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Note

Prisoner Suicide: A Need for a Clearly Established Right to Suicide Prevention Protocols

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**I. Introduction**

Suicide has cemented its place in modern discourse and prisoners are among those most affected by the mental health issues that plague modern society. In fact, suicide is the leading cause of death in jails and the third leading cause of death in prisons.[[2]](#footnote-2) For example, in 2016, the suicide rate in the general population was nearly 12 instances of suicide per 100,000 individuals; by contrast, that number was nearly four times higher in jails, with 46 instances of suicide per 100,000 individuals.[[3]](#footnote-3) Despite all this—as we will see—our current carceral system is not doing nearly enough to safeguard inmates’ healthcare rights. One possible remedy is for the judicial system to recognize the right to suicide prevention protocols in correctional systems.

Inmates do have some options—albeit limited—when it comes to seeking redress after their rights are violated. These methods, however, are inadequate. For instance, an inmate must first prove “deliberate indifference” to vindicate his or her claim under 42 U.S.C. § 1983 (Section 1983).[[4]](#footnote-4) Strikingly, most individuals with suicidal urges do not outwardly express those urges. A state actor cannot be proven “deliberately indifferent” when an inmate did not outwardly display a desire to commit suicide. Other claims derived from Section 1983—such as those based on municipal liability—also require the same showing of deliberate indifference.[[5]](#footnote-5) Considering all this against the background of qualified immunity’s effectiveness in barring claims against most government actors in these situations, an inmate faces an uphill battle when it comes to vindicating their statutory rights. Along the same lines, most individuals whose rights have been violated in suicide-based claims have already lost their most precious resource—their life. This is, in large part, because of the misguided reliance of the judicial system on outdated United States Supreme Court precedent.

The problem of inmate suicide could be better addressed with the implementation of telemedicine and different correctional models that hone in on the root causes of suicide. These methods are preventative in nature and need to be implemented at either booking or in the early stages of an inmate’s confinement. Thus, the lack of a clearly recognized right to suicide prevention protocols stalls any improvement in the screening and prevention of suicide in correctional systems.

In the following Note, I will advocate for a clearly established right to suicide prevention protocols in correctional systems. To begin, in Part II, I will examine the mechanisms behind suits for the vindication of prisoner’s constitutional and statutory rights. Examination of the current vehicles for vindication is important, primarily because most of these methods—though available to prisoners—are insufficient to provide redress. Part III will elaborate on the immense problem of inmate suicide in correctional systems and the steps that need to be taken to move toward the prevention of inmate suicide. Last, Part IV will argue that courts should recognize the right to adequate suicide prevention protocols. Absent a clearly established right to adequate suicide prevention protocols, correctional systems are not incentivized—via potential liability—to adopt those protocols.

**II. Background on Suicide-Based Litigation**

Claims based on a violation of constitutional rights have several possible avenues for relief. Among these claims are ones brought by prisoners against jail officials and municipalities. In the suicide litigation spectrum, these suits include claims based on harms deriving from a jail official’s deliberate indifference to an inmate’s suicide risk and a municipality’s failure to train the municipality’s employees or officials.

First, Section A will cover the origin and development of Section 1983 claims, specifically as related to prisoner suicide. Second, Part B will explain courts’ recognition of suicide-based claims premised on allegations of deliberate indifference. Third, Part C will elaborate on the split among the federal circuits in determining what is required of a plaintiff’s *Monell* claim based on a prisoner’s suicide. And, last, Part D will examine how qualified immunity sometimes precludes suicide-based claims.

**A. 42 U.S.C. § 1983: History and Development**

Section 1983 was enacted by the 42nd Congress in 1871.[[6]](#footnote-6) Section 1983 provides a cause of action for a deprivation of constitutional rights by any person acting “under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia. . . .”[[7]](#footnote-7) Stated differently, “Section 1983 is best understood as a federal statute which creates a fourteenth amendment action for damages.”[[8]](#footnote-8) To state a viable claim under Section 1983, a civil rights plaintiff must establish two elements: “(1) the violation of a right ‘secured by the Constitution or laws of the United States’ and (2) that the person who committed the alleged deprivation was ‘acting under the color of state law.’”[[9]](#footnote-9)

Section 1983 states that “every person” acting under state law is liable for any deprivation of constitutional rights that they may cause. This general statement of “every person,” however, has been limited by the Supreme Court of the United States. For example, the Supreme Court has extended absolute immunity to state legislators, judges, and prosecutors while extending qualified immunity to others.[[10]](#footnote-10) This extension of qualified immunity will be covered later in this Note. Surprisingly, Section 1983 experienced a long period of inactivity until its resurrection in 1961.[[11]](#footnote-11) After its resurrection, Section 1983 saw an increase in usage, especially regarding suits brought by prisoners.[[12]](#footnote-12)

**B. Suicide in the Deliberate Indifference Context**

The treatment of prisoners is subject to the Eighth Amendment’s bar on “cruel and unusual punishment.”[[13]](#footnote-13) To prove an Eighth Amendment violation pursuant to Section 1983, a prisoner must meet a two-prong test. First, the prisoner must satisfy the objective component of the test.[[14]](#footnote-14) This component requires a showing that the violation was objectively harmful enough to be a constitutional violation.[[15]](#footnote-15) Second, the prisoner must then satisfy the subjective component of the two-prong test.[[16]](#footnote-16) To do so, the prisoner must show that the prison official acted with a culpable mental state.[[17]](#footnote-17)

The key question is whether the relevant official acted with “deliberate indifference” regarding the inmate’s, or inmates’, health and safety.[[18]](#footnote-18) The Supreme Court has extended the deliberate indifference test to inmates’ claims of inadequate medical care.[[19]](#footnote-19) Further, in the context of suicide and mental health litigation, courts have recognized that the denial of adequate mental health care can amount to a violation of an inmate’s Eighth Amendment rights.[[20]](#footnote-20) Some courts have even gone as far as to hold that suicide itself rises to the level of an objectively harmful constitutional violation. For example, the Seventh Circuit held that “[i]n prison suicide cases, the objective element is met by virtue of the suicide itself . . . .”[[21]](#footnote-21) Similarly, the Tenth Circuit stated that “[s]uicide qualifies” as sufficient proof of the deliberately indifferent conduct.[[22]](#footnote-22) In essence, not only is the objective component of the deliberate indifference inquiry met by general mental health needs, but in some jurisdictions an instance of suicide alone is sufficient.

However, the objective inquiry is not, alone, sufficient to establish a deliberate indifference claim. Courts have also required the inmate to show that the prison official “(1) subjectively knew the prisoner was at substantial risk of committing suicide and (2) intentionally disregarded the risk.”[[23]](#footnote-23) For current purposes, however, courts acknowledge that mental health and suicide are both sufficiently serious to warrant constitutional protections in the United States.

Further, Section 1983 litigation also encompasses claims—commonly referred to as *Monell* claims—against municipalities.[[24]](#footnote-24) A municipality, however, “may not be sued under § 1983 for an injury inflicted solely by its employees or agents.”[[25]](#footnote-25) Instead, a municipality is only subject to liability when the undertaking of a municipality’s “policy or custom, whether made by its lawmakers or by those whose edicts or acts may fairly be said to represent official policy, inflicts the injury that the government as an entity is responsible under § 1983.”[[26]](#footnote-26)

A common theory of liability sought under *Monell* is a claim for a municipality’s failure to train its own officers or employees to avoid deprivations of constitutional rights.[[27]](#footnote-27) The Supreme Court first recognized the “failure to train” theory as legally cognizable in 1989.[[28]](#footnote-28) The “failure to train” theory can also lead to a plaintiff’s recovery against the municipality in a suit for deliberate indifference to medical needs by jail staff because the execution of the government’s policy or custom will subject the government to civil liability.[[29]](#footnote-29)

In addition, the Supreme Court has also renounced “punishments which are incompatible with ‘the evolving standards of decency that mark the progress of a maturing society.’”[[30]](#footnote-30) Thus, the Court itself has left room for these standards to change alongside social norms. Accordingly, further protections should be afforded to prisoners with serious health needs and suicidal tendencies. One such protection could be afforded through a clearly recognized right to suicide prevention protocols.

**C. Circuit Split: The Showing Needed for *Monell* Liability**

Circuits take slightly different approaches in interpreting the standard for a *Monell* claim, wherein the plaintiff must show that a municipality failed to adequately train employees regarding an inmate’s risk of suicide. The Sixth Circuit has taken a broad approach and held that *Monell* “imposes a duty on the part of municipalities to recognize, or at least not to ignore, obvious risks of suicide that are foreseeable.”[[31]](#footnote-31) The Third Circuit, on the other hand, has taken a narrower one, holding that the plaintiff must satisfy two elements.[[32]](#footnote-32) First, the inmate must “identify specific training not provided that could reasonably be expected to prevent the suicide that occurred . . . .”[[33]](#footnote-33) Second, the inmate must “demonstrate that the risk reduction associated with the proposed training is so great and so obvious that the failure of those responsible for the content of the training program to provide it can reasonably be attributed to a deliberate indifference to whether the detainees succeed in taking their lives.”[[34]](#footnote-34) On the other hand, the Fifth Circuit completely disposed of a prisoner’s claim, in holding that a failure to train officials “in screening procedures to detect *latent* suicidal tendencies does not rise to the level of a constitutional violation.”[[35]](#footnote-35)

While the showing required from a plaintiff to hold a municipality liable for its customs or policies regarding suicide prevention protocols may differ among the circuits, the common thread among all the circuits is that the policies and customs that lead to inmate suicide may be actionable, at least under some circumstances.

**D. Qualified Immunity**

Defendants in Section 1983 litigation may also invoke the affirmative defense of “qualified immunity.”[[36]](#footnote-36) In 1967, in *Pierson v. Ray,* the Supreme Court recognized, for the first time, the principle of qualified immunity as a defense to a Section 1983 claim.[[37]](#footnote-37) In *Pierson*,the Court was first confronted with the question of whether a judicial official possessed immunity from a Section 1983 claim for damages.[[38]](#footnote-38) The Court easily ruled regarding the immunity claim possessed by the judge, noting “[f]ew doctrines were more solidly established at common law than the immunity of judges from liability for damages for acts committed within their judicial jurisdiction . . . .”[[39]](#footnote-39)

Whether to extend immunity to the police officers involved in the case, however, was a more difficult question. Preliminarily, the Court noted that unlike judicial officials, police officers have never possessed absolute immunity.[[40]](#footnote-40) However, the Court determined that the common law defenses of good faith and probable cause that were available to police officers at the time in actions alleging false arrest and imprisonment could be extended to Section 1983 claims.[[41]](#footnote-41) Thus, the principle of qualified immunity in Section 1983 litigation was born.

The newly minted defense of qualified immunity was quickly refined. Soon after the decision in *Pierson* was handed down, the Supreme Court in *Wood v. Strickland* expanded on the test that determines whether a defendant is covered by qualified immunity.[[42]](#footnote-42) Resolving a split between the district court and appellate court over whether the test was objective or subjective, the Court held that “the appropriate standard necessarily contains elements of both.”[[43]](#footnote-43) The Court then went on to say that an official must “be acting sincerely and with a belief that he is doing right . . . .”[[44]](#footnote-44) While the Court in *Wood* restricted its holding to school officials, subsequent rulings cited *Wood*’s holding as the general rule on qualified immunity.[[45]](#footnote-45)

Along the same lines, a few years after the decision in *Wood*, the Court then provided a justification for qualified immunity.[[46]](#footnote-46) At the forefront of the justification was qualified immunity’s ability to dispose of groundless lawsuits or, stated differently, “insubstantial claims.”[[47]](#footnote-47) This disposal, the Court reasoned, would prevent “insubstantial claims” from proceeding to trial.[[48]](#footnote-48) This justification, however, had the opposite effect than the Court likely intended. Years after the Court admonished “insubstantial claims” proceeding to trial, the Court proceeded to reevaluate the subjective element of the qualified immunity analysis in *Harlow v. Fitzgerald*.[[49]](#footnote-49) The Court noted that most questions of fact proceed to trial for the jury’s evaluation.[[50]](#footnote-50) Since the subjective element of qualified immunity was categorized as a question of fact at that time, most qualified immunity cases proceeded to trial.[[51]](#footnote-51) This, the Court reasoned, was incompatible with the Court’s original goals.[[52]](#footnote-52) Noting that inquiry into an official’s state of mind is expensive, and possibly never ending, the Court further stated that “[i]nquiries of this kind can be peculiarly disruptive of effective government.”[[53]](#footnote-53)

After eliminating the subjective inquiry, the Court pronounced a test for the modern age.[[54]](#footnote-54) The Court, in *Harlow*,established the modern test for qualified immunity. The test in its current form states that government officials “generally are shielded from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known.”[[55]](#footnote-55) Reshuffled into an elemental form, the test states that a government official is protected by qualified immunity unless the plaintiff demonstrates “(1) that the official violated a statutory or constitutional right, and (2) that the right was ‘clearly established’ at the time of the challenged conduct.”[[56]](#footnote-56)

*Harlow* established that the boundaries of qualified immunity are not shaped by the common law. Instead, the contours of qualified immunity are shaped by policy considerations.[[57]](#footnote-57) Among these policy considerations are “two important interests—the need to hold public officials accountable when they exercise power irresponsibly and the need to shield officials from harassment, distraction, and liability when they perform their duties reasonably.”[[58]](#footnote-58)

The Court has also noted two other justifications for the doctrine of qualified immunity. First, qualified immunity protects against financial liability on behalf of government officers—though this justification may be futile.[[59]](#footnote-59) Because most government officials are almost always indemnified and rarely pay judgments rendered against them, the “[n]ear certain and universal indemnification drastically reduces the value of qualified immunity as a protection against the burden of financial liability.”[[60]](#footnote-60) Second, like the Court did in *Harlow*,the Court has, on occasion, also justified the doctrine based on the enormous expense on governmental entities incurred from the discovery and trial processes.[[61]](#footnote-61) This justification, like the first, may be similarly insubstantial.[[62]](#footnote-62)Studies demonstrate that qualified immunity is very seldom raised before discovery begins.[[63]](#footnote-63) And, when the defense is invoked, motions seeking dismissal based on qualified immunity are rarely granted.[[64]](#footnote-64) Thus, qualified immunity rarely reduces the expenses on government entities from the discovery and trial processes.

**1. The Development, or Lack Thereof, of a Clearly Established Constitutional Right to Suicide Prevention**

As stated in *Harlow*, a government official must “violate clearly established statutory or Constitutional rights of which a reasonable person would have known,”[[65]](#footnote-65) in order to be liable for civil damages. Of course, the Court has taken the time to further elaborate on what showing is needed to establish these constitutional rights. A constitutional right need not be expressly stated in order to be clearly established but “[t]he contours of the right must be sufficiently clear that a reasonable official would understand that what he is doing violates that right.”[[66]](#footnote-66) And while case law directly addressing the issue is not always required, “existing precedent must have placed the statutory or constitutional question beyond debate.”[[67]](#footnote-67)

**2. The Rocky Beginnings of a Clearly Established Right to Suicide Prevention**

The oft-cited case expanding on an inmate’s constitutional right to suicide screening and prevention measures is *Taylor v. Barkes*. The inmate, Christopher Barkes,suffered from a long history of mental illness and substance abuse problems.[[68]](#footnote-68) Barkes’ history of mental illness included a suicide attempt while incarcerated in 1997.[[69]](#footnote-69) After Barkes’ period of incarceration, he attended a substance abuse program, only to relapse and attempt to fatally overdose.[[70]](#footnote-70) Then, less than a year later, Barkes attempted to commit suicide twice in one day.[[71]](#footnote-71) Soon thereafter, he was found in an intoxicated state by a parole officer.[[72]](#footnote-72) The officer took Barkes to a hospital for treatment, where he once again attempted suicide.[[73]](#footnote-73) A few months later, he violated the terms of his parole resulting in his arrest and subsequent imprisonment.[[74]](#footnote-74)

During booking on the same day of his arrest, Barkes underwent a medical intake and screening conducted by a licensed practical nurse (LPN).[[75]](#footnote-75) This screening included a form that inquired into his mental health, suicidal ideations, and suicide risk factors.[[76]](#footnote-76) Barkes admitted to one earlier suicide attempt, but not the two suicide attempts that took place on the same day.[[77]](#footnote-77) Despite his history, Barkes only met two of the suicide risk factors outlined in the intake and therefore only received “routine” status.[[78]](#footnote-78) The next day, Christopher Barkes was found hanging in his cell.[[79]](#footnote-79)

The cause of action pursued in this case primarily relied on the private medical contractor’s failure to adhere to national guidelines which provided sample intake and mental health forms.[[80]](#footnote-80) Among the discrepancies between the contractor’s actions and the national guidelines was the fact that the mental health screening was administered by an LPN, instead of a licensed mental health provider, as required by the guidelines.[[81]](#footnote-81) Barkes’ family argued that, had a mental health provider administered the assessment, an affirmative answer to the “past attempted suicide” question would have resulted in a referral.[[82]](#footnote-82)

At the trial court, cross-motions were filed by both the plaintiff and defendants.[[83]](#footnote-83) At that point, the defendants raised the issue of qualified immunity.[[84]](#footnote-84) The court, however, denied both motions.[[85]](#footnote-85) The defendants appealed this denial, and after an extensive discussion of supervisory liability, the appellate court turned to the issue of qualified immunity.[[86]](#footnote-86) Applying the two-prong test in reverse order, the court examined the “clearly established” law prong of the qualified immunity analysis. The Court disagreed with the defendant’s definition of the contested right, instead defining the right at issue as “an incarcerated person’s right to the proper implementation of adequate suicide prevention protocols.”[[87]](#footnote-87)

The Third Circuit, at the time of Barkes’ death, “had long recognized that an inmate’s ‘particular vulnerability to suicide’ is a serious medical need that prison officials may not recklessly disregard.”[[88]](#footnote-88) At the heart of the court’s analysis was a 1988 opinion stating that a prison official’s intentional, reckless, or grossly negligent violation of a liberty interest is indistinguishable from a violation where instead of the official inflicting the injury, the prisoner inflicted the injury on themself.[[89]](#footnote-89) The court also turned to Supreme Court precedent, noting that *Estelle v. Gamble* held that prison administrators violate the Eighth Amendment when the administrators “exhibit ‘deliberate indifference to serious medical needs of prisoners.’”[[90]](#footnote-90) Following from this observation, the court determined that a “‘particular vulnerability to suicide’ is a serious medical need encompassed within the rule of *Estelle*.”[[91]](#footnote-91)

The defendants petitioned for certiorari and their petition was granted. The Supreme Court found the Third Circuit’s reasoning unpersuasive.[[92]](#footnote-92) The Court determined that, as of 2004, it had not established “a right to the proper implementation of adequate suicide prevention protocols.”[[93]](#footnote-93) Further deflating the Third Circuit’s reasoning, the Supreme Court highlighted that none of its own precedent even discussed adequate suicide prevention protocols.[[94]](#footnote-94) The Court pointed to opinions from the Fourth, Fifth, Sixth, and Eleventh Circuits, all of which, in some manner or way, rejected the idea that a right to proper suicide screening was a recognized constitutional right.[[95]](#footnote-95) The Court then dissected the Third Circuit cases relied upon by the lower court, noting that neither decision held that a facility must have procedures in place to identify vulnerable inmates.[[96]](#footnote-96) And just like that, with a five-page, *per curiam* opinion, any hope for a clearly established constitutional right to suicide prevention for inmates was dashed.

**3. Other Developments in the Establishment of the Right**

Although the Supreme Court’s holding in *Taylor v. Barkes* certainly dashed hopes of a clearly established right to suicide prevention protocols, some hope remains. In a relatively recent opinion out of the Southern District of Texas, the proposition from *Taylor*—that there is no clearly established right to suicide prevention protocols—was rejected.[[97]](#footnote-97) In that case, the plaintiff alleged that the jail failed to implement adequate suicide protocols after several inmate suicides and disciplinary actions by the Texas Commission on Jail Standards.[[98]](#footnote-98) After one inmate’s psychiatric evaluation—which detailed present suicidal ideations—the jail deemed the inmate “healthy.”[[99]](#footnote-99) The inmate was transferred to the general population after being on suicide watch, but was then transferred to solitary confinement after being belligerent to another inmate.[[100]](#footnote-100) On the inmate’s second day of solitary confinement, the inmate committed suicide.[[101]](#footnote-101)

After a Section 1983 lawsuit was initiated, the defendants brought a motion to dismiss.[[102]](#footnote-102) One of the arguments brought by the defendants was that the plaintiff failed to plead a violation of a “clearly established” right to adequate suicide prevention protocols.[[103]](#footnote-103) What is more, the defendants cited *Taylor* for this proposition.[[104]](#footnote-104) The court, however, took a new approach to complying with the mandate of *Taylor.*

The court held that *Taylor* only stood for the proposition that the right was not “‘clearly established’ for qualified immunity purposes under [then-existing] Supreme Court or Third Circuit case law.”[[105]](#footnote-105) In contrast, the court reasoned, the Fifth Circuit has been much more favorable to inmates’ suicide-based claims.[[106]](#footnote-106) And the court noted that the Fifth Circuit has also recognized that a “failure to provide pre-trial detainees with adequate protection from their known suicidal impulses is actionable under § 1983 as a violation of the detainee’s constitutional rights.”[[107]](#footnote-107)

Another interesting development in the recognition of this constitutional right is an Arizona District Court case. In this case, an allegation was brought against a supervisor of a state correctional facility.[[108]](#footnote-108) The supervisor maintained a policy by which correctional officers were required to turn in their keys and radios before leaving the facility, causing some officers to perform sight checks without keys or radios.[[109]](#footnote-109) The facility was warned that this policy could cause problems with the risk of inmate suicide.[[110]](#footnote-110) Without her keys or radio, one of the correctional officers noticed an inmate hanging by his neck, but was unable to immediately enter the cell to save the inmate.[[111]](#footnote-111)

The defendants, once again, relied on *Taylor*.[[112]](#footnote-112) The court, however, distinguished *Taylor*,finding that in *Taylor*,there were no allegations that a prison’s inadequate protocols “were known to pose a serious risk of harm to the inmates such that every reasonable official should have known that not having specific procedures was violative of the constitution.”[[113]](#footnote-113) Here, the court noted that the defendant was aware that the policies posed a specific risk to inmates and continued to implement the policies anyway, making *Taylor*’s holding not dispositive.

Ultimately, lower courts’ adherence to *Taylor* is inconsistent. Most courts seem to reject any degree of departure from *Taylor*’s mandate. Others, however, such as the United States District Court for the Southern District of Texas, have found some flexibility within the rigid pronouncement of *Taylor*, opting to find a remedy where there previously was none. It is yet to be seen whether more courts will do the same.

**III. The Dynamics of Prison Suicide and Prevention**

As noted, suicide is the leading cause of death in jails and the third leading cause of death in prisons.[[114]](#footnote-114) In the United States—in 2020 alone—45,173 individuals died by suicide, making suicide the tenth leading cause of death among people of all ages.[[115]](#footnote-115) The 2020 total marked an increase of 2,400 deaths since 2014, and an increase of 15,974 deaths since 1994.[[116]](#footnote-116) It is time for the law to assist in the solution of this problem.

**A. The High-Risk Suicidal Nature of Inmates**

As stated above, inmates are a high-risk group of individuals for suicidal tendencies. There are three models that attempt to explain the high-risk nature of inmates. The three models are the importation model, the deprivation model, and the combined model.

**1. The Importation Model**

The premise of the importation model is that “[p]risoners represent a non-random selection of vulnerable individuals who already are at high risk of suicide before imprisonment. The elevated risk of suicide in prisoners is a consequence of the social and health inequalities which they import into prison.”[[117]](#footnote-117) Before incarceration, inmates “comprise a vulnerable population at high risk of suicide.”[[118]](#footnote-118) Common among the incarcerated population is socioeconomic disadvantage, mostly in the form of “poor housing, low educational attainment, poverty, and abuse.”[[119]](#footnote-119) In addition, many individuals in the incarcerated community experience physical health issues, as well as the socioeconomic disadvantages listed above.[[120]](#footnote-120) Further, inmates experience a higher rate of mental illness than that of the general population.[[121]](#footnote-121) Mental disorders are strong risk factors for suicidal behavior, with personality disorders topping the list as being strongly associated with self-harming activities in the prison environment.[[122]](#footnote-122)

While the importation model may explain some of the reasons for the heightened suicidal tendencies among the incarcerated population, the importation model does not consider the environmental factors in prison.[[123]](#footnote-123) Unfortunately, due to the model’s lack of consideration of those aspects of incarcerated life, the model does not account for the actual impact that incarcerated life may have on prisoners.[[124]](#footnote-124)

**2. Deprivation Model**

The deprivation model attempts to accommodate for the importation model’s lack of attention towards environmental factors. This model considers that “isolation, boredom, lack of purposeful activity, and victimization (e.g., bullying and assault) while incarcerated all increase the likelihood of suicide in prisoners.”[[125]](#footnote-125) It has been shown that solitary confinement, by itself, constitutes a risk factor for suicide even after the inmate’s eventual release from prison.[[126]](#footnote-126) And, in general, “disconnection from family and friends on the outside appears to be a strong and consistent risk factor for suicidal thoughts and behaviour in prisoners.”[[127]](#footnote-127)

In accordance with the deprivation model’s general premise that the environmental factors of institutionalization increase the likelihood of suicide in prisons, studies have also shown that the suicide risk rate among the incarcerated population is the highest during the first week of custody.[[128]](#footnote-128) Similarly, transfers and relocations within a facility, and changing legal status, may also contribute to an increased rate of suicide.[[129]](#footnote-129) Ultimately, though, the deprivation model fails to explain why some individuals commit suicide, but not others.[[130]](#footnote-130) In particular, the deprivation model fails to explain why most prisoners will not so much as consider suicide.[[131]](#footnote-131) And the deprivation model does not account for the socioeconomic disadvantage an inmate, the trauma or abuse of an inmate, and an inmate’s prior history of self-harm.[[132]](#footnote-132) Thus, the deprivation model views the prison population as monolithic and “overlooks prisoners’ individual needs and experiences that pre-date imprisonment.”[[133]](#footnote-133)

**3. The Combined Model**

A more comprehensive model for explaining inmates’ risk for suicide has evolved from the shortcomings of both previous models, dubbed “the combined model.” At the heart of this model is the idea that, when exposed to the stressful environment and events within a correctional institution, the underlying problems associated with the incarcerated community are enhanced.[[134]](#footnote-134) Though research on this model is relatively new, and therefore sparse, the model is supported by the older stress-diathesis model which considers the population at large.[[135]](#footnote-135) The stress-diathesis model predicts that suicidal predispositions become heightened under stressors present in the individual’s environment.[[136]](#footnote-136)

As compared with the importation model and the deprivation model, the combined model proves to be a more comprehensive analysis of the high-risk nature of inmates. As stated above, the importation model fails to account for institutional factors in an inmate’s risk of suicide. Likewise, the deprivation model fails to explain why certain inmates commit suicide while incarcerated and other inmates under similar circumstances do not. Through the combined model, however, both of these failures are accounted for, and factored into, the analysis of the susceptibility of inmates to suicidal impulses.[[137]](#footnote-137)

**B. Additional Risk Factors Among the Incarcerated Community**

**1. Mental Illness and Substance Abuse**

As of 2011, around one in seven prisoners had a treatable mental illness.[[138]](#footnote-138) Of these prisoners, the “prevalence of psychosis was around 4%, major depression 10–12%, and personality disorder 40–70%.”[[139]](#footnote-139) Importantly, post-traumatic stress affects up to one in five prisoners.[[140]](#footnote-140) It has also been estimated that between 7%-16% of the total United States prison and jail population and 16% of individuals on parole suffer from mental illness.[[141]](#footnote-141) And in state prisons, a similar theme arises, with around 10% of state inmates having significant mental health problems.[[142]](#footnote-142) Strikingly, the rate of personality disorders ranges between 7% and 35%, depending on the disorder, among the incarcerated community.[[143]](#footnote-143)

In the broader scope, despite the variance in the estimated rates listed above, there is a general consensus that incarcerated individuals experience mental health problems at a rate that far exceeds those found in the surrounding community.[[144]](#footnote-144) Many of these inmates are deemed at risk for suicide precisely because of the “symptoms associated with mental illness and/or an increased likelihood of suicide.”[[145]](#footnote-145) Prisoners also have elevated rates of substance abuse.[[146]](#footnote-146) In fact, a little less than 70% of incarcerated individuals, when asked, were found “to be dependent on or to have abused alcohol or drugs prior to their confinement.”[[147]](#footnote-147) Similarly, around 53% of federal prisoners and 20% of state prisoners are doing time for drug-related offenses.[[148]](#footnote-148) Yet, despite these exaggerated rates of mental illness found in the incarcerated community, around 40-60% of inmates do not receive needed medical services.[[149]](#footnote-149) These statistics also serve to emphasize the need for a clearly established right to suicide prevention protocols.

**C. Possible Solutions**

The solution to the epidemic of suicide by incarcerated persons is not easily solvable. In fact, the solution will likely require participation among all facets of jail and prison administration. Possible solutions, however, have been proposed. With the rise of telemedicine due to the COVID-19 pandemic, another possible solution has gained even more footing.

**1. A Multidimensional Approach**

A multidimensional approach encourages actions by correctional officers, medical staff, and administration to deter suicidal tendencies by inmates. Such an approach also incorporates screening and risk assessment protocols to detect suicidal tendencies. This approach consists of correctional officers who will monitor inmates for suicidal tendencies and any changes in behavior of the inmates;[[150]](#footnote-150) medical staff who will aid suicide intake assessments and other psychological assessments;[[151]](#footnote-151) and administration who will provide guidance to the staff of the institution.[[152]](#footnote-152)

As part of this approach, inmates should be subject to adequate screening and risk assessments. At the very least, an adequate screening questionnaire that covers the known risks of an increased likelihood of suicide should be in place.[[153]](#footnote-153) If this questionnaire yields results that indicate a possible increased risk of suicide in the inmate, the inmate should be referred to a risk assessment interview.[[154]](#footnote-154) This risk assessment interview should be conducted by a qualified mental health professional, who first should consult with the referring correctional officer to further understand the situation.[[155]](#footnote-155) Then, the qualified mental health professional should conduct a thirty-to-forty-minute interview with the inmate, including asking direct questions, in a non-judgmental way, “about suicidal ideation, intent, and plan.”[[156]](#footnote-156)

As the final cog in the machine of risk assessment, a risk analysis must then be undertaken. At this stage, all risk factors should be compiled and examined, along with the screening questionnaire and risk assessment interview.[[157]](#footnote-157) The individual in charge of the evaluation data must then examine the information for inconsistencies, as inconsistencies may weaken the veracity of the claims made by the inmate.[[158]](#footnote-158) This step is crucial, as this step allows the individual in charge of the evaluation to decide whether the inmate should be on, or remain on, suicide watch.[[159]](#footnote-159)

**2. The OCSD Approach**

Another approach that has been advocated for implementation in prisons and jails is the Orange County Sheriff’s Department’s (OCSD) approach to suicide intervention.[[160]](#footnote-160) This approach requires that institutions, such as prisons and jails, first implement suicide intake screening processes.[[161]](#footnote-161) Similar to the multidimensional approach, these screenings should consist of questions inquiring into the inmate’s “prior mental health and medical treatment, and questions to elicit indications of emotional stability.”[[162]](#footnote-162) The responses to these questions should shed light on the inmate’s risk for suicide.[[163]](#footnote-163) The OCSD approach also incorporates mental health professionals into this questionnaire process.[[164]](#footnote-164)

Once the questionnaire process is complete, if an inmate is deemed to be “at-risk,” mental health staff are then able to make decisions as to whether the inmate should be placed on suicide watch.[[165]](#footnote-165) Depending on the risk presented by the inmate, an inmate might need to be housed in a special cell that prevents an inmate from taking his or her own life, or an inmate may simply need a heightened method of monitoring.[[166]](#footnote-166)

Like the multidimensional approach, the OCSD approach encourages communication among all staff members in a jail who work together to address the mental health needs of inmates.[[167]](#footnote-167) For example, the communication process begins when the arresting officer alerts booking personnel of an “at-risk” inmate, or a mental health professional detects that an inmate is “at-risk” upon intake.[[168]](#footnote-168) In a similar vein, correctional staff may have to refer suicidal inmates to mental health professionals within the institution.[[169]](#footnote-169) All officers involved in the communication serve a specific role, yet the responsibility for preventing inmate suicides is a shared responsibility among the officers.[[170]](#footnote-170) Unlike the multidimensional approach, however, the OCSD approach takes a few unique steps. First, as opposed to the multidimensional approach, the OCSD approach requires extensive suicide prevention training that jail correctional staff partake in.[[171]](#footnote-171) Under the OCSD approach, new correctional staff are “required to attend at least two hours of suicide prevention training before they begin their employment.”[[172]](#footnote-172) Beyond that, advanced training—a total of around four hours—takes place during a correctional officer’s first year of service.[[173]](#footnote-173) New officers are not the only officers subject to these training requirements, as veteran officers also undergo training around once a year.[[174]](#footnote-174)

**3. The Rise of Telemedicine**

While prison staffs overall are larger than ever, the psychologist per inmate ratio has declined.[[175]](#footnote-175) Psychologists in the correctional environment also experience a high rate of burnout due to the emotional climate of the environment, the overwhelming needs of inmates for the psychologist’s services, and isolation as a result of working in the correctional environment.[[176]](#footnote-176) Telehealth and telemedicine allow the care to be administered without the usual concerns of physical employment at a correctional facility.

Telehealth is “the delivery and facilitation of health and health-related services . . . via telecommunications and digital communications technologies.”[[177]](#footnote-177) Telehealth makes use of audiovisual technology that brings together “service need populations (*the remote site*) to agencies that have specialist or generalist service providers (*the hub site*).”[[178]](#footnote-178) Slightly differently, telemedicine specifically “encompasses the use of technologies and telecommunication systems to administer healthcare to patients who are geographically separated from providers.”[[179]](#footnote-179) Thus, while telehealth is an all-encompassing term that covers all methods of healthcare conducted through telecommunications, telemedicine “refers specifically to the practice of medicine via remote means.”[[180]](#footnote-180) Telemedicine, in a correctional setting, is “a promising way to extend healthcare services.”[[181]](#footnote-181) As of 2004, around twenty-six state department of corrections and marginally less than half of federal facilities had active telemedicine programs.[[182]](#footnote-182) In addition, forty-six states used videoconferencing for non-medical purposes.[[183]](#footnote-183)

Prison psychologists “often encounter difficulty when trying to coordinate treatment with ‘specialty’ providers, such as psychiatrists.”[[184]](#footnote-184) Additionally, there are security issues with treatment.[[185]](#footnote-185) Telehealth solves these issues by allowing for the physical custody of the inmate in the prison, and avoiding the problems associated with transportation of the inmate, such as costs and security risks.[[186]](#footnote-186) Most importantly, telehealth increases the quality of care among the incarcerated population and ensures that those in the greatest need of services receive those services.[[187]](#footnote-187)

Not only does telehealth provide benefits to the correctional facility in terms of cost benefits and safety benefits, but incarcerated individuals are also satisfied with this avenue of care. For example, inmates participating in the federal pilot implementation of telehealth reported almost unanimous satisfaction among the inmates with the implemented services.[[188]](#footnote-188) Participating providers also expressed their satisfaction with the implementation of telehealth services.[[189]](#footnote-189) One provider stated that the “positive reaction of [the] inmates did much to let him know that relationships are constructed of more than physical proximity.”[[190]](#footnote-190)

Although there are many benefits to telehealth, there are some concerns. For example, research on telehealth in the correctional setting is still in progress. Some research, however, has examined the cost/benefit of the implementation of telehealth in correctional settings.[[191]](#footnote-191) One of the major costs associated with implementation of telehealth is the high initial start-up cost.[[192]](#footnote-192)

The administration of treatment via telehealth may also combat some of the factors elucidated in the combined model and the deprivation model. At the outset, telehealth technologies are “efficient and cost-effective means for delivering and accessing quality health care services and outcomes.”[[193]](#footnote-193) Moreover, telehealth expands access to resources to areas with provider shortages, such as correctional facilities, and allows for higher quality care.[[194]](#footnote-194) These factors culminate into increased patient satisfaction.[[195]](#footnote-195) As an example, some psychologists in the correctional system, who integrate family or marital therapy into their treatment, are prevented from doing so by the inability of family members to travel to the jail or prison.[[196]](#footnote-196) Telehealth could provide a link to that outside world, which is crucial to an inmate’s adaptation to the institutional environment.[[197]](#footnote-197)

**IV. The Case for a Recognized Right**

The severity of prison suicide is recognized in other areas of the law. Courts hold that suicide by an inmate satisfies the objective component of the deliberate indifference test.[[198]](#footnote-198) Additionally, courts have imposed liability on a municipality for failing to train the municipalities’ employees in detecting suicidal tendencies.[[199]](#footnote-199) In the deliberate indifference framework, a prisoner must show that the prison official “(1) subjectively knew the prisoner was at substantial risk of committing suicide and (2) intentionally disregarded the risk.”[[200]](#footnote-200) But through a prison official’s lack of implementation of adequate suicide protocols—which are designed to detect a prisoner’s propensity for suicide—the prison official may never acquire knowledge of an inmate’s substantial risk of committing suicide. Through proper protocols such as the multi-dimensional approach and the OCSD approach, however, these risks can be detected. Unfortunately, *Taylor* allows prison officials to skirt implementing such protocols as there is no penalty for a prison official’s failure to implement the protocols.

Further, the reliance of courts on *Taylor* in granting qualified immunity to prison officials is no longer justifiable. From the express terms of the *Taylor* decision, the *Taylor* Court determined that “no precedent on the books *in November 2004* would have made clear to petitioners that they were overseeing a system that violated the Constitution.”[[201]](#footnote-201) *Taylor* did not purport to speak to the establishment of a right in the future. Nor did *Taylor* foreclose such a right. Rather, *Taylor* examined the lack of judicial decisions establishing a constitutional right to adequate suicide prevention protocols as of 2004. The door was still left open for courts to begin the establishment of a constitutional right to suicide protocols. This, coupled with the Supreme Court’s recognition that norms surrounding punishment evolve with societal standards,[[202]](#footnote-202) provides a gateway for courts to begin the recognition of a clearly established right to suicide detection and prevention protocols.

Buttressing this perspective is the increased knowledge of the explanations behind prisoner suicide, the ever-increasing pandemic of inmate suicide, and the adoption of prevention systems that have proven to be effective in the correctional community. It only follows that it is time for courts to begin the long journey of the recognition of a right to adequate suicide prevention protocols for inmates.

**V. Conclusion**

In summary, the minefield of prisoner’s litigation is no less complicated in the specific field of suicide litigation. Despite the constitutional recognition by circuit courts that suicide is objectively a critical issue, and the requirements placed on municipalities to train their employees to detect the suicidal tendencies of inmates, the judiciary as a whole refuses to begin the process of clearly establishing a right to adequate suicide prevention protocols.

The recognition of this right would be the beginning of the end to the pandemic of inmate suicide. Additionally, protocols have never been easier to implement than they are now, with the increased access and availability of telemedicine. Thus, the refusal to recognize a clearly established right to adequate suicide screening prevention and protocols remains irreconcilable with the current climate of inmate suicide.

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186. . *Id.* at 544. [↑](#footnote-ref-186)
187. . Ax et al., *supra* note 140, at 896. [↑](#footnote-ref-187)
188. . Magaletta et al., *supra* note 175, at 546. [↑](#footnote-ref-188)
189. . *Id.* [↑](#footnote-ref-189)
190. . *Id.* [↑](#footnote-ref-190)
191. . Ax et al, *supra* note 140, at 901. [↑](#footnote-ref-191)
192. . *Id.* [↑](#footnote-ref-192)
193. . Shilpa N. Gajarawala & Jessica N. Pelkowski, *Telehealth Benefits and Barriers*, 17 The J. for Nurse Pracs. 218, 218 (2021). [↑](#footnote-ref-193)
194. . *Id.* [↑](#footnote-ref-194)
195. . *Id.* [↑](#footnote-ref-195)
196. . Magaletta et al., *supra* note 175, at 546. [↑](#footnote-ref-196)
197. . *Id.* [↑](#footnote-ref-197)
198. . *Collins*, 462 F.3d at 760; *Bame*, 566 F. App’x at 738. [↑](#footnote-ref-198)
199. . *Andrews*, 957 F.3d at 724; *Palakovic*, 854 F.3d at 233. [↑](#footnote-ref-199)
200. . *Rosario*, 670 F.3d at 821 (quoting Minix v. Canarecci, 597 F.3d 824, 831 (7th Cir. 2010)). [↑](#footnote-ref-200)
201. . *Taylor*,575 U.S. at 827 (emphasis added). [↑](#footnote-ref-201)
202. . *Estelle*, 429 U.S. at 102. [↑](#footnote-ref-202)