indicators of the effectiveness of the screening protocol were also sought and are described in detail below.

No direct compensation for survey completion was provided in either year. As part of focus group participation, inmates were provided with snacks and liquid refreshments which might otherwise not be accessed in the jail. These snacks and liquid refreshments were set out for consumption before the beginning of the formal focus group questioning, and those inmates present were encouraged to enjoy the refreshments even if they later chose to return to their housing units without participating in the study. Officers who participated in the officer focus group were compensated for the overtime hours spent in the focus group.

Quantitative Instrumentation – Year 1

Current Suicide Screening Form: In ***year one*** of this research, following jail procedure, the "New York Suicide Prevention Screening Guidelines" (NYSPSG) questionnaire was asked of every new detainee shortly after s/he was brought into the pre-booking area of the jail. Consistent with accepted jail practice and with the legal and correctional literature, these questionnaires were always completed prior to the inmate being asked to participate in the research.

Developed in New York and implemented in its jails and lockups in 1986 in response to systemic problems thought to be contributing to a high rate of suicide in those facilities, this suicide screening instrument was designed to assess two groups of risk variables: factors

enhancing the level of risk at the time of booking and demographic and personal characteristics correlated with suicide risk[28]. During the initial year of its use, suicide rates dropped 33% in New York's local jails and lockups.[29] This form has been widely distributed and published in various professional journals and its use is not uncommon in jails located outside of New York. As noted earlier, there has been no published research addressing its validity and reliability measures when used in other states and/or with specific ethnic and racial populations, particularly with American Indians of the Northern Plains.

Self-Report Survey: Also in ***year one***, in addition to the New York Suicide Prevention Screening Guidelines, a 10-15 minute self-report survey consisting of measures of constructs most commonly associated with suicidal ideation was administered. With the exception of the relatively few self-report surveys completed early in this project and which were completed just prior to the detainee being moved into his/her housing unit, all self-report surveys were completed in the booking area within approximately four hours of their admission into the jail. This survey sought demographic and predictive information and consisted of the following:

- *Demographic information* includes age, gender, ethnic identity and tribal affiliation, educational level, income, marital status, and official charges for arrest.
- *Suicide Ideation* was measured using the 19-item version of the Scale for Suicide Ideation (SSI) [23, 24]. Correlations between this self-report and clinically rated versions for inpatients and outpatients are more than .90, suggesting strong concurrent validity. The Cronback coefficient alphas are in the .90s indicating high internal consistency.
- *Anxiety* was ascertained by a 21-item Beck Anxiety Inventory (BAI) found to have internal consistency and reliabilities (α = .92; r (81)=. 75.)[25]. The BAI discriminates anxious diagnostic groups from non-anxious diagnostic groups.
- *Hopelessness* was measured by the 20-item Beck Hopelessness Scale assessing the expectation that one will not be able to overcome an unpleasant life situation or attain the things one values (reliability coefficient was .93)[26].

- *The Jail Stress Scale.*[27] This scale was designed to assess the amount of stress experienced and perceived in relation to being in the jail environment (e.g., fear for safety, isolation from family, humiliation, guilt and ostracism, fear of prison time, living with other inmates, poor environmental conditions).
- *Family History* questions included family or important others' history of suicide attempts and completions.
- *Spiritual or Religious beliefs* were measured by a scale developed specifically for American Indian use by the National Center for American Indian/Alaska Native Mental Health Research.
- *Multidimensional Scale of Perceived Social Support* (a 12-item self-report inventory) was used to assess subjective social support adequacy from three specific sources: family, friends, and significant other. It has been proven as a psychometrically sound instrument with adequate internal and test-retest reliability.[30] Help-seeking within the past six months was adapted from the Health Care Utilization module of the The Medical Outcomes Study.[31]
- *The Revised UCLA Loneliness Scale* was used as a measure of perceived loneliness. A 4-item version consisting of two positively worded and two negatively worded items was used. The original reliability of .75 was deemed adequate for inclusion in this study.[32]
- *Brief-Cope Scale* is a 28-item instrument that is theory-based and developed to assess a variety of coping reactions/strategies in response to stress. Alpha reliabilities have ranged from .50 to .90. This instrument consists of 14 subscales.[33]
- *Stressful Life Events Screening Questionnaire* is a self-report instrument designed to be applicable to a wide range of populations. This screening instrument has good test-retest reliability (kappa of .73). The authors report good discrimination between events that meet DSM Criterion A specifications for trauma and those that do not.[34]

Qualitative Instrumentation – Year 1

The goal of the qualitative portion of this first year research endeavor was to develop the clearest, most straightforward assessment of suicide ideation criteria in this specific

American Indian/non-Indian jail setting using a semi-structured focus group interview format. Seven focus groups were convened, two American Indian male and non-Indian male, two American Indian female and one non-Indian female group in all. Every inmate participant's informed consent was obtained prior to initiation of the group process and questioning. This systematic qualitative research was intended to guide the final adaptation of screening items and intervention for suicide ideation to the Northern Plains Indian and non-Indian cultural contexts.

The first sets of focus groups addressed the NYSPSG screening instrument, examining each item through probative questions. The second focus group set reviewed in similar fashion, the jail's suicide prevention policies and procedures. "Would this _____ be viewed as adequate and appropriate in intervening in someone's attempt to self-harm?", "What else could jail staff do/ask that might make it easier for the detainee to verbalize his emotional state?", etc. Focus group discussions generally lasted 1½ - 2 hours. All focus group discussions were audiotaped and later transcribed and summarized. Field notes of on-site observations, informal discussions, and interactions were also maintained. Special attention was paid to data regarding the cultural meanings of any suicide ideation and behavior, and its social and cultural contexts.

Quantitative Instrumentation – Year 2

Feedback and Satisfaction Survey. Four interventions (demonstrations) were planned and to some extent carried out so that explicit comparisons could be made between or across the intervention conditions and the control to test the research hypotheses.[35] Initially, the researchers hoped to create a new or revised suicide prevention/risk detection screening instrument (either expanding upon or substituting for the NYSPSG), using culturally appropriate language and procedures by which new detainees could be assessed. However, the common themes that emerged from the first year focus groups indicated that language alone would not likely produce a significant change in detainees' responses and, as will be addressed in the discussion section later in this report, multiple concerns about the jail's liability further inhibited plans to alter the screening document. Our subsequent

methodology and results thus do not speak to actual rewording or adaptation of the NYSPSG. However, they do speak to the need to revisit this agenda in later research.

Thus, the ***year two*** protocols reflected efforts to test different screening conditions for four experimental groups and one control group of new detainees. Each group was to be assigned to a specific data collection period during which inmates admitted into the jail on a certain day and during a certain time period would be considered potential participants. The control group (Group A) consisted of inmates booked in under normal procedures without any change to the assessment tool or process already in use in the jail. Additionally, for those subjects included in Group A, there were no changes made in the characteristics or credentials of the person doing the screening; nor was there a change in the type of setting in which the screening occurred. The use of this control group allowed for an accounting of the effects of each of the subsequent four experimental groups.

The first experimental group (Group B) was to consist of new detainees screened in a *private area* of the booking section of the Detention Center by a *uniformed officer*.

The second experiment group (Group C) was to consist of all incoming inmates being screened by an *Indigenous (American Indian) officer* in the more *private* area of the jail.

The third experimental group (Group D) would have had incoming inmates *screened, in private,* by someone with a *credentialed mental health background.*

The fourth experimental group (Group E) was to consist of all incoming inmates being screened, in *private*, by a *non-uniformed Indigenous* (American Indian) person.

These interventions are illustrated as follows:

Summary of Planned Control and Experimental Groups and Interventions

EXPERIMENTAL GROUPS	INTERVENTION
Group A –	None – control
Group B –	Use of new assessment protocol Uniformed Officer Privacy
Group C -	Use of new assessment protocol Indigenous Officer Privacy
Group D -	Use of new assessment protocol Non-uniformed Person with Mental Health Credentials Privacy
Group E -	Use of new assessment protocol Non-uniformed Indigenous Person Privacy

The measurable outcome variables were included in a 7-15 minute self-report survey (38 items) consisting of measures of demographics, comfort experience during booking and the screening process, self-efficacy management of depression, knowledge of the mental health support available within the jail, and the detainee's general well-being. All study participants were asked to complete this self-report survey after their booking and screening process was complete and just prior to either their release on bond or their transfer to housing units within the detention center.

Modeled in part after consumer satisfaction surveys, research subjects were able to complete the survey within 7 to 15 minutes. Demographic information sought included age, gender, ethnic identity and tribal affiliation, and the pending criminal charges. Twenty questions followed that inquired about the inmate's comfort and truthfulness response levels during the screening process. Again, these questions were adapted from a review of several service satisfaction surveys. During the initial year of study, it was found that a long survey is onerous for both the inmate and officers when completed during the booking process. Thus, to maximize the amount of information obtained and to allow better analytic possibilities, the response or rating scales for individual items were larger (1-10) and semi-continuous. Eight additional questions delved into the inmate's self-efficacy to perform self-

management behaviors for depression. These questions consisted of the *SE Control/Manage Depression Scale* of the Stanford Patient Education Research Center for use in its studies of chronic disease self-management programs, specifically the Chronic Disease Self-Management Study[36]. Published internal consistency was .92 with .82 test-retest reliability. Item-scale correlations ranged from .74-.82.

Qualitative Instrumentation – Year 2

In addition to the quantitative components of this study, focus group interviews provided valuable qualitative data about the impact of the various screening protocols on suicide behaviors, particularly among the American Indian inmates.

Systematic, semi-structured questioning (see, Appendix C4) of focus group participants, subsequent only to the securing of their informed consent (see, Appendix C5), during or after each of the experimental interventions has informed the final interpretation of the survey data. What was this screening procedure like for you? Did you feel comfortable answering the questions asked, at the time, and under the conditions they were asked? Was the screening process helpful in terms of seeking medical and / or mental health care, if needed? Were your answers honest? What suggestions do you have for improvement in the screening system?

Further, a focus group comprised of officers having primary responsibilities in both the intake and housing areas of the jail was held. Again, a semi-structured questioning method which allowed for the pursuit of emerging themes was utilized (See Appendices C6 and C7). Several queries were made: What were their perceptions of the different group processes of suicide screening? How comfortable do inmates appear to be during the screening interviews? Did officers believe they were able to elicit honest answers from the detainees in this process?

In all cases during the second year of research, inmate focus group discussions lasted approximately one hour and were guided by suggestions from Krueger (1994).[37] The officer's focus group lasted nearly two hours, and occurred after their evening shift, from approximately 11:00 p.m. to 1:00 a.m. All discussions were audiotaped for later transcription and summarization. Field notes of on-site observations, informal discussions,

and interactions were maintained. Special attention was paid to data regarding the cultural perceptions of the process, and the social and cultural contexts.

Finally, observation provides direct personal researcher contact with the process and booking environment and allows better understanding of the context in which this process takes place. The research team observed several of the experimental interventions. Further, screeners were encouraged to record field notes describing the process as well as their impressions, thoughts, and feelings.

V. ANALYSES & RESULTS

Overview

This section describes the approaches used in the analyses of both the qualitative and quantitative data resulting from the methods used in ***Years 1 and 2***. Each project year's analyses and results will be presented in a stepwise fashion for clearer understanding of the progression of the research.

Data Management

To protect confidentiality, all quantitative data were entered into a computer database using an assigned unique identifier. Paper copies of all the survey instruments and jail intake information were stored in a locked file cabinet with only principal investigator access. SPSS® for Windows Base 10.0 statistical software was used for data input, cleaning, and subsequent analyses. All qualitative data (audiotapes of focus groups or notes taken during observations and encounters) were entered into text data using first a word processing program and then downloaded into Atlas^{ti} qualitative software. This software facilitated coding, management and retrieval of the test data during analyses.

Data Analytic Strategy

Initial strategy for all quantitative data included descriptive parametric and nonparametric analyses (frequencies, standard deviations, proportional testing, chi-squares and t-tests as appropriate) to allow assessment of endorsement patterns for all measures first as total survey sample, then by race and in some cases, gender. Internal consistencies of all screening scales and measures were calculated (Cronbach's alpha).

Year 1 quantitative data analyses (for Specific Aim #2) included descriptives of the sample population. Next, rate calculations were done of the prevalence of suicide ideation *(Specific Aim #1)* by Indian and non-Indian using the SSI. Calculations of suicide ideation were also to be done by *positive* precautions actions indicated by the New York Suicide Prevention Screening Guidelines (NYSPSG) for comparison. However, the incompleteness of the data (officers in the majority of the cases had not completed the "Action" part of the

form) made this impossible. For *Specific Aim #2,* calculation of percent agreement, kappa's, and sensitivity and specificity (criterion validity) compared endorsements of the NYSPSG and the Mental Health Survey. Qualitative analyses used basic a priori codes based on the NYSPSG items reviewed. This codebook expanded to important factors that surfaced during the discussions of suicide screening and protocol procedures (emerging codes). Special attention was paid to data regarding the cultural perceptions of the process, and the social and cultural contexts of the suicide risk assessment screening. These findings were synthesized by group, highlighting major themes and domains by inter- and intra-cultural variations. Data identification procedures divided the text data into analytically meaningful coded segments that were retrieved and reviewed for contextual and item-specific information *(Specific Aim #3 & #4).*

Year 2 data analytic strategies followed closely those of Year 1. First, descriptive analyses of the quantitative data included frequencies, measures of dispersion, chi-squares and t-tests, as appropriate. These analyses allowed assessment of endorsement patterns for all measures by race and in some cases gender. The Feedback and Satisfaction Survey items were then analyzed individually and by protocol using proportions, chi-squares, and t-tests (testing mean rating scores across groups for comfort levels). Tests across screening groups were conducted to determine which items made for more honest disclosures. Qualitative analyses again used basic a priori codes based on the questions asked during the focus groups. In-depth analysis of this data for emerging codes was not done as in Year 1 since the question to be answered concerned the process of the different screening protocols only. Additionally, while conducting the groups it was noted that the emerging themes seemed to repeat those recorded in the first year's data. The goal of sampling in qualitative methodology is "sample until saturation or redundancy," i.e. sample until no new information is revealed.[31] This saturation period came earlier in the second year of research, thus negating the need for all of the focus groups originally proposed.

A. YEAR ONE DATA ANALYSES

Description of the Samples

Total Study Population.

During the first year data collection period (October, 1999 through January, 2000) there were 2586 bookings. Table 1 below shows this booking population broken down by non-Indian and Indian. Because there are missing race indicators for 273 of these bookings, the true Indian prevalence is between 40 – 50.6%. Of those for whom this information is available, 45% were Indian.

Table 1. Total Study Bookings

	Frequency	Percent	Valid Percent
Non-Indian	1278	49.4	55.2
Indian	1035	40.0	44.8
Sub-Total	2313	89.4	100.0
Missing Data	273	10.6	
Total	2586	100.0	

Table 2 below outlines certain specific descriptive characteristics of these detainees' bookings. The majority of the new detainees are male with a mean age of 31, residing in the city in which the jail is based. Alcohol is involved in approximately 40% of the charges. Significantly more females are American Indians, and Indians are older and have more alcohol-related charges than non-Indians. There were no significant differences found in these characteristics between those persons included in the total bookings and the subjects of the research (i.e., those who consented to completing the Mental Health Surveys).

Table 2. Characteristics of Total Study Population by Race

Characteristic	Total	American Indian (n=1035, 44.8%)	Non-Indian (n=1278, 55.2%)[a, ***]
Male[b]	2040 (79.1%)	792 (76.6%)	1042 (81.7%)**
Female[b]	538 (20.9%)	242 (23.4%)**	234 (18.3%)
Mean Age[c]	31 (M=19, R=18-80)	32 (M=19, R=18-79)***	30 (M=19, R=18-79)
Residence in City[b]	1737 (67.2%)	693 (33.0%)	855 (33.1%)
Alcohol-related Charges[b, d]	1028 (39.8%)	472 (46.6%)***	779 (36.9%)

Column percents
[a] = binomial test
[b] = chi-square tests (n=2310/gender analysis; n=1548/residence analysis; n=1251/ charge analysis)
[c] = independent sample t-test (n=2095)
[d] = Alcohol-related charge variable was recorded from booking data that indicated the charge as alcohol-related.
M=Mode
R= Range
*,**,*** = p<.05, <.01, <.001, respectively

Table 3 presents the total population charge categories for these bookings. Some bookings included multiple charges which in turn increased the total number of charges recorded. Charge categories consist of:

- Administrative: Assisting other agencies, detainer, information only, transportation-writ habeas corpus, trips east, and warrants.
- Assault: Aggravated, simple, vehicular, manslaughter, murder, and stalking.
- Auto & Driving Related (not DWI/DUI): Driving under revoked/suspended driver's license.
- Contempt of Court: Order to show cause.
- Domestic Violence: Family – child abuse/neglect, protection order, and violation – no contact bond.
- Drugs and Alcohol (no DWI/DUI): Liquor-open container/motor vehicle.
- DWI/DUI
- Nuisance Charges: Disorderly conduct, littering, trespassing, vagrancy, liquor-drunk-emergency alcohol hold protective custody, liquor-open container in public, and vandalism, unlawful deposit.
- Probation & Parole Violations: Aftercare violation.

- Sex Offenses.
- Stealing: Fraud (displaying another's driver's license, possession of altered/revoked driver's license, unlawful use of phone), forgery, burglary, robbery, and theft-shoplifting.
- Miscellaneous: Accessory to crime, animal at large, civil non-criminal, conspiracy to commit offense, escape, fail to comply direct of officer, fail to pay sales tax, fugitive, lies, sealed record, tax related, throw match/burning object from motor vehicle, and weapons.

Table 3. Total Population Charge Category Data by Race[1]

Charge Category	Total	American Indian	Non-Indian
Administrative	310 (12.0%)	117 (40.5%)	172 (59.5%)
Assault	145 (5.6%)	69 (55.2%)*	56 (44.8%)
Auto-related (DWI/DUI excluded)	566 (21.9%)	207 (41.6%)	291 (58.4%)
Contempt of Court	308 (11.9%)	167 (57.4%)***	124 (42.6%)
Domestic Violence	199 (7.7%)	82 (47.4%)	91 (52.6%)
Drugs/alcohol (DWI/DUI excluded)	467 (18.1%)	183 (43.7%)	236 (56.3%)
DWI/DUI	542 (21.0%)	151 (32.4%)	315 (67.6%)***
Nuisance	376 (14.5%)	240 (73.8%) ***	85 (26.2%)
Probation/Parole Violations	134 (5.2%)	49 (41.9%)	68 (58.1%)
Sex Offenses	31 (1.2%)	6 (22.2%)	21 (77.8%)*
Stealing	393 (15.2%)	157 (43.0%)	208 (56.9%)
Miscellaneous	43 (1.7%)	13 (36.1%)	23 (63.9%)

[1]Total Charges = 2586, 10.7% missing race indicator thus n for chi-square analyses =2313
Chi-square totals will not add up to total charge numbers to missing data.
*,**,*** = $p<.05$, $<.01$, $<.001$, respectively

As is apparent, the majority of the offenses involve driving an automobile. Non-Indians were significantly more likely to have been charged with DWI/DUI while Indians were significantly more likely to be charged with nuisance charges, contempt of court, and assaults.

Survey Sample Bookings

During this data collection period, a total of 2586 detainees booked into the detention center were asked to participate in the survey. The only exclusion criteria applied was mental incompetence and/or English illiteracy (10.6% of bookings). The response rate was 30.1% or 701 bookings or 677 individuals (some individuals were booked more than once during data collection). The following descriptive information was run either with the total bookings in order to inform the booking process or solely with the individuals when individual history was deemed more likely to inform overall jail management. Indications of the samples used for analysis are designated below as "booking survey sample" or "individual sample".

Table 4 provides a summary of the personal characteristics of the Mental Health Survey sample. The majority of subjects were male with a mean age of 30, though the majority of subjects were 19 years old. Also, the majority of the booking sample lived within the city in which the jail is situated. Approximately 30% of the booking sample had alcohol-related charges and another 30% had achieved more than a high school education. Almost half of the booking sample was employed either full or part-time. Seventeen percent of the sample population were incarcerated as a result of their first arrest. For those remaining with arrest histories, they reported a mean number of five (5) past arrests. Twenty-two percent of the sample indicated this was their first time in jail. The mean number of prior incarcerations for the remainder of the sample was five (5). Indians were significantly more likely to be female, have alcohol-related charges and prior incarcerations than were non-Indians. Non-Indians were more likely to have been employed and for this to be their first time in jail than were the Indian detainees.

Table 4. Characteristics of Survey Sample

Characteristic (n=701)	Total	Indian (39.5%)	NonIndian (60.1%)**
Male	77%	72%	80%
Female	23%	28%*	20%
Mean Age	30 ± 10	30 ± 10	26 ± 10
City Residence	67%	67%	67%
Alcohol-Related Charges	29%	34%*	28%
More Than HS Education	30%	32%	30%
Employed FT/PT	48%	39%	58%*
First Arrest	17%	11%	21%*
Mean # of Past Arrests	5 ± 11	7 ± 15*	4 ± 8
First Time in Jail	22%	12%	29%*
Mean # of Past Jailings	5 ± 11	6 ± 13*	4 ± 9
Married/Living With Someone	35%	40%*	33%
No Children	59%	51%	65%**

Column percents
*,**,*** = $p<.05$, $<.01$, $<.001$, respectively
n=701 (the number of persons actually booked into the jail facility)

Exploration of detainees' prior service utilization was of interest, especially for its possible use as prevention and intervention points. That is, what hospitalizations have these detainees experienced, and what services have been received within the past six months prior to their booking? This information was thought likely to highlight possible points of intervention. Table 5 shows the proportion of the individual survey sample that had prior hospitalizations at some time in their lives. When relative risk is one (1), the risk in Indians for hospitalization equals the risk to non-Indians. Chi-square analyses were used to test proportions. As one can see from this table, the Indian population's relative risk for

hospitalization was higher for all three problems as well as for any problem. This situation was significantly so for alcohol problems.

Table 5. Individual Survey Sample – Prior Hospitalization

Problem	Indian	Relative Risk	Non-Indian
Any Problem	43%***	1.53	28%
Emotional Problem	12%	1.42	9%
Alcohol Problem	38%***	1.85	20%
Drug Problem	15%	1.36	11%

*** $p<.001$
chi-square analyses

Looking at prior six-month service usage, Indians have significantly higher relative risk for past six-month service utilization for all the problems as well as for any problem (see Table 6). Approximately 45% of the Indian population compared to 36% of the non-Indian population has been seen in some service sector prior to their incarceration. This may indicate that including these areas of service in an intervention scheme designed to reduce incarceration levels might prove to be advantageous.

Table 6. Individual Survey Sample – Prior Six Month Service Use

Problem	Indian	Relative Risk	Non-Indian
Any Problem	45.2%*	1.25	35.9%
Emotional Problem	28.3%**	1.46	19.4%
Alcohol Problem	31.7%***	1.85	17.1%
Drug Problem	17.1%**	1.68	10.2%
Health Problems	27.5%**	1.71	16.1%

*, **, *** $p<.05$, $p<.01$, $p<.001$, respectively
chi-square analyses

One of the research assumptions was that the detained population experiences many stressful life events. In the Mental Health Survey, subjects were asked to indicate traumatic experiences encountered over their lifetimes. Table 7 outlines the individual responses.

Table 7. Trauma History

Trauma	All	Indian	Non-Indian
All Items Mean Score	3.0 ± 2.8	3.1 ± 3.0	2.9 ± 2.7
Life-threatening Illness	14.3%	15.6%	13.6%
Life-threatening accident	32.9%	32.8%	33.1%
Force/weapon used against you in robbery	17.6%	17.6%	17.6%
Someone close died in accident	34.6%	39.6%*	31.8%
Successful force used for sex against wishes	11.5%	9.3%	12.6%
Attempted force used for sex against wishes	10.4%	10.4%	10.5%
Touched private parts or made to touch	10.7%	10.5%	11.0%
As child, slapped, beaten, harmed by caregiver	21.2%	22.6%	20.6%
As child, slapped, beaten, harmed by others	37.1%	40.2%	35.3%
Ever threatened with weapon other than above	38.7%	36.8%	41.4%
Ever present when another killed, injured, assaulted	30.2%	31.6%	29.8%
Ever seriously injured/life in danger (combat, war zone, gunpoint)	25.4%	28.1%	23.7%
Ever in extremely horrifying/frightening situation not covered above	15.2%	15.3%	15.2%

*, **, *** $p<.05$, $p<.01$, $p<.001$, respectively
chi-square analyses

The data support the research assumption – this population experiences a substantial amount of trauma, more than one would normally expect. Indians experienced significantly more automobile-related trauma than non-Indians. ***Of the suicide ideators, 93.1% indicated that they had experienced at least one listed traumatic event ($p<.001$).*** Additionally, a logistic regression using traumatic event summary scores as the only predictor for suicide ideation (suicide ideators = 70 and non-ideators = 539) controlled by age and gender shows an odds ratio of 1.3 (CI = 1.13 – 1.33, $p<.001$).

Year 1 – Aim #1 Results

One of the original hypotheses for the first year of this research was that the prevalence of suicide ideation is higher among American Indian detainees than non-Indian detainees. Thus, the first aim was to determine the prevalence rates of suicide ideation between Indian and non-Indian subjects in the survey sample. The full booking survey database (n=701) was analyzed using all those who responded to question #4 (active contemplation) and/or question #5 (passive contemplation) on Beck's Scale for Suicide Ideation[38]. The pairwise method for handling missing data (3.6%) was utilized, thus, the final *n* for prevalence calculation is 676.

Table 8. Booking Survey Sample – Suicidal Ideation.

	Total Booking Sample (n=676)	Indian	Non-Indian
Suicide Ideation	**80 (11.8%)**	**30 (11.3%)**	**48 (11.8%)**

There were no significant differences between Indian and non-Indian groups found, thus this hypothesis proved to be false using this quantitative data analysis. The rate of suicide ideation was lower than expected. However, this finding must be interpreted within the context of the qualitative data, which, as explained later in this report, suggest that the incidence of suicide ideation may be underreported for two reasons: (1) the likelihood that new detainees, particularly Indian detainees, will not answer this question honestly and (2) the timing of questions about suicide ideation may result in underreporting of suicide ideation. These caveats are supported, too, by the jail's own data regarding actual suicide "incidents", recorded since 1996 (See Table 9). The prevalence of suicide behaviors is not inconsistent with our finding of low ideation.

Table 9. Jail Data re Suicide Behaviors, 1996 - YTD 2001

	1996			1997			1998		
	Incidents	ADP*	Per 100	Incidents	ADP	Per 100	Incidents	ADP	Per 100
1st Quarter	2	229.69	0.87	4	230.73	1.73	4	254.48	1.57
2nd Quarter	9	226.63	3.97	3	227.23	1.32	15	245.78	6.10
3rd Quarter	4	203.43	1.97	3	249.59	1.20	1	259.54	0.39
4th Quarter	2	209.46	0.95	4	240.17	1.67	3	260.67	1.15
Yearly	17	217.3025	7.82	14	236.93	5.91	23	255.12	9.02

	1999			2000			2001		
	Incidents	ADP	Per 100	Incidents	ADP	Per 100	Incidents	ADP	Per 100
1st Quarter	3	253.38	1.18	6	303.15	1.98	2	268.91	0.74
2nd Quarter	2	263.95	0.76	4	290.62	1.38			N/A
3rd Quarter	5	282.42	1.77	3	293.72	1.02			N/A
4th Quarter	6	263.93	2.27	6	293.66	2.04			N/A
Yearly	16	265.92	6.02	19	295.29	6.43			N/A

*ADP= Average Daily Population
In 1996, there were 7.90 suicide gestures per 100 inmates. With an ADP of 217.30, there were 17 suicide gestures
In 1997, there were 5.91 suicide gestures per 100 inmates. With an ADP of 236.93, there were 14 suicide gestures
In 1998, there were 9.02 suicide gestures per 100 inmates. With an ADP of 255.12, there were 23 suicide gestures
In 1999, there were 6.02 suicide gestures per 100 inmates. With an ADP of 265.92, there were 16 suicide gestures.
In 2000, there were 6.43 suicide gestures per 100 inmates. With an ADP of 295.29, there were 19 suicide gestures

Year 1 – Aim #2 Results

The second purpose of the initial year of this study was to examine the concordance of the jail's intake suicide screening tool (NYSPSG) with other self-report measures of suicide ideation and associated risk factors (construct validation). First, individual scale reliabilities were run on concordance scale measures to see if the individual items within the scales "hung together" in measuring the same construct (using the total booking survey data (n=701) and pairwise methods for handling missing data.) Table 10 depicts the reliability results.

Table 10. Scale Reliabilities

Survey Sample – Scale Reliabilities	Overall Reliability	Indian Sample	Non-Indian Sample
Suicide Ideation Scale	.86	.88	.85
Beck Anxiety Inventory	.95	.96	.95
Beck Hopelessness Scale	.89	,84	.90
Revised UCLA Loneliness Scale	.44	,23	.54
Jail Stress Scale	.90	.90	.90
Brief Coping Scale	.90	.93	.88
Multidimensional Scale of Perceived Social Support	.95	.96	.95

Table 10 shows that on only one scale were there some problems with internal consistency. The revised UCLA Loneliness Scale showed lower than expected reliability overall and especially within the Indian sample. (This scale's reported reliability was modest to begin with, at .75, as reported earlier.) The other scale measurements showed acceptable to excellent reliabilities in overall samples as well as in sub-samples. Scale scores were then run for each of these measures. Table 11 shows the results for the overall, Indian, and non-Indian samples. By completing these two procedures, a close examination of the scales' performances was accomplished by examining results for abnormalities. Did the measurements seem to be working across all samples?

Table 11. Measurement Scale Scores

Survey Sample – Scale Scores[1]	Possible/ Range	Overall	Indian Sample	Non-Indian Sample
Suicide Ideation Severity Scale (only ideators - 12%)	38/ 0 - 36	6.1 (sd: 7.5)	5.3 (sd: 7.9)	6.8 (sd: 7.3)
Beck Anxiety Inventory	63/ 0 - 63	9.4 (sd:12.4)	9.3 (sd:13.2)	9.5 (sd:11.9)
Beck Hopelessness Scale	20/ 0 - 20	3.6 (sd: 4.1)	3.6 (sd: 4.4)	3.4 (sd: 3.6)
Rev. - UCLA Loneliness Scale	20/ 4 - 20	14.3 (sd. 2.9)	14.2 (sd: 2.6)	14.2 (sd: 3.0)
Jail Stress Scale	40/ 0 - 40	17.6 (sd:10.4)	16.5 (sd:10.3)	18.4 (sd:10.4)*
Brief Coping Scale	84/ 0 - 84	35.7 (sd:16.2)	35.8 (sd:18.3)	35.6 (sd:14.8)
Multidimensional Scale of Perceived Social Support	72/ 2 - 14	10.7 (sd: 3.3)	10.6 (sd: 3.4)	10.8 (sd: 3.2)

[1]The lower the score the lower the measure.
*$p<.05$

Table 11 reveals low scores on all measures except loneliness. Although one could interpret this as the samples having higher levels of loneliness, which seems to be confirmed with the low level of social support endorsed, the reliability analysis showed that the Loneliness Scale was not working as expected. Thus, any interpretation that the subjects experienced higher levels of loneliness should be made with caution. The Indian and non-Indian samples show low severity on the suicide ideation measures and low levels of anxiety, hopelessness, jail stress, and social support. Additionally these samples showed the use of low to medium level coping skills. The only significant difference across ethnic groups was that Indian detainees indicated lower jail stress than the non-Indian detainees.

To run concordance data, an analysis plan was developed using pertinent items on the SPSQ and congruent dichotomous measures on the self-report survey. Table 12 shows the plan for analyses.

Table 12. Concordance Analysis Plan

Item From the NYSPSG	Concordance Measurement/Scale in Survey
Lacks close family or friends	Social Support Scale – Used 0-3 as low/4-6 as high
Family has attempted suicide	Variable computed with either a positive for mother, father, sibling, grandparent, stepparent, other relative, friend "ever" attempted suicide
Has psychiatric history	Hospitalization for emotional problems
Has history of drug/alcohol abuse	Variable computed that includes either a positive response for hospitalization or past six months service use for substance abuse problem
Thinking of killing him/herself	SSI – positive for either Q. #4 and/or Q. #5
Has previous suicide attempt	SSI – Q.# 20
Nothing to look forward to in future	BHS – summary scale score, then 0-3 no, >4 yes
Appears depressed	BHS – Q#2
Appears overly anxious	BAI – summary scale score, then 0-7 no, >8 yes
First arrest	Survey item# 9

Percent agreements, kappas, sensitivity by all, Indian and non-Indian, and specificity were then run as Table 12 indicates. *Percent agreement* is the proportion of true positives and true negatives across both the NYSPSG and the survey item, divided by the total number of subjects. Kappa is the percent observed agreement minus the percent agreement expected by chance alone divided by the 100% minus percent agreement expected by chance alone[39].

The sensitivity of the NYSPSG is defined as the ability of this test to identify correctly those who have indicated a positive response with the concordance measure in the survey (how correctly does the NYSPSG pick up the positive cases of the construct as measured by the concordance measure?). Specificity, on the other hand, is defined as the ability of the test to identify correctly those who did not indicate the concordance measure in the survey (how correctly does the NYSPSQ pick up the negative cases of the construct as measured by the concordance measure?). Table 13 shows the results.

Table 13. Concordance Analyses Results.

Suicide Prevention Screening Guidelines	Percent Agreement	Kappa	Sensitivity	Indian Sens.	Non-Indian	Specificity
Lacks close family or friends	47.8%	-.04	90.1%	91.9%	88.5%	5.8%
Family has attempted suicide	81.5%	.40	37.6%	32.8%	43.4%	95.4%
Has psychiatric history	89.7%	.49	53.4%	42.9%	63.3%	94.4%
Has history of drug/alcohol abuse	82.9%	.39	78.1%	60.0%	94.1%	83.4%
Thinking of killing him/herself	86.6%	.06	4.6%	0.0%	8.6%	99.0%
Has previous suicide attempt	93.3%	.72	66.0%	57.9%	76.7%	98.0%
Nothing to look forward to in future	89.3%	.10	9.3%	0.0%	16.0%	97.6%
Appears depressed	88.5%	.07	11.4%	7.0%	15%	94.6%
Appears overly anxious	95.1%	-.03	0.0%	0.0%	14.3%	95.1%
First arrest	81.8%	.56	81.8%	22.7%	59.3%	90.8%

As one can see, almost all of the concordance, if measured by the percent agreement, is high. The exception is the NYSPSG item "lacks close family or friends." However, further analyses show low kappas and sensitivity in almost all items except for "lacks close family or friends." Thus, the NYSPSG items did not pick up the positive cases as indicated by the survey. This is especially true within the Indian sample. Measures of *suicide ideation, hopelessness, and being overly anxious did not successfully identify any of the Indian cases, and in the case of the depression measure, was very low*. The specificity on almost all items proved high. Thus, the percent agreement represents how well the NYSPSG

items are picking up the negative cases but not the positive cases. The only item in which this pattern is reversed is the "lack of close family or friends". This item picks up the positive cases of *low* social support and not the negative cases. *These results indicate that the NYSPSG screening tool is not successful in identifying suicide ideation and risk factors within this jail sample, especially for the American Indian population.*

Year 1 – Aim #3 & 4 Qualitative Research Results: Similar Findings Across Indian/Non-Indian Groups

A full report of the extensive first year qualitative work is included in the Appendices (see, Appendix A8). In this section only the findings of the focus group analyses are summarized. The experiences reported below reflect the detainee perspective and they provide a glimpse of what is experienced by ***both*** Indian/Non-Indian detainees at the time of intake into the jail facility.

The person arrives angry after being picked up by the police officer. S/he is worried that s/he might not be able to contact her or his family and/or job about her or his whereabouts. Suicide screening is done immediately upon the initial contact with yet another uniformed stranger with whom there is no established relationship. The procedure is sometimes rushed and not always done in a private place. Distrust of "how this information will be used" and fears of confidentiality breaches are prominent. From prior experience, detainees have learned that if they are thought of as being suicidal or otherwise potentially harmful to themselves, they are dressed in the "oven mitt" and put in the "fish bowl", a specially designed room in the booking area which affords no privacy. These people are afraid that they will then be thought of as "crazy". Consequently, they chose not to answer correctly when asked how they feel.

As is evident, complicated perceptions are in play at the time a person is processed into the jail. This complicated process is further aggravated by the procedure of asking sensitive questions to accurately ascertain a person's suicide intent and expecting the person to be truthful in response. Without fully understanding these perceptions and their causes, as well as ascertaining the "truthfulness of responses," it is difficult to truly evaluate the usefulness of any instrument in identifying suicidal intent. Below, a summary of the

qualitative findings from this research may help produce better understanding about what factors are in play when accessing for suicide in a jail setting during the booking process. Similarities across groups seem to cluster around the *process* of screening/assessment rather than around the actual questions asked via the NYSPSG.

While issues of *building relationships, privacy, consequences of disclosure (i.e., putting the person in the oven mitt, etc.), confidentiality, and distrust* are common across groups, gender differences did exist. These differences surfaced in the *types of worries* that the inmates brought to the jail. Both men and women expressed worry about their jobs: who will notify their employers of their predicament, and the status of their jobs when they get "out"? However, women were more concerned about their children or family caretaking or the family's welfare and responsibilities than were men. Who will know that they are in jail? Who will take care of the children and/or family in their absence? In contrast, men worry about their relationships with the family or significant other. What will their families think? Will they see their wives /girlfriends and/or their children again? It was also interesting that the women generally expressed a more positive outlook about their futures than did the men.

Differences Across Groups

The differences across Indian/non-Indian groups seemed to fall in the area of the framing of the screening questions. Differences were found in the concepts and definitions of *family, community and psychiatric/psychological problems or in the concepts of mental health*. Indians think of family and community in a more extended way, not restricted by geography. Large extended family tends to be a more important point of reference in the American Indian culture than in other segments of society.

Indian interpretations of mental and emotional problems are also different. Certain behaviors or symptoms seen in mainstream society may not be interpreted in the same way. Such problems are viewed as unnatural and thus externally caused, and not due to psychological conflicts. In general, the American Indian participants indicated having greater acceptance and tolerance of personal peculiarities or social deviance without either rejecting that person or labeling him/her as "mentally ill" or "crazy." Additionally, people who experience compelling intuition, visions, and powerful dreams are often valued for

special knowledge and are thought to be blessed. Unless extremely disturbing or bizarre, they are not judged in a pathologized way. Severe disturbance might be caused by "soul loss, spiritual possession, loss of breath of life, or evil work by an enemy."

"Respect" has wider connotations in many Indian cultures than in mainstream culture. Respect for and working with others is of great importance historically in tribal life survival. Respect includes knowing one's proper place in the social structure and the proper place of other persons as well. Thus, in deciding if a person holds a respectful position within the community and is thus at elevated risk for suicide, one needs to take into consideration that all Indian people hold this respect and that is not defined by monetary or career accomplishments. Another aspect of respect is recognition of individual differences and private experiences. Individuality is highly developed in the Northern Plains culture and many of life's most important experiences are personal and private. What is right for one person may well be wrong for another and no one person is qualified to judge if it is right or wrong for another person. It is generally considered disrespectful to tell other people what to do or to pry too deeply into the thoughts, feelings or inner experiences of others. Thus, questioning into sensitive areas without first establishing a relationship is looked upon as disrespectful.

Special emphases on *risk for suicide* for Indians emerged in our discussions. These special issues include *loss* (including historical cultural loss) beyond that of immediate family; being jailed far from home (which may be a reservation several hundred miles away), and the *presence of outside influences* such as alcohol or "ghosts/spirits." Being jailed so far from home is especially important for Federal prisoners who may be transported great distances (interstate) from home. The outside influences leave the detainee vulnerable.

Communication may not only differ from non-Indian communication patterns but from other Indian groups as well. Northern Plains Indians in our focus groups indicated that *direct questioning of negative outcomes can provoke these outcomes* either through planting of thoughts or by allowing external spirits (wanagi) access to the person's essence (ghost illness). *Framing* of questions becomes very important. Focus group participants mentioned that questions are too negatively phrased, and that more positively framed

questions might bring different responses. For example, instead of asking "Are you going to hurt yourself?" ask "Are you going to make it?"

Longstanding mistrust is and will always be present within this cultural minority group as well as for others minority groups. Mainstream oppression has resulted in the destruction of traditional tribal ways of life, victimization, and alienation in their relationship to the dominant society. Uniformed officers and the pressure to sign official government-sponsored papers/forms have never proven to be "good" for Indian peoples. A basic knowledge of the major events and trends in Indian and non-Indian relationships is a necessary background for anyone working with and wanting to have even a rudimentary understanding of these cultural groups.

Indian-specific programming and activities such as "talking circles," "beading or quilting," and access to traditional healers and rituals was suggested by all Indian groups. This type of programming was thought to aid in the refinding of the "nagi" or soul, as well as for enhancing coping abilities and reducing or alleviating depression. The cultural factors involved in complex behaviors such as suicide and deviancy are important, needing of respect, and of the involvement of someone who lives this worldview.

The above results tell us that non-Indian and Indian detainees do not always accurately disclose when asked specific suicide risk assessment questions. Many reasons for this seem to be at play and are also outlined above. Some of these factors are similar across groups, and some are culturally distinct. To determine specificity and sensitivity of any instrument, one must assume that respondents "give truthful responses." Our groups told us that they do not. Rather than characterizing this as a pattern of dishonest responses to the screening questions, participants indicated that they understood the questions asked and supported the reasons for asking them (e.g. suicide prevention), but were not comfortable answering them given the lack of a caring and empathic dialogue between the interviewer and the detainee. In essence the reluctance to answer screening questions honestly seems to be rooted in the detainees' discomfort in disclosing their personal and sensitive thoughts and feelings, and also in fears about the consequences of disclosure – consequences that are established and well-known within this setting.

B. YEAR 2 DATA ANALYSES

Overview

The specific objective of the second year of research was to identify through the use of an experimental design, a suicide screening process that influences Northern Plains' detainees' comfort levels in disclosure of suicidal ideation as well as management of future help-seeking behavior and depression within the jail setting. Specifically, does the setting (private vs. non-private) where screening takes place and the type of screener make a difference in the detainee's comfort level for self-disclosure, management of depression and future help-seeking behavior?

Due to the limitations of doing research in the jail setting, the proposed methodology did not proceed as originally planned. While a sizable sample consented to participate in taking the Satisfaction Survey, it became impossible to accurately identify the timing of the different screening protocols. Additionally, two of the four interventions called for an American Indian officer to serve as the screener. When this research was first initiated in 1999, there were two American Indian officers employed in the detention center. By mid 2000, one of those officers had left for a position in a reservation community and the other was unable to work on assignment in the booking area of the jail. Ultimately, through collaboration with a graduate counseling program at the local university, counseling students, including one American Indian male, were hired to work as the screeners consistent with the research protocols. An effort was made to employ these students to work in the jail on the busiest intake days / evenings. The jail's training officer held a specially prepared class to "train" these students in the appropriate way to administer the NYSPSG. The initial group of four students quickly decreased to two, though thankfully one of those remaining was an American Indian male. All three protocols carried out by students were done in a private area of the booking section. Unexpectedly, officers assigned to the booking area exercised considerable caution in allowing students – especially the female student – to do the risk assessment screening in the secure but somewhat removed and private location. Consequently, this exercise of discretion resulted in lower numbers of subjects screened under the varying protocols.

The sample numbers for each of the protocols were further reduced because of a general and unexpected reduction in jail admissions. While it was estimated that nearly 375 inmates would be brought in over the five-week period that the students were employed in the jail, in the end, only 89 subjects came in under these protocols ***and*** agreed to participate in the research. This low number necessarily limits the statistical analyses that could be done with integrity. Valuable information was gained nonetheless.

The initial hypotheses were that (1) inmates of all races and ethnic backgrounds experience discomfort when asked directly about suicide ideation and mental health status through current screening measures; (2) reliable, valid, and effective suicide screening at intake is a matter of both the wording of questions being asked and the manner or context in which they are asked; and (3) relieving the inmate's discomfort during the screening process by utilizing culturally-respectful wording and conversation will lead to more personal comfort and disclosure of honest information from Indian detainees.

While the participant numbers were very low for each of the individual protocols to be tested according to the original plan, it is possible to still speak to these hypotheses and the research objective. From October 20, 2000 through May 15, 2001 a Feedback / Satisfaction Survey was instituted for those being booked into the jail on the daily 3-11 pm shift. Later, when implementing the different protocols, data collection was limited to Thursday, Friday, and Saturday evening shifts, to accommodate the student screener schedules as well as be present during the busiest time of the week in regards to booking numbers.

In total, 742 detainees completed the Feedback/Satisfaction Surveys. Not having access to total booking data for that time period means that the representativeness of this sample cannot be substantiated. Nor is this total sample able to be identified by screening protocol status (only 89 surveys could be identified by tested protocol). However, the information gained from these 742 surveys is important in terms of confirming results yielded from Year 1 data. In the following pages, the information gathered in the 89 surveys, identified by protocol, is detailed.

Description of Full Survey Sample.

The description of the survey completers does not vary from the descriptors of our more empirically obtained sample from the first year, as shown by Table 14 below. The sample consists of mostly males, in their early 20s, living in the city where the jail is located, who are employed approximately 50% of the time. The survey completer sample is 45-50% Indian.

Table 14. Characteristics of Year Two Feedback/Satisfaction Survey Completers

Characteristic of Survey Completers (n=742)	
Age	Mean = 29.9 ± 9.9 Mode = 22.0
Male	72.4%
Employed Full or Part-time	42.1%
Resident of in City	69.6%
Indian	45.2%

Results of Survey Data

The results of the first year of research (especially focus group discussions) lead us to the conclusion that detainees do not fully disclose their actual experiences or feelings for a variety of reasons (i.e., consequences, distrust, timing of questions, etc.). Confirming these results, chi-square analyses of our Satisfaction Survey data showed that honesty levels for questions related to physical health, mental health, and drugs / alcohol were significantly lower for American Indians than for non-Indians (See Table 15).

Table 15. Mean Honesty on Questions Related to Different Conditions

Mean Honesty (1-10)	All	Indian	Non-Indian
Physical Health	9.45 ±1.67	9.28 ±1.40**	9.64 ±1.85
Mental Health	9.34 ±1.80	9.20 ±1.99*	9.46 ±1.61
Drugs/Alcohol	9.20 ±1.80	9.01 ±2.26*	9.39 ±1.77

n=742
chi-square testing
*,**, *** $p<.05, .01, .0001$, respectively

Table 16 shows that the mean comfort the Indian sample was significantly higher for physical health related questions.

Table 16. Mean Comfort Levels on Answering Questions Related to Different Conditions

Mean Comfort (1-10)	All	Indian	Non-Indian
Physical Health	9.19 ± 4.31	8.83 ±2.33*	9.52 ±5.53
Mental Health	8.84 ±2.31	8.75 ±2.44	8.98 ±2.16
Drugs/Alcohol	8.79 ±2.42	8.63 ±2.59	8.91 ±2.27

n=742
chi-square testing
*,**, *** $p<.05, .01, .0001$, respectively

Table 17 shows that the Indian detainees are significantly more concerned about privacy than are non-Indian detainees.

Table 17. Mean Comfort Levels with Privacy Concerns

Mean Comfort With Privacy (1-10)	All	Indian	Non-Indian
Private Enough	8.48 ± 2.54	8.17 ±2.84**	8.78 ±2.18

n=742
chi-square testing
*,**, *** $p<.05, .01, .0001$, respectively

However, a discrepant pattern could exist when asking about overall booking experience (see Table 18). Indians, though not statistically significant through chi-square testing, rate the booking experience higher or more comfortable than do non-Indians. This situation is also true when reporting the confidence felt in being able to handle one's depression at the time the booking experience is over (Table 19).

Table 18. Mean Rating of Overall Booking Experience

Mean Rating of Overall Experience (0-4)	All	Indian	Non-Indian
Experience	2.82 ± 1.01	2.89 ± .98	2.77 ±1.04

No gender or ethnic differences
n=742
chi-square testing

Table 19. Mean Rating in Confidence in Handling Depression

Mean Confidence in Handling Sadness & Down in Dumps Experience (1-10)	All	Indian	Non-Indian
Experience	7.39 ± 2.94	7.52 ±2.96	7.32 ±2.88

No gender or ethnic differences
n=742

One of the evolving hypotheses was that detainees bring anger into the jail, especially toward the arresting officer, and that this anger influences subsequent detainee and uniformed correctional officer interaction. Table 20 shows that this hypothesis is only partially supported. Detainee's anger is more likely to be self-directed rather than directed at the arresting officer. No one in the sample indicated they felt anger with the booking officer.

Table 20. Percent of Who Detainee Angry With At Booking

Angry With:	
Myself	264 (64.7%)
Other	92 (22.5%)
Arresting Officer	25 (6.1%)
Friends	17 (4.2%)
My Family	10 (2.5%)

Tables 21, 22, and 23 show confirmation of the first year's conclusions that a trusting relationship as well as the officer's affect when it reflects concern for the detainee is important to full and honest disclosure, especially with the Indian population (chi-square testing). Concern for the inmate and information about how information that is disclosed will be used clearly needs to be conveyed to the detainee by the officer. Information is more easily disclosed if there is trust that this information will get to the right people.

Table 21. Percent Of Positive Responses of Why Detainee Answered Medical Condition Questions Honestly by Ethnic Group

Reason Why Answered *Medical Condition* Questions	Indian	Non-Indian
Person seemed concerned about me	65.5%***	34.5%
I knew I needed help immediately	64.3%*	35.7%
Concerned I would harm myself if I didn't tell someone	58.8%	41.2%
On medication and wanted it prescribed while in jail	47.8%	52.2%
Felt I could trust person to get info to right staff	56.9%**	43.1%

Row percents
Chi-square testing
*,**, *** $p<.05, .01, .0001$, respectively

Table 22. Percent Of Positive Responses of Why Detainee Answered Mental Health Condition Questions Honestly by Ethnic Group

Reason Why Answered *Mental Health Condition* Questions	Indian	Non-Indian
Person seemed concerned about me	70.1%***	29.9%
I knew I needed help immediately	52.2%	47.8%
Concerned I would harm myself if I didn't tell someone	56.3%	43.8%
On medication and wanted it prescribed while in jail	50.0%	50.0%
Felt I could trust person to get info to right staff	52.5%	47.5%

Row percents
Chi-square testing
*,**, *** $p<.05, .01, .0001$, respectively

Table 23. Percent Of Positive Responses of Why Detainee Answered Drug/Alcohol Condition Questions Honestly by Ethnic Group

Reason Why Answered *Drug/Alcohol Condition* Questions	Indian	Non-Indian
Person seemed concerned about me	66.9%***	33.1%
I knew I needed help immediately	65.0%**	35.0%
Concerned I would harm myself if I didn't tell someone	57.1%	42.9%
On medication and wanted it prescribed while in jail	60.9%	39.1%
Felt I could trust person to get info to right staff	54.7%*	45.3%

Row percents
Chi-square testing
*,**, *** $p<.05, .01, .0001$, respectively

Protocol Testing Sample

Protocol type could be identified in 89 of the surveys. However, only 63 of these surveys contained enough responses to be suitable for analysis. Table 24 shows the overall characteristics of the Protocol Population and Table 25 shows similar characteristics of the Protocol Sample. There were significantly more females and city residents in the final protocol sample that was analyzed.

Table 24. Characteristics of Protocol Population.

Characteristic of Protocol Population (n=89)	
Age	Mean = 28.4 ± 9.6 Mode= 22
Male	76.4%
Employed full or part-time	27.4%
Resident of City	67.4%
Indian	74.4%

Table 25. Characteristics of Protocol Sample

Characteristic of Protocol Sample (n=63)	
Age	Mean = 28.4 ± 9.6 Mode= 22
Male	69.8%*
Employed full or part-time	26.2%
Resident of City	74.6%*
Indian	74.2%

Chi-square testing
*$p<.05$

Results of Protocol Testing

The first query asked if the detainees (any ethnicity) remembered questions by screeners as to their physical health, mental health or emotional well-being, and their use of drugs and / or alcohol. Table 26 shows that the majority of the respondents answered in the positive - they remembered this type of questioning.

Table 26. Perception of Questioning

Questioned About..	Percent Yes
Physical Health	90.3%
Mental Health/Emotional Well-Being	88.7%
Use of Drugs/Alcohol	93.5%

After examining frequencies, the need to collapse categories for enough power to detect maximal differences was noted. (Detecting medium or minimal differences would be impossible given the final sample size.) Thus, cases were collapsed by three categories: civilian with privacy (n=30), American Indian as screener (n=15), and normal screening (control) (n=18). No significant differences were found by chi-square testing within each group by Indian or non-Indian status. Independent sample t-tests were run to compare mean responses (i.e. honesty, comfortableness, etc.) by inclusion or exclusion in the individual protocols for all ethnicities. Table 27 shows the mean for honest answers. Both intervention protocols showed higher mean scores for honesty across the three health domains. Civilian with privacy showed significantly more honest answers when questioning about physical health status. Normal screening showed significantly fewer honest answers.

Table 27. Mean Honest Answers by Protocol

Mean Honest Answers (1-10)	Civilian with Privacy		Indian Screener		Normal Screening	
	Yes	No	Yes	No	Yes	No
Physical Health	9.77*	9.03	9.60	9.33	9.00*	9.77
Mental Health	9.60	9.06	9.33	9.33	9.03	9.71
Drugs/Alcohol	9.70	9.06	9.40	9.37	9.03	9.61

T testing
*$p \leq .10$

Table 28 reports on comfort levels by protocol. Significantly higher scores were found for civilian with privacy when questioning about physical health and drugs/alcohol. Mental health was also reported higher but not significantly so. The Indian screener protocol shows a higher mean response for physical health and drugs/alcohol but a very slight lower score for mental health. None of these response categories were significant. Normal

screening again showed a lower comfort level for all three domains, and significantly so for physical health and mental health.

Table 28. Comfort Levels by Protocol

Mean Comfort Answers (1-10)	Civilian with Privacy		Indian Screener		Normal Screening	
	Yes	No	Yes	No	Yes	No
Physical Health	9.63 **	8.03	9.33	8.65	7.97	9.64**
Mental Health	9.33	8.43	8.73	8.93	8.38	9.35**
Drugs/Alcohol	9.67**	8.23	9.40	8.78	8.17	9.68

T testing
*,** $p<.10, .05$ respectively

The mean rating of the overall booking experience reveals mixed results (see Table 29). Civilian with privacy is slightly higher in rating; Indian screener and normal screening slightly lower. Since all of these scores are so close and no significant findings were found, one can conclude that the small sample did not adequately allow us for testing whether the protocols had an affect on the detainee's overall rating of the booking experience.

Table 29. Mean Overall Rating by Protocol

Mean Rating of Overall Experience (1-4)	Civilian with Privacy		Indian Screener		Normal Screening	
	Yes	No	Yes	No	Yes	No
Experience	3.04	2.90	2.86	3.00	2.90	3.03

Table 30 shows that the mean rating of comfort level was higher in an intervention protocol than for the control. However, no significant difference was detected through t testing.

Table 30. Comfort Level by Protocol

Mean Rating of Comfort with Privacy	Civilian with Privacy		Indian Screener		Normal Screening	
	Yes	No	Yes	No	Yes	No
Privacy	8.83	7.71	8.43	8.20	7.71	8.83

There was interest in determining whether intervention protocols would affect the confidence in detainee management of depression after the booking experience, thus possibly being protective for suicidal ideation and behavior. Table 31 shows mixed results which are possibly due to the small sample size. While the Indian screener protocol shows slightly higher confidence in handling depression, the civilian with privacy protocol does not. Additionally, the normal screening protocol shows higher confidence in depression management than for those that participated in the new protocols. No significance was found across t-test analyses.

Table 31. Confidence in Detainee Perception of Depression Management

Mean Rating of Confidence in Handling Depression	Civilian with Privacy		Indian Screener		Normal Screening	
	Yes	No	Yes	No	Yes	No
Privacy	6.83	7.42	7.20	7.11	7.33	6.93

Once again, questions were answered honestly (t testing) because of the officer's perceived concern (p=.08) and perceived trust in handling of information (p=.10).

Year 2 – Qualitative Results

The data from the limited number of focus groups completed during year two of this research mirrors much of what was found in focus group discussions during year one. Given the comprehensive and complex nature of the data reported in the quantitative sections of this report, and because focus group content during the second year of study added little to further inform suicide risk assessment procedures, we do not report on year two focus groups.

VI. DISCUSSION and SIGNIFICANCE OF FINDINGS; CONCLUSIONS

General Observations on Jail Suicide Research

Clearly there are many facets of this research which could be discussed at length. Simply the description of who is in jail, the charges they face, and the descriptors used to humanize this kind of institution, one which is often portrayed in negative stereotypes, makes this research valuable. The County Detention Center is remarkable for its desire to evaluate its operation – and for that reason, should be seen as a progressive and reflective institution. Many jails collect and maintain data but do nothing to share the information outside its walls. By disseminating the findings of this research, perhaps more jail administrators will be willing to self-evaluate their management strategies, the instruments they use to effect those strategies, and the ways evidence-based practices can alter the nature of their operations.

One of the unfortunate products of prior jail suicide research has been the creation of the personal profile: the picture of the average inmate who completes suicide in the jail. It has been against this profile that jail suicide efforts have been measured and further, that jails have built and evaluated their own suicide prevention programs. In fact, to date, the profile of the suicidal inmate is typically all encompassing, telling us little but that most of those who kill themselves in jails are White males, under the age of 40, housed in isolation, and they use hanging as the method to effect their deaths[40]. In reality, these features represent the majority of persons passing through jails each year, thus the profile does little to help detect potentially suicidal inmates or to predict suicide risk. Another unfortunate byproduct of relying on the suicide profile is that these criteria have been used to establish legal expectations. While an astute judge wrote, in a famous opinion in 1980, that an identification program for determining suicide risk was fundamental to the operation of a minimally constitutionally adequate mental health program[41], identification programs themselves have been challenged as having had little to do with the continued rate of suicides in jails. Some authors suggest that determined suicidal prisoners have not been deterred by "electronic surveillance, death watches, and isolation" [42] and that deception with regard to their responses to screening questions is not uncommon among prisoners contemplating suicide.[43]

The research results presented in this report support these theses both in the data and in the systemic challenges faced in attempting to collect these data. In terms of the prevalence rate of suicide ideation among all detainees, there were no significant differences between the American Indian detainees and the non-Indian detainees. An overall rate of 12% was ascertained; a rate lower than expected.

On Truthfulness, Trauma, and Timing

First, it is important to view the inconsistent findings about inmates' truthfulness in responding to some of the questions on the NYSPSG questionnaire as well as the low sensitivity found with the instrument as evidence that this screening protocol alone cannot be relied upon to make a valid assessment of risk. Rather than see this as a measure of either the detainee's honesty or deception, it seems critical to view the inconsistent responses as being indicative of the variances between objective and subjective appraisals of the screening process. A significant number of these inmates reported, in focus groups and in the survey data, that while they understand why questions about suicide ideation are asked and agree that they should be asked (the objective appraisal), as to the likelihood of their answering those questions honestly, they would not (the subjective appraisal). Is this dishonesty? To the contrary, it seems to be an honest commentary on the personal impact of an impersonal process. Though the results are not conclusive, indications from the second year of research suggest that, regardless of who asks the questions, if they are asked in a private place and a trusting relationship has been even minimally developed presumably with the undivided attention of the person who is asking them, the detainee is more likely to answer the questions honestly. This is an important finding, one which requires further investigation.

Findings of a high prevalence of lifetime trauma among all detainees as well as its very high correlation with suicide ideation within this detained population merits additional study. Trauma has not been identified in the literature as a significant risk factor for suicide ideation with jail or prison inmates. This study suggests that screening for trauma should be included in all suicide assessments with this population. The research reported herein suggests "timing" is a critical factor in suicide assessments. Such histories combined in some cases with very personal experiences of traumatic deaths of loved ones, by suicide, in

this and other jails in the country, result in a twofold affront to the detainee as s/he enters the jail door: deeply personal questions asked in an atmosphere characterized by a lack of privacy and rote procedural inquiries in the absence of a trusting relationship, and direct questioning about family suicide histories which conjures up memories (ghosts; spirits) of those who have completed suicide.

What more of the timing of suicide risk assessments for new detainees? In reaction to various national suicide studies which set forth the profile of the inmate who has succeeded in suicide, several researchers have written about specific programs and in particular, the apparent anomalies of these programs. Farmer et al. (1996) set forth the picture of the Galveston County Jail, where suicide attempts were studied, and where the average suicide attempt occurred some 137 days after admission to the jail, in contrast with the now famous profile of the "average" inmate who completes suicide within the first 24-48 hours.[44] They also reviewed suicide incidents that occurred in the jails of the New York Department of Corrections finding that most of the suicide attempts occurred much later after the inmate's admission and occurred while the inmate was housed in general population. Farmer et al concluded that risk prediction might be better accomplished by looking at substantive events such as histories of psychiatric hospitalization, suicidal acts, and ongoing stressors, than by focusing on the kinds of demographic variables frequently presented in the picture of the average profiled inmate.

Screening Forms, Questions, and Procedures

The analyses of the concordance between the items listed on the NYSPSG and the Mental Health Survey indicates that answers to certain questions on the NYSPSG are not consistent with scaled responses to measures included on the Mental Health Survey. Further, this appears to be especially significant when the results are viewed by race: concordance measures for the Indian detainees are particularly significant. While it is tempting to summarily disregard the NYSPSG as being insensitive in picking up particular emotional states within the American Indian culture, restraint is appropriate. The complex nature of intake processing – the personalities, procedures, and context involved – mean that caution is required to avoid the summary exclusion of any one piece of the screening equation. Still,

further research is warranted to determine the sensitivity of the NYSPSG that includes actual clinical assessment, particularly when used with culturally diverse populations residing in distinctive areas of the country.

Though the implications of the qualitative data have been woven thus far through this discussion section, there are central themes gleaned from focus groups which should inform future research and practice into suicide screening practices. There is no perfect way to present these findings, but for clarity, central culture-specific issues will be presented first; cross-cultural issues will follow.

To date, jails follow commonly accepted and distributed suicide screening procedures and practices. Actual screening forms, like the NYSPSG, are commonly distributed at training forums which are sponsored by accreditation agencies and by technical assistance agencies such as the National Institute of Corrections. These procedures and practices have reflected a "one size fits all" approach, based on assumptions that risk assessment and risk prediction is a transcultural, transracial, and transecological/environmental phenomenon. Focus group feedback indicates that this is not so. The American Indian participants pointed out many culture-specific, unique perspectives on and interpretations of these risk assessment practices. First, in some American Indian communities there seems no clear corollary to the non-Indian notion of "mental health". Mental illness by some Indians is considered a White person's disease. Consequently, asking questions about one's mental health history may be interpreted inconsistently and thus not have integrity as a predictive or assessment factor.

In the Indian community, who is "important" may be very different than one who would be considered important in a non-Indian community. This variance comes home in the border jail, when many of the detainees are from (currently, recently, or in the distant past) a reservation, where the status of someone deemed "important" has no meaning in the non-reservation city. This must be looked at as a potential misunderstanding that occurs in context: it is not that an officer or screener cannot hear who is important to an American Indian detainee, rather, it is the detainee's own personal sense of knowledge of that importance and the officers lack of the same knowledge that may lead to feelings of despair, isolation, being misunderstood. In other words, it is not the question in itself that is

misleading or erroneous, it is the interpretation of the response that may not be culturally valid.

In a similar vein, concepts of "community" differ between Indian and non-Indian detainees. "Community" to an American Indian detainee may mean something much wider – spatially and spiritually – than to a non-Indian detainee.

Clearly the concept of "loss" has particular meaning for the Indian detainee. The experience of multiple losses, some related to the experience of trauma in the person's life and some related simply to the events of the arrest and detention, compound an evaluation of risk. Officers may interpret loss as related to death, divorce, or freedom. The American Indian detainees suggest that loss is a cumulative, interrelated as opposed to discreetly defined series of events and experiences.

Repeated comments were heard from Indian detainees about the personal discomfort that results from the perceived disrespect inherent in being asked direct, highly personal, and evocative questions about family history, suicide intent, and personal suicide history and behaviors. These reactions suggest that some adaptations can be made in the wording of the questions and reinforce what much of the mental health research literature has already established: that relationship is a (perhaps the) key variable in establishing a helping relationship. This is, in fact, precisely what was revealed in the focus groups in both years of the research. Asking direct, intrusive questions when there is no sense of relationship between the interviewer and the detainee is likely to yield dishonest answers. Additionally, the negative wording of the screening questions further inhibited honest disclosures. Asking directly about suicide history and ideation conjures up the memories of those who have died by suicide. Those memories, as mentioned earlier, result in "ghosting". When asked what kind of wording would be appropriate and more likely to yield truthful results, the Indian detainees suggested wording in more positive and future oriented terms would be more productive. One example heard from several different inmates in several different focus groups, is to ask instead about the detainee's well-being, e.g. "how is your well-being" instead of "are you thinking of hurting yourself". Clearly, such a language substitution would require further consideration not to mention a healthy bit of intestinal fortitude (for reasons discussed later in this section).

Though for both groups of inmates – American Indians and non-Indians – questions and concerns about how the information gained during the screening process might be used against them at some time and place, for the Indian detainees, the historical context of their experiences as oppressed peoples carries over at the booking desk. The County Jail staff are White, uniformed agents of a system that is by design, about social control. Questions about what stands to be lost for the Indian detainee if s/he provides information, signs forms, and submits to the authority of this uniformed person are quite possibly at the fore. While they may not be acted upon in any hostile or demonstrative way, the act of deception is a passive method of registering one's objection. This is not a definitive assessment but is a phenomenon which must be explored further if culturally sensitive suicide (and mental health) risk assessment instruments and procedures are to be developed.

Systemic Challenges in Jail Research

Certain aims of the first year of this research were carried over into the second year of research and included developing measures of culture specific symptoms of suicide ideation that could be incorporated into a suicide screening protocol and providing recommendations for culturally sensitive suicide ideation detection and intervention of treatment protocols in the detention setting. Indeed, these aims were in part met. The screening protocols were established for evaluation during the second year of this research. However, attempts to create a more culturally sensitive suicide risk assessment tool were impeded by concerns for the jail's liability. Because jail suicide is an event almost certain to end in litigation (but not necessarily in a finding of liability), the expense to counties forced to defend their jails and jail staff make it exceedingly difficult to develop a research instrument that may be potentially substantively different than a conventional screening tool. This constraint on change will be addressed further in the final section of this report.

The aims of the second year of research were foiled as a result of a myriad of systemic challenges. While a sizable sample consented to participate in taking the Feedback and Satisfaction Survey, being able to determine the effects of different screening protocols on the detainee's willingness to honestly report his/her health, mental health, and substance use history proved more difficult. Two of the four interventions called for an American

Indian officer to serve as the screener. When this research was first initiated in 1999, there were two American Indian officers employed in the detention center. By mid 2000, one of those officers had left for a position in a reservation community and the other was unable to work on assignment in the booking department. Despite the jail's fervent efforts to recruit Indian officers, these efforts were frustrated.

Ultimately, through collaboration with a graduate counseling program at the local university, counseling students, including one American Indian male, were hired to work as the screeners consistent with each of the protocols. An effort was made to employ these students to work in the jail on the busiest intake days / evenings. The detention center's training officer held a specially prepared class to "train" these students in the appropriate way to administer the NYSPSG. The initial group of four students quickly decreased to two. The researchers met with the students and had other communication with them to encourage them to record their perceptions of the screening process and inmates' reactions to their interviews. They were encouraged to provide the screening to every possible new detainee during the days they were assigned to work in the facility. Each reported a fair degree of comfort working in the facility (in fact, the American Indian student was so well respected that he was offered a position as an officer).

Because the central mission of this (and of any) detention center is to ensure the safety and security of the staff and inmates inside the facility and of the public, officers exercised their discretion when determining whether an intoxicated or particularly angry detainee could be safely screened by one of the students. All three protocols carried out by students were done in privacy. Unexpectedly, officers assigned to the booking area exercised considerable caution in allowing students – especially the female student – to do the risk assessment screening in a secure but somewhat removed and private section of the intake area. Consequently, this exercise of discretion resulted in lower numbers of subjects being screened under the varying protocols.

Numbers were further reduced because of a general reduction in admissions on the specific days during which the protocols were being recorded. While it was estimated that nearly 375 inmates would be admitted into the jail over the five week period that the students were employed there, in the end, only 89 subjects came in under these protocols and agreed

to participate in the research. This lower than expected number of admissions coupled with the small number of those who consented to participate in the survey necessarily limits the statistical analyses that could be done with integrity. Disappointing, yes; though valuable information was gained nonetheless.

Research Limitations

There are systemic challenges endemic to the jail environment which makes the validity of suicide risk evaluations questionable. Some of these challenges were described in the preceding pages.

As noted earlier, tribes that reside in the Northern Plains share many historical, governance, and cultural erosion similarities with tribes in other geographical settings, and parallel current socioeconomic conditions and contact with the criminal justice system. These shared characteristics suggest many of our findings may be relevant to other Indian populations;[45] however, local cultural symptoms, signs, and definitions of depressive-like experiences that may lead to suicide ideation are specific to tribes located in the Northern Plains. Generalizability of these conclusions is constrained by this specific Indian sample and should be advanced with caution.

Additionally caution is in order with respect to the information obtained. Except for the information concerning offender status which came from the jail's booking records, the only informants for this study were the detainees themselves in a self-report format. The lack of other key informants such as clinicians and family may have resulted in the underestimation of both the prevalence of suicide ideation and the concordance with other measures. It is also possible that conducting the surveys in the detention facility itself may have introduced some immeasurable bias into the individuals' responses. Though detainees indicated in focus group contacts that the research was explained, that they were offered the opportunity to participate, and asked to sign a consent form before doing so, all of which are safeguards to work against feelings of coercion, there is no doubt that the inherent power differentials at play in the detention environment make coercion a mighty force with which to reckon.

Conclusions

This exploratory study lays the foundation for more descriptive and exploratory research to come. The results described here represent a beginning in the effort to fill the knowledge gap as to the cultural and social factors affecting suicidal behavior and the screening tools used to accomplish risk assessments in correctional settings.

Clearly, a "one size fits all" screening tool used in a non-personalized manner will not serve to adequately assess suicide ideation among people of any culture, and this is particularly true as it applies to American Indians. These results suggest that further study is needed which explores the impact of the timing of risk assessments in the jail environment (and perhaps in other environments like hospitals and police lock-ups, as well) on a person's likelihood to answer truthfully about their thoughts and intentions. Additionally, research must lead to the development of rigorously tested assessment tools and procedures that address the specific cultural and social factors mentioned throughout this report.

These lofty recommendations, however, raise thorny issues around both legal liability and upping the ante in terms of the institution's duty to care for its detainees. With regard to legal liability, the managers of the county jail studied here – the Sheriff and Jail Administrator – are not unlike the managers of every other county jail in the country. They have very real concerns about being used as a "test site" for a new protocol, especially when that means that a tried and accepted, albeit not optimal, screening tool and procedure are already in place. As was discovered in the second year of this research, asking an institution to test a new screening instrument without any proof of its reliability and validity is asking the institution to risk a detainee's life. Such a predicament is neither ethical nor reasonable. One alternative is to develop and test in a side-by-side procedure the old instrument along with the new instrument – something which approximates the methodology employed in this research endeavor but which uses a simplified method of generating information about suicide risk. While there are still some inherent problems with this design, it would offer the jail some protection against litigation should a suicide occur during the test period. Further, a multi-site project with all the jail sites using the same new and old instruments would perhaps offer additional safeguards against litigation.

In addition, the jail's duty to care for its inmates cannot be separated from the issue of liability and thus it is critical that researchers understand and respect the 35-year history of judicial intervention in jail medical and mental health – especially suicide prevention – intervention efforts.

Of course, cultural context is paramount in this developmental process and should be included in any further investigations and/or exploratory "best practices" endeavors. Additionally, longitudinal descriptive case studies that include more social and cultural network analyses of different experiences in help seeking would greatly enrich and expand our knowledge of identification and treatment pathways for suicidal behaviors within this kind of restrictive and highly volatile setting. Empirical intervention studies could examine novel detention practices that use specific cultural contexts as their theoretical core. Also, system studies seem warranted that are designed to examine and therefore inform, how the integration of more culturally appropriate interventions impact both the detainee and the agency outcomes, especially the systems' change processes.

We have learned that assessment of suicide ideation in this setting is a complex process at play in a complex system; a process which is neither linear nor necessarily predictable. The process and outcomes of assessment within this setting are products of social dynamics that do not fit neatly into reductionistic study strategies. Thus, relationships among key social and cultural variables also need to be primary objects of future research. Effective interventions depend on understanding the cultural, personal, and socio-familial characteristics of and their interactive affects on the detainees, officers, and the internal (jail) and external (community) systems in which they are bonded.

All of the information – the data, the new knowledge, and the ideas for future research and interventions – that are contained in this report would not have been possible without the dedication of a particular sheriff who was willing to take a risk; a particular jail administrator who not only opened up his facility for scrutiny, but committed himself to discovering more about the links between culture, the jail institution, and inmate and staff behaviors, and many very dedicated jail staff members. For their courage and commitment and for their countless hours spent hearing instructions, being questioned, and carrying out the mission of this research, we express a special "thank you" to the entire staff of this

particular county jail. This study would not have succeeded without the new and unique research and evaluative collaboration that was established between this local institution and two university research organizations. We hope it will serve as a model for other jail managers and staffs and researchers to start looking at their jail populations, their information systems, and their desires and willingness to study what is happening to and within those systems. At minimum, we believe such information will enhance understanding of the socio-cultural variables at play in risk prediction and prevention strategies, particularly for – though not limited to – local jail systems.

References

[1] Throughout this report the terms "jail" and "detention center" are used interchangeably and both connote an institution whose primary purpose is to safely and securely house pre-trial inmates to ensure their appearance at trial. We have deleted the name of the county, city, state, and jail for confidentiality reasons.

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APPENDIX A: INSTITUTIONAL REVIEW BOARD DOCUMENTS

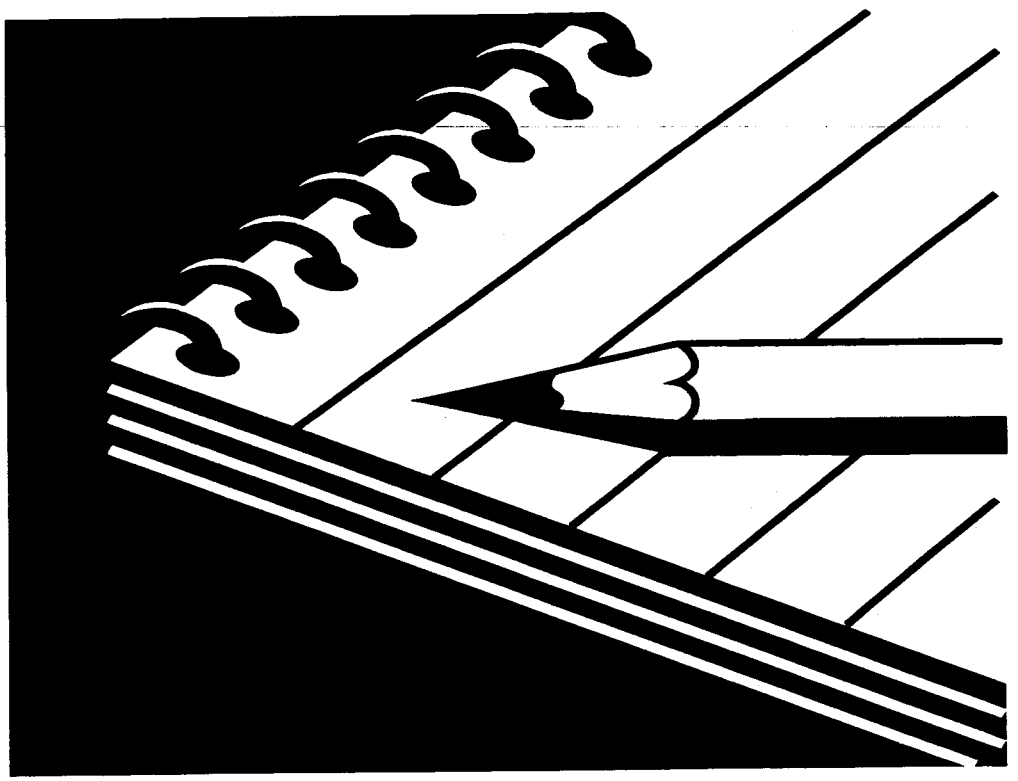
Appendix A 1: Miscellaneous IRB Documents

APPENDIX B: YEAR 1 RESEARCH INSTRUMENTS

Appendix B 1: Research Protocol

[Anonymous] County Detention Facility

MENTAL HEALTH SURVEY PROTOCOL



University of Kansas at Lawrence
University of Colorado Health Sciences Center

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I. BACKGROUND INFORMATION

A. History of the Project

The Mental Health Project of the [Anonymous] County Detention Facility is a one-of-its-kind research project to evaluate current suicidal ideation assessment tools used within the facility for cultural competency. The project will study the current screening instruments, and then develop a modification where appropriate to improve the State, local and tribal correctional agencies ability to more effectively screen for suicidal ideation among American Indian detainees. The results will address the current gap in knowledge around how culture affects suicidal ideation and behavior within a jail setting.

Your administrator, Mr. [Jail Adminstrator], became concerned over the over-representation of American Indian suicidal behavior within the facility. He subsequently called Drs. Christine Duclos & Margaret Severson to discuss this issue, both having worked with this issue in Indian Country. The jail is a state-of-the-art detention facility evidenced through both ACA and NCCHC accreditation. Since you are using the latest mental health screening instruments, it was felt that maybe these instruments were not sensitive to the specific cultural nuances of thought and behavior among this special population. Other studies point to differences in cultural norms, psychological stress, individual coping skills, and institutional and interpersonal factors, which carry serious life saving implications for the identification, care, and management of incarcerated persons of varying ethnic backgrounds. There have been no evaluation efforts of cultural competency of current suicidal ideation screening tools widely used in correctional settings. Your facility's current inmate characteristics (approximately 40% Indian) presented a perfect opportunity to study this issue. Thus, Drs. Severson & Duclos submitted a proposal to the National Institute of Justice was subsequently funded.

This study addresses the following questions:

1) What is the extent of American Indian suicidal ideation in jails?

2) Are current screening techniques as well as intervention practices culturally appropriate for this group?

We will use a mixed-method for this study. First we will survey all intakes for a specific amount of time asking about their depression, loneliness, suicide thoughts and history, coping skills, etc. This is the quantitative part of the study – collecting survey data that we can then analyze in a quantitative manner. The second part includes conducting focus groups with the detainees themselves (Indian and nonIndian) about the current way of asking these questions, why people may not be responding, is there another more appropriate way to inquire about suicidal thought and behavior, etc. These focus groups (qualitative data) will gives us context as well as insight into why current practices are working or not working, and ways for improvement. This

qualitative inquiry will help us answer what role culture plays in the experience of suicidal ideation, the presentation of symptoms, and in outcomes of suicide risk detection in the jail setting.

The specific objectives to be accomplished are:

1) Obtain prevalence rates of suicide ideation among a sample of jail detainees differentiated by Indian and nonIndian groups using this facility's current suicide detection screening tool, and another self-report method.

2) Examine concordance as well as specificity and sensitivity of the current tool with other self-report measures of suicidal ideation and risk factors.

3) Examine through focus group review, the cultural relevance of the current suicide risk screening tool and of the intervention methods employed in response to suicidal behavior within this particular jail setting.

4) Develop measures of culture-specific symptoms and syndromes of suicide ideation that will be incorporated into a suicide screening protocol.

5) To provide recommendations for culturally sensitive suicide ideation detection and intervention or treatment policy/procedures in the detention setting.

A summary of the research findings and the implicated policy issues will be presented both to the [Anonymous] County Sheriff's Office and the National Institute of Justice for publication in a *NIJ Research in Brief.* Nationally distributed publications of the findings and recommendations will help inform other facilities serving the American Indian population.

B. The Principal Investigators & Staff

The principal investigators and their staff (a research name for those responsible for the study) are:

Margaret Severson, JD, MSW is an Associate Professor, School of Social Welfare, University of Kansas. She has extensive experience in the interface of mental health and criminal justice systems as evidenced by numerous publications. Dr. Severson's research and teaching interests are correctional mental health program development and implementation; mental health policy and practice with pre-trial detainees and sentenced prisoners; suicide prevention and crisis intervention in pre-trial detention and state correctional facilities, expert consultation in jail suicide and mental health-related litigation; legal issues impacting on professional mental health administration and practice; and mental health policy and procedure development and delivery of clinical services.

Christine Duclos, PhD, MPH is an Assistant Professor, Department of Family Medicine, and a Research Associate with the Center on Studies in Family Medicine at the University of Colorado Health Sciences Center (UCHSC). She is also a fellow with the Open Society's Center on Crime, Community, and Culture, and most recently with the American Academy of Family Physicians' Grant Generating Project. Dr. Duclos's research and teaching interests have focused on the mental and medical health issues of the incarcerated as well as their families for the past 18 years. As a consequence of her former work as Research Associate with UCHSC Department of Psychiatry's National Center for American Indian and Alaska Native Mental Health Research, her current work has centered on American Indian issues. This work has included consultations with numerous Tribal Nations, National Commission on Correctional Health Care (NCCHC), Denver's Juvenile Court, American Correctional Health Services Association, National Institute of Corrections, and appointment to the Department of Interior, Bureau of Indian Affairs - Law Enforcement Services, Subcommittee on Jails & Detentions.

Susanne Holtquist, a social welfare doctoral student at the University of Kansas and **Amie Staudenmaier**, Research Assistant at UCHSC's Center for Studies in Family Medicine, will assist Drs. Severson and Duclos in this project.

Detention staff that will be active in the administration of the study are **[Jail Adminstrator]**, the detention administrator (on-site oversight); **Christa Cavenah**, inmate records (quantitative data collection), and **Nancy Fleming**, mental health worker (focus group coordination).

C. Confidentiality Policy

The study and the [Anonymous] County Detention Facility has established the following policies to assure that the confidentiality of prisoners is respected and that the identity of individual participants is protected.

Computer Data Sources

Information sent to the University will have a numeric identifier. No names will be attached to any surveys or computer listings of intake rosters. All paper copies after input into data files will be locked in files. These files are only accessible to the Principal Investigators and project staff during the time of the study. After the completion of the project, two clean copies of the databases will be made available for archiving with NIJ as required by funding. Any other external access will be prohibited except with the expressed permission of the appropriate Sheriff Department officials.

Data Management

Once the surveys are completed, each questionnaire is provided with an identification number – the inmate booking number. University staff will not have access to the names of participants. The raw data with booking number is entered onto computer by contract services external to the University. Data entry personnel will not have access to any identifying information such as names. Focus group discussions will be transcribed without names identified. Focus group participants will be recruited by the facility's mental health worker, thus research staff will again have no access to names.

Intake Officers

Intake officers and jail staff will follow routine confidentiality policy and procedures of the detention facility. Any breaches of confidentiality (except as provided under Emergency Procedures) are grounds for review.

Reported Analyses of Data

Research results will be reported in several formats. A final report is required by NIJ. Articles for journals (i.e., *NIJ Research in Brief*) and conference presentations will be prepared to share the results to improve scientific investigation and service provision. In all cases, unless otherwise agreed upon, the University and Sheriff's Department will not identify the individual participants. The identification of the facility will be decided by an agreement with the Sheriff's Department.

D. RIGHTS OF RESEARCH PARTICIPANTS:

Even though we want as many of the incoming detainees to participate as possible, there are ethical guidelines to keep in mind. All research conducted must follow strict ethical guidelines to protect the rights of the research participants. The following guidelines must be followed ***by all*** to insure that the participants are not harmed by their participation in this study.

1) Respondents have the right to refuse to participate in the study.

2) Respondents have the right to withdraw from the study at any time.

3) Refusing to participate or withdrawing from the study will not affect the detainees' length of stay at the detention facility, their treatment, or their case disposition.

4) Respondents must be informed about the general purpose of the study.

"This study involves the use of questions of emotional problems you might be experiencing. The results will better help us design screening tools and policy and procedures to better take care of you."

5) Respondents must be informed about what they will be asked to do if they agree to participate in this study.

"This study asks respondents to answer a list of questions about their behaviors, emotions and various situations that they been exposed to during their life."

6) Respondents must be informed of the potential risks associated with participation in the study.

"The risks may include psychological discomfort related to discussion of topics which may be painful or bring back unpleasant memories."

7) Respondents must be informed of potential benefits with participation.

"The respondents will not benefit directly from participation in the study. However, they might be comforted to know that they took part in a study that could help this and other facilities take better care of future prisoners' needs. "

8) Respondents must be informed about confidentiality.

"All information that the respondents give will be kept confidential, with the exception of reports of intention to do harm to themselves or others, which we are required to report by law. Confidentiality means that all information the respondent shares will remain private. Respondents will remain anonymous, which means that code numbers will be on the materials instead of names. The project staff will take precautions for safe-guarding all materials."

9) Respondents must be informed about whom they can call if they have questions.

"This information is included on the SUBJECT CONSENT FORM."

10) Respondents must sign and receive a copy of the SUBJECT CONSENT FORM to indicate that they have been informed of their rights as research participants.

II. THE SURVEY DEVELOPMENT

A. Development of the Survey

The self-report survey includes many published and validated "scales" or measurements of risk factors for suicide ideation or behavior. In research, it is imperative that the precise questions asked in the survey and the resulting answers adequately and accurately capture the concepts that we want to measure. Are we measuring what we really want to measure (validity)? Also will this hold across all subjects during all times (reliability)? The process of translating ideas or concepts into questions to be asked in a survey is very complicated, time consuming, and expensive. Thus, utilizing scales developed by other researchers saves money and time. The survey contains 12 sections that measure 12 topics or "constructs." As pilot tested, the mean time to complete the survey by nine incoming detainees was approximately 20 minutes (range 15-40 minutes).

B. Areas of Questioning

The mental health survey is composed of the following instruments:

About You is the demographic section that asks questions of age, gender, etc. It also asks about their previous arrest history and experience being jailed, or hospitalized for emotional or drug/alcohol problems.

Thoughts of Hurting Yourself is the Beck Scale for Suicide Ideation (BSS). This scale is a 21-item self-report instrument that is used to detect and measure the severity of suicidal ideation in adults and adolescents. The BSS is a clinical rating instrument that has been used since 1970 for assessing suicidal ideation. The scores when developed are best regarded as indicators of *suicide risk* rather than predictors of eventual suicide in a given case.

Religious Beliefs measures to what extent that the respondent perceives themselves practicing within a particular belief system (i.e., American Indian, Christian, Jewish traditional beliefs, etc.).

Support is the Multidimensional Scale of Perceived Social Support that measures perceived social support from family, friends, and significant others. Respondents use a 7- point Likert-type scale (very strongly disagree to very strongly agree) to respond to the 12-item instrument.

Help Seeking asks if the respondent has received help from resources other than family or friends during the past 6 months for specific problems (i.e., emotional support, alcohol use or abuse, drug use or abuse, domestic violence, anger control, health problems, or housing).

Anxiety is the Beck Anxiety Inventory (BAI). The BAI consists of 21 descriptive statements of anxiety symptoms which they might be experiencing, which are rated on a 4-point Likert scale from (0) "not at all" to (3) "severely; I could barely stand it".

How You Feel is a shortened version (4-item) of the Revised UCLA Loneliness Scale. The critical items of the full version of the scale presents possible statements of how the respondent might feel in relation to being lonely. Responses are then measured by 5-point Likert scale (never to almost always).

Stress of Being in Jail scale comes from studies of Ronald Bonner and Alexander Rich on suicide ideation and stress in jail populations. It is a 10-item scale that provides statements of experiences one might experience in jail, and asks how stressful this might be for them from a 5-point Likert scale (0, no stress to 4, extreme stress).

About the Future is the Beck Hopelessness Scale (BHS), a 20-item scale for measuring the extent of perceived negative attitudes about the future. The respondent is asked if a statement describes their attitude in the past week, including the day of the survey. Answer format is Yes/No.

Suicide Experiences asks questions on family history of suicidal behavior. Questions are asked if "ever" a particular suicidal behavior happened (i.e. mother, father, etc.), and then again if it happened in the past six months.

Stress & Trauma History section is the Stressful Life Events Questionnaire. This scale is a 13-item scale that asks if particular traumatic event ever happened to the respondent.

Brief Coping Questions is the Brief COPE Inventory. This 28 –item inventory consists of 14 scales, of two items each: active coping, planning, positive referring, acceptance, humor, religion, using emotional support, using instrumental support, self-distraction, denial, venting, substance use, behavioral disengagement, and self-blame. The respondent is asked if they have been doing certain things to cope with stress in their lives (4-point Likert scale: 1, "I haven't been doing this at all to 4, I've been doing this a lot"). This scale was strategically placed at the end of the survey for its more positive aspects.

II. SURVEY ADMINISTRATION

A. Sample

You will be asking ***all*** persons (male and female) over the age of 18 being booked if they would be willing to participate in the survey – even if a repeat booking and the person has filled out a survey before. We are evaluating the current screening instruments and procedures, and since the facility's normal screening policy is to again screen "repeats," we also need to resurvey. A "full sample" does not bias the data that we receive by time and day of booking. We will continue this procedure until we have sufficient number of positive consents and completed surveys. We anticipate that we need approximately 800 positive consents which yields 800 surveys. We need this number to provide us with enough statistical "power" for us to make appropriate statistical conclusions. Please continue the survey process until you hear that you can stop from Detention Administration.

It is very important to document if the person answered "no" or "yes. Write across the consent refused or other reason why not participating. We will be keeping track of all intakes and whether they participate or not.

B. Your Role

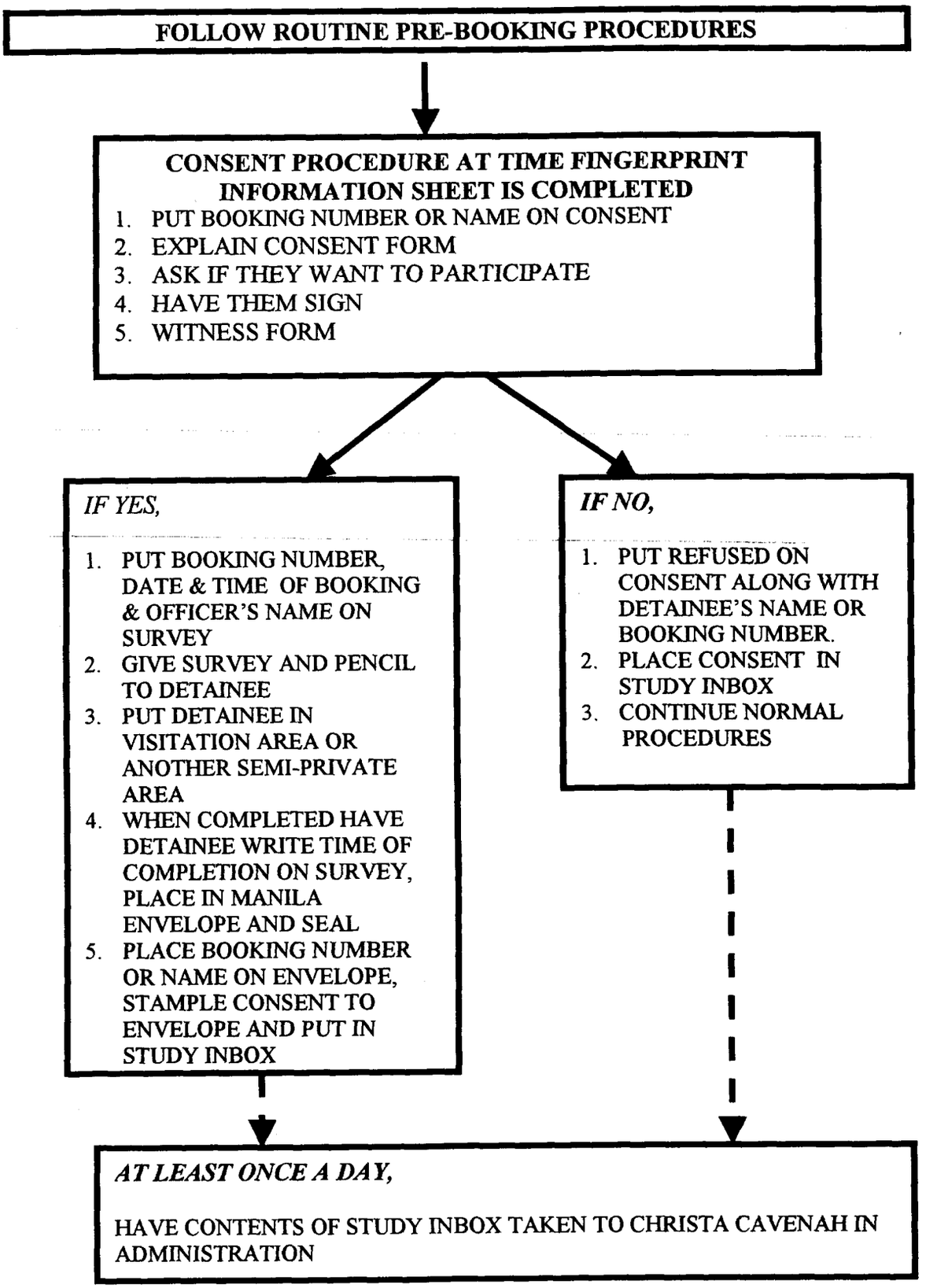
Most people prefer answering questions in a self-report booklet form rather than answering questions face-to-face with an interviewer. Additionally, some of the questions are very sensitive, and thus, are easier to answer in self-report format. For this reason, the survey booklet is provided.

Please begin normal routine pre-booking procedures. After these are completed and the detainee is brought into booking area and the fingerprint information sheet is completed, you will ask if they want to participate in a study that the jail is doing to assess the current booking procedures.

Your role "in a nutshell" for the survey process is as follows: 1) put booking number if available on consent otherwise in pencil write detainee name, 2) explain and obtain consent/refusal, 3) (if yes) put booking number if available on survey and manila envelope, hand out survey and pencil, 4) if the booking number is not available, fill out booking time and date and officer's name, and 5) when completed write in time of completion on survey, hand inmate manila envelope, have him/her place completed survey in manila envelope and seal, 6) on envelope write booking number and/or inmate's name and paperclip or staple consent to it, and 7) place in burgundy project inbox and Christa Cavenah will collect at least once a day.

WE WILL NEED A CONSENT/REFUSAL FORM WITH BOOKING NUMBERS FOR ALL INCOMING DETAINEES!!!! PLEASE REMEMBER TO PUT THE PERSON'S BOOKING NUMBER ON A CONSENT FORM, SURVEY, AND ENVELOPE!!!

THE SURVEY PROCESS AT INTAKE



B. Techniques for Obtaining Consent

A consent form must be obtained from each participant ***before*** they fill out the booklet.

Explaining the Consent:

The following items should be ***emphasized*** when obtaining the consent:

1) Explain the project and purpose.

   "The University of Colorado and The University of Kansas are doing a survey of emotional problems that incoming people you might be experiencing (for example, stress, depression, etc.). The results will better help us design screening tools and policy and procedures to better take care of future detainees. I'd like to explain this consent form, and they you have the option to participant in the study."

2) All people being booked into the detention facility are being asked to participate. They are not being singled out.

3) There are no benefits other than feeling good that they have participated in a project that will make things better in the future for people coming into the facility.

4) If during or after the survey, they feel any emotional discomfort from the survey, the jail has mental health staff they can talk with.

5) All information provided will be kept confidential with the exceptions of reports to harm him/herself or others, which by law the study personnel are required to report. Information that the researchers get will only have booking numbers, ***no names.*** Researchers do not have access to the booking lists that have names attached.

6) Their participation will no affect their case disposition or care that they receive within the facility.

7) Participation is ***strictly*** voluntary. Even after signing the consent, the person can terminate their participation at any time.

8) They may choose not to answer certain questions.

9) There are two parts to the consent: consent to participate and consent for release of information in the records by booking number.

Techniques for Obtaining Consent

Your relationship with the person on intake is very important. In the crucial first minutes you must convince the person that the routine screening information that you gather is to better take care of them. Next, you must ask them about a research project. ***Remember this also is to better take care of them and future detainees, in the process making your job easier.***

You want to convince them that this is an important and worthwhile project, and their participation is vital to the research success. You and your words must convey your credibility. You should be serious, pleasant, and self-confident, that you, yourself, believe this is important.

You should be prepared to answer in a calm, professional manner, any questions the subject might ask. In order to do this you must learn as much about the study as you can and write out your explanations in your own words. This serves to focus your thoughts and reinforce your confidence. You should have several different explanations and approaches ready so as to adjust your introduction to suit the person you are talking to. Approach each person as if s/he were friendly and interested. You should assume that if they aren't, it is because they are not yet informed about what we are doing. Listen carefully to what they have to say, the tone of their voice, any background noises, and respond accordingly. Some subjects will be quite willing to participate with only a brief explanation of purpose; for others you will need to go into some detail. It is best to begin with a brief explanation and save your more detailed explanation to use as needed. Don't overwhelm the person with more information than they want or need. Talk to them, not at them. If they believe you are really interested in what they have to say, they are more likely to participate.

Your state of mind is often reflected in your respondent's reaction. If your approach is uncertain or uneasy, this feeling will be communicated to the respondent who will react accordingly. If you have a pleasant, positive, and well-informed approach, this again will be reflected in the respondent's attitude. Your effectiveness will be increased by the knowledge that survey research is legitimate and important.

Refusal Conversion
REFUSAL CONVERSION:{tc \l 3 "**REFUSAL CONVERSION**:"}
Persuasion techniques are important in order to avoid refusals.

1) Be confident - take pride of the facility's participation in this study and your association with both Universities as well as a one-of-a-kind National Institute of Justice study.

2) Have a very smooth introduction; do not pause or hesitate.

   a. Know all about the study you are working on and be ready to answer all questions.
   b. START simply - the person you are speaking with will ask for more information if they want it.
   c. SLOW DOWN - and use words in your explanations that are easily understood.

3) Listen carefully - you cannot respond to people's reaction to you if you don't listen carefully to inflections in their voices; and feedback they give you while you are answering their questions.

4) Be so well prepared that there is nothing the respondent can say that will surprise you. You must offer a solution to any excuse or concern.

5) Try not to push a refusal - leave the door open or take a refusal and ask again while they remaining in booking.

6) Increase your knowledge of the survey in order to build your self confidence.

7) Anticipate common subject comments and questions, and write out explanations in your own words.

Rights and Responsibilities/Confidentiality

Confidentiality means that information is not shared outside the setting where it was obtained; it is kept secret or private. There are several types of confidentiality involved with this study.

1) Employee/Researcher confidentiality means that personal information will not be shared outside the project staff.

2) Respondent confidentiality means that we will not reveal the names of the detainees who participated in the study. Actually the researchers will have only booking numbers and not have names available to them. When they share the results of the study with others, no individual's responses can be identified. It also means that the researchers at the University will not discuss any personal information that they learn during the course of any survey with anyone including detention staff except where they might be required by law if you reveal plans to hurt others. Please see the section Confidentiality Policy for other ways that we will protect the information we collect.

3) Community confidentiality means that we safeguard the identity of the specific setting in which this research takes place unless agreed upon with appropriate persons

when talking or writing about the results in public forums. When referencing the setting, research staff can say a County Detention Facility located in the "Northern Plains".

4) Exceptions to confidentiality occur when someone may be dangerous to himself/herself or others. However, research staff will not receive the surveys until almost a week after the survey is completed and then not analyzed for months later. There will be weekly mailings of the survey to the University. Thus, this process can prolong any reporting.

5) Survey Confidentiality means that the survey materials that we will be using are not to be shared with anyone except research staff. It is important to let respondents in the study know what the study is about and the nature of the questions we will be asking (see Rights of Research Participants). However, we will not show individual survey materials to people outside of the study. These materials are tools for research that are only to be used by people who have been trained to administer them. Always keep the completed surveys in a safe place.

C. When to Delay the Survey

This issue is pretty simple. ***Delay the survey process anytime that you would delay the booking screening process***: combative situations or when the person during intake is too intoxicated, mentally, or physically impaired to doing the regular booking screening procedures. Wait the normal amount of time that you would attempt to complete screening, and after screening, offer their participation in the survey process.

Once consent is given, if an inmate is identified as being unable to read the survey, forward the completed consent and the survey to Nancy Fleming, the mental health worker who will then administer the survey.

There are only two times when not to ask detainees to participate: 1) If they are under the age of 18. Please mark the consent form of this, and 2) If you are unable to obtain a signed consent. Again please mark their consent form "refused."

D. When to Make A Referral

During the survey, some questions may bring back painful memories or stir up emotions. We do not expect this to happen very often. However, we need to be aware that this is a possibility. If the situation arises, use your normal mental health referral policy and procedure. Any time a respondent becomes emotional, you should suggest ask if they need help. The respondent can then decide if they would like to be referred

or not to mental health. Since we also need to be made aware of this, please make documentation of this, and have a copy sent to Christa Cavenah who will forward to us.

If a person does not request a mental health referral but seems upset, a special watch is indicated, and let the supervisor and mental health worker know.

For any situation that makes you uncomfortable or seems out of the ordinary, please contact your supervisor who will in turn then contact [Jail Adminstrator].

IV. DETENTION ADMINISTRATION

A. Intake Information

Weekly, Christa will print out intake information by booking number. This information should include **all** those that have been booked into the detention facility during that last week or reporting period. We have developed a database in which we will track all intakes to make sure everyone that is eligible has been asked to participate. Since the booking process has a consecutive numbering system, tracking will be made easier. Additional information to be pulled off the computer for **each** individual includes:

Booking #
Master ID #
Booking Date
Time of Booking
Ethnicity
Gender
Charges
If charges were alcohol-related
If the person agreed to fill out a survey

Additionally, **copies** of the *New York Suicide Screening Form* and your regular computer *health and mental health screening* be copied for each intake – ***names must be blacked out on all information, and appropriate booking numbers attached.***

B. Mailing to University of Kansas

Weekly, Christa or whoever she designates, will mail this information, plus all completed surveys and consents/refusals to the University of Kansas. **We should have a consent/refusal, survey in manila envelope if appropriate, and additional booking information on everyone that is included in the weekly computer roster.**

This information should be send overnight using the Federal Express forms provided. ***Please mark on the form, that signature is required for delivery***. It is extremely important to treat this data like gold, tracking is very important. We do not want to lose any valuable data. It might be best to keep a shipping log by date of all information by booking numbers to make tracking easier.

ADDRESS: Margaret Severson/Susanne Holtquist
University of Kansas, School of Social Welfare
303 Twente Hall
Lawrence, KS 66045-2510

Remember that the information contained in these documents is **confidential**. Be sure these documents are not accessible to anyone but project staff.

C. Questions & Contact Information

Please do not hesitate to call either Drs. Severson or Duclos, or their assistants for anything!

Margaret Severson	785-864-4720 (w) 785- 749-5272 (h)	Chris Duclos	303-315-9700 (w) 303-399-8315 (h)
Susanne Holtquist	785-864-9026 (w) 785-838-4312 (h)	Amie Staudenmaier	303-315-9700 (w) 303-873-6517 (h)

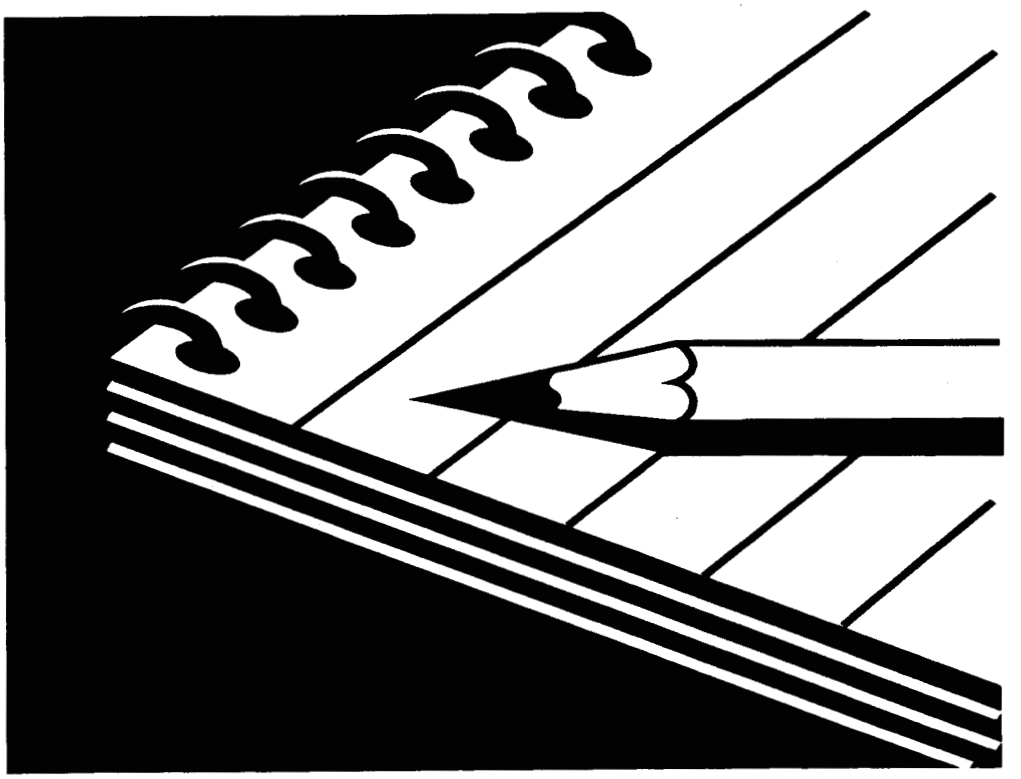
Appendix B 2: Consent Forms for Mental Health Survey

ID # _____
*Officer*_____

Booking Time and Date _____
*Time and Date When Completed*_____

[ANONYMOUS] COUNTY DETENTION FACILITY

MENTAL HEALTH SURVEY



*ID #*_____ *Booking Time and Date*_____
*Officer*_____ *Time and Date WhenCompleted*_____

The following pages contain questions about yourself and your experiences in the past as well as in the present. The answers you give will be kept ***confidential***. Your name will not be on the survey so no one in the community will know your answers. Please answer each question honestly. Sometimes it may be hard to pick the best answer. It may seem that none are exactly the way you feel or sometimes more than one answer may seem to apply. Please choose ***only one answer*** unless the directions indicate otherwise. If none of the answers seem right, choose the one that is closest to how you feel. If you have any questions that you are uncomfortable answering, write a "U" next to the question number and leave the question blank. If you don't understand a question, please let an officer know so that he/she may assist you.

Your help is VERY IMPORTANT to us. Thank you for your participation.

ABOUT YOU

1. What is your age? _____

2. Are you? O Male
   O Female

3. Check (4) the group that best describes you?

   O White
   O Black
   O Hispanic or Spanish
   O American Indian
   Tribal Affiliation_____
   O Asian
   O Pacific Islander
   O Other

4. Please check (4) which of the following best describes your current marital status. Are you...

   O Married
   O Not married but living with a partner
   O Widowed
   O Divorced or separated or
   O Never married

5. How many children do you have? _____

   How many children live with you? _____

   How many individuals live in your household? _____

6. Are you currently…

   - O employed full-time or part-time
   - O self-employed
   - O student
   - O retired
   - O disabled
   - O temporarily unemployed
   - O not looking for paid employment
   - O other

7. Where do you live?

   - O in [City]
   - O another area/town in South Dakota
   - O on a reservation, which one_____
   - O out-of-state, where_____
   - O homeless

   How many times have you changed addresses in the last year? _____

8. How many years of school have you completed? Circle the years completed.

Elementary Through High School												*College*				*Graduate*				
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**more**

9. Is this your first time that you have been arrested?

   - O No
   - O Yes

   Is this your first time in jail?

   - O No
   - O Yes

   If No,

   How many times other than this time have you been in arrested? _____

   How many times other than this time have you been in jail? _____

10. Have you ever been hospitalized for an emotional problem?

O No
O Yes

Have you ever been hospitalized or in inpatient treatment for an alcohol problem?

O No
O Yes

Have you ever been hospitalized or in inpatient treatment for a drug problem?

O No
O Yes

THOUGHTS ABOUT YOURSELF

Please carefully read each group of statements below. Circle the statement in each *group* that best describes how you have been feeling for the past week, including today. Be sure to read all of the statements in each group before making a choice. ***Remember this is for the past week, including today.***

Part 1

1. O I have moderate to strong wish to live.

   O I have a weak wish to live.

   O I have no wish to live.

2. O I have no wish to die.

   O I have a weak wish to die.

   O I have a moderate to strong wish to die.

3. O My reasons for living outweigh my reasons for dying.

   O My reasons for living or dying are about equal.

   O My reasons for dying outweigh my reasons for living.

4. O I have no desire to kill myself.

O I have a weak desire to kill myself.

O I have a moderate to strong desire to kill myself.

5. O I would try to save my life if I found myself in a life-threatening situation.

O I would take a chance on life or death if I found myself in a life-threatening situation.

O I would not take the steps necessary to avoid death if I found myself in a life-threatening situation.

⇒*NOTE:* **IF YOU MARKED THE FIRST STATEMENT IN GROUP 4 OR 5 ABOVE, THEN SKIP TO GROUP NUMBERED 20.**

Part Two

6. O I have brief periods of thinking about killing myself which pass quickly.

O I have periods of thinking about killing myself which last for moderate amounts of time.

O I have long periods of thinking about killing myself.

7. O I rarely or only occasionally think about killing myself.

O I have frequently thoughts about killing myself.

O I continuously think about killing myself.

8. O I do not accept the idea of killing myself.

O I neither accept nor reject the ideal of killing myself.

O I accept the idea of killing myself.

9. O I can keep myself from committing suicide.

O I am unsure that I can keep myself from committing suicide.

O I cannot keep myself from committing suicide.

10.

○ I would not kill myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.

○ I am somewhat concerned about killing myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.

○ I am not or only a little concerned about killing myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.

11.

○ My reasons for wanting to commit suicide are primarily aimed at influencing other people, such as getting even with people, making people happier, making people pay attention to me, etc.

○ My reasons for wanting to commit suicide are not only aimed at influencing other people, but also represent a way of solving my problems.

○ My reasons for wanting to commit suicide are primarily based upon escaping from my problems.

12.

○ I have no specific plan about how to kill myself.

○ I have considered ways of killing myself, but have not worked out the details.

○ I have a specific plan for killing myself.

13.

○ I do not have access to a method or an opportunity to kill myself.

○ The method that I would use for committing suicide takes time, and I really do not have a good opportunity to use this method.

○ I have access or anticipate having access to the method that I would choose for killing myself and also have or shall have the opportunity to use it.

14.

○ I do not have the courage or the ability to commit suicide.

○ I am unsure that I have the courage or the ability to commit suicide.

○ I have the courage and the ability to commit suicide.

15.

O I do not expect to make a suicide attempt.

O I am unsure that I shall make a suicide attempt.

O I am sure that I shall make a suicide attempt.

16.

O I have made no preparations for committing suicide.

O I have made some preparations for committing suicide.

O I have almost finished or completed my preparations for committing suicide.

17.

O I have not written a suicide note.

O I have thought about writing a suicide note or started to write one, but have not completed it.

O I have completed a suicide note.

18.

O I have made no arrangements for what will happen after I have committed suicide.

O I have thought about making some arrangements for what will happen after I have committed suicide.

O I made definite arrangements for what will happen after I have committed suicide.

19.

O I have not hidden my desire to kill myself from people.

O I have held back telling people about wanting to commit suicide.

O I have attempted to hide, conceal, or lie about wanting to commit suicide.

20.

O I have never attempted suicide.

O I have attempted suicide once.

O I have attempted suicide two or more times.

⇒ **NOTE: IF YOU PREVIOUSLY ATTEMPTED SUICIDE, PLEASE CONTINUE WITH THE NEXT STATEMENT GROUP. IF YOU HAVE *NOT* SKIP TO THE NEXT SECTION - Religious Beliefs**

21. ○ My wish to die during the last suicide attempt was low.

ρ My wish to die during the last suicide attempt was moderate.

ρ My wish to die during the last suicide attempt was high.

RELIGIOUS BELIEFS

We would now like to ask you some quick questions about what belief system you practice.

1. To what extent do you practice or follow the religious or spiritual beliefs of,

(a) Traditional Indian Beliefs (e.g., Lakota, Navajo, etc.)

○ Never
○ Rarely
○ Sometimes
○ A lot

(b) Christian Beliefs

○ Never
○ Rarely
○ Sometimes
○ A lot

(c) Jewish Beliefs

○ Never
○ Rarely
○ Sometimes
○ A lot

(d) Other Beliefs _____

○ Never
○ Rarely
○ Sometimes
○ A lot

SUPPORT

Please tell us whether these statements are true or false about the support you might get from the people around you. **Circle the number that best describes your own experience.**

0 = Very strongly disagree
1 = Strongly disagree
2 = Disagree
3 = Neither disagree or agree
4 = Agree
5 = Strongly agree
6 = Very strongly agree

1. There is a special person who is around when I am in need.	0	1	2	3	4	5	6
2. There is a special person with whom I can share my joys and sorrows.	0	1	2	3	4	5	6
3. My family really tries to help me.	0	1	2	3	4	5	6
4. I get the emotional help and support I need from my family.	0	1	2	3	4	5	6
5. I have a special person who is a real source of comfort to me.	0	1	2	3	4	5	6
6. My friends really try to help me.	0	1	2	3	4	5	6
7. I can count on my friends when things go wrong.	0	1	2	3	4	5	6
8. I can talk about my problems with my family.	0	1	2	3	4	5	6
9. I have friends with whom I can share my joys and sorrows.	0	1	2	3	4	5	6
10. There is a special person in my life who cares my feelings.	0	1	2	3	4	5	6
11. My family is willing to help me make decisions.	0	1	2	3	4	5	6
12. I can talk about my problems with my friends.	0	1	2	3	4	5	6

HELP SEEKING

In the **past 6 months**, have you gotten help from resources **other than friends or family** for the following services? (Please circle yes or no for each category)

	No (0)	*Yes (1)*
1. Emotional support or counseling	N	Y
2. Alcohol use or abuse	N	Y
3. Drug use or abuse	N	Y
4. Domestic Violence	N	Y
5. Anger Control	N	Y
6. Health problems	N	Y
7. Housing	N	Y

ANXIETY

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the **past week, including today**, by checking (4) the appropriate box next to each symptom.

	Not At All	**Mildly** *It did not bother me much.*	**Moderately** *It was very unpleasant, but I could stand it.*	**Severely** *I could barely stand it.*
1. Numbness or tingling	○	○	○	○
2. Feeling hot	○	○	○	○
3. Wobbliness in legs	○	○	○	○
4. Unable to relax	○	○	○	○
5. Fear of the worst Happening	○	○	○	○

	Not At All	Mildly *It did not bother me much.*	Moderately *It was very unpleasant, but I could stand it.*	Severely *I could barely stand it.*
6. Dizzy or lightheaded	○	○	○	○
7. Heart pounding or Racing	○	○	○	○
8. Unsteady	○	○	○	○
9. Terrified	○	○	○	○
10. Nervous	○	○	○	○
11. Feelings of choking	○	○	○	○
12. Hands trembling	○	○	○	○
13. Shaky	○	○	○	○
14. Fear of losing control	○	○	○	○
15. Difficulty breathing	○	○	○	○
16. Fear of dying	○	○	○	○
17. Scared	○	○	○	○
18. Indigestion or discomfort in abdomen	○	○	○	○
19. Faint	○	○	○	○
20. Face flushed	○	○	○	○
21. Sweating (not due to heat)	○	○	○	○

HOW YOU FEEL

Indicate how often you feel the way described in each of the following statement by checking (4) the appropriate box.

1. I feel in tune with the people around me.

   - ○ Never
   - ○ Rarely
   - ○ Sometimes
   - ○ Often
   - ○ Almost Always

2. No one really knows me well.

   - ○ Never
   - ○ Rarely
   - ○ Sometimes
   - ○ Often
   - ○ Almost Always

3. I can find companionship when I want it.

   - ○ Never
   - ○ Rarely
   - ○ Sometimes
   - ○ Often
   - ○ Almost Always

4. People are around me but not with me.

   - ○ Never
   - ○ Rarely
   - ○ Sometimes
   - ○ Often
   - ○ Almost Always

STRESS OF BEING IN JAIL

Spending time in jail has been considered a HIGH STRESS time. Think about how much stress and pressure you feel about being locked up today, then please indicate the amount of stress/pressure you are currently feeling.

0 = No Stress
1 = A Little Stress
2 = Some Stress
3 = High Stress
4 = Extreme Stress

1. Having to be locked up in jail. _____
2. Having to live with others in jail. _____
3. Being separated from family and friends while in jail. _____
4. Not knowing when you will get out or how much time you will do. _____
5. Being concerned about your safety in jail. _____
6. Having no support or place to go once you are released. _____
7. Feeling guilty about your charges as if you have let yourself or others down by being in jail. _____
8. Concerned that you might have to do some prison time. _____
9. Having family or friends reject you because of being in jail. _____
10. Being concerned about your health while in jail _____

ABOUT THE FUTURE

This section consists of 20 statements. Please read the statements carefully one by one. If the statement describes your attitude for the **past week including today**, check (4) the **True** box in the column next to the statement. If the statement does not describe your attitude, check (4) the **False** box in the column next to this statement. **Please be sure to read each statement carefully.**

	True	False
1. I look forward to the future with hope and enthusiasm.	O	O
2. I might as well give up because there is nothing I can do about making things better for myself.	O	O
3. When things are going badly, I am helped by knowing that they cannot stay that way forever.	O	O
4. I can't imagine what my life would be like in ten years.	O	O
5. I have enough time to accomplish the things I want to do.	O	O
6. In the future, I expect to succeed in what concerns me most.	O	O
7. My future seems dark to me.	O	O
8. I happen to be particularly lucky, and I expect to get more of the good things in life than the average person.	O	O
9. I just can't get the breaks, and there's no reason I will in the future.	O	O
10. My past experiences have prepared me well for the future.	O	O
11. All I can see ahead of me is unpleasantness rather than pleasantness.	O	O
12. I don't expect to get what I really want.	O	O
13. When I look ahead to the future, I expect that I will be happier than I am now.	O	O
14. Things just won't work out the way I want them to.	O	O
15. I have great faith in the future.	O	O
16. I never get what I want, so it's foolish to want anything.	O	O

	True	False
17. It's very unlikely that I will get any real satisfaction in the future.	O	O
18. The future seems vague and uncertain to me.	O	O
19. I can look forward to more good times than bad times.	O	O
20. There's no use in really trying to get anything I want because I probably won't get it.	O	O

SUICIDE EXPERIENCES

1. Have any of the following people attempted suicide and ***survived?***

Check (4) the "No" or "Yes" box for each person
1) If they ever attempted suicide, and
2) If they attempted suicide in the past 6 months.

	Ever		In The Past 6 Months	
	No	Yes	No	Yes
a. Mother	O	O	O	O
b. Father	O	O	O	O
c. Sister or Brother	O	O	O	O
d. Grandparent	O	O	O	O
e. Stepparent	O	O	O	O
f. Other Relative	O	O	O	O
g. Friend	O	O	O	O

For the following, check (4) the "Yes" box if that person *EVER* committed suicide and did not survive or "No" if that did not happen.

2. Your mother committed suicide:

O No
O Yes

3. Your father committed suicide:

O No
O Yes

4. Your sister or brother committed suicide:

O No
O Yes

5. Your grandmother or grandfather committed suicide:

O No
O Yes

6. Your aunt or uncle committed suicide:

O No
O Yes

7. Other relative committed suicide:

O No
O Yes

8. Friend committed suicide:

O No
O Yes

STRESS & TRAUMA HISTORY

The following is a series of questions about serious stress or traumatic life events. These types of events actually happen a lot and they affect how people feel about, react to, and/or think about things afterwards. Knowing about the occurrence of such events, and reactions to them, will help us to develop programs for intervention, education, and other services. For each event, please check whether this ever happened to you at any time during your life.

1. Have you ever had a life-threatening illness?

   O No
   O Yes

2. Were you ever in a life-threatening accident?

   O No
   O Yes

3. Was physical force or a weapon ever used against you in a robbery or mugging?

   O No
   O Yes

4. Has an immediate family member, romantic partner or very close friend died as a result of an accident?

   O No
   O Yes

5. When you were a child or more recently, did anyone (parent, other family member, romantic partner, stranger or someone else) ever succeed in physically forcing you to have intercourse, or oral or anal sex against your wishes or when you were in some way helpless?

   O No
   O Yes

6. Other than experiences mentioned in item 5, has anyone ever used physical force or threat to TRY to make you have intercourse, oral or anal sex, against your wishes or when you were in some way helpless?

   O No
   O Yes

7. Other than experiences mentioned in items 5-6, has anyone ever actually touched private parts of your body or made you touch theirs against your wishes, or when you were in some way helpless?

O No
O Yes

8. When you were a child, did a parent, caregiver or other person ever slap you repeatedly, beat or otherwise attack you or harm you?

O No
O Yes

9. Other than experiences mentioned in item 8, have you ever been kicked, beaten, slapped around or otherwise physically harmed by a romantic partner, date, sibling, family member, stranger or someone else?

O No
O Yes

~~9. Other than the experiences already covered, has anyone ever threatened you with a~~ weapon such as a knife or gun?

O No
O Yes

10. Have you ever been present when another person was killed, seriously injured, or sexually or physically assaulted?

O No
O Yes

11. Have you ever been in any other situation where you were seriously injured or your life was in danger (e.g. involved in military combat, living in a war zone, held at gun point)?

O No
O Yes

12. Have you ever been in any other situation that was extremely frightening or horrifying that has not been covered above?

O No
O Yes

If yes, please explain_____

LAST SECTION – ALMOST DONE!

BRIEF COPING QUESTIONS

These items deal with ways you've been coping with the stress in your life. There are many ways to try to deal with problems. These items ask what you've been doing to cope. Obviously, different people deal with things in different ways, but we're interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not – just whether or not you're doing it. Try to rate each item separately in your mind from the others. Circle your answers. Make your answers as true FOR YOU as you can.

---

1. I've been turning to work or other activities to take my mind off things.

   1 = I haven't been doing this at all
   2 = I've been doing this a bit
   3 = I've been doing this a medium amount
   4 = I've been doing this a lot

2. I've been concentrating my efforts on doing something about the situation I'm in.

   1 = I haven't been doing this at all
   2 = I've been doing this a bit
   3 = I've been doing this a medium amount
   4 = I've been doing this a lot

3. I've been saying to myself "this isn't real."

   1 = I haven't been doing this at all
   2 = I've been doing this a bit
   3 = I've been doing this a medium amount
   4 = I've been doing this a lot

4. I've been using alcohol or other drugs to make myself feel better.

   1 = I haven't been doing this at all
   2 = I've been doing this a bit
   3 = I've been doing this a medium amount
   4 = I've been doing this a lot

5. I've been getting emotional support from others.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

6. I've been giving up trying to deal with it.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

7. I've been taking action to try to make the situation better.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

8. I've been refusing to believe that it has happened.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

9. I've been saying things to let my unpleasant feelings escape.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

10. I've been getting help and advice from other people.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

11. I've been using alcohol or other drugs to help me get through it.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

12. I've been trying to see it in a different light, to make it seem more positive.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

13. I've been criticizing myself.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

14. I've been trying to come up with a strategy about what to do.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

15. I've been getting comfort and understanding from someone.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

16. I've been giving up the attempt to cope.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

17. I've been looking for something good in what is happening.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

18. I've been making jokes about it.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

20. I've been accepting the reality of the fact that it has happened.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

21. I've been expressing my negative feelings.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

22. I've been trying to find comfort in my religion or spiritual beliefs.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

23. I've been trying to get advice or help from other people about what to do.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

24. I've been learning to live with it.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

25. I've been thinking hard about what steps to take.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

26. I've been blaming myself for things that happened.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

27. I've been praying or meditating.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

28. I've been making fun of situations.

1 = I haven't been doing this at all
2 = I've been doing this a bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

YOU ARE FINISHED!

Please put this booklet in an envelope and seal it and return the envelope to the officer.

Thank you for your participation!

NYSPSG Form

B-4

SUICIDE PREVENTION SCREENING GUIDELINES

DETAINEES NAME:	SEX	DATE OF BIRTH	MOST SERIOUS CHARGE(S)	DATE	TIME

ARRESTING OR TRANSPORTING OFFICER	NAME OF SCREENING OFFICER	Detainee showed serious psychiatric problems during prior incarceration Yes No

Check appropriate column for each question

	Column A YES	Column B NO	GENERAL COMMENTS/OBSERVATIONS
OBSERVATIONS OF TRANSPORTING OFFICER 1. Arresting or transporting officer believes that detainee may be a suicide risk. If YES, notifiy Shift Supervisor			
PERSONAL DATA 2. Detainee lacks close family or friends in the community	No family or friends		
3. Detainee has experienced a significant loss within the last six months (e.g. loss of job, loss of relationship, death of close family member)			
4. Detainee is very worried about major problems other than legal situation (e.g. serious financial or family problems, a medical condition, or fear of losing job)			
5. Detainee's family or significant other (spouse, parent, close friend, lover) has attempted or committed suicide			
6. Detainee has psychiatric history (Note current psychotropic medications and name of most recent treatment agency)			
7. Detainee has history of drug or alcohol abuse			
8. Detainee holds position of respect in community (e.g. professional, public official) and/or alleged crime is shocking in nature. If YES, notify Shift Supervisor			
9. Detainee is thinking about killing himself. If YES, notify Shift Supervisor			
10. Detainee has previous suicide attempt (Check wrists and note method)			
11. Detainee feels that there is nothing to look forward to in the future (expresses feelings of helplessness or hopelessness) If YES, to 10 and 11, notify Shift Supervisor	Nothing to look forward to		
BEHAVIOR/APPEARANCE 12. Detainee shows signs of depression (e.g. crying, emotional flatness)			
13. Detainee appears overly anxious, afraid, or angry			
14. Detainee appears to feel unusually embarrassed or ashamed			
15. Detainee is acting and/or talking in a strange manner (e.g. cannot focus attention, hearing or seeing things which are not there)			
16. A. Detainee is apparently under the influence of alcohol or drugs			
B. If YES, is detainee incoherent, or showing signs of withdrawal or mental illness? If YES to both A&B notify Shift Supervisor			
CRIMINAL HISTORY 17. This is detainee's first arrest			

TOTAL Column A _____

ACTION

If total checks in Column A are 8 or more, notify Shift Supervisor

Shift Supervisor notified: Yes_____ No_____

Supervision Instituted: Routine_____ Active_____ Constant_____

Detainee Referred to Medical/Mental Health:

Yes_____ No_____

	EMERGENCY	NON-EMERGENCY
If Yes:		
	medical_____	medical_____
	mental health_____	mental health_____

Medical/Mental Health Personnel Actions (To be completed by medical/MH staff)

Appendix B 5: Focus Group Consent Form

Appendix B 6: Focus Group Guide/Questions

Focus Group Questions Concerning Current Screening Instrument

Introductions. We are studying the suicide prevention procedures of the jail and want to be able to make suggestions on making them better. We've asked to speak to a group of detainees about their viewpoints on these issues. To day we want to discuss the current suicide screening form that the booking officers use when you first come in. We will go through this form question by question to ask you such things as how was this asked of you, did you understand the officer's question, did you find any trouble answering it, etc. We want you to feel free to join in the discussion. Your help will improve how things are done here. First we need to get your consent that you are willing to be in this group and will help us. Let me go over the consent form before you sign it.

Now I'll ask you the first question?

(1) Using the form, the officer asks a question about if you have or do not have close friends/family in the community.

a) The officer was trying to get at this information. How did the officer ask you this question?
b) Was it easy for you to answer?
c) Is there a better way to ask you for this information?

(2) Detainee has experienced a significant loss within the last six months. (Job, death, close family member, etc.)

a) Did you understand the question the officer asked?
b) Was it easy for your to answer?
c) If you had experienced a significant loss, would you have told this officer? Why or why not?
d) If the loss was a death, job, or a relationship, would any of these events make you respond differently?

(3) Detainee is very worried about major problems other than legal situation such as family situation, medical condition, fear of losing job.

a) Same as #2

(4) Detainee's family or significant other has attempted or committed suicide?

a) Did you understand the question the officer asked?
b) Was it easy for you to answer this a question? If not, why?
c) What is a better way to ask this question that might be more appropriate and respectful?

(5) Detainee has psychiatric history. Medications? Treatment agency?

a) How was this question asked of you?
b) Did you understand when the officer asked you these questions?
c) Were these questions easy for you to answer?
d) Do you think this is information the officer needs to know about you?

(6) Detainee has history of drug or alcohol use?

a) Did you understand the question the officer asked?
b) How was this question asked?
c) Was this question easy for you to answer?
d) Do you think this is information the officer needs to know about you?

(7) Detainee holds position of respect in the community? E.g. professional, public official, crime of shocking nature.

a) How was this question asked of you?
b) Did you understand it?
c) When we say community, what does that mean to you?
d) Are there particular crimes that your community/family would find shocking?
e) What would you consider to be a shocking crime?

(8) Detainee is thinking about killing himself.

a) How was this question asked?
b) Did you understand the question?
c) Would you have answered the question? If no, why?
d) Is there better way to get this information?

(9) Detainee has previous suicide attempts?

a) How was this question asked?
b) Did the officer check your wrists for scars
c) Did the officer ask you for details?
d) If you had a previous attempt, would you be likely to tell the officer? Why?

(10) Detainee feels that there is nothing to look forward to in the future? Hopelessness, depression.

a) How was this question asked?
b) Did you understand the question?
c) Is looking forward to the future important to you?
d) Describe someone who has hope and someone who does not have hope.
e) Describe someone who is helpless and someone who is not helpless.

11) What was your biggest worry coming when you were booked into the jail?

Filler Questions

(1) Unless there was some physical reason you could not answer when you were first brought in, these questions were asked right away. What did you think of that timing? If they were asked at a different time, would you have been more open or less open to answering them? Why?

(2) Whether in jail or not, what is it like for you to be asked about suicide? What mind set does this put you in? Is it easier to talk about suicide in general than about your own experience with suicide?

(3) Do you know why the jail staff ask you these questions?

(4) What do you think of this procedure?

(5) If you were going to improve this screening process so that the officers could get the information they need to help keep you safe while in jail, what would you do?

Possible additional questions (need more focus group time):

a) How do you know when someone is depressed?
b) Without asking, how would you know if someone is depressed?
c) How can you tell if someone is angry? Anxious? Fearful?
Would this be different if a male? If a female?

Appendix B 7: Qualitative Data Analyses and Report

RESULTS OF FOCUS GROUP DATA

Qualitative methods make it possible to uncover many "untold stories" concerning issues under study. Revealing this perspective can eventually lead to clearer understanding of the complex social interactions underlying behavior such as suicide and deviancy. This section of this research describes the qualitative portion of the multimethod study of assessment of suicide ideation in a county jail facility located near several American Indian reservations. It outlines the methods that were used and the results and discussion of the analysis. The purpose of this section of the report is to extend the current knowledge gained through the quantitative analysis of suicidal ideation and behavioral assessment among Northern Plains American Indians detainees, by integrating with that knowledge the inmate perspective and related contextual factors.

Background

Because of the researchers' interest in generating information that would yield clear meaning about cultural and social influences, naturalistic inquiry was chosen[1]. This form of inquiry considers all aspects of reality interrelated; it is not possible to isolate one aspect from its context without altering its meaning.[2] This method also assumes that there is not a single reality, but multiple realities of which we, as observers, must be aware. *Participatory inquiry,* sensitive to the role of participants, is also fundamental. [3] We have emphasized doing this project *with* the people involved in order to produce knowledge and action directly useful to the group (improvement in quality). The participants were expected to participate not only as objects to be studied, but also with real influence in the processes and outcomes. The goal of the qualitative portion of the study was to attempt to culturally validate the current screening assessment tool and procedures for Northern Plains Indians. It was anticipated that the results would inform the process of developing, if indicated, more culturally appropriate procedures for use with this special population.

Answers to two specific questions were sought: 1) "Are current screening techniques culturally appropriate or acceptable for this special population?" and 2) "Are there "culture-specific experiences that can better inform the assessment process?" (The answers address the original Specific Research Objectives 3 & 4). The aim was to gather information using

the structured focus group interview format that would inform developments for the clearest, most straight forward assessment of suicide ideation in this jail setting.

Screening instrument and procedure validation involves a series of steps leading to an instrument/procedure that then yields a valid measure in all or specific cultures. Flaherty et al. (1988) proposed five major dimensions in instrument cross-cultural equivalence:[4]

1. *Content equivalence.* The content of each item of the instrument is relevant to the construct of each culture being studied.
2. *Semantic equivalence.* The meaning of each item is the same in each culture after translation into the language and idiom (written or oral) of each culture.
3. *Technical equivalence.* The method of assessment (e.g., pencil paper, interview) is comparable in each culture with respect to the data that it yields.
4. *Criterion equivalence.* The interpretation of the measurement remains the same when compared with the norm for each culture studied.
5. *Conceptual equivalence.* The instrument is measuring the same theoretical construct in each culture.

The authors listed these equivalence dimensions in the order thought to be logically sound and most convenient for instrument development. However, each dimension is mutually exclusive of the others. Any item or instrument may, therefore, be cross-culturally equivalent on one or more of these dimensions and not equivalent on others. An instrument that is shown equivalent on all five dimensions could be called culture-free. Flaherty et al., note that achieving cultural freedom is the exception and not the rule. The exact opposite of a culture-free instrument is a culture-bound instrument. In practice, the authors note that adaptation of instruments across two or more cultures rarely yields universality. Instruments can fall anywhere along the continuum. The results reported here support this conclusion.

Methodology

Two detailed reviews are reported in this qualitative work: 1) The cultural appropriateness of each of the questions asked by intake personnel and recorded on the "New York Suicide Prevention Screening Guidelines" (NYSPSG) questionnaire, and 2) the appropriateness of the jail's suicide assessment procedures. The NYSPSG questionnaire is the suicide risk assessment tool currently being used in this detention center. Developed in

New York in 1986 in response to systemic problems thought to be contributing to a high rate of suicide in New York jail and lockup facilities, this suicide screening instrument was designed to assess two groups of risk variables: factors enhancing the level of risk at the time of booking, and demographic and personal characteristics correlated to suicide risk.[5] This form has been widely distributed and published in various professional journals and its use is not uncommon in detention centers situated outside of New York. However, there has been no published research addressing its validity and reliability when used in other states and/or with specific ethnic populations.

The goal was to convene four focus groups (male non-Indian, female non-Indian, male Indian, female Indian) during each of two site visits (for a total of eight focus groups). These groups systematically reviewed each item on the NYSPSG instrument for appropriateness, understanding, and contexts that may have impacted detainees' responses. During the site visit made in December, 1999, convening a non-Indian female group was impossible given that there were no non-Indian female inmates in the jail at the time. Thus, the first non-Indian female group was postponed until the February 2000 visit.

Each item of this tool that normally would be asked by the intake officer was presented and discussed using the same semi-structured focus group guide for each group (See Focus Group Guide: *Focus Group Questions Concerning Current Screening Instrument* and *Focus Group Questions Concerning Jail Policies and Procedures* in Appendix B6). The second data collection period (February, 2000) convened three groups specifically charged with reviewing the jail's policies and procedures. Again, too few non-Indian females were incarcerated at that time to convene a second non-Indian female group for policy and procedure review. However, content from the first group discussion of screening questions is relevant, since policies and procedures were often mentioned within that group.

Drs. Severson and Duclos co-facilitated all groups. Questions were designed and delivered so that preconceived categories or causal patterns were not imposed and the cultural viewpoint was allowed to emerge. In an effort to keep focus group discussions impartial, it was not disclosed that this was a study specifically of Northern Plains Indian behavior. Rather the study was presented to both the Indian and non-Indian groups as a general study of jail policies and procedures around suicide prevention. A research assistant took notes and monitored the audio recording of the discussions. The length of discussions

ranged from1.5 to 2.5 hours. **Project research instruments and protocol were approved in advance by the *Advisory Committee on Human Experimentation, University of Kansas.*** Informed consent was obtained prior to participation (See Appendices A1; B5; C5).

Sampling /Participants.

Stratified purposeful sampling was used for focus group recruitment.[6] The interest was in talking with inmates who, within the past six months, had been booked into this county jail and who fell into two groups – Indian and non-Indian. The aim was to capture major variations between groups as well as to identify a common core within each group (jail inmates who were non-Indian/Indian and male/female). Convenience sampling was used and necessarily included those in the facility at the time of data collection, which meant, at times, that no non-Indian female group could be formed.

Drs. Severson & Duclos, not having access to roster lists prior to the site visit, relied on the cooperation of the facility's Mental Health Counselor to recruit focus group participants. Shortly before the scheduled site visit, the Counselor approached individuals within the facility and explained that groups would be convened to talk about mental health issues and policies within the jail. Any detainee willing to participate could volunteer to do so by indicating his/her willingness to the mental health counselor. Once jail security procedures were satisfied (ensuring that "enemies" or those who presented safety and security risks would not attend a group), the mental health counselor would see that the inmate's name would be put on a list of those approved to attend.

The traditionally recommended size of focus groups ranges from 6 to 12 participants.[7] Only one of the focus groups fell below that range (see table below).

Focus Group	Total #	Racial Makeup	Age Range
Male Non-Indian Group [1]	6	5 White & 1 Hispanic	20 – 40 years
Male Indian Group [1]	7	7 American Indian	20 – 35 years
Female Non-Indian Group [1]	6	6 White & 1 African-Amer.	20 – 30 years
Female Indian Group [1]	6	6 American Indian	19 – 40 years
Male Non-Indian Group [2]	6	4 White, 1 Black, 1Asian	20 – 49 years
Male Indian Group [2]	6	6 American Indian	20 – 35 years
Female Indian Group [2]	5	5 American Indian	20 - 40 years

[1] Screening Question Review
[2] Procedure Review

It is important to mention that ***all*** groups were extremely cooperative and very respectful of not only the researchers but of each other as well. They were very appreciative of having the opportunity to give input and provide feedback about jail screening from their own perspectives. This opportunity to contribute facilitated respectful disclosure and thoughtful participation. Examples of participants' comments reinforce these assumptions:

Non-Indian Male: "It's really nice, you know, somebody out there that really cares."

Non-Indian Male: "Not only as far as this program (suicidal issue), but there a are other issues, too, you know. We thank you guys for coming in here."

Non-Indian Female: "Thank you for the treats and asking us to help. Are you coming back...?"

Data Management & Analysis.

Audio-recordings of focus group discussions were transcribed into individual computer text files. For validation, the co-investigators reviewed each transcript and made necessary corrections. The text files were prepared in a format suitable for downloading into ATLAS/ti™ software for qualitative analysis.

These data were analyzed according to a standard qualitative data analysis procedure: coding, finding themes, and clustering[8]. Our experiences and observations during data collection as well as prior jail programming and research experience influenced the interpretations.

The main goal of the analyses of focus group data was the synthesis of item-by-item review, with consensus on the appropriateness of the wording, cultural meaning(s), and the influences on participant responses to each item on the NYSPSG. We started with a template approach to analyze the text as outlined by Crabtree and Miller (1999).[9] First, an a priori preliminary template of codes based on the New York screening form questions was created, and then these codes were applied to the text data. Three different qualitative analysts read paper copies of each transcript and hand wrote in the text margins emerging themes or observations as they related to significant issues in the respondents' truthfulness, comfort level, and appropriateness of each screening question/procedure. Next, the analysts met to discuss these themes and organized these observations into agreed upon additional categories

or emerging "codes."[10] Combining the template and the editing style of analysis allowed the text to alter the codes as necessary. The two approaches were merged to create a single set of categories that represented the themes of the respondents' opinions (final codebook). A final codebook was developed in this fashion (see, attachment at the end of this report). Using ATLAS/ti ™, the data was computer coded, line-by-line. The goal of the computer coding was to match text data with the organizational strategy of the codebook.

After computer coding was completed, qualitative software was used to sort and organize related text into one place, which were then reread and interpreted into a summary of the data. This inquiry was an iterative process, which required continual interaction with the data. Triangulation or confirmation from other focus group discussions and jail data verified the credibility, dependability and conformability of these analyses.[11]

NOTE: It is believed that many of these data and subsequent results would be obtained in other jail settings and are not necessarily specific to this site. The very nature of the confinement process puts officers and inmates in oppositional roles. Thus, negative perceptions and comments from inmates are common and expected and may not truly reflect actual happenings. However, repeated comments from multiple sources can highlight issues, which can later be addressed. ***It must be emphasized that, when the inmates were asked if this jail was worse than others they have been in, the majority of time their responses were "no"***, many indicating that they ***"have been in worse jails/prison"*** environments.

One important point to note is that while the Northern Plains Tribes share a similar plight in the erosion of their culture due to the oppressive forces of the dominant society, there are still notable distinctions between each tribe and their cultural beliefs, and in some cases, between each band of the same tribe. For example: there are differences in the Oceti Sakowin (Seven Bands) of the Great Sioux nation – dialects: Lakota, Dakota, and Nakota all of which are represented in this area. The diversity of these bands is not understood to a great extent.[12]

Results

The qualitative results are presented in two subsections. The first section speaks to the actual review of the current screening tool. The second section focuses on emerging themes in the review of the overall assessment procedure. Many pages of text were reviewed and

many more quotes were marked. However, in this summary format the researchers have carefully chosen a certain number of quotes that adequately summarize the best overall discussion of the particular topical area.

A. Review of the *New York Suicide Prevention Screening Guidelines Questionnaire.*

The individual questions of the NYSPSG are used to organize the results. Some of the quotes used as examples overlap with different questions as well as with emerging issues or themes.

Question # 2 on NYSPSG Form: *Detainee lacks close friends/family in the community.* Overall the question was perceived to be fairly straightforward by all group participants and if asked, easy to answer. A few related issues were noted.

➢ Issue 1: No Remembrance of the Question.

More *non-Indian* discussants (both male and female) noted that they did not remember being asked this question.

Non-Indian Male: "I don't believe we were even asked that question."

Non-Indian Male: "He never asked me that."

Non-Indian Female: " I guess that I didn't get that one."

Non-Indian Female: "Nobody ever did that to me."

➢ Issue 2: Confusion Over Terminology

Cultural differences were noted with the definition of "community." The non-Indian group seemed to define the term geographically as in "_____ city", while the Indian group members defined it more broadly to include "family or ethnic" affiliation and/or wider geographic region that would include their home reservation communities.

Indian Female: "...all of my friends. Everybody that I know."

Indian Female: "... relatives. We have family over there too."

Indian Female: "...when they ask if I have friends in _____, I always say no."

Indian Male: "What the hell does that – I mean, most of us Feds, right here, are Native American. We're like two hours away from here. We don't need to live in this town, you know. ....Who is your

community now? What kind of question is that...? I understood the question, I just didn't want to answer it. I was in no damn mood to answer it."

Non-Indian Female: "The area where you live and the town you're in. Where you are right now."

➢ Issue 3: Initial Contact

All groups mentioned the suddenness and "rushness" of this *initial* contact. Asking this and more personal questions immediately upon arrival and in a rushed manner by a stranger was perceived as premature, invasive, and too personal. Without any introduction or context as to why the questions were being asked gave the perception of it being just a routine and of the officers having a uncaring attitude.

Indian Male: "He asked it very fast-like."

Non-Indian Female: "Yeah, personally I felt it was handled too fast, and too, I remember I thought a few of the questions were very irritating. It was just – it was too soon. I mean, I was like surprised that the Federal Marshal's come in and pick me up, and then I'm here, and he wants to ask me all these details of my life. If I was suicidal, he was the last person I would have ever told in the first place."

Indian Male: "....Maybe I'm just being' inconsistent now, but I think if they would just come out and ask instead of asking all these other questions at that point.....the FBI brought me in, I was sober, you know, and I was clear of thought, and I was kind of angry, you know...I didn't want to answer them kind of questions. I wasn't in no damn mood to..."

Question #3 on Form: Detainee has experienced a significant loss within the last six months. All groups easily understood and thought this an acceptable question.

➢ Issue 1: Loss

Discussions confirmed that "loss" is very heavily felt within the tragic history of American Indian life (e.g. historical grief and trauma). A significant number of Indian people have and still are experiencing staggering losses, often in rapid succession.[13] Indian tradition provides important ways to cope with grief and loss and can be of enormous help in resolving these losses and grief. However, when loss

happens in rapid succession, coping becomes very strained. This one question was identified as important to the assessment of the Indian population for suicidal or self-destructive behavior. However, it seems just *asking* the question is not enough.

Indian Female: "...have a significant loss? Mm-hmm. So, I just told them, 'Which time? Which time? How many times over the past couple of months?'"

Indian Female: "They just asked if you'd had a significant loss like in the last six months or whatever. I said, "Yeah, I had a brother-in-law that hung himself last year and it affected my family. They had a little one that passes away a couple of months ago." But, that's all he asked, you know. He didn't even write it down. I don't think he really wanted to know. But it meant a lot to me."

Indian Female: "Just telling him (about her losses) makes it worse, you know. I know, they don't have like, whoever, the lady – they don't have one on 24 hours, but ...have someone right there to talk to you."

Indian Female: "Like why are you really asking? Do you care? Are you just going to put me in a straight (jacket), or blue dress, you know. It makes you not want to answer them properly. No, they will just then try to humiliate you."

Indian Male: "I mean, a lot of my friends that I grew up with have committed suicide, and in my mind, I mean, I was very close to 'em...Why did they wreck off the road just to die? Why? What was so wrong with them...?"

Indian Male: "It would be hard — I mean, it would be hard — if I lost somebody and then I knew I was goin' back to prison and I then felt like I was gonna hang it up, I don't think I'd answer any of those questions, really. If I was gonna do it, I would not answer. I wouldn't show any signs or anything, you know. I mean, that is serious, too, you know. The loss of significant other or family member or somethin' and then come to jail, going that you're going to go through time and think about it. It's just like, no. Some people would do it."

Non-Indian Female: "I answered it no, because, truthfully, I've never – I mean, I never had anybody in my family nor have I had a close friend or anybody (die) – But, I thought about it sittin' there. I thought, if I was somebody that was even thinking about this, I wouldn't say, 'Oh, yeah, I'm gonna commit suicide while I'm in here.' Man, they're gonna have me in that potholder and in that cell before you know what hits ya."

➢ Issue 2: Types of "Loss"

All groups (Indian and non-Indian) were confused over "what type of loss" the officer was inquiring about. While perceived most of the time as a loss of a family member, our discussions suggested that different types of loss might solicit different answers.

Non-Indian Male: "I would answer it differently now that I know there are other types of losses they might be looking for. I lost my kids because I'm in here now, you know. You know, that's a loss to me. Yeah, I would answer it differently."

Non-Indian Female: "Unless it was brought up to me in each one of them different points, I wouldn't know what – just, you know, off the top of my head, I would probably say "No". If they said, "Oh, what about a job or, you know , a friend?, then I would probably be able to answer it that way."

Question #4 on Form: Detainee is very worried about major problems other than legal situation. This question seemed appropriate with all groups. Issues seem to be gender-based more than culture-based: the discrepancies being between men and women respondents not remembering the question and the types of worries they actually brought into the facility.

➢ Issue 1: No Remembrance of Questions

Female participants often did not remember being asked this question. Males remembered the question and felt that the direct wording of the question was appropriate. Since it was perceived that no help would be offered for their worries, they perceived that the question was worthless and usually answered in the negative.

Indian Female: "They don't ask that."

Indian Female: "I never got asked that."

Indian Female: "No. They never did say, "Do you worry?"

Indian Female: "Our children. Who's watching them?"

Non-Indian Female: "Are you worried about anything other than being incarcerated? No. It's not, Oh yeah. I'll lose my job. I got my kids at home (alone), and shoot, I don'' even know if the babysitter is gonna find out if I'm in jail. There's a lot of things, but you are gonna say no...Well, because they don't give a damn if you've got children sitting at home or a mother that can't take care of herself for that matter. They don't care. You're here to be incarcerated and put in. No matter what you say, you are going. I mean, what are they gonna do? They let you have one phone call, and if you can't get through, Oh well. So what can you do about it, even if you're worried about it. You've got to sit here and deal with what's happening in front of you."

➢ Issue 2: Types of Worries

Detainees were asked what specific worries they actually had when brought to the jail. Females mentioned the status and care of their children, job, and/or household: who would take over these responsibilities? The men mentioned missing their children and families, rather than worrying about their direct care. The majority of the detainees felt that answering in the positive would be futile. The officer was perceived as someone who could do nothing to help them.

Non-Indian Female: "I think the best think they can do...is if they put pay phones in like the Federal system, especially when it comes to women trying to ..at least they could be able to call their children and call a babysitter, instead of just bein' left hopeless because in the middle of the night, those feelings build up and a wrong decision can be fatal."

Non-Indian Female: "Mine would have been my job. Because when you come in here...They said 'No you can't make that phone call.' I'm one of those that has to be to work at 5:30 in the morning. If I'm not there, the doors don't open. So, at 5:30 that next morning, I wasn't there. I have no idea what happened. I couldn't call. I couldn't tell anybody. So, now, obviously when I go out, I

probably am unemployed, you know....So what am I gonna go out to? Nothing. So, that puts – that puts depression, anxiety, and all this on ya, and you start having these attacks and stuff."

Indian Female: "I never received, you know, my initial — when you come to jail, you get one free phone call. I never received it. Because I was gonna call my cousin to have her turn off my soup, because I had a crock of soup at home. Because I was planning on going home. I wasn't planning on going to jail. I didn't think I was ever going to go to jail, because I would have turned it off if I did. But, I left it on, and I don't know if the person that was staying at the house with me knew that it was on, and if they turned it off when they left or anything. My house may be gone."

Non-Indian Female: (suggestion on how to ask question differently) "Is there anybody you need to contact? They (should) ask you that before any of these other questions."

Non-Indian Female: "Yeah, is there anybody you need to contact? You need to get these worries that are on your mind out of the way. You know, if they brought you in the jail and said, 'Okay is here somebody that you need to contact right away as far as children goes, your boss or whomever?' – that would put the person more at ease at this point, and then go on with asking questions."

Non-Indian Male: "It's got to be my family. My family, letting down my family. It's sad."

Non-Indian Male: "Not being able to see my little boy's birth. That's probably the one that hit me the most. That and probably never seeing my parents or going to the funeral of my parents."

Non-Indian Male: "What difference does it make, you know, if I'm worried about losing a job or whatever? I mean, are you going to do somethin' about it?, because they don't. So, why say anything. I could cop an attitude with that question. Like, say for instance I get arrested at 2 o'clock in the afternoon and I've got to be at work at 3:30, I've never come in here and been offered a (phone call) or asked if there's someone I need to get a hold of. So, why ask me that question. You are not goin to try to make any effort for me to try to rectify that. So what's the use in asking?"

Question #5 on Form: Detainee's family or significant other has attempted or committed suicide. All group members remembered being asked this question. Responses to this question were varied. Mistrust of the potential use of this type of information prevented affirmative answers. Suicide in Northern Plains Indian communities is a tragic common occurrence, so that more Indians than non-Indians have the potential for positive responses. Interestingly, the one Indian female group cited the reason they would respond truthfully was to ***"honor"*** and remember the deceased rather than see it as a suicidal risk.

➢ Issue 1: Distrust re How The Information Would Be Used

The main concerns focused on how this information would be used by jail personnel, and then on its relevancy to the current situation. The jailing was personal to them and did not involve their families.

Indian Female: "The thought that came to my head was, 'What business is it of yours?', you know, 'Who cares if I know somebody who tried to commit suicide?,' you know...I thought this was supposed to be my questions – about me."

Non-Indian Male: "No, because really I don't want any officer knowing anything about my family. You know, I'm the one that's being arrested, not my family. You know it's not what my family has done or what they are going to do, it's me."

Indian Female: "No, I think it's important, and I know the paperwork would be in my file. I know I am a Federal inmate and I know they go through your file, and whatever they find will be used on your case."

Non-Indian Female: "And the first thing that popped into my head again was, 'What does that got to do with why I'm here?' I mean, I didn't feel like having – I mean, I answered it. I had no problem answering , but it was just like 'Why do you want to know if somebody in my family has committed suicide or attempted it? What's that got to do with me?'"

Non-Indian Female: "...and the trust level, you know. That to me, is the ultimate thing right there. Being able to –because you've just been treated like crap by this cop that's brought you in. This other one comes in, and you're going 'Oh boy. What's this one gonna give me?" So, I think I'd not be more likely to answer the questions."

Indian Male: "Why – does suicide run in the genes or somthen'? What would that question have to do with a person who is hand gun' it up or somthen'?"

Non-Indian Male: "I think that's a pretty good question, the way they asked me. You know, they just get straight to it, you know. 'Anybody in your family been hurt?' 'Are you trying to hurt yourself in any way?' That's how they asked me. I think that's the right way to go about it."

- Issue 2: Remembrance and Honor

  The Indian female group mentioned the importance of answering truthfully to honor the dead, to remember who they were. However, they cited a lot of discomfort with the abrupt response to their truthfulness.

Indian Female: "Most people do. Most Native Americans know somebody who has...I always put yes...Then he just when on to the next question (rushed). He never asked who. (didn't care)"

Indian Female: "It goes through your mind when they ask you, and you think those names of who those people are that you knew, that will go through your mind real quick. I mean, for me, it does. I think, 'Oh gee.' I name em all in my mind, and then it goes away real quick."

Indian Female: "Especially with the Indians, I mean, you know, in the Indian community because there's mainly Indians in this jail....So I really think it is important that they ask, and that they remember themselves who it was. They shouldn't just forget those people like that."

Indian Female: (When asked if it was important to ask for their own protection)."Not protection, but as far as remembering your people, yeah. Because they are important to us."

Question #6 on Form: Detainee has psychiatric history. This question prompted much discussion and differences between groups. The non-Indian male group had the least amount of concern in answering this question. This question, however, was deemed a very personal and invasive question for the other groups. Having a psychiatric history is thought by the majority of discussants as very stigmatizing as well as labeling. Officers were perceived as not being the appropriate persons to whom one should disclose this type of

information. Women who work in the psychiatric field, on the other hand, were mentioned as more appropriately suited for this line of inquiry.

Cultural beliefs also played a role in responses. The Indian groups pointed out that "psychiatric" or "mental health" is a very mainstream concept and does not really apply to them. Some Indian communities do not have a concept of "mental health." There were many suggestions for reframing this question since the term "psychiatric" was seen as a very complicated, inappropriate, and easily misunderstood term.

- Issue 1: Psychiatric History As Stigmatizing and Labeling

Being diagnosed as having a mental health disorder or having to see a psychiatrist or psychologist in most societies is unsettling. Fear of being "crazy" and labeled as such has been shown to keep people from needed services. Having mental health problems was not as acceptable to these groups as having medical or even alcohol problems.

Indian Female: (In response to question asking how this was asked) "If you've been in a psychiatric ward or if you've been on medication. I said no, because I felt self-conscious."

Indian Male: "Because, more or less, some places (where they ask questions) are just right out and open where they'll start asking these kind of questions. Some people like have been to – hospitalized or in that suicidal state don't want to like...was saying, he don't wanna be goin' out and tellin' everybody else now, you know."

Indian Female: (When asked what the term "psychiatric" made them think?) "Crazy...nuts."

- Issue 2: Easier to Disclose Psychiatric History to Women

Psychiatric information is very sensitive. Women are frequently viewed as "helpers," thus perceived as one in whom a person can confide.

Non-Indian Male: "Well, I think a lot of these questions have to deal with a medical aspect of sorts, and I don't understand why a medical person isn't doing this. You're either evaluating someone's emotional stability, psychological stability, physical/medical stability or what ever, the case may be, um I don't know. It seems like, I mean, if you're going to have someone really here

asking those questions, it should be someone who has some kind of medical background. But , and I think it would help – I know it would help me-it's usually easier to open up with someone with medical – I mean, not to sound sexist, but they are women, and I have an easier time opening up with women than I do with some men, you know. Sometimes you kind of get the attitude, you know, I don't know, 'I don't want to hear it.' Or 'Quit your whinin', you know."

Indian Female: "Because the cop who is arresting you already, why should you tell 'em what's goin' on, because that cop is already gonna make out a police report on you. Why make it worse on yourself? A female might be easier."

Indian Female: "If there were more women down there than men..."

Non-Indian Male: "No, it's like – it's like, if it is a medical personnel or psychiatric personnel, (female) yeah. You know I feel they have the right to ask that question. Just the plain booking officer – I'm not going to answer any questions. That's what I told 'em when they booked me in. I said 'Fine, I'll talk to medical personnel or psychiatric personnel, but not to you.'"

➢ Issue 3: Cultural Beliefs

"Mental illness" as understood by mainstream society can be seen as shameful and *unnatural* in some Indian cultures, and therefore tends not to be recognized or reported.[14] However, it is generally agreed that mental illness exists in Indian society as in other cultures, but it is interpreted differently. Being viewed as a mainstream "concept", some respondents did not think it pertained to Indian people. Mentally ill people were treated differently. In some Indian cultures, there were no jails, mental health institutions, hospitals, schools, and the culture dealt with specific problems / issues in a different way than the White man. Special needs people were considered "wakan" or holy, and belonged to the creator. Thus, they were treated accordingly.[15] Indian people show great acceptance and tolerance of personal peculiarities or social deviance without either rejecting or labeling a person as being mentally ill. Our discussions did reflect this worldview. In fact, these "people" may be considered "gifted" and thus as very spiritual persons.

Indian Female: "Psychiatric are mental, where we stand in one spot and shake our head...we don't know nothing like that, you know."

Indian Female: "Yeah, because Indians don't have that psychiatric history \ all that much. I've never knew any – I don't really know any women, even in prison, as far as I've been in prison, I don't know any women who have psychiatric problems in there, and they try to put a lot of 'em on that Trazodone, but that was to sleep, as far as I know. If that is a psychiatric problem – but, a lot of white girls, I notice have real bad psychiatric problems."

Indian Female: "I think mental problems do exist in Indians, it is just not as recognizable. They don't really seem... (we have) depression or anxiety."

Indian Female: (In response to the above comment.) "But, that's not psychiatric - depression (sadness)."

Indian Male: "See, we, in our – in our culture, it's – it's taken a little differently than in other people's culture. See, we think that they're gifted. Society – mainstream society would think that an off person is off and be careful and don't give him sharp objects. Where we respect that person because he's touched. The same way with homosexuals, you know. We treat them with a little bit more respect...Some of us still believe in that way, and we still – if I see that, you know, we got the off person in the community (not locked up). (We have) that chick (that) is always smokin'. I mean, she'll walk right into your house. If you have a pack of cigarettes on the table, boom they are gone. You know, and 'Let me have one.' I'll give her a cigarette, because out of that respect for my culture. I never tested it, I never...I just know that I've been told that, and that's the way it goes, and so I respect that person. Then it all works out. The person doesn't – I remember one time she jumped into the car while I was warmin' up. She jumped in my car and took a cruise down the hill and came back up. I didn't take her nowhere. Just came back, right? Then she went in my house, and she turned on the big stereo system. She said, '////, let me have this.' I came out of the shower and just .....the doors are open, you know. I think because of that respect that I gave her that little bit..."

➢ Issue 4: Reframing of Question

Since this question was problematic, we spent time exploring better ways to frame the question. It was generally agreed that the question needed to be less direct and simplified.

Indian Female: "Put it into more simple language, you know, like put it, 'have you ever felt sadness, bummed?' You know bummed, sadness. You know, put it in easier terms to where - because sometimes people don't understand what that means... 'Have you ever felt this way?'"

Indian Female: " They could say, 'How is your health right now? Do you feel like you need to talk to (someone)?'...instead of saying 'Have you ever', saying 'Do you need...?'"

Indian Female: "Or they could say, 'Do you have problems? What are your problems?' Or somethin like that. Not psychiatric." Gee (laughter)

Indian Male: "Yeah, I think if they disguised that question a little bit more, you would get a more positive answer, you know. Like he said, you know. 'Have you ever been hospitalized for any reason.'"

Question #7 on Form: Detainee has history of drug or alcohol abuse. Surprisingly, this question was very acceptable to all groups. It seemed easier to admit to alcohol/drug use or abuse than to having a psychiatric history – perhaps because substance use / abuse is less stigmatizing than mental illness.

➢ Issue 1: Redundancy of Question

Asking this question when the "obvious" was apparent felt unnecessary to the groups.

Indian Female: "They always say alcohol...because it's pretty obvious, you know, if you're sittin' there (drunk)."

Non-Indian Female: "I remember laughing, because they brought me in on a DUI, of course, I indulged in alcohol. But, to me, that – I remember when he said that, it was like, 'Duh, I'm sitting here. They just took my....and you know I'm drunk, and you ask me that question?"

Non-Indian Female: "He said, 'Have you had any alcohol or any drugs - or alcohol tonight?' I just kind of looked at him, you know. It's like, 'Gee, no'."

Non-Indian Male: "I don't know. I don't have a problem telling 'em. I'm a good old' boy standing down by the bar."

➢ Issue 2: Legal Consequences of Disclosure.

For those not obviously drunk or brought in on alcohol or drug-related charges, perceived legal ramifications was a barriers to positive responses.

Indian Female: "Legal, legal. I'd probably tell anybody else, but these guys up in here, boy. Nope, nope, nope."

Question #8 on Form: Detainee holds a position of respect in community. The majority of the discussants indicated that they were never asked this question. In a later focus group with officers, they reported having been told during their training that this question could be confusing and thus could be skipped. The discussion turned to respect in the community and what that means for the different groups. Who deserves "respect" was defined differently within the Indian groups. Additionally, these discussions revealed that being incarcerated was not as stigmatizing for the Indian groups.

➢ Issue 1: Respect

In Indian worldview, it is a spiritual necessity to live in harmony with all other beings, not only because it is "nice" or desirable to do so, but because it would be dangerous not to. To be in a state of conflict, or to offend other people, is to be in disharmony and in a dangerous and vulnerable state. Respect is not merely a matter of giving honor, praise or positive recognition; it is also a way of maintaining a safe and circumspect distance from unpredictable powers. This holistic view sees all parts of life as interrelated, thus worthy of respect.[16]

Indian Female: "I've never been asked this question, but I know – I know I would say yes. I would say yes...I have a lot of friends."

Indian Female: "I feel like I'm somebody, you know. I feel like I'm well respected in the community. The Indian community, that is. Not nothing to do with the white community at all. I mean, not that I'm prejudiced, but just the Indian community recognizes you as being somebody and the white community don't."

Indian Female: "...But you know, when we came here, it just totally twisted around, and it was a totally different (experience). Over there, it seemed like it was a lot easier. I always had a job, you know, He always had a job. We worked. And you know people saw us as that. And then now, over here, it's a lot different. My husband started...it's like he lost that part of himself. He's even told me that. He uses the expression, 'I feel like a white man.' He started crying.

➢ Issue 2: Jail Stigma

Past experience with Indian Country jails has shown that jail is not as stigmatizing for some of the Northern Plains members as for many who live in mainstream society. Shame does not necessarily follow unless the crime is against tribal mores or value systems.[17] Historically, jails were and still are seen as a part of the European system of justice imposed on native societies and not a part of the native regulating system.[18] Focus groups confirmed these different viewpoints.

Indian Male: (When asked what their community would think of them in jail.) "Well, basically, they would recognize it as a mistake. The community recognizes this as a mistake, not something that is shocking. They know everybody makes mistakes...You feel so defamed (in mainstream society) that you just don't want nothing to do them. You feel like — you feel like everybody (mainstream society) is looking at you like a loser, when they should be not lookin' down on you. I mean, not lookin' down on you. Instead, they should be tryin' to help you."

Indian Female: "I wish I wasn't so recognized, you know, as an inmate, but I am, and it's ok because I get a lot of different reactions from the jailers than other inmates do. They, you know, they know me more. They've known me like for ten to twenty years, I've been coming to the jail."

Question #9 on Form: Detainee is thinking about killing himself. Much discussion from all groups was had about this question: the *consequences* of responding "yes" were the biggest concerns. This same concern was heard many times. The directness of the question actually seemed suggestive of planting thoughts of suicide for some Indian groups (more fully explained in a later section). Both groups commented that a special interviewer might get a more truthful response.

➢ Issue 1: Consequences of a Positive Response

Most inmates told us that they would not be honest because of the *consequences* they perceived would happen.

Non-Indian Female: "No. Who would you tell? Who are you gonna go up and tell? If you 're sitting in here, who are you gonna tell? If you tell the CO or somebody 'I'm committing suicide,' – ooh, man, I'm gonna be in a blue dress."

Indian Male: "Myself, when I first came in, I know I was goin' back (prison), and you know I couldn't accept it. They asked me 'How do I feel?' I said 'Right now, I feel angry and I feel emotional.' Right away they said I was suicidal. They took me downstairs...put me in a dress and put me in a cell...they lied to me and put me in a cell. I asked 'Why am I here?' ...they had to yell it out, so everybody knows. It made me, I don't know – it made me think more (about answering truthfully next time)."

Indian Male: "Because some of us would think like, you know, if you ask me if I'm suicidal the court – you don't know if these guys will tell the court. 'Yeah, he is suicidal.' Of course they're not gonna let you out because you're suicidal. Then they will hold you back. I want to know right then and there if – to make me feel more comfortable about answering – will the courts know-will these people tell the courts."

➢ Issue 2: Asking about Suicide Directly Suggests (Ghosting)

Some of the Indian groups were very concerned about the directness of asking if someone was suicidal or going to hurt him/herself. They felt that this placed negative

suicidal thoughts into the minds of those being asked. Some (which was not recorded) mentioned that direct questioning about behaviors such as suicide allowed ghosting (related to the spirits of those trapped in the jail who had previously died of suicide enter spiritless people and in turn these spirits are responsible for the suicidal behavior). A more detailed description of this experience follows in another section.

Indian Female: "Because you know other people that did it and accomplished it. If you even think about it, maybe you will start thinking that way, too. "Yeah, they did it. How did they do it? How did they have the strength to do that?" When we go through the knock-down period, that's what I think of. I look on the walls, and I think, how could you hang yourself in a place like this. I'll look around. There will be just that tiny cubicle. That whole hour you're sittin' in there. You can just think of ways. 'Well, maybe I could just hang myself like this,' like certain ways. 'How did they do it?, you know. You think like that and maybe that's how they started to think of suicide. I know that's how I think every time I'm in lock-down. I do."

Indian Female: "Sometimes wanagis (native word for ghosts/ tricksters) can work with your mind a little bit."

Indian Male: "I don't — I don't know what — there's probably — it's not kind of like the right time. When I was comin' in, it probably wasn't a good time to be talkin' about some things, you know. Although I was, you know, I'd been in that position before. Just like //// said, over there, you're like - you're out of options at that point in time. All of a sudden, they say, you know, 'Do you feel suicidal?' and boom, there's an option, you know. You know, 'What if I am.' Then you sort of you know, start thinkin' about — I remember the first — when I was a kid, I was asked those kind of questions. I probably don't even remember the words, but, hell, yeah, I was suicidal then."

Indian Male: "There's an impact — making the person have negative thoughts. Giving people negative thoughts instead of, you know."

Indian Male: "That's what I was gonna say. I don't think so. If I was suicidal, I wouldn't say it, you know. That would be like embarrassing. What if — what if it was just as stage that a person went through, you know. Now you feel like a champ and you're not gonna do as much time or you're not — the situation has

changed, and then you feel better about the out — you know, you went through that stage and now you feel you can handle it or cope or whatever, and then to say, 'Yeah, I did try to commit suicide,' it just puts you back in that stage. I don't know. All of us are different, man. You know, but that is personally what I would do."

Indian Female: "They need to ask you these questions to make you feel comfortable enough to answer. To answer them without worrying about what might happen."

Indian Female: "That's why I don't answer those things truthfully. I lie. Like they ask if you know somebody who committed suicide, I tell them, 'No.'. 'Have you thought about it?' 'No'. I lie on everything, because I don't want to be treated like that."

➢ Suggestions for New Wording

Less direct ways of getting this information were offered.

Indian Female: "What I said was (native language), it just means 'Are you having a bad head?'...just means, 'Are you having bad thoughts?'"

Indian Male: (When asked what is a better way to ask if someone is suicidal) "You know, you gonna hang it up?' or, "you feeling alright?'"

Indian Male: (When asked what is a better way to ask if someone is suicidal) "Are you going to make it?"

Indian Male: "...(Take him aside) You know, you just ask him in a respectful manner. 'How do you feel? It's okay to talk, because whatever is said here, stays here.' That kind of setting would change a lot of things inside the facility."

Indian Male: "Back to that question, you know, about what she asked, I think that indirectly – like an indirect question, sort of like, 'Will you make it?' would be more appropriate. If I had 20 years and a CO came up to me and said 'Are you gonna commit suicide?', I don't wanna hear that. I'd rather hear, 'Do you think you're gonna make it?' or 'Do you feel that you can make it?'

➢ Suggestion on the Best Person to Ask Questions

When asked directly about the gender of interviewer, the majority of the participants said that they would feel more comfortable with a female or someone of their "own kind." Those discussants who did not feel gender mattered suggested that the person must just show a caring attitude.

Indian Male: "If you're first comin' into intake, and you have a white guy come up and say, 'Hey, you suicidal?' You're not gonna answer him the truth. But, if an Indian guy comes in and takes you in the corner and kind of like plays a role to try to keep it undercover and says 'Hey, how are you doin'?' Yeah. It's sort of like that, you know."

Indian Male: "I wouldn't tell them. I would tell someone I know."

Indian Male: "Let a person enter that stuff by his own kind. Like somebody of his own race or nationality. Because they got different officers, you know, like black, Native American, Caucasian, Spanish."

Non-Indian Female: "You know, there's the Bishop and ////. She's a very nice woman. She cares. She is really interested. She is really concerned about the inmates.

Non-Indian Male: "Somebody that's going to take their time and really talk to somebody. I mean, because most of the officers down here, they are just going to get it done and over with. But, if they had somebody who sat down and really looked like they really cared, it would be a lot better on people. Especially people that's going to be here awhile. And, like he said before, they should have follow-up evaluations. You know, like every month or so. Go down and see you in your cell. See how you're gettin' along and stuff. They should do that."

Non-Indian Male: "It would be better if they had somebody that acted like they really cared."

Question #10 on Form: Detainee has previous suicide attempt. The majority of the detainees both Indian and non-Indian admitted giving untruthful answers when asked this question.

➢ Issue 1: Truthfulness

Asking about past suicide attempts was perceived as a futile exercise. The majority of participants responded that they do not or would not truthfully answer this question if they had past experience with suicide behavior. The main barriers to a truthful response were the interviewer and the consequences to the inmate if s/he admits having a history.

Indian Male: "...so you don't have to be afraid of being locked \ down or don't have to , um, go up on stage, like a consequence – having to be watched all of the time, like 'Why are you watching me all of the time?' - just after saying yes to that certain question, you know."

Indian Male: "No, I wouldn't tell someone. I wouldn't want to get locked up, you know. Getting' locked up makes things worse. They've got you all tied in."

Indian Male: "/// (mental health counselor) or someone I know from my hometown, but not an officer."

Non-Indian Male: " I think if you were planning on doing it, and you've answered yes, you've tried, you wouldn't tell them the truth, because they would prevent you from doing it (by putting locking you up)."

Non-Indian Male: "That would be my feeling. You know, if I was thinking about committing suicide, I'm not going to tell anybody before hand that I'm thinking about it again."

Non-Indian Male: "I don't remember. I don't recall if I ever answered yes here. I don't think I did. The one time I tried, I did try in here. I think every other time I answered no. I mean, when I've been in like treatment and other whatever, when that question has been asked...I said yes...I don't know."

Non-Indian Male: "I think it boils down to what this guy said. It – it, for me, you get someone else askin' that question, and you might find a hole different set of answers. And, you might find that I will elaborate more with somebody else than I would with an officer. For myself, if I'm asked that question or all of these questions by someone in Medical or someone in BMS or somethin', you are going to get more accurate picture of where I'm at emotionally and psychologically and all those things than you are from an officer."

Non-Indian Female: "Why? What does it have to do with what I've been arrested for? I'm not being arrested for this or that."

Question #11 on Form: Detainee feels that there is nothing to look forward to in the future. The majority of the detainees thought that this was an appropriate question to ask, however, the wording or way it is asked confused them. The women (both Indian and non-Indian) in their discussions seemed to have a better outlook on life, or things to look forward to (e.g. jobs, kids, etc.) then the men.

- Issue 1: Framing of Question

The wording or the way officers currently ask the detainees seemed to confuse them. Reframing this question might make it easier for a more honest response.

Non-Indian Female: "He just come out – the officer that booked me – he just come out and said 'Do you have anything to look forward to when you get out of here?' I kind of looked at him kind of funny. (He had to rephrase the question.)"

Non-Indian Male: "The same way you just asked. Right? You know, they as you, um what they are trying to get at is 'Is it worth living?' An, um, yes, of course, I answered. They didn't ask me any more \ after that. I just told them "Yes, sir.'"

Indian Male: "When the officer said that, I went 'What?'"

Indian Male: "Here's how (to rephrase) 'Are you lookin' forward to getting' out?'" (All in group were in agreement.)

- Issue 2: Male/Female Response to "Looking Forward"

It was quite clear that the females seemed to be more positive with their lives by citing their children and jobs as being important to them. Males on the other hand displayed more anger/frustration when talking of the future.

Non-Indian Female: "When you do, you got your kids to look forward to, you know."

Non-Indian Female: (Responding to what someone might look like if they had hope) "/// Take a picture of her. They can put her in the dictionary. I think there's a difference between people that have something to look forward to and come out to. It's the way they talk. They blossom."

Indian Female: "I know I do. I have a job. I have my kids. I have things to think of besides what I'm in here for... Anyone has hope."

Indian Male: "Not any more...Not now that I'm going back (to prison)."

Indian Male: "Back to asking somebody with 20 years about the future."

Non-Indian Male: "Sometimes you just have to sit and wait. The anticipation, you know. 'What is going to happen to me now?'"

Non-Indian Male: "I think it depends on whether you've been sentenced or not. If you've got to be here for a long time, a lot of 'em are going to sleep it off. But I haven't been sentenced yet, some of them hang on hopes that they can get into treatment or somethin' like that, you know. Hope they can get (help)."

B. Emerging Issues and Themes for the Overall Screening Procedure

Other issues emerged from these discussions that speak to the organizational, social, spiritual, and cultural contexts of suicidal assessment within this setting. Two major organizing themes emerged: 1) Factors or issues related to the assessment process or organization external to the detainee, and 2) Internal detainee characteristics.

➢ Assessment & Organizational Factors

1. Assessment Issues

- ***Timing*** – Most detainees, both non-Indian and Indian, felt that being asked these questions immediately upon arrival was premature. On intake, moods are usually negative. Asking very personal questions at this time felt more negative. Additionally, it was perceived that depressive thoughts come after withdrawal from alcohol, not during.

Indian Female: "What 'till their hangover is over. That first period when you're down from drinkin' is a real crucial time for people to act irrationally and try to kill themselves."

Indian Male: "(Depression/sadness) That's natural. That's from withdrawal from alcohol, you know. That's a feeling that comes to you."

Indian Male: "I was sober, you know, and I was clear of thought, and I was kind of angry, you know. And, I'm sure a couple of us were angry and know how I felt. I didn't want to answer them kind of questions. I wasn't in no damn mood to."

Indian Male: "Settle in, like maybe two or three days. Like I said, two or three days to me, any rational person has come to his thoughts by then, you know... and then now you can get information from him, instead of askin' him right when it's bottled — it's just bottled up, and he's about ready to burst, and you're askin' him some crazy question, and he comes off the wall, you know. Somethin' the matter."

Indian Male: "To me I'd say like two or three days after, when everything gets settled in, and you know what you're looking at, because by this time you've been to court and you know what's goin' on. You know where you're gonna be goin' or what's gonna happen, you know."

Non-Indian Male: "I think I'm probably defensive and somewhat angry about where I'm at. Um, I'm probably — I'm probably more likely to answer questions in a different way two to three hours down the road, when I've come to an acceptance of the fact of where I'm at and what's going to happen. You know, then I'll answer them cooperatively and with a different frame of mind. Whereas, if I come in and I'm defensive and angry, then I won't answer nothin' at all."

Indian Female: "Yeah. It was right when you were arrested. Of course, you are going to be depressed. Of course, because you're comin' in. Already, with your arrest, you are going to have all kinds things. Anxiety. Why do they give the screening right then when you're getting arrested? Can't they do it the next day or somethin' like that?"

- ***Framing*** – Almost every detainee / participant mentioned that the questioning hit them "cold" and very negative. Some kind of introduction was suggested as being helpful as well as non-threatening. It was felt that more of a conversational style might also elicit more truthful response. As it is done now, they perceive officers as

just following a routine procedure to protect officer/facility liability, not really caring about true their emotions.

Indian Male: I think it's alright where it is, but they should just put a little saying (introduction) in front of it, you know, like, 'I'm gonna ask you some questions.' Maybe, 'I have some concerns for your life.' Somethin' to prepare you for the questions."

Indian Male: "...you were kind of saying what we started off here saying is some of these questions might be tough to talk about, but we want to ask you because we're concerned about you' or something like that. Some sort of statement in front of those questions."

Indian Male: "(Just ask) 'Have you ever been institutionalized before?' 'Have you ever been down this road before?' Because if you know they have then its less worry. They know that you know how to cope with whatever."

Non-Indian Female: "I felt on that whole thing it was deceptive, like what are you getting at. Personally, I don't care how educated you is or if they're uneducated, if you come right out and say 'Now, I really need to help you, and I want to know if you're suicidal.' Start out that way, instead of all of a sudden, it's like where are you trying to get with this, you know. All of a sudden, there is an automatic distrust instead of a bond."

Indian Female: "I think they should say something like, "Do you have any worries? Do you have something on your mind right now? Is there anything that would (pause) that we need to know about? Or somethin' like that."

Both of the Indian groups mentioned the negativity of the questioning. This negativity actually was perceived as making the detainee feel "bad", or respond inappropriately. It was felt more positive phrasing might bring out more appropriate disclosure. Talking negative brings on negative thinking.

Non-Indian Female: "...There is so little positive input in the system, that depression is a very easy thing to come. Negative questions bring more negative. I mean, I find myself sometimes. It's

like, you just want to blow up at somebody. Emotionally, you can't hold it any more. You have no release for it."

Indian Male: "I've got somethin' to say about that. When you first come in, you're not even thinking about anything like that. They deprive you of thinking (positive). Right away they put you on stage (spot). Ask you negative questions. It's a forceful (negative) attitude (that you get)."

- ***Rushed Screening*** – Again, the hurried nature of the screening process was perceived as being just officer routine. They felt that officers wanted and actually preferred negative responses to not disrupt the routine. In most cases, the detainees complied with this perception.

Non-Indian Male: "There ain't no way he can figure you out in three minutes."

Non-Indian Male: "It would be a lot easier if they didn't sound like they were in such a rush to get it over with."

Non-Indian Male: "Well, it seems like the officer wants you to say no, so that way he don't have to go ...into detail. He has a lot of people to intake or classify."

Non-Indian Male: "Most of the time they hope you don't say, 'Yeah, I'm trying to hurt myself', because there's more paperwork that they have to do. So, they try to get you in and out as quickly as possible."

Indian Male: "People listening in...that's the other thing. They're kind of close by. I've always felt kind of rushed. They don't give too much dialogue. Yes. No. 'Okay, go back and sit down.'"

Indian Male: "At the same time, too, I've seen officers ask those questions, and they're joking around about some other thing, about lunch or - they're writin' 'em down, but at the same time they're talkin' to someone else and not really putting all their attention to you. So you know, it's kind of like, he's right. They just want to get it over with (and don't care)."

- ***Where Screening Takes Place.*** Screening is done immediately upon arrival prior to booking or during the booking process. Many inmates felt that asking sensitive questions in the very busy booking area was a barrier to honest answers. Privacy issues were very important and came up repeatedly.

  Non-Indian Male: "If they would probably approach you outside of the booking process, um, because when I'm asked the question by the booking clerk at the computer. You know, gosh, they're trying to get your fingerprints, they're trying to get this stuff entered in – they don't want a whole lot of dialogue, you know. That's the impression you get. That's the way you feel."

  Indian Male: "Get them away from all the action."

- ***How Screening Is Done*** – Currently, the actual screening process experience seemed to vary. We were told sometimes it was done by interview, sometimes inmate self-report, and sometimes officers filled the forms out without asking the questions.

  Indian Female: "He read them to me."

  Indian Female: "He handed them to me to fill out."

  Indian Female: "I've been coming in for 10 years. They say, 'We know you.' They then just starting markin' them. (Responding to if this bothered her.) Yeah, it does. But, it's a procedure. They have to do it, you know..."

  Non-Indian Male: "Some will just give you the form and say, 'Here, answer these.' Some of them might go over the questions if they've got the time. But if they are hurried, they are not going to bother."

  Non-Indian Male: "I've had an officer tell me that before. 'Give me a yes or no answer.'"

- ***Confidentiality of Screening*** - All detainees had privacy concerns and were afraid that positive answers to questions might be overheard and passed between people. This lack of privacy and the fears associated with it inhibited them from proper disclosure.

  Indian Male: "But, if an Indian guy comes in and takes you in the corner and kind of like plays a role to try to keep it undercover and says 'Hey, how are you doin?'"

  Non-Indian Male: "People listening – that's the other thing. They're kind of close by."

  Non-Indian Male: "Well, there are other inmates kind of back there. I don't know who said it, but I don't think you want to discuss your personal problems with other people standing by that can hear your conversation."

  Non-Indian Male: "I just know that when I've been asked those questions at the counter, there is a feeling of, you know, I've got people on my shoulder."

  Indian Female: "There's no privacy."

  Indian Male: "Like yeah, you tell this guy everything, and he'll turn \ around and tell this other person and this other person, and it goes through the jail, and the next thing you know, they'll beat you up."

- ***Who Screens*** - Interviewers proved to be one of the most important factors in honest disclosure. Discussants described different versions of the appropriate person. Some respondents wanted non-uniformed officers, some women, and some medical personnel. However, the general theme running through all answers for all detainees was someone that *truly seemed to care and wanted to help.* Indians did mention that someone of their background would be nice, however, references to the mental health counselor were very favorable as were some comments about certain officers. They indicated that it was the person's nature that was most important.

Non-Indian Male: "Somebody that's going to take their time and really talk to somebody. I mean, because most of the officers down here, they are just goin' to get it done and over with. But, if they had somebody who sat down and really looked like they really cared, it would be a lot better on people. For guys that are going to be here awhile, they should have follow up evaluations. You know like every month or so. Go down and see you in your cell and see how you're getting' along and stuff."

Non-Indian Male: "She's a very nice woman. She cares. She is really interested. She is really concerned about the inmates."

Indian Male: "Yeah, I think with the same nationality, things probably would work good."

Indian Male: "An uncool guard is one that disrespects you."

Indian Male: "This person pulls him aside and talks to him. He will be free to express himself, because he's comfortable with this person. Because the person is not mad or anything or expecting to hear something. You know, you just ask him in a respectful manner. 'How do you feel? It's okay to talk, because whatever is said here, stays here.' That kind of a setting would change a lot of things inside the facility."

Non-Indian Female: "It would be better if they had somebody that acted like they really cared."

Non-Indian Male: " Be friendly with him. 'So, what are you here for? Do you have kids? Oh really.' They could kind of work on getting your confidence...a conversation. Your trust in them. They could go about it that way, and you would open up to someone a little more instead of 'Oh, yeah. I have family out there. I am depressed."

Non-Indian Male: "For me, it would have been different. I think it's got to do with the officer. If the officer is sincere, and you can honestly tell him, then you can tell your problem. But, yeah, it is easier here to talk with a woman. If the officer – I mean just says 'Yes. No. Yes. No. But if he sits there and talks about it, it's going to make a difference."

Non-Indian Male: "Most of 'em, you know, don't care. They just want to go on to the next one. You can tell that by the way they ask the questions. Boom, boom, boom."

Non-Indian Male: "...with their lack of whatever, they put 'em in booking, because they are the ones that is harder for inmates to get along with...But some officers would be different be a little more – just in the way they hold you (if drunk) or the way they try to help you through the door or something like that would give you an indication of maybe whether or not ..."

Indian Male: "Treat you like a human being. They talk to you like you're a person instead of a monster. When talking with you (the good ones) use my first name. **(Not Chief).** I know they're cool."

Indian Female: "...to ask questions that you guys really want to know about us."

- ***Consequences*** - Consequences of answering in the affirmative were cited many times and mentioned previously. Fear of the impact or subsequent consequences if suicide ideation or risk was disclosed influenced answers - especially for the repeat detainee who "knew the ropes." The consequences were viewed as "punishment for telling honest feelings." Two types of consequences were routinely mentioned.

  – ***How The Information Would Be Used (Mistrust)*** – All groups showed distrust in that disclosures could show up later in legal proceedings and used against them. Indian mistrust is deeply embedded and stems from the long history of betrayal by mainstream society.

Indian Female: "I thought they were getting into my business and that this was going to be used against me."

Indian Female: "I knew the paperwork would be in my file. I am a Federal inmate, and I know they go through your file and whatever they find that will be used on your case."

Non-Indian Male: "It seems like you're leery of answering anything they ask, because they are going to use it against you."

Indian Female: "They know everything, even the State...If they want to

analyze you clear to your childhood from how you were raised up. That" how sneaky the wasicu (white man) is. They know everything."

- ***Being Put in the "Blue Oven Mitt," "Blue Dress", and "Fish Bowl"*** - All groups mentioned these descriptives as the outcome one faces if one was to admit they were having suicidal ideation. They would avoid this "punishment" by negative disclosure.

Indian Female:	"Are you going to put me somewhere else, or, you know. Does that mean you're gonna have to put in a straight...It makes you not want to answer them correctly."
Indian Female:	"Yeah, or you're sitting there thinking, 'Are you going to put me in a blue dress?'...Then you won't answer, you won't answer."
Non-Indian Female:	"I think if they would do away with their barbaric suicide intervention process and maybe have a 24 hour clergyman on or something to where the person could get some counseling instead of a barbaric – they stick you in this pot-holder-like blue suit that they Velcro on ya. And they then stick you in the fish tank cell."
Non-Indian Female:	If somebody – if you've ever been incarcerated before, you know what happens if you say (yes) to any of these questions."
Non-Indian Female:	"They need something here, you know that you can...a safe place...not something that they criminalize you (for saying yes), and treat you really, really bad."
Non-Indian Male:	"That is one question where I would hedge a little bit, because I was worried about the classification aspect of it."
Non-Indian Male:	"The demeanor of different officers around here is that they have to use something against you...It seems like you're leery of answering anything they ask, because they are going to use it against you."

2. **Organizational Issues** – Organizational issues or factors were uncovered which were not directly related to the assessment process itself, but still seemed to impact the process.

- ***Jail Turnover*** – Jail staffing and turnover was mentioned frequently as a hindrance to good detainee and officer relationships. The detainees perceived that the job in the jail was just a "stop gap" until promotion to patrol, and as such, a "secondary position."

  Non-Indian Male: "...this jail has a hell of a turnover...they are constantly training new officers here. These new officers think they have to get all their stars the first two weeks, you know...then (on to) patrol."

- ***Long Length of Intake Time*** – While the screening process was perceived as too rushed, the complete intake process was perceived as taking too long.

  Non-Indian Male: "For the size of this jail, I mean, _____County where you've got hundreds of people comin' in, it takes you just as long to get upstairs from the time you go into the tank before you go upstairs to a pod...That's a question I've always wondered about is why does it take so long...you get all kinds of thoughts in your mind with that time."

- ***Lack of Indian-specific Programming*** – Culturally appropriate programming was a great concern for the Indian groups. The Indian culture and religion has its own set of healing and coping rituals that they feel are not available to them.

  Indian Male: "They were startin' a program, but it hadn't went through yet, but they are bringin' people in to take care of somethin' like that, once or twice a week...to where they have a group or you sit there and you make your prayer ties and things like that."

  Indian Male: "That's what is the biggest complaint, you know. You got, you got Catholic services, you got church services, but you have nothin' for the Native Americans....sweats, etc."

➢ **Detainee Factors**

1. **Risk Factors/Critical Periods** – Specific risk factors and critical periods for suicide ideation assessment were offered. The majority of these suggestions were very similar to those already published in the literature. Only one was Indian-specific, thus, not previously identified before within the criminal justice literature.

   - **First Time Incarceration** - Both Indian and non-Indian detainees recognized first time incarceration as a risk for suicide ideation and the need for special assessment and support.

Indian Male:	"...because if they know you have (been in before) they know that you know how to cope with whatever hurt from the outside."
Indian Male:	"Because if this is their first time, then they have to go through all this emotional distress... shock, distress."
Indian Male:	"Remember we had that little gooba up there, and he flipped out. He was young and never had been in jail or trouble or nothin'. He flipped out upstairs. He tried to kill himself."
Non-Indian Female:	"I had never been in jail before, and I was scared to death."

   - **Long Sentence** – Being handed down a long sentence can be devastating for a detainee. After court disposition was suggested as a critical period for reassessment for suicide ideation.

Indian Male:	"I'm lookin' at a lot of time myself...'Can I (you) make it?'"
Non-Indian Male:	"I think it depends on your charge (and sentence) and how you feel when you come in the door, because I was pretty much devastated. I found a federal case and lost it. I had lost my whole future. I was

devastated. But, if I was in here for just a weekend stay, I probably wouldn't have a problem at all."

Non-Indian Male: "People who are facing life in prison and then you got kids out there. You've got a mother and father, who you probably won't see again, because they are already at that age – that's the kind of things you have to go by. Now if you're in here for two months..."

Indian Male: "The best time to ask is after court, you know. For real, That's the time. That's the time when you feel like... "

- **Molestation or Offense Against Another** – Being charged with a crime against another was cited as having a special affect on a detainee's mental state.

Non-Indian Male: "You know what? A lot of things have to do with your case. A lot of people say I want to get out – I just want say something – some people are here for drugs, others are for assault, others are here for child molestation or rape. Now, drugs is not as bad as child molestation. When you go to prison for drugs, you'll be labeled as just one of the guys. If you go to prison and you've got the molestation charge or that rape charge, yeah, you're in trouble. Most people say, 'I don't wanna go there.' Because some people think the best way is killin' themselves because the treatment in prison once they get there, it's probably ten times worse than killing themselves. So, it's got to do a lot with their charge."

Non-Indian Male: "There is people in here who are in here for hurting their parents or hurting someone. I mean, you know, and they have that at the back of their mind, 'God, can I live with myself? How can I live with myself?'"

- **Shame** – The non-Indians thought shame was an important risk factor for suicide ideation.

Non-Indian Female: "When I was first arrested for my federal offense, I had spent 17 years as an R.N., and I was well looked upon member of that - that was my first suicide attempt, because it was so devastating."

- **Becoming Sober** - Being intoxicated during intake as well as the sobering up period were mentioned.

Non-Indian Male: "But, as I sobered up and I was in one of those cells where they don't check on you quite as often, I did ...make an attempt, you know...it seems like once you start to sober up and you start to feel those feelings of – well, I felt shame and guilt. Boy, then it was really intense."

- **Not Being Able to Communicate to the Outside** – Having no communication to the outside world, especially during the intake process, was cited often by all groups as having a great impact on mental status. Not being able to tell your family, the children's babysitter, or your boss where you are and how long you might be there was very stressful.

Indian Female: "The way I see it, it is being able to communicate with the outside world – work, children, and family."

Indian Female: "Communication, yeah, with our families. That would put a stop to a lot of..."

Non-Indian Male: "But, what about not being able to see your family forever. That's emotional."

Non-Indian Female: "They need to put pay phones with debit cards, like the Feds... They are cost effective. Then the person just needs money in the account instead of makin' a collect call, because so many people have blocks...You'd think, especially when it comes to women trying to – you come in with ten bucks in the account – at least they could be able to call their

children and call a babysitter, instead of just bein' left hopeless because, in the middle of the night , those feelings build up..."

Indian Female: "In _____, as soon as you get there, they give you a counselor, and you have a free phone to call. Either that woman, she'll come around when they hold you in the holding cell, she'll come around and say, "You need to make a phone call?" She'll give you a cell phone. I thought that was really neat. That way you could get a hold of your family."

Indian Female: "You should be able to contact al least one person and let somebody know that you're here. See, with my situation, I'm still worried. I don't know if that pot's still burning or, you know. I just don't know. It was a slow cooker, so you never know. It's just like I expect my apartment to burn down or ...."

Indian Female: "It puts a lot of stress on you because I notice a lot of girls who can get a hold of somebody and some who couldn't. She couldn't call her boss. She was crying because she can't get to him on the phone."

- **Contact with Significant Person from Outside** – Contact with significant family on the outside impacts depression.

  Indian Male: "I see some guys breaking, just get off the phone, and they're like, 'Ohhhh.' You know, and I know where they're at. I've been there."

- **Being Away from Children** –For mothers, it is especially hard being away or having no contact with their children.

  Non-Indian Female: "At the time I said no (when asked about thoughts of suicide). But, after stayin' here for so long, after really stayin' here for so long and bein' pregnant, it did cross my mind. I was away from my kids too long, and I felt like my whole world was comin' down. Yes, it did cross my mind."

- **Moving Off the Reservation or Being Far from Home**– Moving from the familiar and accepting community to another community was perceived as disconcerting.

  Indian Female: "Over there, it seemed like it was a lot easier. I always had a job, you know. And then now, over here, it's a lot different. My husband started drinking constantly. It's like he's lost himself."

  Indian Male: "Most of us Feds, right here, are Native Americans. We're like two hours away from here. We don't need to live in this town, you know. .."

2. **Respect** – One theme running through all discussions was "respect". Once a person is arrested and put in jail, respect is perceived as lost.

  Indian Male: "They say, 'Yo, Chief, come here.' I'm no chief."

  Indian Male: "(Called) Coyote, come here."

  Indian Male: "Treating each other with equal civil liberty. Helpin' each other understand what has happened or why it happened. We've got to learn how to understand each other how to balance the scale."

  Non-Indian Female: "She may not have been thinkin' of any suicide or anything at the beginning, but when you're in here day after day, and the humiliation that you do receive from the CO's and the different people, and the abrupt way they speak to you, like you're a five year old child, and you have no knowledge, and the disrespect that you're treated with - you can take it so long, and then pretty soon you're to the point of, 'God, I just want to - I want to rebel.' Man, you know. Then they give you this hour of Anger Management Class. Well, big deal. That ain't gonna get it, you know. Respect is such a small thing to make things work easy.

  Non-Indian Male: "Have some type of training, because some people you can talk to in certain ways, and some people you might say, 'Well, he was gruff and disrespectful of me. I'm not gonna answer any of his questions.'"

Non- Indian Female: "I want somebody not to treat me like a criminal...You know we aren't as violent as they think we are. I realize there are a lot of different crimes that people are in here for, but I think they seem to categorize all of us into a maximum security-type thing..."

3. **Spiritual/Cultural** - All human experiences and social interactions are culturally determined. Although it is possible to change our attitudes and level of understanding, it is not possible to totally separate ourselves from our cultural roots. Generally, people only learn about the nature and personal importance of their own culture through encounters with other cultures. It is through these exchanges that understanding happens.

Due to cultural sensitivities, certain Indian spiritual experiences are not described in detail. Many Indian people regard these experiences as intensely personal, private, and sacred. There is a great reluctance to share spiritual information with non-Indians. We were very grateful and honored that the Indian participants in the focus groups felt comfortable enough to allow a glimpse of these influences on their jail experiences.

Most Indian people choose some mixture of traditional and mainstream value orientations. Northern Plains' Indian value orientation and its clashes with majority cultural orientation are important to understand. Indian people do not take spiritual realms of life lightly. This part of life is viewed as powerful, and is just as powerfully felt as majority religious beliefs. While these forces or powers often have a favorable affect on humans, they can also be destructive. Therefore, some spiritual forces are good, some bad, and some just neutral. Most Indian people approach spiritual matters with great care and respect.

With this introduction, some discussion of how the spiritual belief system of Northern Plains Indians impacts suicide ideation as well as the assessment process related in focus groups, key informant interviews, and the literature is important.

The purpose in doing so is to help the field of detention management become more aware and sensitive to cultural differences and its impact on actual practice.

A. Importance of Balance – Harmony or balance is a commonly espoused value across tribes. Wellness is harmony in the body, mind, and spirit. These elements are inseparably connected and continuously interacting. Unwellness is then disharmony among these three elements. Everything is seen as being the result of something else and this cause–and-effect relationship creates an eternal chain. Causality is complex and usually external to the person. Cases are evaluated on an individual basis. Each individual case is examined for the nature of the "imbalances." Natural unwellness stems from biological, social, and / or cultural violations or taboos. Unnatural unwellness is external, being introduced by the "outside."

Certain behaviors or conditions, which are seen in non-Indian society as "mental illnesses", may not be interpreted in this way at all by some Indian people. Personal problems are more likely to be seen as externally caused than resulting from internal psychological conflicts. Personal problems can be attributed to physical illness, historical events, family conflict, alcohol, misbehavior or spiritual forces. The suicide ideation case described below is an example of cause coming from the "outside."

Indian Male: "This is the guy.' He has you labeled already. You know, even though this person is not even thinking of it. Then what's this person being put into...a state. You know, when he gets in that cell back there, what's he start thinkin'? You know, he starts going through all of these mixed emotions. You know, he's thinkin' about what's been said to him. Again, he's thinkin' about outside (what others told him). Now he's caught in between, unable to — unable to balance the levels of both sides of what he heard. And it starts — it starts confusing him, you know, overpowering him, and then he starts pacing. He starts getting all of these thoughts (that were introduced), like, 'I'm a loser.'... when (originally) you were not in this mood state, rather you were feeling comfortable and not thinking about

anything like that. But, all of a sudden, they just put the thought into your mind, just by saying it. All of a sudden, click. Then you start thinkin' in a whole different way. I don't know what — there's probably — it's not kind of like the right time. When I was comin' in, it probably wasn't a good time to be talkin' about some things, you know. "

B. **Alcohol as an "Unnatural" Cause of Behavior** - External unwellness results from "alcohol" as the "agent" or cause of behavior and not the individual. Alcohol was introduced to Indian communities by "outsiders". Alcohol as an outside element is "unnatural,"and causes unnatural behaviors to appear. The following conversation is illustrative.

Indian Male: "I was blank. I was blank for two days."

Same Indian Male:"Yeah, alcohol and drugs. I don't remember."

Indian Male: "Yeah, it was (alcohol) — yeah...yeah. When I came to, they were askin' me if I was alright. 'Do you (still) want to commit' — I was,' No. What's the matter with you guys? Why do you think I want to commit suicide?' I didn't know. I didn't know I was actually sayin' these things. (It was the alcohol peaking)"

C. **Death & Spirituality** – While viewing death as a natural and accepted part of life, death and dying can still be a shocking and disorienting event for anyone. Most Northern Plains tribes view life and death in a circular pattern rather than in a linear pattern that is more typical of Western worldview. Life flows into death which flows into life – creation and re-creation. The body is viewed as sacred and housing the essence of the deceased. For some of the Northern Plains tribes, the first four days after death are crucial. It is believed that the spirit of the deceased is still present, and if you pray for them their spirits are at rest and will not wander. It is during this time, loss also can bring vulnerability and susceptibility. Once vulnerable, outside influences can change thoughts and behaviors.

Suicide, especially of a young person, was never acceptable for Northern Plains Indians and thus, can complicate normal grieving processes. Burial takes place at the end of the fourth day and the spirit begins his/her final journey. "Ghosts" (wanagis) usually remain or appear in connection with an unwillingness or some other barrier to leaving (ex., excessive grieving is thought to keep spirits from continuing their journey.) Not providing the normal journey rituals can also "keep" spirits from moving into the next life.

Using the Lakota beliefs as an example, the very nature of being deviant and thus incarcerated for a Northern Plains Indian is unwellness and unnatural. Being in this state and situation, one is thought to have lost his or her true nagi (spirit/soul). To become balanced again, he or she must regain this lost nagi or true spirit. However, during this time of spiritlessness, a person is very susceptible to the other spiritual forces that may be present (for example, "ghosts" or wanagis in the jail). Absence of prayer and "releasing" rituals after death can cause wanagis to become "stuck." These "stuck wanagis" can become dangerous especially in their efforts to have "others" who are spiritless join them.

Some Northern Plains Indians' worldview includes a strong belief in and experience of spirits. Belief in ghosts or spirits is natural. Using the Lakota view as an example, there are four aspects of the Northern Plains Indian soul: Ni or niya (spirit or breath), Nagi or wanagi (spirit or ghost like image), or Sicun (spirit-like power that all things possess), and Taku Skan Skan (that which causes all life to move and live). It is the nagi that attracts the most attention especially at times of death and grieving. Nagi is the element which is free from the physical constraints of the body and can leave the body during sickness, visions, and dreams. Good spirits and bad spirits are both nagi. When a person dies the nagi lingers close, usually for the four days mentioned previously. Then it begins the journey on the Ghost path, wanagi chanku, and

makes its way toward the Spirit World. It is believed that if you grieve too much or cry too much for the deceased you are holding on to them and not letting them go. In fact, it is not uncommon to mention the person's relationship to you rather than their name after death. A restless nagi or wanagi with unfinished business may wander or get "stuck" with no home. It is believed that wanagi after death can be dangerous because it grieves and will try to entice others to join it unless released for its journey to the Spirit World. This becomes very important in understanding the Northern Plains Indian jail suicide behavior. It is not uncommon for wanagi spirits to be present within jail environments. In this particular jail, wanagis have been perceived by some Indian inmates. These spirits might be the result of past suicides that have not been allowed or wanted release to the next world. At times during the progress of this study, special ceremonies and rituals have been performed within the jail to release the spirits felt to be present.

The belief that the spirit must be released so it may travel to the Spirit World is crucial and very complicated. If this release does not happen, then spirits or "ghosts" get "stuck." It was mentioned that direct questioning about suicide or self-destructive behavior allows the wanagi entrance to the detainee's lost "spirit" or "soul." In a fashion, this wanagi replaces the detainee's nagi and can introduce suicidal ideation and behavior. Thus, the wanagi has "taken over" and causes the behavior.

Indian Male: "While I'm incarcerated, I've been tryin' to help our culture – help them along by teaching of the natural and unnatural worlds."

Indian Male: "If you asked directly, it could influence somebody's mindset, so it could be best to as in an indirect way."

Indian Male: "But, all of a sudden, they just put the thought into your mind, just by saying it. All of a sudden, click. They you start thinkin' in a whole different way."

Indian Female: "Especially with the Indians. I mean, you know, the Indian community...A lot of the people that carry power in medicine, they can hear these people (ghosts) in here (wanagis). A lot of them still (are here). A lot of them are upstairs and you know in the (cellblocks). You can hear 'em. I really think it is important that they (you) ask and that they remember themselves who it was (suicide deceased) and (they are still here)."

D. Suicide as Honor – There still exists the possibility of suicide being part of the culture. Warrior societies staked themselves to the ground and vowed to fight to the death in battle with the enemy. These societies existed a short 126 years ago. The act of suicide could be viewed as a battle with the non-Indian system, and a way of winning that battle. In this way, there is still honor.[19]

Discussion

The interpretation of qualitative data is complex and dynamic. Crabtree & Miller (1999) describe it as a "dance" towards sensemaking. The above section reports the initial year's qualitative phase of study. What does this all mean? Immersion with the data text has provided some insights, but has also generated more questions. In addition, it has strengthened the resolve to "understand the cultural forms through which 'truths' are generated and involved people that live this cultural life."[20]

Similar Findings Across Indian/Non-Indian Groups

In summarizing these findings, we outline themes that were explored or emerged as those similar between Indian and non-Indian groups first, then point out the differences. The experience below is from the detainee perspective and summarizes what happens on intake by ***both*** Indian/Non-Indian detainees.

The person arrives angry after being picked up by the police officer. S/he is worried that they might not be able to contact family and/or job about their whereabouts. Suicide screening is done immediately upon the initial contact with yet another uniformed stranger with whom there is no relationship established; sometimes

rushed, and not always done in a private place. Distrust of "how this information will be used" and fears of breaches of confidentiality are present. From prior experience they have learned that if anyone is thought of as suicidal or self-destructive, they are put in the "fish bowl dressed in the "oven mitt." These people are afraid that they then will be thought of as "crazy." They choose not to answer correctly as to how they feel.

Clearly, complicated perceptions are in play at the time a person is processed into a jail. Added to this are sensitive questions about a person's intent and expectations that the person will be truthful in response. Unless these perceptions and their causes are fully understood, it will be impossible to truly evaluate whether the instrument is useful in identifying suicide intent. Below is a summary of the qualitative findings that helps in better understanding what factors are in play when assessing for suicide in a jail setting during booking. Similarities across groups seemed to cluster around the process of screening / assessment rather than the actual questions of the NYSPSG.

While issues of relationship, privacy, confidentiality, and distrust are common across groups, gender differences did exist. These differences surfaced in the types of worries that the inmates brought to the jail. Both genders worry about their jobs, who will notify the job, and the status of the job when they get "out." However, women were also concerned about children or family caretaking and welfare. Who will know that they are in jail? Who will take care of the children and/or family in their absence? Men worry about their relationships with the family or significant other. What will their family think? Will they see their wife/girlfriend and/or children again? It was also interesting that the women had a more positive outlook.

Differences Across Groups

The differences across Indian/non-Indian groups seemed to fall in the framing of the screening questions. We found differences in the concepts and definitions of **family, community** and **psychiatric/psychological** problems. Indians think of family and community as more extended and not restricted by geography. Large extended family tends to be more important than for mainstream society.

Indian interpretations of mental and emotional problems are also different. Certain behaviors or symptoms seen in mainstream society may not be interpreted in this way at all. These problems are viewed as unnatural and thus externally caused, and not due to psychological conflicts. Thus, some Indians do not have the concept of "mental illness." Indians show greater acceptance and tolerance of personal peculiarities or social deviance without either rejecting that person or labeling them as "mentally ill" or "crazy." Additionally, people who experience compelling intuition, visions, and powerful dreams are often valued for special knowledge and thought to be blessed. Unless extremely disturbing or bizarre, they are not judged to be pathological. Severe disturbance might be caused by "soul loss, spiritual possession, loss of breath of life, or evil work by an enemy."

"Respect" has wider connotations in many Indian cultures than in mainstream culture. Respect for and working with others is of great importance historically in tribal life survival. One respects all things including each other. Respect includes knowing one's proper place in the social structure and that of other persons. Thus, deciding if a person holds a respectful position within the community and thus is at risk for suicide, needs to take into consideration that all Indian people hold this respect. Another aspect of respect is recognition of individual differences and private experiences. Individuality is highly developed in Northern Plains culture and many of life's most important experiences are personal and private. What is right for one person may well be wrong for another. No one is qualified to judge if it is right or wrong for another. It is generally considered disrespectful to tell other people what to do, or to pry too deeply into the thoughts, feelings or inner experiences of others. Thus, questioning sensitive areas without establishing a relationship is looked on as disrespectful.

Special emphases in ***risk*** for Indians emerged in our discussions. These special issues include **loss** (including historical cultural loss and trauma) beyond that of immediate family. In attempting to understand the plight of the American Indian in any setting, one has to understand the historical trauma the Indian has endured over the past one hundred plus years.[21] Risk also speaks to being jailed far from home (e.g. reservation), and the presence of outside influences such as alcohol or "ghosts/spirits." Being jailed so far from home is especially important for Federal prisoners who come from great distances (interstate) from home. The outside influences leave the detainee vulnerable.

Communication can not only differ from non-Indian patterns but from other Indian groups as well. Northern Plains Indians in our focus groups indicated that **direct questioning** of negative outcomes can bring on these outcomes either through planting of thoughts or by allowing external spirits access to the person's essence. **Framing** of questions becomes very important. It was mentioned often that questions are too negative, and more positively framed questions might bring different responses.

Longstanding mistrust is and will always be present within this minority group. Mainstream oppression has resulted in destruction of traditional tribal ways of life, victimization, trauma, and alienation in their relationship to the dominant society. Uniformed officers as well as "signed papers" have proven never to be "good" for Indian peoples. A basic knowledge of the major events and trends in Indian and non-Indian relationships is necessary background for anyone working with this group. A full discussion of these historical factors is not possible here but can be garnered from numerous books and other resources.

Indian-specific programming and activities such as "talking circles," "beading or quilting," and access to traditional healers and rituals were suggested by all Indian groups. This type of programming was thought to aid in the refinding of the "nagi" or soul, as well as use for coping and depression. The cultural factors involved in such complex behaviors such as suicide and deviancy are important, needing of respect, and involvement of someone who lives this worldview.

Conclusions

Returning to the five major dimensions in instrument cross-cultural equivalence cited in the Background Section, important equivalency problems with some items of the NYSPSG exist. These problems fall into all of the five dimensions mentioned in content, semantics, technical (method), criterion (interpretation), and concept. Thus, these findings support the hypothesis that adaptation of instruments across two or more cultures rarely yields universality.[22] The above results suggest that non-Indian and Indian detainees do not always tell the truth when asked these suicide specific assessment questions. Many factors for this seem to be at play and are outlined above. Some of these factors are similar across groups, and some are culturally distinct. To determine specificity and sensitivity of an

instrument, one must assume that respondents "give truthful responses." Our focus groups told us that they do not. The overall reason seems to be discomfort in disclosing these personal and sensitive issues. The questions then remain: Do we continue to use this screening form and process? If so, how then can we decrease the discomfort so that more accurate responses are given and then allow testing of the instrument for sensitivity and specificity?.

Limitations

Limitations to the qualitative portion of this study include focus group participant selection. Any naturalistic inquiry relies on purposive sampling rather than on the techniques of random sampling.[9] Within purposive sampling, we employed opportunistic sampling while trying to achieve maximum variation through stratification. However, we did rely on the use of the mental health counselor for recruitment in individuals. This method of recruitment might have biased the groups to those individuals who had known or had past contact with the counselor due to having had mental health concerns. Other important potential participants may have been missed.

The template analysis style of qualitative research has advantages and disadvantages. One advantage is that developing codebooks that are then applied to the text materials can be quickly reviewed and reproduced to validate the research. The same processes, however, have the disadvantages of error by omission of possibly other important codes. Thus, our application of an editing style of coding which allowed for looking beyond the a priori codes to emergence of other themes and issues. We have provided enough information within this report for other observers to judge the applicability and transferability of the results. Should another person wish to test conclusions from these groups, all of the study's transcripts and cleaned qualitative dataset remain accessible for an independent dependability audit trail.[11]

No two social settings are similar enough to allow us to simply generalize these results from one tribal ethnic group to another. Generalizability of these conclusions is constrained by the nature of this sample and setting – Northern Plains. However, this sample and jail setting was specifically chosen for allowing subsampling of a number of the largest Indian tribes in the United States. The tribes that reside in the Northern Plains share similar histories of colonization, externally imposed forms of governance, and the erosion of cultural

beliefs and practices. While one needs to keep in mind the differences between and within tribes, the shared characteristics ensure that many of the findings are relevant to other border and reservation jail settings.

Codebook

```
|HU:  Jail Project
File:  [c:\program files\scientific software\atlasti\textbank\Jail
Project]
Edited by: Super
Date/Time: 07/10/01 03:48:13 PM
---------------------------------------
Code-Filter: All
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.critical period. moving off res
.critical period: after booking
.critical period: after sentencing
.critical period: sobering/detox
.issue. appropriateness
.issue. consequences
.issue: being away from kids
.issue: beliefs
.issue: culture
.issue: detainee condition/demeanor
.issue: disclosure/truthfulness
.issue: disrespect
.issue: don't see relevance of question to themselves or what is happening
 at that time
.issue: how information used
.issue: inmate intervene
.issue: jail system/organization issues
.issue: loss
.issue: mistrust
.issue: training
.issue: worry
.issue:disclosing suicidal ideation: would not tell officials or other
 inmates
.procedure: affect/demeanor
.procedure: framing question
.procedure: how
.procedure: privacy/confidentiality
```

.procedure: suggestions

.procedure: timing

.procedure: use of other inmates

.procedure: where

.procedure: who screens

.risk factor.shame

.risk factor: charge

.risk factor: contact with significant others on the outside

.risk factor: first timer

.risk factor: hazing

.risk factor: long sentence

.screening question #10

.screening question #11

.screening question #2

.screening question #3

.screening question #4

.screening question #5

.screening question #6

.screening question #7

.screening question #8

.screening question #9

.screening question feedback

alcohol

balance

jail?

jailp

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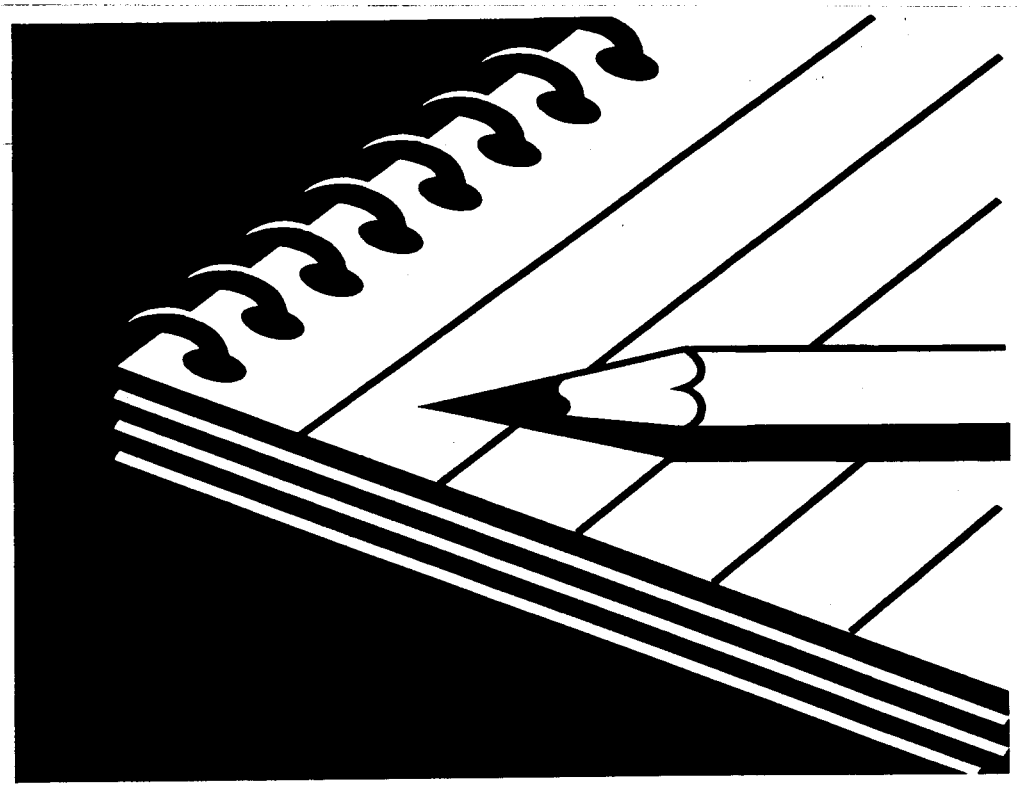
Appendix B 8: Year One
Quantitative Data
(CD-ROM)

APPENDIX C: YEAR 2 RESEARCH INSTRUMENTS

Appendix C 1: Research Protocol

[Anonymous] County Detention Facility

SATISFACTION SURVEY PROTOCOL



University of Kansas at Lawrence
University of Colorado Health Sciences Center

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I. BACKGROUND INFORMATION

A. History of the Project

The Mental Health Project of the [Anonymous] County Detention Facility is a one-of-its-kind research project to evaluate current suicidal ideation assessment tools and procedures used within the facility for cultural competency. The project is studying the current screening instruments and procedures, and then will develop a modification where appropriate to improve the State, local and tribal correctional agency's ability to more effectively screen for suicidal ideation among American Indian detainees. The results will address the current gap in knowledge around how culture affects suicidal ideation and behavioral assessment within a jail setting. The National Institute of Justice is funding this study.

Your administrator, Mr. [Jail Adminstrator], became concerned over the over-representation of American Indian suicidal behavior within the facility. He subsequently called Drs. Christine Duclos & Margaret Severson to discuss his concerns, both having worked with this issue in Indian Country. They have considered the possibility that the intake screening instruments are not sensitive to the specific cultural nuances of thought and behavior among the American Indian population. Other studies point to differences in cultural norms, psychological stress, individual coping skills, and institutional and interpersonal factors, which carry serious life saving implications for the identification, care, and management of incarcerated persons of varying ethnic backgrounds. There have been no evaluation efforts of cultural competency of current suicidal ideation screening tools widely used in correctional settings. Your facility's current inmate characteristics (approximately 40% Indian) presented a perfect opportunity to study this issue. Thus, Drs. Severson & Duclos submitted a proposal to the National Institute of Justice that was subsequently funded. We are now in our second year of funding. The first year resulted in identifying the screening questions that seemed to be working and those that did not, as well as suggestions for alternative wording. Results also pointed to the fact that the way that screening occurred sometimes prohibited inmates from responding truthfully. Our first year results pointed to possible alternate booking procedures that might enhance more appropriate responses when screening for suicidal ideation with incoming detainees. Thus, the purpose of this survey is to test whether current procedures or alternative procedures being tested lead to more truthful and appropriate responses to questions on mental health and suicidal thoughts.

This second part to our study addresses the following question: *Which screening procedures aid in eliciting more comfort and thus more honest responses from American Indians and other detainees during the booking process?*

For this part of the study, there will be separate data collection periods using the current booking screening procedures and four alternative procedures. During each of these periods, we will survey (brief survey) all new detainees admitted asking about their responses to and comfort level with the questions they were asked at intake. The second part of this study includes conducting focus groups with the detainees themselves (Indian and nonIndian) about the different ways the questions were asked and how they responded and felt about them. We will also talk with the officers who participated in the different screening processes.

The specific objectives of this study are to:

1) Develop appropriate questions for culture-specific suicide ideation.

2) Provide recommendations for culturally sensitive suicide ideation screening procedures in the detention setting.

A summary of the research findings and policy implications will be presented both to the [Anonymous] County Sheriff's Office and the National Institute of Justice for possible publication in a *NIJ Research*

in Brief. Nationally distributed publications of the findings and recommendations will help inform other facilities serving the American Indian population.

B. The Principal Investigators & Staff

The principal investigators and their staff (a research name for those responsible for the study) are:

Margaret Severson, JD, MSW is an Associate Professor, School of Social Welfare, University of Kansas. She has extensive experience in the interface of mental health and criminal justice systems as evidenced by numerous publications. Dr. Severson's research and teaching interests are correctional mental health program development and implementation; mental health policy and practice with pre-trial detainees and sentenced prisoners; suicide prevention and crisis intervention in pre-trial detention and state correctional facilities, expert consultation in jail suicide and mental health-related litigation; legal issues impacting on professional mental health administration and practice; and mental health policy and procedure development and delivery of clinical services.

Christine Duclos, PhD, MPH is an Assistant Professor, Department of Family Medicine, and a Research Associate with the Center on Studies in Family Medicine at the University of Colorado Health Sciences Center (UCHSC). She is also a fellow with the Open Society's Center on Crime, Community, and Culture, and most recently with the American Academy of Family Physicians' Grant Generating Project. Dr. Duclos's research and teaching interests have focused on the mental and medical health issues of the incarcerated as well as their families for the past 18 years. As a consequence of her former work as Research Associate with UCHSC Department of Psychiatry's National Center for American Indian and Alaska Native Mental Health Research, her current work centers on American Indian issues. This work includes consultations with numerous Tribal Nations, National Commission on Correctional Health Care (NCCHC), Denver's Juvenile Court, American Correctional Health Services Association, National Institute of Corrections, and appointment to the Department of Interior, Bureau of Indian Affairs - Law Enforcement Services, Subcommittee on Jails & Detentions.

Susanne Holtquist, a social welfare doctoral student at the University of Kansas and **Amie Staudenmaier**, Research Assistant at UCHSC's Center for Studies in Family Medicine, will assist Drs. Severson and Duclos in this project.

Detention staff active in the administration of the study are **[Jail Adminstrator]**, the detention administrator (on-site oversight); **Christa Cavenah**, inmate records (quantitative data collection), and **Nancy Fleming**, mental health worker (focus group coordination).

C. Confidentiality Policy

The Principal Investigators and the [Anonymous] County Detention Facility have established the following policies to assure that the confidentiality of inmates is respected and that the identity of individual participants is protected.

Computer Data Sources

Information sent to the University will have a numeric identifier only. Any inmate names inadvertently included with the data will be permanently and completely deleted from surveys and computer listings of intake rosters prior to input into the data files. After input into data files, all paper copies will be locked in a file cabinet at the University of Kansas. These files are only accessible to the Principal Investigators and project staff during the time of the study. After the completion of the project, two clean copies of the databases will be made available for archiving with NIJ as required by the funding agreement. Any other external access will be prohibited except with the expressed permission of the appropriate Sheriff Department officials.

Data Management

Once the surveys are completed, each questionnaire is given a specific identification number – the inmate booking number. University staff will not have access to the names of participants. The raw data with booking number is entered onto computer by project staff. Data entry personnel will not have access to any identifying information such as names. Focus group discussions will be transcribed without identified names. Focus group participants will be recruited by the facility's mental health worker, thus research staff will again have no access to names.

Intake Officers

Intake and floor officers as well as jail staff will follow routine confidentiality policy and procedures of the detention facility. Any breaches of confidentiality (except as provided under Emergency Procedures) are grounds for review.

Reported Analyses of Data

Research results will be reported in several formats. A final report is required by NIJ. Articles for journals (i.e., *NIJ Research in Brief*) and conference presentations will be prepared to share the results to improve scientific investigation and service provision. In all cases, unless otherwise agreed upon, the University and Sheriff's Department will not identify the individual participants. The identification of the facility will be decided by an agreement with the Sheriff's Department.

D. RIGHTS OF RESEARCH PARTICIPANTS:

Even though we want as many of the incoming detainees to participate as possible during these five data collection periods, there are ethical guidelines to keep in mind. All research conducted must follow strict ethical guidelines to protect the rights of the research participants. The following guidelines must be followed ***by all*** to insure that the participants are not harmed by their participation in this study.

1) Respondents have the right to refuse to participate in the study.

2) Respondents have the right to withdraw from the study at any time.

3) Refusing to participate or withdrawing from the study will not affect the detainees' length of stay at the detention facility, their treatment, or their case disposition.

4) Respondents must be informed about the general purpose of the study.

"This study involves the use of questions of experiences that you had when being booked into the jail. The results will help us design screening tools and policy and procedures to better take care of you."

5) Respondents must be informed about what they will be asked to do if they agree to participate in this study.

"This study asks respondents to answer a very short list of questions about their experiences being booked into the jail and any thoughts that they might have had."

6) Respondents must be informed of the potential risks associated with participation in the study.

"The risks may include psychological discomfort related to discussion of topics which may be uncomfortable."

7) Respondents must be informed of potential benefits with participation.

"The respondents will not benefit directly from participation in the study. However, they might be comforted to know that they took part in a study that could help this and other facilities take better care of future prisoners' needs. "

8) Respondents must be informed about confidentiality.

"All information that the respondents give will be kept confidential, with the exception of reports of intention to do harm to themselves or others, which we are required to report by law. However we do not ask directly about these intentions. Confidentiality means that all information the respondent shares will remain private. Respondents will remain anonymous, which means that code numbers will be on the materials instead of names. The project staff will take precautions for safe-guarding all materials."

9) Respondents must be informed about whom they can call if they have questions.

"This information is included on the SUBJECT CONSENT FORM." (Please point this out to them."

10) Respondents must sign and receive a copy of the SUBJECT CONSENT FORM to indicate that they have been informed of their rights as research participants.

II. THE SURVEY DEVELOPMENT

A. Development of the Survey

The short self-report survey includes 16 questions. It should take approximately 3-5 minutes to complete.

B. Areas of Questioning

The booking survey is composed of the following instruments:

Booking Experience asks twelve questions about their experience of being asked screening questions about their medical/mental/emotional health, if they were honest in their answers, why they were honest, why they were not honest, how comfortable they felt about answering, and their overall experience of the screening process. There is additional space provided for comments/suggestions to make the screening process better.

About You asks four demographic questions such as age, gender, ethnicity, and employment status.

SURVEY ADMINISTRATION

A. Sample

As an officer in booking or in the orientation housing units, you will be asking ***all*** persons (male and female) over the age of 18 if they would be willing to participate in the survey – even if the person has filled out a survey on a previous admission. Repeat admissions are asked to complete a new survey because we are evaluating a total of five different booking screening procedures. This survey should not burden you at all – since detainees will complete them, on their own, either prior to their being released from the facility or, if taking to the orientation unit after booking, while in the orientation unit.

You should ask all new detainees to complete a survey between October 1, 2000 through the early months of 2001 – when we have a sufficient number of positive consents and completed surveys to analyze. We anticipate needing approximately 200 positive consents which yields 200 completed surveys *per study period.* We need this number to provide us with enough statistical "power" for us to make appropriate statistical conclusions. Again, please continue the survey process until you hear that you can stop.

It is very important to document if the person answered "no" or "yes" on a consent form. Write across the consent refused or another reason why they did not participate. We will be keeping track of all intakes and whether they participate or not.

B. Your Role

Most people prefer answering questions in self-report form rather than answering questions face-to-face with an interviewer. Additionally, some of the questions are sensitive, and thus, are easier to answer in self-report format.

In addition to the way intake screening is currently done, we will be testing four slightly modified intake screening procedures. This survey will ask inmates to give us feedback on the current way of doing things and on each of the new procedures. So that inmates are not unnecessarily delayed in the booking area, this survey is copied in two colors: inmates who have never been moved into a housing

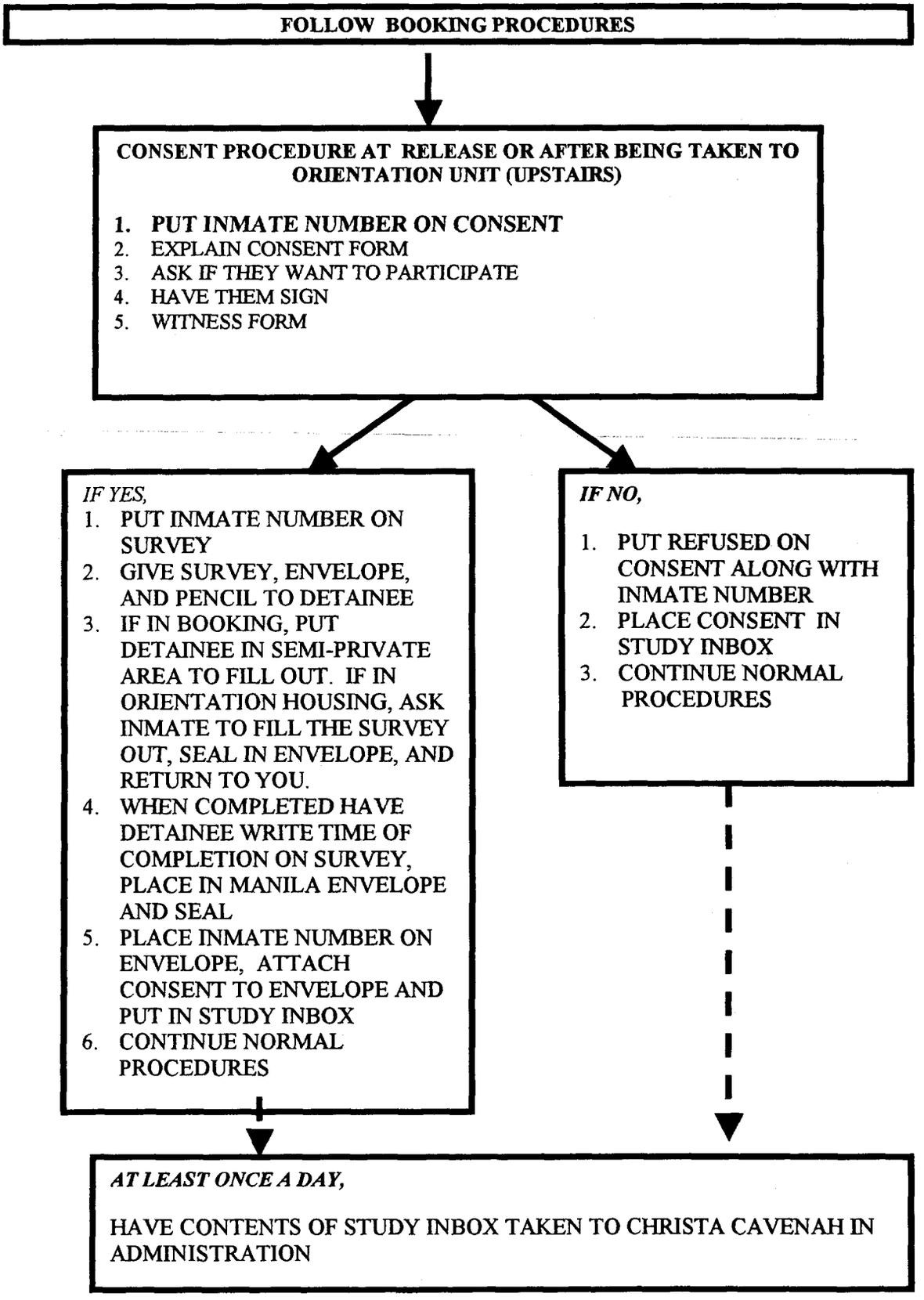
area and who complete the survey in the booking area just prior to their release from jail, will complete the surveys printed on blue paper. Inmates who are moved into the orientation unit will be asked to complete the surveys printed on green paper. Therefore, once the inmate goes through the screening procedure and is taken to the orientation unit or is about to be released (ex. on bond), the release or orientation unit officer will explain the study, ask the inmate to participate in the study, and have the inmate sign a consent form. The inmate's master number will be put on a survey, along with the date/time of completion. A manila envelope will be handed out with the survey. The inmate will be instructed to put the completed survey in the envelope and seal. The officer will make sure that the inmate number is on envelope or survey and will place the filled envelope in the study basket.

When asking the inmate to participate in the survey, wording that might help gain their consent is: "Do you want to participate in a study that the jail is doing to assess the current booking procedures, and that will help us better take care of you?" For those that do not want to participate, the officer should mark "refused" on the consent form along with the inmate number and place it in the special study basket.

Your role in the survey process is as follows: 1) put the inmate's number on the consent form or otherwise write the detainee's name on the sealed envelope, in pencil, 2) explain and obtain detainee's consent or refusal to participate, 3) if the inmate consents, put the inmate number on the survey and manila envelope, hand out a survey and pencil, 4) when the survey is completed and sealed in the envelope, write the inmate's number on envelope, and 7) place in study project inbox. Christa Cavenah will collect the envelopes at least once a day.

WE WILL NEED A CONSENT/REFUSAL FORM WITH INMATE NUMBERS FOR ALL INCOMING DETAINEES!!!! PLEASE REMEMBER TO PUT THE PERSON'S INMATE NUMBER ON A CONSENT FORM, SURVEY, AND ENVELOPE!!!

THE SURVEY PROCESS AFTER INTAKE



B. Techniques for Obtaining Consent

A consent form must be obtained from each participant ***before*** they fill out the survey.

Explaining the Consent:

The following items should be ***emphasized*** when obtaining the consent:

1) Explain the project and purpose.

> "The University of Colorado and The University of Kansas are doing a survey of our intake screening procedures. The results will help us design screening tools and procedures to better take care of future detainees. I'd like to explain this consent form, and then you have the option to participant in the study."

2) All people being booked into the detention facility are being asked to participate during the data collection periods. No one is being singled out.

3) There are no benefits other than feeling good that you have participated in a project that will make things better in the future for people coming into the facility.

4) If during or after the survey, you feel any emotional discomfort from the survey, the jail has mental health staff you can talk with (please refer).

5) All information will be kept confidential with the exception of reports to harm yourself or others, which by law the study personnel are required to report. Information that the researchers get will have only inmate numbers, ***no names.*** Researchers do not have access to the jail lists that have names attached. We are not directly asking questions about harming self or others on this particular survey.

6) Your participation will not affect the disposition of your case or the care that you receive within the facility.

7) Participation is ***strictly*** voluntary. Even after signing the consent, you can terminate your participation at any time.

8) You may choose not to answer certain questions.

9) There are two parts to the consent: consent to participate and consent for release of information in the records by inmate number.

Techniques for Obtaining Consent

Your relationship with the person when asking them to participate is very important. You must convince the person that the survey is to better serve them. ***You too, should remember that this research is being done to better assess current and future detainees, and in the process make your job easier.***

You want to convince them that this is an important and worthwhile project, and their participation is vital to the research success. You and your words must convey your credibility. You should be serious, pleasant, and self-confident, that you, yourself, believe this is important.

You should be prepared to answer in a calm, professional manner, any questions the inmate might ask. In order to do this you must learn as much about the study as you can and write out your explanations in your own words. This serves to focus your thoughts and reinforce your confidence. You should have several different explanations and approaches ready so as to adjust your introduction to suit the person you are talking to. Approach each person as if s/he were friendly and interested. You should assume that if they aren't, it is because they are not yet informed about what we are doing. Listen carefully to what they have to say, the tone of their voice, any background noises, and respond accordingly. Some subjects will be quite willing to participate with only a brief explanation of purpose; for others you will need to go into some detail. It is best to begin with a brief explanation and save your more detailed explanation to use as needed. Don't overwhelm the person with more information than they want or need. Talk to, not at them. ***If they believe you are really interested in what they have to say, they are more likely to participate.***

Your state of mind is often reflected in your respondent's reaction. If your approach is uncertain or uneasy, this feeling will be communicated to the respondent who will react accordingly. If you have a pleasant, positive, and well-informed approach, this again will be reflected in the respondent's attitude. Your effectiveness will be increased by the knowledge that survey research is legitimate and important.

Refusal Conversion

Persuasion techniques are important in order to avoid refusals.

1) Be confident - take pride in the facility's participation in this study and your association with both Universities as well as a one-of-a-kind National Institute of Justice study.

2) Have a very smooth introduction; do not pause or hesitate.

a. Know all about the study you are working on and be ready to answer all questions.
b. START simply - the person you are speaking with will ask for more information if they want it.
c. SLOW DOWN - and use words in your explanations that are easily understood.

3) Listen carefully - you cannot respond to people's reaction to you if you don't listen carefully to inflections in their voices; and feedback they give you while you are answering their questions.

4) Be so well prepared that there is nothing the respondent can say that will surprise you. You must offer a solution to any excuse or concern.

5) Try not to push a refusal - leave the door open or take a refusal and ask again while they remaining in booking.

6) Increase your knowledge of the survey in order to build your self-confidence.

7) Anticipate common subject comments and questions, and write out explanations in your own words.

Rights and Responsibilities/Confidentiality

Confidentiality means that information is not shared outside the setting where it was obtained; it is kept secret or private. There are several types of confidentiality involved with this study.

1) Employee/Researcher confidentiality means that personal information will not be shared outside the project staff.

2) Respondent confidentiality means that we will not reveal the names of the detainees who participated in the study. Actually the researchers will have only inmate numbers and not have names available to them. When they share the results of the study with others, no individual's responses can be identified. It also means that the researchers at the University will not discuss any personal information that they learn during the course of any survey with anyone including detention staff except where they might be required by law if the detainee reveals plans to hurt others. Please see the section Confidentiality Policy for other ways that we will protect the information we collect.

3) Community confidentiality means that we safeguard the identity of the specific setting in which this research takes place unless agreed upon with appropriate persons when talking or writing about the results in public forums. When referencing the setting, research staff can say a County Detention Facility located in the "Northern Plains".

4) Exceptions to confidentiality occur when someone may be dangerous to himself/herself or others. However, research staff will not receive the surveys until almost a week after the survey is completed and then they will not be analyzed for months. There will be weekly mailings of the survey to the University. Thus, this process can prolong any reporting. Also we do not ask about these items in this survey.

5) Survey Confidentiality means that the survey materials that we will be using are not to be shared with anyone except research staff. It is important to let respondents in the study know what the study is about and the nature of the questions we will be asking (see Rights of Research Participants). However, we will not show individual survey materials to people outside of the study. These materials are tools for research that are only to be used by people who have been trained to administer them. Always keep the completed surveys in a safe place.

C. When to Delay the Survey

This issue is pretty simple. ***Delay the survey process anytime that you would delay the orientation process or release***: combative situations or when persons are mentally, or physically impaired to doing regular orientation procedures. Wait the normal amount of time that you would attempt to complete orientation procedures, and after starting orientation, offer their participation in the survey process.

Once consent is given, if an inmate is identified as being unable to read the survey, forward the completed consent and the survey to Nancy Fleming, the mental health worker who will then administer the survey.

There are only two times when you should not ask detainees to participate: 1) If they are under the age of 18. Please mark the consent form "underage", and 2) if you are unable to obtain a signed consent. Again please mark their consent form "refused."

D. When to Make A Referral

During the survey, some questions may bring some emotional discomfort. We do not expect this to happen. However, we need to be aware that this is a possibility. If the situation arises, use your normal mental health referral policy and procedure. Any time a respondent becomes emotional, you should ask if they need help. The respondent can then decide if they would like to be referred or not to mental health. Since we also need to be made aware of this, please make documentation of this, and have a copy sent to Christa Cavenah who will forward to us.

If a person does not request a mental health referral but seems upset, a special watch is indicated, and let the supervisor and mental health worker know.

For any situation that makes you uncomfortable or seems out of the ordinary, please contact mental health and your supervisor who will in turn then contact [Jail Adminstrator] who will contact Drs. Duclos & Severson.

IV. DETENTION ADMINISTRATION

A. Intake Information

Weekly, Christa will print out intake information by booking and inmate number. This information should include **all** those that have been booked into the detention facility during that last week or reporting period. We have developed a database in which we will track all intakes to make sure everyone that is eligible has been asked to participate. Since the booking process has a consecutive numbering system, tracking will be made easier. Information to be pulled off the computer for **each** individual intake during the data collection period and mailed includes:

Booking #
Master ID #

Booking Date
Time of Booking
Age
Gender
Charges
Copies of the "Alternate Suicide Screening Form"
Consent
This Survey

Names must be blacked out on all information, and appropriate numbers attached.

B. Mailing to University of Kansas

Weekly, Christa or whomever she designates, will mail this information, plus all completed surveys and consents/refusals to the University of Kansas. **We should have a consent/refusal, survey in manila envelope if appropriate, and additional booking information on everyone that is included in the weekly computer roster.**

This information should be send overnight using the Federal Express forms provided. ***Please mark on the form that signature is required for delivery***. It is extremely important to treat this data like gold, tracking is very important. We do not want to lose any valuable data. It might be best to keep a shipping log by date of all information by booking numbers to make tracking easier.

ADDRESS: Margaret Severson/Susanne Holtquist
University of Kansas, School of Social Welfare
303 Twente Hall
Lawrence, KS 66045-2510

Remember that the information contained in these documents is **confidential**. Be sure these documents are not accessible to anyone but project staff.

C. Questions & Contact Information

Please do not hesitate to call either Drs. Severson or Duclos, or their assistants for anything!

Margaret Severson	785-864-4720 (w) 785-749-5272 (h)	Chris Duclos	303-315-9700 (w) 303-399-8315 (h)
Susanne Holtquist	785-864-3825 (w)	Amie Staudenmaier	303-315-9700 (w) 303-873-6517 (h)

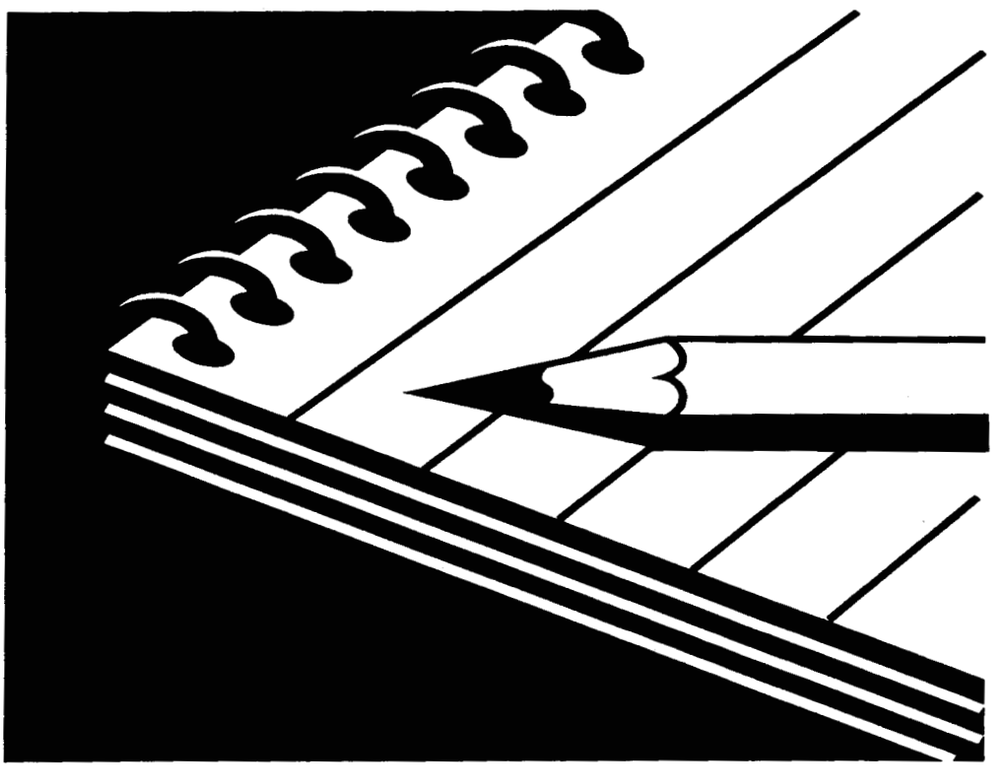
Thank you for your hard work and efforts. You are contributing to a better booking process!

Appendix C 2: Feedback and Satisfaction Survey

Booking ID # _____

[ANONYMOUS] COUNTY DETENTION FACILITY

FEEDBACK AND SATISFACTION SURVEY



*Booking ID #*_____

Booking Survey

This survey asks about your experience when you were booked into the jail. We are studying our booking procedures, especially the questions you were asked when you first came in to the jail. The answers to this survey will be kept ***confidential***. Your name will not be on the survey so no one will know your answers. The survey will be given to researchers who are helping us to improve our booking procedures. ***Please answer each question honestly.*** If you don't understand a question, please let an officer know so that he/she may assist you.

Your help is VERY IMPORTANT to us. Thank you for your participation.

1. When you were brought into jail, did someone ask you questions about your:

Physical Health	○ NO	○ YES
Mental Health/Emotional Well-Being	○ NO	○ YES
Use of Drugs/Alcohol	○ NO	○ YES

2. How honest were you when this person asked you about your:

Physical Health?

Not At All Honest	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*Totally Honest*

Mental Health / Emotional Well-Being?

Not At All Honest	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*Totally Honest*

Use of Drugs / Alcohol?

Not At All Honest	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*Totally Honest*

3. How comfortable were you answering the questions asked about your:

Physical Health?

Not At All Comfortable	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*Totally Comfortable*

Mental Health / Emotional Well-Being?

Not At All Comfortable	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*Totally Comfortable*

Use of Drugs / Alcohol?

Not At All Comfortable	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*Totally Comfortable*

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4. **How comfortable were you with the amount of privacy you had during this questioning?**

Not At All Comfortable	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*Totally Comfortable*

5. **If you answered that you had a medical condition, was it because (please check <u>all</u> that apply):**

   - O The person seemed concerned about me
   - O I knew that I needed immediate help
   - O I was concerned that I would harm myself if I didn't tell someone
   - O I am on medication and wanted it to be prescribed while I was in jail
   - O I felt like I could trust this person to get the information to the right medical and/or mental health staff

6. **If you answered that you had a mental health / emotional condition, was it because (please check <u>all</u> that apply):**

   - O The person seemed concerned about me
   - O I knew that I needed immediate help
   - O I was concerned that I would harm myself if I didn't tell someone
   - O I am on medication and wanted it to be prescribed while I was in jail
   - O I felt like I could trust this person to get the information to the right medical and/or mental health staff

7. **If you answered that you had an drug / alcohol problem, was it because (please check <u>all</u> that apply):**

   - O The person seemed concerned about me
   - O I knew that I needed immediate help
   - O I was concerned that I would harm myself if I didn't tell someone
   - O I am on medication and wanted it to be prescribed while I was in jail
   - O I felt like I could trust this person to get the information to the right medical and/or mental health staff

8. **If you did <u>not</u> tell the person that you had a medical condition, was it because (please check <u>all</u> that apply):**

   - O I do not have a problem
   - O The person did not seem concerned about me
   - O I did not think that I needed immediate help
   - O I was not thinking of suicide or harming anyone else
   - O I am not on any medication
   - O I did not feel like I could trust the person
   - O I did not think the information would get to the medical staff

CONTINUED ON NEXT PAGE

9. If you did not tell the person you had a mental health condition or emotional problem, was it because (please check all that apply):

- ○ I do not have a problem
- ○ The person did not seem concerned about me
- ○ I did not think that I needed immediate help
- ○ I was not thinking of suicide or harming anyone else
- ○ I am not on any medication
- ○ I did not feel like I could trust the person
- ○ I did not think the information would get to the medical and/or mental health staff

10. If you did not tell the person you had a drug / alcohol problem was it because (please check all that apply):

- ○ I do not have a problem
- ○ The person did not seem concerned about me
- ○ I did not think that I needed immediate help
- ○ I was not thinking of suicide or harming anyone else
- ○ I am not on any medication
- ○ I did not feel like I could trust the person
- ○ I did not think the information would get to the medical and/or mental health staff

11. How would you rate your overall experience when you were asked these questions?

- ○ Excellent
- ○ Very good
- ○ Average
- ○ Not so good
- ○ Poor

12. How confident are you that you can keep from feeling sad or down in the dumps?

Not at all Confident	1	2	3	4	5	6	7	8	9	10	**Totally Confident**

13. When you came into jail, were you most angry with (check one)

- ○ myself
- ○ my family
- ○ friends
- ○ the arresting officer
- ○ the booking officer in the jail
- ○ other (please write that person's relationship to you) _____

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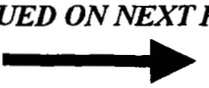

14. Your opinions are important to us. What was helpful about being asked these questions? How could we improve this process?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ABOUT YOU

1. What is your age? _____

   Are you? ○ Male

   ○ Female

2. Check (4) the group that best describes you?
   - ○ White
   - ○ Black
   - ○ Hispanic or Spanish
   - ○ American Indian
     Tribal Affiliation_____
   - ○ Asian
   - ○ Pacific Islander
   - ○ Other _____

4. Are you currently …
   - ○ Employed full-time or part-time
   - ○ Self-employed
   - ○ Student
   - ○ Student and employed full-time or part-time
   - ○ Retired
   - ○ Disabled
   - ○ Temporarily unemployed
   - ○ Not looking for paid employment
   - ○ Other

THANK YOU

PLEASE RETURN THIS TO THE OFFICER

Appendix C 3: Feedback and Satisfaction Survey Consent Forms

Group: _____
Date: _____

YEAR TWO: FOCUS GROUP QUESTIONS
SCREENING PROTOCOL: _____

1. At some point when being booked into the jail, officers asked you some questions about suicide, if you felt like hurting yourself, have you tried to hurt yourself in the past, etc. Do you remember that? Do you remember where you were?

   - Where did this happen?
   - How did it happen?
   - Who asked you the questions?

2. How did this go?

   - What do you remember about being asked?

3. How comfortable were you when you were asked these questions?

   - Were you honest with your answers?

   If yes, why?_____.

   - What do you think helped you in being honest?

   If no, why? _____.

   - What might have helped you in being more honest?

4. If you have been here before, have you noticed any difference in the booking screening procedures?

   - What is different?
   - Is this for the better or not?
   - Why?

5. Do you think the jail should be asking these questions?

6. Were you asked to take the two-page survey right before you were moved upstairs asking about comfort level during booking screening?

   - Did you? Why? _____ Why not? _____
   - Were you honest? If so, why? _____
   - What made you answer honestly? _____

   - If not, why?_____
   - What would have helped make you more honest with these answers?

7. Is there anything else you want to tell us?

Appendix C 5: Focus Group Consent Form – Inmates' Group

Appendix C 6: Focus Group Guide/Questions – Officers' Group

Officer Focus Group Questions

1. Do you know why you ask the suicide screening questions at booking?
   Probes:
   - How useful do you think the screening is?
   - Is this a good time to ask these questions?
   - Is there a better time?
   - Is there an additional time these questions should be asked?

2. Were you trained in how to ask these screening questions?
   Probes:
   - If yes, who gave the training?
   - Do you think the training was adequate?
   - If no, what would have helped?

3. Every person develops their own style of asking these questions. Without assuming there is any right or wrong way, can you describe your individual styles?

4. The first question asks about the arresting officer's opinion if the detainee is suicidal. How do you get the answer to that?
   Probes:
   - Do they tell you, fill out themselves, etc.?
   - If the officer gives you information, how does the response impact your assessment?

5. Do some of those questions make more sense than others questions to you?

6. Do some of these questions make you feel uncomfortable?
   Probes:
   - For example, one question asks you to note if the inmate is currently suicidal. How do you find that out?
   - How comfortable are you asking someone specifically about being suicidal?
   - Also, one of the questions asks if the detainee holds a position in the community. Do you understand that question? How do you ask that question?

7. How do you get to your conclusions about suicide risk?
   Probes:
   - Is it from the screening form's questions & answers?
   - Are there other things you take into account that are not on the form?
   - If so, how did you learn that?
   - Are you the person who ought to be doing this screening?

8. Are there different ways you might ask some of the questions?
   Probes:
   - Federal vs. local
   - Indian vs. nonIndian
   - Male vs. female

9. OK. You believe someone is suicidal, what do you do?
   Probes:
   - Do you feel comfortable responding?
   - Do you feel competent responding?
   - When you go home believing some detainee that you booked in that night how do you manage that?

10. If you could do something that in your opinion would improve screening, what would that be?

11. Do you think screening done at intake prevents suicide?

12. Is there anything else you would like to tell us that we didn't ask about this issue?

Appendix C 8: Year Two Quantitative Data (CD-ROM)