JAIL SUICIDE/MENTAL HEALTH UPDATE

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A PRACTITIONER'S GUIDE TO DEVELOPING AND MAINTAINING A SOUND SUICIDE PREVENTION POLICY

Despite increased general awareness of the problem, research that has identified precipitating and situational risk factors, emerging correctional standards that advocate increased attention to suicidal inmates and demonstration of effective strategies, suicide prevention remains piecemeal and inmate suicides continue to pose a serious public health problem within correctional facilities throughout the county. In fact, although national suicide rates in both jails and prisons have been seemingly reduced during the past decade, hundreds of inmates continue to commit suicide in correctional facilities each year. Many of these deaths are preventable and we can do more to reduce these numbers.

*Since its inception, the **Jail Suicide /Mental Health Update** has been devoted to providing timely information in the area of suicide prevention within correctional facilities, including pertinent research, training, standards, litigation, model programs, and case vignettes of preventable and/or other tragic deaths. We have previously highlighted the fact that few state jail standards mandate comprehensive suicide prevention programming, and many correctional systems have either ignored or not fully implemented critically important suicide prevention components (as offered by national standards) into their policies. Within juvenile facilities, a recent national study found that few facilities experiencing a youth suicide maintained comprehensive suicide prevention programs.*

In an effort to more adequately address piecemeal prevention efforts, this special issue is entirely devoted to developing and maintaining a sound suicide prevention policy, and includes the guiding principles to suicide prevention, critical components to a suicide prevention policy, and a sample suicide prevention policy (with attachments). Our hope is that the information contained in this special 24-page issue, as well as future issues highlighting model suicide prevention programs, will help jumpstart more comprehensive suicide prevention programming throughout the country.

According to available records, 49-year-old Michael Singer was originally arrested by the Evans County Sheriff's Office on October 4, 2002 and charged with "defrauding a secured creditor and concealment or removal of secured property."[1] The arrest was based upon a warrant from a neighboring state. Mr. Singer was booked into the Evans County Jail and responded "no" to two questions regarding prior and current risk for suicide. Due to his employment as a sergeant at the Pinehurst State Prison, Mr. Singer was placed in a single cell in the jail. No bail was permitted.

During the afternoon of October 4, Mr. Singer's wife (Susan) and brother-in-law (Bruce Tyler) visited with him in the jail. According to his wife and brother-in-law, Mr. Singer appeared distraught, confused and, as a correctional officer, feared for his safety. Most importantly, he also threatened suicide, stating to his wife and brother-in-law that he would be found "hanging in his cell." Mrs. Singer and Mr. Tyler immediately informed Evans County Jail staff, specifically Officer Keith Smith, of the suicide threat. According to the subsequent deposition testimony of Susan Singer, Officer Smith informed them that "Don't worry. I'll take care of it and I promise we won't let anything happen to Mike." Officer Smith subsequently informed Sheriff David Pile of the threat and then went to talk with Mr. Smith who denied making a suicide threat. Apart from a brief notification in the Jail Officer's Daily Log at 3:00pm on October 4 that read "Pass down from 270 (Sheriff Pyle), 271 (Under Sheriff Salisbury), and 286 (Officer Smith). Received word to watch Singer," no other action was apparently taken in response to Mr. Singer's risk or suicide.

Throughout his week of confinement at the Evans County Jail, Mr. Singer displayed disturbing behavior to jail staff. According to various staff, he was observed as being "very stressed," "quiet," "distraught," "crying," "pacing the cell," "acting very peculiar," etc. Mr. Singer was particularly concerned about his impending extradition to another

[1]In order to ensure complete confidentiality, certain identifying information regarding the victim, facility, and staff have been changed. No other modifications have been made.

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state in a transportation vehicle containing other inmates who might recognize him as a correctional officer from Pinehurst State Prison. During the evening of October 7, 2002, Dispatcher Ralph Tanner, who had previously worked with Mr. Singer at the state prison, went back into the cell block area and briefly conversed with his friend. According to Mr. Tanner's subsequent deposition testimony, Mr. Singer "was pacing a lot in the cell, you know. And he just looked like very stressed, you know. He was going through a hard time." According to his incident report, Dispatcher Tanner wrote, in part, that during their October 7 conversation "I also told Mike I hope you are not going to do anything stupid, like suicide, Mike replied, 'no I am not'….Then I told Mike I needed to get back to dispatch, if he needed anything let someone know, I also informed him I was watching him in the camera."

During the evening of October 10, 2002, both jail and family members observed Mr. Singer (during a visit) to be very distraught and crying regarding his impending extradition, thought to be scheduled for the following day. According to the incident report written by Sheriff Pyle, Officer Jack Terry informed him at approximately 8:00pm on October 10 that Mr. Singer was "quiet and distraught" following the visit with his wife and "Mike looked like he had been crying and acted like he wanted to cry as he was walking but was trying to keep from showing emotions."

Both Officer Paula Hacket and Dispatcher Tanner worked the overnight shift (11:00pm to 7:00am) of October 10-11, 2002. Both individuals noticed that Mr. Singer appeared agitated during the shift. According to Officer Hacket's subsequent deposition testimony, Mr. Singer appeared distraught and was crying. According to Dispatcher Tanner, Mr. Singer "was constantly watching the window in his cell door," pacing the cell, and "acting very peculiar." Both Officer Hacket and Dispatcher Tanner agreed to "just keep an eye on him." through making regular rounds of the cellblock area and observing Mr. Singer's cell via closed circuit television monitoring (CCTV).

During the shift change in the early morning of October 11, both Officer Hacket and Dispatcher Tanner informed in-coming Officer Keith Smith of their observations and concerns regarding Mr. Singer during their shift. According to the subsequent deposition testimony of Dispatcher Tanner, "When Keith Smith came to work Paula and I informed him the way he'd been behaving and they needed to keep an eye on him 'cause he wasn't acting right at all…I don't recall the exact words, but I said, Mike's not acting right, something's wrong, you know, something may be wrong with him, you know, he may do something, stupid, I don't know, and that he needed to be watched and Paula addressed her concern to him also." According to the dispatcher, when they informed Officer Smith of their concerns regarding Mr. Singer, Officer Smith "just basically shrugged his shoulders and said, oh, well, you know, it's like it's another day." Dispatcher Tanner also informed the in-coming dispatcher, Ryan Houser, of their concerns. Mr. Houser apparently did not give any verbal reply, however, both Officer Hacket and Dispatcher Tanner subsequently testified that Dispatcher Houser had previously stated it was ***not*** his responsibility to monitor inmates via the CCTV equipment.

According to Officer Mike Weiner, he conducted a round of the cellblock area at approximately 9:00am on October 11, 2002 and observed Mr. Singer to be sitting on his bed. Approximately one hour later at 9:55am, Officer Weiner conducted another round and observed a blanket tied around the door of Mr. Singer's cell, and the inmate could not be observed. Officer Weiner ran up to the control office to get assistance from Officer Smith. While returning to the cellblock area, Officer Weiner told Dispatcher Houser to turn *on* the CCTV monitor for Mr. Singer's cell and try to locate the inmate. Officers Weiner and Smith, as well as Sheriff Pyle, arrived at Mr. Singer's cell and initially had difficulty gaining entry because the blanket was tied around the door and soap had been jammed into the key hole. Upon entering the cell, Mr. Singer was discovered hanging from the shower knob by a bed sheet. His body was cut down and laid on the cell floor. Emergency medical services (EMS) personnel arrived, examined the victim, and decided not to initiate cardiopulmonary resuscitation. According to EMS personnel, Mr. Singer's body "had mottling on his back and buttocks area," an apparent indication that the victim had been dead for a considerable period of time. Michael Singer was later pronounced dead.

Following the death, county attorney George Dawson told a local newspaper reporter that "Mr. Singer had been in jail a couple of days and otherwise was an unremarkable inmate. He didn't appear despondent or unduly agitated. Our jail staff feels bad about it, but the suicide really wasn't preventable."

The family of Michael Singer disagreed and subsequently filed a federal lawsuit against Evans County, its sheriff and jail personnel. Among several allegations in the lawsuit was that the county failed to maintain a written suicide prevention policy. In fact, the practice of Evans County Jail personnel was simply to inform Sheriff Pyle if an inmate became suicidal during confinement. No mental health referral, no suicide precautions, no policy! The lawsuit is still pending.

In a similar case, readers of the ***Update*** will recall the recent federal appeals court ruling in ***Wever v. Lincoln County*** (No. 03-3633, 2004 U.S. App. Lexis 22974, 8th Cir. 2004). In November 2004, the U.S. Court of Appeals for the Eighth Circuit ruled that Lincoln County Sheriff Jim Carmen was not entitled to qualified immunity for the jail suicide of Dennis Wever. The lawsuit had alleged that the sheriff failed to take any corrective action in the areas of training and supervision of personnel following two other prior inmate suicides in the jail, as well as maintaining a grossly inadequate suicide prevention policy. The appeals court agreed and scolded the sheriff as follows:

> "Carmen asserts that 'the jail had a good-faith policy in place for dealing with those prisoners and pretrial detainees presenting suicidal risks. Furthermore, after the September 1999 incident, the policy was implemented for approximately two (2) years before the incident at issue occurred.'…. The implication of this statement is that after the 1999 suicide, Carmen implemented a constitutionally adequate suicide policy that was in effect at the time of Wever's suicide. However….we note that the quoted assertion is entirely without support in the record. The 'policy' Carmen cites is a single page….and wholly without context. One cannot tell when, how, or even whether it was adopted, why Carmen believed it would adequately respond to the problem of inmate suicide, or how officers were trained to implement it….One cannot discern when the 'policy' was adopted, and Carmen neglected to make any mention of it in his affidavit in support of his motion for summary judgment. As the district court stated, 'Sheriff Carmen did not present any

evidence showing what training procedures, if any, were in place for handling potentially suicidal detainees or inmates.'

In June 2005, the case was settled for an undisclosed amount. It remains unclear as to whether Lincoln County developed a sound jail suicide prevention policy.

Guiding Principles to Suicide Prevention

More times than not, we do an admirable job of safely managing inmates identified as suicidal and placed on suicide precautions. After all, few inmates successfully commit suicide on suicide watch. When they do, you can surely expect to incur some liability. What we continue to struggle with is the ability to prevent the suicide of an inmate who is not easily identifiable as being at risk for self-harm. Kay Redfield Jamison, a prominent psychologist and author, has best articulated the point by stating that if "suicidal patients were able or willing to articulate the severity of their suicidal thoughts and plans, little risk would exist."[2] With this in mind, the following guiding principles to suicide prevention are offered.

1) The assessment of suicide risk should ***not*** be viewed as a single event, but as an on-going process. Because an inmate may become suicidal at any point during confinement, suicide prevention should begin at the point of arrest and continue until the inmate is released from the facility. In addition, once an inmate has been successfully managed on, and discharged from, suicide precautions, they should remain on a mental health caseload and assessed periodically until released from the facility.

2) Screening for suicide during the initial booking and intake process should be viewed as something similar to taking one's temperature – it can identify a current fever, but not a future cold. The shelf life of behavior that is observed and/or self-reported during intake screening is time-limited, and we often place far too much weight upon this initial data collection stage. Following an inmate suicide, it is not unusual for the mortality review process to focus exclusively upon whether the victim threatened suicide during the booking and intake stage, a time period that could be far removed from the date of suicide. If the victim had answered in the negative to suicide risk during the booking stage, there is often a sense of relief expressed by participants of the mortality review, as well as a misguided conclusion that the death was not preventable. Although the intake screening form remains a valuable prevention tool, the more important determination of suicide risk is the ***current*** behavior expressed and/or displayed by the inmate.

3) Prior risk of suicide is strongly related to future risk. At a minimum, if an inmate had been placed on suicide precautions during a previous confinement in the facility or agency, such information should be accessible to both correctional and health care personnel when determining whether the inmate might be at risk during their current confinement.

4) We should not rely ***exclusively*** on the direct statements of an inmate who denies that they are suicidal and/or have a prior history of suicidal behavior, particularly when their behavior, actions and/or history suggest otherwise. Often, despite an inmate's denial of suicidal ideation, their behavior, actions, and/or history speak louder then their words. For example:

[2]Jamison, Kay R. (1999). *Night Fails Fost — Understanding Suicide*. New York, NY: Alfred A. Knopf:150.

WE'RE STILL LOOKING FOR A FEW GOOD PROGRAMS

Future issues of the ***Jail Suicide/Mental Health Update*** will be devoted to exemplary suicide prevention programs operating within correctional facilities throughout the country. Does your facility's suicide prevention policy contain, and do your practices reflect, the following critical elements?

- Intake screening to detect both current and prior suicidal behavior, as well as further and periodic assessment of suicide risk by mental health staff;
- Suicide prevention training for correctional, medical, and mental health staff;
- Levels of communication between outside agencies, among facility staff, and with the suicidal inmate;
- Suicide-resistant, protrusion-free housing of suicidal inmates;
- Levels of supervision for suicidal inmates;
- Timely emergency intervention by correctional and medical personnel following a suicide attempt;
- Provision of critical incident stress debriefing to affected staff and inmates, as well as completion of a multidisciplinary mortality review following an inmate suicide and/or serious suicide attempt; and
- A low rate of inmate suicides for an extended period of time.

If you believe your correctional facility operates an exemplary suicide prevention program, and would like it to be considered as a possible case study in an upcoming issue of the ***Update***, please send copies of your suicide prevention policy, screening/assessment forms utilized to identify suicidal inmates, and total number of suicides and your facility's average daily population for each year from 1995 thru 2004 to:

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In Washington State, an inmate was booked into a county jail and informed the intake officer that she had a history of mental illness, had attempted suicide two weeks earlier, but "will not hurt herself in jail." Jail records indicated that the inmate threatened suicide during a recent prior confinement in the facility. The inmate attended a court hearing two days later and the escort officer noticed that she appeared despondent, was crying, and appeared worried about her children. She was not referred to mental health staff, nor placed on suicide precautions. The inmate committed suicide the following day.

In Michigan, police were called to the home of a man who accidentally shot and killed a friend during a domestic dispute with his estranged wife. Upon arrival of the police, the suspect placed a handgun to his head and clicked the trigger several times. He also encouraged the officers to shoot him. Following five hours of negotiations, the suspect surrendered without incident. He was transported to the county jail and denied being suicidal during the intake screening process. The inmate was not referred to mental health staff, nor placed on suicide precautions. He committed suicide the following day.

It is not all that surprising that these preventable deaths often escape our detection. Take, for example, the booking area of a jail facility. It is traditionally both chaotic and noisy; an environment where staff feel pressure to process a high number of arrestees in a short period of time. Two key ingredients for identifying suicidal behavior – time and privacy – are at a minimum. The ability to carefully assess the potential for suicide by asking the inmate a series of questions, interpreting their responses (including gauging the truthfulness of their denial of suicide risk), and observing their behavior is greatly compromised by an impersonal environment that lends itself to something quite the opposite. As a result, the clearly suicidal behavior of many arrestees, as well as circumstances that may lend themselves to potential self-injury, are lost.

In yet another example, a suicidal inmate may appear to be stable in front of a mental health clinician, even deny suicide risk, only to be discharged from suicide precautions and returned to the correctional facility from a hospital where they again revert to the same self-injurious behavior that prompted the initial referral. Given such a scenario, correctional staff should not assume that the clinician was cognizant or even appreciative of this cyclical behavior. On the contrary, regardless of what the clinician might have observed and/or recommended, as well as the inmate's denial of risk, whenever correctional staff hear an inmate verbalize a desire or intent to commit suicide, observe an inmate engaging in suicidal behavior or otherwise believe an inmate is at risk for suicide, they should take immediate steps to ensure that the inmate's safety.

5) Facility officials must provide useful pre-service and annual suicide prevention training to all staff. While implementing suicide precautions for an inmate that verbally threatens suicide requires little training, identifying suicidal behavior of inmates unwilling and/or unable to articulate their feelings, or who deny any ideation, requires both pre-service and annual training. Simply stated, correctional staff, as well as medical and mental health personnel, cannot detect, make an assessment, nor prevent a suicide for which they have little, if any, useful training.

All suicide prevention training must be ***meaningful***, i.e., timely, long-lasting information that is reflective of our current knowledge base of the problem. Training should not be scheduled to simply comply with an accreditation standard. A workshop that is limited to an antiquated videotape, or recitation of the current policies and procedures, might demonstrate compliance (albeit wrongly) with an accreditation standard, but is not meaningful, nor helpful, to the goal of reducing inmate suicides. Without regular suicide prevention training, staff often make wrong and/or ill-informed decisions, demonstrate inaction, or react contrary to standard correctional practice, thereby incurring unnecessary liability.

6) As previously offered, many preventable suicides result from poor communication amongst correctional, medical and mental health staff. Communication problems are often caused by lack of respect, personality conflicts, and other boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides. As aptly stated by one clinician:

> The key to an effective team approach in suicide prevention and crisis intervention is found in throwing off the cloaks of territoriality and embracing a mutual respect for the detention officer's and mental health clinician's professional abilities, responsibilities and limitations. All of us, regardless of professional affiliation, need to make a dedicated commitment to come forward and acknowledge that suicide prevention and related mental health services are only effective when delivered by professionals acting in unison with each other. Just as the security officer alone can not ensure the safety and security of the jail facility, neither can the mental health clinician alone ensure the safety and emotional well-being of the individual inmate.[3]

7) On size does not fit all and basic decisions regarding the management of a suicidal inmate should be based upon their individual clinical needs, not simply on the resources that are said to be available. For example, if an acutely suicidal inmate requires continuous, uninterrupted observation from staff, they should not be monitored via CCTV simply because that is the only option the system chooses to offer. Further, a clinician should never feel pressured, however subtle that pressure may be, to downward and/or discharge an inmate from suicide precautions simply because additional staff resources (e.g., overtime, post transfer, etc.) are required to maintain the desired level of observation. Although they would never admit it, clinicians have prematurely downgraded, discharged, and/or changed the management plan for a suicidal inmate based upon pressure from correctional officials.

[3]Severson, Margaret (1993). *Jail Suicide Update*, 5(3):3.

8) We must avoid creating barriers that discourage an inmate from accessing mental health services. Often, certain management conditions of a facility's policy on suicide precautions appear punitive to an inmate (e.g., automatic clothing removal/issuance of safety smock, lockdown, limited visiting, telephone, and shower access, etc), as well as excessive and unrelated to their level of suicide risk. As a result, an inmate who becomes suicidal and/or despondent during confinement may be reluctant to seek out mental health services, and even deny there is a problem, if they know that loss of these and other basic amenities are an automatic outcome. As such, these barriers should be avoided whenever possible and decisions regarding the management of a suicidal inmate should be based solely upon the individual's level of risk.

9) Few issues challenge us more than that of inmates we perceive to be manipulative. It is not unusual for inmates to call attention to themselves by threatening suicide or even feigning an attempt in order to avoid a court appearance, or bolster an insanity defense; gain cell relocation, transfer to the local hospital or simply receive preferential staff treatment; or seek compassion from a previously unsympathetic spouse or other family member. Some inmates simply use manipulation as a survival technique.

   Although the prevailing theory is that any inmate who would go to the extreme of threatening suicide or even engaging in self-injurious behavior is suffering from at least an emotional imbalance that requires special attention; too often we conclude that the inmate is simply attempting to manipulative their environment and, therefore, such behavior should be ignored and not reinforced through intervention. Too often, however, a feigned suicide attempt goes further than anticipated and results in death. Recent research has warned us that we should ***not*** assume that inmates who appear manipulative are not also suicidal, i.e., they are not necessarily members of mutually exclusive groups.

   Although there are no perfect solutions to the management of manipulative inmate who threaten suicide or engage in self-injurious behavior for a perceived secondary gain, *the critical issue is not how we label the behavior, but how we react to it.* The reaction must include a multidisciplinary treatment/management plan.

10) As previously noted, few suicides take place when inmates are managed on suicide precautions. Rather, most deaths suicides take place in "special housing units" (intake/booking, classification, disciplinary/administrative segregation, mental health, etc.) of the facility. One effective prevention strategy is to create more interaction between inmates and correctional, medical and mental health personnel in these housing areas by: increasing rounds of medical and/or mental health staff, requiring regular follow-up of all inmates released from suicide precautions, increasing rounds of correctional staff, providing additional mental health screening to inmates admitted to disciplinary/administrative segregation, and avoiding lockdown due to staff shortages (and the resulting limited access of medical and mental health personnel to the units).

11) A lack of inmates on suicide precautions should not be interpreted to mean that there are no currently suicidal inmates in the facility, nor a barometer of sound suicide prevention practices. We cannot make the argument that our correctional systems are increasingly housing more mentally ill and/or other high risk individuals and then state there are not any suicidal inmates in our facility today. Correctional facilities contain suicidal inmates every day; the challenge is to find them. The goal should not be "zero" number of inmates on suicide precautions; rather the goal should be to identify, manage and stabilize suicidal inmates in our custody.

12) We must avoid the obstacles to prevention. Experience has shown that negative attitudes often impede meaningful suicide prevention efforts. These obstacles to prevention often embody a state of mind (before any inquiry begins) that inmate suicides cannot be prevented (e.g., "If someone really wants to kill themselves there's generally nothing you can do about it" and/or "We did everything we could to prevent this death, but he showed no signs of suicidal behavior," etc.) There are numerous ways to overcome these obstacles, the most powerful of which is to demonstrate prevention programs that have effectively reduced the incidence of suicide and suicidal behavior within correctional facilities. As one administrator has offered: "When you begin to use excuses to justify a bad outcome, whether it be low staffing levels, inadequate funding, physical plant concerns, etc., issues we struggle with each day, you lack the philosophy that even one death is not acceptable. If you are going to tolerate a few deaths in your jail system, then you've already lost the battle."[4]

13) We must create and maintain a comprehensive suicide prevention programs that include the following essential components: staff training, intake screening/assessment, communication, housing, levels of observation, intervention, reporting, follow-up/mortality review.

Critical Components to a Sound Suicide Prevention Policy

Comprehensive suicide prevention programming has been advocated nationally by such organizations as the American Correctional Association (ACA), American Psychiatric Association (APA), and National Commission on Correctional Health Care (NCCHC). As offered in our last issue (see ***Jail Suicide/Mental Health Update***, Volume 13, Number 3, Winter 2004), these groups have promulgated national correctional standards that are adaptable to individual jail, prison and juvenile facilities. The APA and NCCHC standards provide the more instructive standards/guidelines that offer recommended ingredients for a suicide prevention program: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, review, and critical incident debriefing. Consistent with these national correctional standards, the following eight (8) components encompass a sound suicide prevention policy.

[4]Hayes, Lindsay M. (1998). *Jail Suicide/Mental Health Update,* 8(1):6.

Staff Training

The essential component to any suicide prevention program is properly trained correctional staff, who form the backbone of any correctional facility. Very few suicides are directly prevented by mental health, medical or other professional staff because suicides are usually attempted in inmate housing units, and often during late evening hours or on weekends when program staff are not present. Suicides, therefore, must be prevented by correctional staff who have been trained in suicide prevention and have developed an intuitive sense about the inmates under their care. Correctional officers are often the only staff available 24 hours a day and form the primary line of defense in preventing suicides.

Although not specified in national correctional standards, it is strongly recommended that all correctional staff, as well as medical and mental health personnel, receive at least eight (8) hours of initial suicide prevention training, followed by two (2) hours of refresher training each year. Training should include why correctional environments are conducive to suicidal behavior, staff attitudes about suicide, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identification of suicide risk despite the denial of risk, liability issues, critical incident stress debriefing, recent suicides and/or serious suicides attempts within the facility/agency, and details of the facility/agency's suicide prevention policy. In addition, all staff who have routine contact with inmates should receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff should also be trained in the use of various emergency equipment located in each housing unit. In an effort to ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training.

Intake Screening/Assessment

Screening and assessment of inmates when they enter a facility is critical to a correctional facility's suicide prevention efforts. Although there is no single set of risk factors that mental health and medical communities agree can be used to predict suicide, there is little disagreement about the value of screening and assessment in preventing suicide. Intake screening for all inmates and ongoing assessment of inmates at risk is critical because research consistently reports that two thirds or more of all suicide victims communicate their intent some time before death and that any individual with a history of one or more self-harm episodes is at a much greater risk for suicide than those without such episodes. Although it is preferred that the intake screening process be performed by medical staff, correctional personnel who have received specific training can also perform the task.

Screening for suicide risk may be contained within the medical screening form or as a separate form, and should include inquiry regarding the following: past suicidal ideation or attempts; current ideation, threat, plan; prior mental health treatment-hospitalization; recent significant loss (job, relationship, death of family member/close other, etc.); history of suicidal behavior by family member/close other; suicide risk during prior confinement; and arresting-transporting officer(s) belief that inmate is currently at risk. The process should also include referral procedures to mental health and/or medical personnel for assessment. Following the intake process, if staff hear an inmate verbalize a desire or intent to commit suicide, observe an inmate engaging in any self-harm, or otherwise believe an inmate is at risk for self-harm or suicide, referral procedures should be implemented. Such procedures direct staff to take immediate steps ensuring that the inmate is continuously observed until appropriate medical, mental health, and supervisory assistance is obtained.

In addition, given the strong association between inmate suicide and special management (i.e., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit should receive a written assessment for suicide risk by mental health (or medical) staff upon admission. In addition, the inmate's health care records should be thoroughly reviewed to ensure that the placement is not contraindicated or requires special treatment.

Finally, the screening and assessment process is only one of several tools that increases the opportunity to identify suicide risk in inmates. This process, coupled with staff training, will only be successful if an effective method of communication is in place within the correctional facility.

Communication

Certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and communicated to others, may prevent a suicide. There are essentially three levels of communication in preventing inmate suicides: 1) communication between the arresting or transporting officer and correctional staff; 2) communication between and among facility staff, including medical and mental health personnel; and 3) communication between facility staff and the suicidal inmate.

In many ways, suicide prevention begins at the point of arrest. What an individual says and how they behave during arrest, transportation to the jail, and at booking are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time. Arresting officers should pay close attention to the arrestee during this time; thoughts of suicide or suicidal behavior may be occasioned by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers such as family and friends. Any pertinent information regarding the arrestee's well-being must be communicated by the arresting or transporting officer to correctional staff. It is also critically important for correctional staff to maintain open lines of communication with family members who often have pertinent information regarding the mental health status of inmates.

Effective management of suicidal inmates in the facility is based on communication among correctional officers and other professional staff. Because inmates can become suicidal at any point during incarceration, correctional officers must maintain awareness, share information and make appropriate referrals to mental health and medical staff. At a minimum, the facility's shift supervisor should ensure that appropriate correctional staff are properly informed of the status of each inmate placed on suicide precautions. The shift supervisor should also be responsible for briefing the incoming shift supervisor regarding the status of

all inmates on suicide precautions. Multi-disciplinary team meetings (to include correctional, medical and mental health personnel) should occur on a regular basis to discuss the status of inmates on suicide precautions. Finally, the authorization for suicide precautions, any changes in suicide precautions, and observation of inmates placed on precautions should be documented on designated forms and distributed to appropriate staff.

Facility staff must use various communication skills with the suicidal inmate, including active listening, physically staying with the inmate if they suspect immediate danger, and maintaining contact through conversation, eye contact, and body language. Correctional staff should trust their own judgment and observation of risk behavior, and avoid being misled by others (including mental health staff) into ignoring signs of suicidal behavior.

The communication breakdown between correctional, medical, and mental health personnel is a common factor found in the reviews of many inmate suicides. Communication problems are often caused by lack of respect, personality conflicts, and other boundary issues. Simply stated, facilities that maintain a multidisciplinary approach generally avoid preventable suicides.

Housing

In determining the most appropriate housing location for a suicidal inmate, correctional officials (with concurrence from medical or mental health staff) often tend to physically isolate and sometimes restrain the individual. These responses might be more convenient for all staff, but they are detrimental to the inmate because the use of isolation escalates the inmate's sense of alienation and further removes the individual from proper staff supervision. To every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. Further, removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, straitjackets, etc.) should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Handcuffs should not be used to restrain a suicidal inmate. Housing assignments should be based on the ability to maximize staff interaction with the inmate, avoiding assignments that heighten the depersonalizing aspects of incarceration.

All cells designated to house suicidal inmates should be suicide-resistant, free of all obvious protrusions, and provide full visibility. These cells should contain tamper-proof light fixtures and ceiling air vents that are protrusion-free. Each cell door should contain a heavy gauge Lexan (or equivalent grade) glass panel that is large enough to allow staff a full and unobstructed view of the cell interior. Cells housing suicidal inmates should ***not*** contain any electrical switches or outlets, bunks with holes and ladders, towel racks on desks and sinks, radiator vents, corded telephones of any length, clothing hooks (of any kind), or any other object that provides an easy anchoring device for hanging. Finally, each housing unit in the facility should contain various emergency equipment, including a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool (to quickly cut through fibrous material). Correctional staff should ensure that such equipment is in working order on a daily basis.

Levels of Supervision

The promptness of response to suicide attempts in correctional facilities is often driven by the level of supervision afforded the inmate. Brain damage from strangulation caused by a suicide attempt can occur within four minutes, and death often within five to six minutes. Standard correctional practice (and ACA standards) requires that "special management inmates," including those housed in administrative segregation, disciplinary detention and protective custody, be observed at intervals not exceeding every 30 minutes, with mentally ill inmates observed more frequently. According to NCCHC standards, inmates held in medical restraints and "therapeutic seclusion" should be observed at intervals that do not exceed every 15 minutes. In addition, health care personnel should conduct rounds of special managements units and observe each inmate (not simply those receiving medication and/or on a mental health caseload) at least three times per week.

Consistent with national correctional standards and practices, two levels of supervision are generally recommended for suicidal inmates: close observation and constant observation. *Close Observation* is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. Staff should observe such an inmate at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes, etc.). *Constant observation* is reserved for the inmate who is actively suicidal, either threatening or engaging in suicidal behavior. Staff should observe such an inmate on a continuous, uninterrupted basis.

Other aids (e.g., closed-circuit television monitoring, inmate companions or watchers, etc.) can be used as a supplement to, but ***never*** as a substitute for, these observation levels. In addition, suicidal inmates should ***never*** be placed on a protocol level requiring observation at 30-minute intervals. Finally, mental health staff should assess and interact with (not just observe) suicidal inmates on a daily basis.

Intervention

The degree and promptness of staff intervention often determines whether the victim will survive a suicide attempt. A correctional facility's policy regarding intervention should contain three primary components. *First*, all staff who come into contact with inmates should be trained in standard first aid procedures and cardiopulmonary resuscitation (CPR). *Second*, any staff member who discovers an inmate engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. If facility policy prohibits an officer from entering a cell without backup support, the first responding officer should, at a minimum, make the proper notification for backup support and medical personnel, secure the area outside the cell, and retrieve the housing unit's emergency response bag (that should include a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool). *Third*, staff should never presume that the inmate is dead, but rather should

initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, medical personnel should ensure that all emergency response equipment is in working order on a daily basis.

Reporting

In the event of a suicide attempt or suicide, all appropriate correctional officials should be notified through the chain of command. Following the incident, the victim's family should be immediately notified, as well as appropriate outside authorities. All staff who came into contact with the victim prior to the incident should be required to submit a statement including their full knowledge of the inmate and incident.

Follow-Up/Mortality Review

An inmate suicide is extremely stressful for staff, who may feel angry, guilty, and even ostracized by fellow personnel and administration officials. Following a suicide, reasonable guilt is sometimes displayed by the officer who wonders: "What if I had made my cell check earlier?" When suicide or suicidal crises occur, staff affected by such a traumatic event should receive appropriate assistance. One form of assistance is critical incident stress debriefing (CISD). A CISD team, made up of professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, fire fighters, clergy, and mental health personnel), provides affected staff an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and develop ways of dealing with those symptoms. For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident.

Experience has demonstrated that many correctional systems have reduced the likelihood of future suicides by critically reviewing the circumstances surrounding instances as they occur. While all deaths are investigated either internally or by outside agencies to ensure impartiality, these investigations are normally limited to determining the cause of death and whether there was any criminal wrongdoing. The primary focus of a mortality review should be two-fold: What happened in the case under review and what can be learned to help prevent future incidents? To be successful, the mortality review team must be multidisciplinary and include representatives of both line and management level staff from the corrections, medical and mental health divisions.

Therefore, every completed suicide, as well as each suicide attempt of high lethality (e.g., requiring hospitalization), should be examined through a mortality review process. (If resources permit, clinical review through a psychological autopsy is also recommended.) The mortality review should include: (a) critical review of the circumstances surrounding the incident; (b) critical review of jail procedures relevant to the incident; (c) synopsis of all relevant training received by involved staff; (d) pertinent medical and mental health services/reports involving the victim; (e) possible precipitating factors leading to the suicide; and (f) recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures.

A MODEL SUICIDE PREVENTION POLICY

GENERAL ORDER	DATE OF ISSUE	EFFECTIVE DATE	DIRECTIVE NO.
REFERENCE		RESCINDS	

INDEX AS: SUICIDE PREVENTION PROCEDURES

SUICIDE PREVENTION PROCEDURES

I. PURPOSE: To outline specific measures taken to identify and respond to the needs of suicidal inmates.

II. PROCEDURE: The following measures comprise the eight (8) step suicide prevention program: staff training, identification/ referral/assessment, communication, housing, levels of observation, intervention, reporting, follow-up/ mortality review.

A) Staff Training

A1. All staff (including correctional, medical, and mental health personnel) who have regular contact with inmates shall be initially trained in the identification and management of suicidal inmates, as well as in the eight components of the agency's suicide prevention program. Initial training shall encompass eight (8) hours of instruction. New employees shall receive such instruction through the training academy. Current staff shall receive such instruction through scheduled training workshops.

A2. The initial training should include inmate suicide research, why the environments of correctional facilities are conducive to suicidal behavior, staff attitudes about suicide, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite their denial of risk, components of the facility's suicide prevention policy, critical incident stress debriefing, and liability issues associated with inmate suicide.

A3. All staff who have regular contact with inmates shall receive two (2) hours of annual suicide prevention training. The two-hour

training workshop shall include a review of predisposing risk factors, warning signs and symptoms, identifying suicidal inmates despite their denial of risk, and review of any changes to the agency's suicide prevention program. The annual training shall also include general discussion of any recent suicides and/or suicide attempts in the agency.

A4. All staff who have regular contact with inmates shall receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff shall also be trained in the use of various emergency equipment located in each housing unit. In an effort to ensure an efficient emergency response to suicide attempts, "mock drills" shall be incorporated into both initial and refresher training for all staff (see also Section F).

B) Identification/Referral/Assessment

B1. *All* inmates (apart from those exceptions listed in No. 10 below) shall be administered the Intake Screening Form prior to placement in any housing unit. The Intake Screening Form (***Attachment A***) shall be administered during the admission and booking process by the Booking Officer or other designated staff (e.g., medical staff).

B2. The Intake Screening Form shall include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; and arresting/transporting officer(s) belief that the detainee is currently at risk.

B3. The Booking Officer or Designee shall question the arresting and/or transporting officer(s) regarding their assessment of the inmate's medical, mental health or suicide risk. The Arresting and/or Transporting Officer Questionnaire (***Attachment B***) shall include observed behavior and information from family members and/or others. Such information shall also be documented on the Intake Screening Form.

B4. If the inmate is being received from another facility (e.g., county jail, intra-system, etc.), the sending agency shall be required to complete a Sending Agency Transfer Form (***Attachment C***) which documents any medical, mental health, and suicide risk needs of the inmate.

B5. The Booking Officer or Designee shall determine (either through the inmate management system or manual check) whether the inmate was a medical, mental health or suicide risk during any prior contact and/or confinement within the agency. Such information shall be documented on the Intake Screening Form.

B6. The Booking Officer or Designee shall make all appropriate observations, and ask all questions, as contained on the Intake Screening Form. All information received shall be entered in the appropriate spaces of the Intake Screening Form.

B7. Although an inmate's verbal responses during the intake screening process are critically important to assessing the risk of suicide, staff should not exclusively rely on an inmate's denial that they are suicidal and/or have a history of mental illness and suicidal behavior, particularly when their behavior and/or actions or even previous confinement in the facility suggest otherwise.

B8. Following completion of the Intake Screening Form, the Booking Officer or Designee shall confer with the Shift Supervisor. The Shift Supervisor will review the form for accuracy and completeness, and then confer with medical and/or mental health personnel in determining the appropriate disposition (i.e., general population, suicide precautions, hospital, mental health referral, release, etc.). The Intake Screening Form shall be signed by both the Booking Officer or Designee and Shift Supervisor.

B9. If identified as a risk for suicide, the inmate shall be immediately placed on "Suicide Precautions" (see Section E) and the Shift Supervisor shall immediately contact medical and/or mental health personnel for further assessment.

B10. The assessment of suicide risk by medical and/or mental health staff shall include, but not be limited to, the following: description of the antecedent events and precipitating factors; suicidal indicators; mental status examination; previous psychiatric and suicide risk history, level of lethality; current medication and diagnosis; and recommendations/treatment plan. Findings from the assessment shall be documented on both the Suicide Risk Assessment (***Attachment D***) and health care record.

B11. Although any facility staff may place an inmate on Suicide Precautions and/or upgrade those precautions, ***only*** designated mental health (or medical) staff may downgrade and discontinue Suicide Precautions. Medical staff must confer with mental health staff prior to downgrading or discontinuing suicide precautions.

B12. A completed Intake Screening Form shall be performed on all inmates prior to assignment to a housing unit, ***except*** under the following circumstances: a) Inmate refuses to comply with process; b) Inmate is severely intoxicated or otherwise incapacitated; c) Inmate is violent or otherwise belligerent; or d) Inmate is undergoing a "court-ordered" booking and will be immediately released.

B13. For inmates listed in 8:a-c above, the Booking Officer or Designee shall still complete all non-questionnaire sections of the inmate's Intake Screening Form and make a notation on the form regarding why the inmate was unable to answer the questionnaire section. The Shift Supervisor shall then make the appropriate Disposition. A continuing, but reasonable effort shall be made to complete the entire Intake Screening Form on inmates listed on 8:a-c above at least every two (2) hours.

B14. Any inmate placed in a housing unit without having been administered a *completed* Intake Screening Form shall be placed on Suicide Precautions until such time as the Form is completed or until the inmate is released from the facility.

B15. A nursing supervisor staff shall review each completed Intake Screening Form for accuracy and completeness within 24 hours.

B16. All inmates shall be asked to sign a release of information form authorizing the disclosure of health records from outside providers. Medical staff shall make a reasonable effort to obtain records of

previous medical and mental health treatment, including both in-patient and out-patient treatment services.

B17. Within 14 days of admission into the facility, all inmates shall receive post-admission mental health screening by mental health and/or trained medical staff. The screening shall include inquiry into *history* of psychiatric treatment, violent and suicidal behavior, victimization, learning disabilities, cerebral trauma or seizures, and sex offenses; and *current* mental status, psychotropic medication, suicidal ideation, drug and alcohol use, and orientation to person, place, and time; and emotional response to incarceration. Inmates with a positive screening for mental health issues shall be referred to mental health staff for a full mental health evaluation.

B18. Given the strong association between inmate suicide and special management (e.g., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit shall receive a written assessment for suicide risk by mental health and/or medical staff upon admission to the special unit.

C) Communication

C1. What an inmate says and how they behave during arrest, transport to the facility, and at intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the individual. Arresting and/or transporting officers shall pay close attention to the inmate during this time; suicidal behavior may be manifested by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers such as family members and friends. Any pertinent information regarding the inmate's well-being must be communicated by the arresting or transporting officer to Booking Officer or Designee.

C2. All staff shall maintain awareness, share information and make appropriate referrals to mental health and medical staff.

UPDATE
ON THE INTERNET

Recent issues of the ***Jail Suicide/Mental Health Update*** are now available on the Internet at:

www.ncianet.org/cjjsl.cfm

Check us out on the Web!
www.ncianet.org/cjjsl.cfm

Other jail/juvenile suicide prevention and jail mental health resources, including several recent articles by Lindsay M. Hayes, can be found at the following web sites:

www.hhpub.com/journals/crisis/1997
www.nicic.org/jails/defrault.aspx
www.ojp.usdoj.gov/managingoffenders/mentalhealth.htm
www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
www.pbstandards.org/resources.aspx
www.gainsctr.com

C3. All staff shall use various communication skills with the suicidal inmate, including active listening, staying with the inmate if they suspect immediate danger, and maintaining contact through conversation, eye contact, and body language.

C4. All incidents of suicidal behavior shall be documented on the Suicide Precautions Observation Sheet, which shall also be utilized to document all physical cell checks of suicidal inmates (see Section E).

C5. The Shift Supervisor shall keep a separate daily roster of all inmates on Suicide Precautions. The roster shall be distributed to appropriate correctional, medical, and mental health personnel.

C6. The Shift Supervisor shall ensure that appropriate staff are properly informed of the status of each inmate placed on Suicide Precautions. The Shift Supervisor shall also be responsible for briefing the incoming Shift Supervisor regarding the status of all inmates on Suicide Precautions.

C7. Should an inmate be returned to the facility following temporary transfer to the hospital or other facility for suicide risk assessment and/or treatment, the Shift Supervisor shall inquire of medical and/or mental health officials what further prevention measures, if any, are recommended for the housing and supervising the returning inmate.

C8. Authorization for Suicide Precautions, reassessment and any changes in Suicide Precautions shall be documented on the Authorization for Suicide Precautions/Reassessment or Change in Observation Level Form (***Attachment E***) and distributed to appropriate staff (including housing unit where inmate is placed, medical and mental health personnel, shift supervisor, and classification).

C9. Multidisciplinary case management team meetings (to include facility officials and medical and mental health personnel) shall occur on a weekly basis to discuss the status of inmates on Suicide Precautions.

C10. Whenever an inmate is placed on Suicide Precautions, the Shift Supervisor shall notify classification staff and pertinent information will be entered into the facility's inmate management system.

D) Housing

D1. Any inmate placed on Suicide Precautions shall be housed in a cell that has the most visibility to staff. All cells designated to house suicidal inmates shall be as suicide-resistant as is reasonably possible, free of all obvious protrusions, and provide full visibility.

D2. Removal of an inmate's clothing (excluding belts and shoelaces) and the use of any physical restraints (e.g., restraint chairs or boards, leather straps, etc.) shall be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Metal handcuffs shall never be utilized for restraint.

D3. If the decision is made to remove clothing from a suicidal inmate, they shall be issued a safety smock or other protective clothing that is suicide-resistant.

D4. The Shift Supervisor shall immediately notify medical and/or mental health personnel when a decision has been made to remove an inmate's clothing or to apply any physical restraints.

D5. Regardless of whether restraints are initiated by custody or health care personnel, the use of *any* restraints shall include adherence to the following minimal guidelines:

a) Restraints shall not be used for punitive purposes;
b) Restraints require an order by a qualified health care professional (physician, nurse practitioner, or physician's assistant) order;
c) Inmates shall never be restrained in an unnatural position;
d) Restraint equipment must be medically appropriate;
e) Inmates placed in restraints shall be under the constant observation of correctional staff;
f) Vital signs of inmates placed in restraints shall be assessed every 30 minutes by medical staff;
g) Each restrained limb shall be untied for at least 10 minutes every two hours to allow for proper circulation;
h) Restrained inmates shall be allowed bathroom privileges as soon as practical;
i) Restraint orders shall be reviewed by the qualified health care professional every 2 hours, and must be reduced as quickly as possible to the level of least restriction necessary to protect the inmate and others as determined by the qualified health care professional; and
j) Restraint orders shall be automatically terminated after 12 hours and, if the inmate remains in a highly agitated state after 12 hours that they cannot be released because of physical danger to self or others, they shall be transferred to the hospital.

D6. Unless contraindicated by medical and/or mental health staff, each inmate on Suicide Precautions shall continue to receive regular privileges (e.g., showers, telephone, visiting, recreation, etc.) commensurate with their security level.

D7. Given the strong association between inmate suicide and special management (e.g., disciplinary and/or administrative segregation) housing unit placement, medical staff shall make rounds of the special housing unit at least three (3) times per week and mental health staff shall make rounds at least once (1) per week. At a minimum, medical and mental health staff shall visually observe *each* inmate confined in the unit (not simply those receiving medication, requesting services, and/or on a caseload). Documentation of the rounds shall be made in the housing unit log, with any significant findings documented in the inmate's health care record.

D8. Each housing unit in the facility should contain various emergency equipment, including a first aid kit; pocket mask, face shield, or Ambu-bag; and emergency rescue tool (to quickly cut through fibrous material). The Shift Supervisor staff should ensure that such equipment is in working order on a daily basis.

E) Levels of Observation

E1. "Suicide Precautions" is defined as an observational status placed on suicidal inmates requiring increased surveillance and management by staff. Suicide Precautions shall include two levels of observation:

a) *Close Observation*: Reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, shall be placed under close observation. Staff shall observe the inmate at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes).

b) *Constant Observation*: Reserved for the inmate who is actively suicidal, either threatening or engaging in self-injurious behavior. Staff shall observe such an inmate on a continuous, uninterrupted basis and have a clear non-obstructed view of the inmate at all times.

E2. Other supervision aids, including closed-circuit television monitoring, use of other inmates, etc., can be used as a supplement to, but shall never be a substitute for, the physical observation checks provided by staff.

E3. For each inmate placed on Suicide Precautions, staff shall document the *close observation* check as it occurs (but no more than staggered 15-minute intervals), and the *constant observation* check every 15 minutes, on a Suicide Precautions Observation Sheet (***Attachment F***).

E4. The Shift Supervisor shall make periodic visits to the housing units containing inmates on Suicide Precautions to ensure that Suicide Precautions Observation Sheets are complete and accurate.

E5. Suicidal inmates shall remain on Suicide Precautions until such time as they are transferred and/or released from the facility, or removed from the status by medical and/or mental health personnel.

E6. Medical and/or mental health staff shall assess and interact with (not just observe) inmates on Suicide Precautions on a daily basis.

E7. An inmate shall not be downgraded or discharged from Suicide Precautions until the responsible medical and/or mental health staff has assessed the inmate, thoroughly reviewed the inmate's health care record, as well as conferred with correctional personnel regarding the inmate's stability.

E8. An inmate placed on *constant observation* shall always be downgraded to *close observation* for a reasonable period of time prior to being discharged from Suicide Precautions.

E9. In order to ensure the continuity of care for suicidal inmates, all inmates discharged from Suicide Precautions shall remain on the mental health caseload and receive regularly scheduled follow-up assessment by mental health staff until their release from the facility. Unless their individual treatment plan directs otherwise, the reassessment schedule shall be as follows: daily for 5 days, once a week for 2 weeks, and then once every month until release.

F) Intervention

F1. All staff who come into contact with inmates shall be trained in standard first aid and cardiopulmonary resuscitation (CPR).

F2. All staff who come into contact with inmates shall participate in annual "mock drill" training to ensure a prompt emergency response to all suicide attempts.

F3. All housing units shall contain an emergency response bag that includes a first aid kit; pocket mask, face shield, or Ambu-bag; latex gloves; and emergency rescue tool. All staff who come into regular contact with inmates shall know the location of this emergency response bag and be trained in its use.

F4. Any staff member who discovers an inmate attempting suicide shall immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for the facility's medical personnel, and bring the emergency response bag to the cell. If the suicide attempt is life-threatening, Central Control personnel shall be instructed to immediately notify outside ("911") Emergency Medical Services (EMS). The exact nature (e.g., "hanging attempt") and location of the emergency shall be communicated to both facility medical staff and EMS personnel.

F5. Following appropriate notification of the emergency, the First Responding Officer shall use their professional discretion in regard to entering the cell without waiting for backup staff to arrive. With no exceptions, if cell entry is not immediate, it shall occur no later than four (4) minutes from initial notification of the emergency.

F6. Should the emergency take place within the Special Housing Unit and require use of the Cell Entry Team, the Team shall be assembled, equipped and enter the cell as soon as possible, and no later than four minutes (4) from initial notification of the emergency. Correctional staff shall ***never*** wait for medical personnel to arrive before entering a cell or before initiating appropriate life-saving measures (e.g., first aid and CPR).

F7. Upon entering the cell, correctional staff shall *never* presume that the victim is dead, rather life-saving measures shall be initiated immediately. In hanging attempts, the victim shall first be released from the ligature (using the emergency rescue tool if necessary). Staff shall assume a neck/spinal cord injury and carefully place the victim on the floor. Should the victim lack vital signs, CPR shall be initiated immediately. All life-saving measures shall be continued by correctional staff until relieved by medical personnel.

F8. The Shift Supervisor shall ensure that both arriving facility medical staff and EMS personnel have unimpeded access to the scene in order to provide prompt medical services to, and evacuation of, the victim.

F9. Although the scene of the emergency shall be preserved as much as possible, the first priority shall always be to provide immediate life-saving measures to the victim. Scene preservation shall receive secondary priority.

F10. An Automated External Defibrillator (AED) shall be located in the Medical Unit and/or Special Housing Unit. All medical staff, as well as designated correctional personnel, shall be trained (both initial and annual instruction) in its use. The Medical Director or Designee shall will provide direct oversight of AED use and maintenance.

F11. The Medical Director or Designee shall ensure that all equipment utilized in the response to medical emergencies (e.g., crash cart, oxygen tank, AED, etc.) is inspected and in proper working order on a daily basis.

F12. All staff and inmates involved in the incident will be offered critical incident stress debriefing (see Section H).

F13. Although not all suicide attempts require emergency medical intervention, all suicide attempts shall result in the inmate receiving immediate intervention and assessment by mental health staff.

G) Reporting/Notification

G1. In the event of a suicide, all appropriate officials shall be notified through the chain of command.

G2. Following the incident, the victim's family shall be immediately notified, as well as appropriate outside authorities.

G3. All staff who came into contact with the victim before the incident shall be required to submit a statement including their full knowledge of the inmate and incident.

H) Follow-Up/Mortality Review

H1. Critical Incident Stress Debriefing (CISD) provides affected staff and inmates an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and seek ways of dealing with those symptoms. In the event of a serious suicide attempt (i.e., requiring medical treatment and/or hospitalization) or suicide, all affected staff and inmates shall be offered CISD. For maximum effectiveness, the CISD process and other appropriate support services shall occur within 24 to 72 hours of the critical incident (see CISD policy).

H2. Every completed suicide, as well as serious suicide attempt (e.g., requiring hospitalization), shall be examined by a multidisciplinary Mortality Review Team that includes representatives of both line and management level staff from the corrections, medical and mental health divisions.

H3. The Mortality Review process shall comprise a critical inquiry of: a) circumstances surrounding the incident; b) facility procedures relevant to the incident; c) all relevant training received by involved staff; d) pertinent medical and mental health services/reports involving the victim; e) possible precipitating factors leading to the suicide; and f) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. The inquiry shall follow the outline described in the Mortality Review Checklist (***Attachment G***).

H4. When appropriate, the Mortality Review Team shall develop a written plan (and timetable) to address areas that require corrective action. The plan, as well as all written documentation pertaining to the Mortality Review process, shall be maintained by the Quality Assurance Coordinator in a locked file cabinet. ❑

Developed by the NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES

Attachment A

INTAKE SCREENING FORM

Inmate's Name:_____ Date of Birth: _____ Sex: _____ Date:_____ Time:_____

Most Serious Charge: _____ I.D. Number: _____ Screening Officer: _____

Was inmate a medical, mental health or suicide risk during any prior contact and/or confinement within the facility?
Yes___ No___ If Yes, explain:_____

Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency/facility, family member/guardian, etc.) that indicates inmate is a medical, mental health or suicide risk now? Yes___ No___
If Yes, explain: _____

STAFF OBSERVATION

Yes	No		Yes	No	
___	___	Assaultive/Violent Behavior	___	___	Crying/Tearful
___	___	Loud/Obnoxious Behavior	___	___	Confused
___	___	Any Noticeable Marks/Scars	___	___	Uncooperative
___	___	Bizarre Behavior	___	___	Passive
___	___	Alcohol/Drug Withdrawal	___	___	Intoxicated
___	___	Unusual Suspiciousness	___	___	Scared
___	___	Hearing Voices/Seeing Visions	___	___	Incoherent
___	___	Observable Pain/Injuries	___	___	Embarrassed
___	___	Other Observable Signs of Depression	___	___	Cooperative

Explain: _____

MEDICAL HISTORY

Yes	No	
___	___	Are you injured? If Yes, explain:_____
___	___	Are you currently under a physician's care? If Yes, explain:_____
		_____
___	___	If female, are you pregnant?
___	___	Are you currently taking any medication? If Yes, list type(s), dose(s), and frequency: _____
		_____

DO YOU SUFFER FROM ANY OF THE FOLLOWING

Yes	No		Yes	No	
___	___	Hepatitis	___	___	Heart Disease
___	___	Shortness of Breath	___	___	Chest Pain(s)
___	___	Abdominal Pain(s)	___	___	Asthma
___	___	High Blood Pressure	___	___	Venereal Disease
___	___	Tuberculosis	___	___	Diabetes
___	___	Alcohol Addiction	___	___	Drug Addiction
___	___	Epilepsy/Blackouts/Seizures	___	___	Ulcers
___	___	Other Medical Problems and/or Diseases	___	___	HIV/AIDS (Optional)

Explain: _____

SUICIDE RISK ASSESSMENT

Yes **No**

___ ___ Have you ever attempted suicide? If Yes, When?_____ Why? _____
_____ How? _____

___ ___ Have you ever considered suicide? If Yes, When?_____ Why? _____
_____

___ ___ Are you now or have you ever been treated for mental health or emotional problems? If Yes,
When?_____ Inpatient: _____ Outpatient: _____ Both:_____

___ ___ Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
If Yes, explain: _____
_____
_____

___ ___ Has a family member/close friend ever attempted or committed suicide? If Yes, explain: _____
_____
_____

___ ___ Do you feel there is nothing to look forward to in the immediate future (inmate expressing helplessness and/or
hopelessness)? If Yes, explain: _____
_____
_____

___ ___ Are you thinking of hurting and/or killing yourself? If Yes, explain:_____
_____
_____

Additional Remarks: _____
_____

DISPOSITION

___ General Population

___ Suicide Precautions
1) Supervision Levels: CLOSE (5-15 Minutes)_____ CONSTANT_____ OTHER_____
2) Housing Assignment: Infirmary_____ Mental Health Unit_____ Room #_____
3) Other Precautions Taken (restraints, safety smock, bedding, etc., if appropriate)

___ Local Hospital. If inmate is later returned to facility, list any special observation recommendations: _____
_____

___ Other Disposition/Referral/Transfer: _____
_____

FAILURE TO ANSWER/REFUSAL OF TREATMENT

Inmate refused to answer (circle) or unable to answer (circle and state why) verbal response sections of this form.

I, _____ (print name) refuse any type of medical treatment.

SIGNATURES: Inmate: _____

Screening Officer: _____ Supervisor: _____

Attachment B

ARRESTING/TRANSPORTING OFFICER QUESTIONNAIRE

Yes	No	
___	___	Does the detainee appear to be under the influence of alcohol and/or drugs?
___	___	Has the detainee made ***any*** comments (e.g., "I'm going to kill myself," "I want to die," "I have nothing to live for," "Everyone would be better off without me around") or engaged in ***any*** behavior that would be cause for concern? If Yes, explain: _____
___	___	Has another individual with knowledge of detainee informed you and/or made comments that suggest that detainee is potentially suicidal and/or has a history of suicidal behavior, has a history of mental illness, has medical problems, or is under the influence of alcohol and/or drugs? If Yes, explain: _____
___	___	Does the detainee appear to be overly ashamed, embarrassed, scared, depressed, or exhibiting bizarre behavior? If Yes, explain: _____
___	___	Are there any facts or circumstances surrounding the arrest and/or alleged crime that may suggest the detainee is potentially suicidal? If Yes, explain: _____
___	___	Do you have any other information that would be helpful to us while the detainee is confined in this facility? If Yes, explain: _____

COMPLETED BY: _____

(Print and Sign)

Agency: _____ **Date:** _____

Attachment C

SENDING AGENCY TRANSFER FORM

Sending Agency Section

Inmate's Name:_____ Date of Birth: _____ Sex:_____ Date:_____ Time:_____

Was inmate a medical, mental health or suicide risk during any prior contact and/or confinement within your facility?
Yes___ No___ If Yes, explain: _____

Is the inmate currently taking any medication? Yes ___ No ___
If Yes, list type(s), dose(s), and frequency:

Is the inmate currently receiving mental health services? Yes ___ No ___
If Yes, explain: _____

Is the inmate currently on suicide precautions and/or had a history of suicidal behavior in your facility? Yes ___ No ___
If Yes, explain: _____

Additional Information: _____

SIGNATURE/TITLE (Sending Agency): _____ **DATE:** _____ **TIME:** _____

Transporting Officer Section

Do you have any information (e.g., from observed behavior, documentation from sending agency/facility, family member/guardian, etc.) that indicates inmate is a medical, mental health or suicide risk now? Yes ___ No ___
If Yes, explain: _____

SIGNATURE/TITLE (Transporting Officer): _____ **DATE:** _____ **TIME:** _____

Receiving Agency Section

Received Medical File, Mental Health File, Court-Order Evaluation, Other (_____). Circle all that apply.

SIGNATURE/TITLE (Receiving Agency): _____ **DATE:** _____ **TIME:** _____

Attachment D

SUICIDE RISK ASSESSMENT

Inmate's Name: _____ **I.D. Number:** _____
(Last) (First) (M.I.)

DOB: _____ **Age:** _____ **Sex:** _____ **Initial Assessment:** _____ **Reassessment:** _____ **Date:** _____

Suicide Precautions During Prior Confinement: Yes ___ (Most Recent Date;_____) No ___

Reason for Referral/Precipitating Factors: _____

Suicidal Indicators (Check all that apply):

- ❑ Suicide Attempt
- ❑ Depressed
- ❑ Hostile/Aggressive
- ❑ Lethargy
- ❑ Giving Away Possessions
- ❑ Afraid/Fearful
- ❑ Suicide Ideation/Gesture
- ❑ Agitated
- ❑ Sleep Problems
- ❑ Excessive Weight Gain/Loss
- ❑ Intoxicated
- ❑ Bizarre Behavior (explain above)
- ❑ Self-Mutilation
- ❑ Mood Change
- ❑ Recent Loss
- ❑ Withdrawal
- ❑ Hopeless/Helpless
- ❑ Other (explain above)

Type of Threat/Attempt: ❑Hanging ❑Cutting ❑Jumping ❑Ingestion ❑Overdose ❑Other _____
Previous Psychiatric/Suicide History: _____

Current Medications: _____

Assessment of Lethality: Low (1)_____ Medium (2)_____ High (3)_____

Diagnosis:

- ❑ Schizophrenia
- ❑ Borderline Personality
- ❑ Substance Abuse Disorder
- ❑ Major Depression
- ❑ Panic Disorder
- ❑ Other _____
- ❑ Generalized Anxiety Disorder
- ❑ Bi-Polar Disorder

Findings/Recommendations/Treatment Plan: _____

Actions:

Suicide Precautions Authorized: ❑Yes ❑No
Level: ❑Close (Physical checks at staggered intervals not to exceed every 15 minutes)
❑Constant (Continuous, uninterrupted observation)
❑Other (Specify) _____
Restraints: ❑Yes ❑No
Safety Smock: ❑Yes ❑No
Items *Allowed* (Check): ❑Clothing ❑Undergarments ❑Blankets ❑Mattress ❑Pillow
❑Reading Materials ❑Toiletries ❑Other _____
Housing Assignment: _____
Transfer Recommendations: _____
Other Referrals/Recommendations: _____

Signature/Title: _____ **Time:** _____
(Qualified Mental Health Professional)

Attachment E

AUTHORIZATION FOR SUICIDE PRECAUTIONS/REASSESSMENT OR CHANGE IN OBSERVATION LEVEL

Inmate's Name: _____ **I.D. Number:** _____
(Last) (First) (M.I.)

- ❑ **Placed on *Close* Observation** (physical checks at staggered intervals not to exceed every 15 minutes)
- ❑ **Placed on *Constant* Observation** (continuous, uninterrupted)
- ❑ **Transferred from *Constant* Observation to *Close* Observation ***
- ❑ **Transferred from *Close* Observation to *Constant* Observation**
- ❑ **Continued on *Close* Observation**
- ❑ **Released from *Close* Observation***

*May only be authorized following face-to-face consultation with a qualified mental health professional.

Housing Assignment: _____ **Restraints:** ❑Yes ❑No **Safety Smock:** ❑Yes ❑No

Items *Allowed* (Check): ❑Clothing ❑Undergarments ❑Blankets ❑Mattress ❑Pillow ❑Reading Materials ❑Toiletries ❑Other

Transfer Recommendations: _____

Other Referrals/Recommendations: _____

Reason for Observation (Provide Details): _____

Follow-Up Recommendations: _____

SIGNATURE/TITLE: _____ **DATE:** _____ **TIME:** _____
(Shift Supervisor)

APPROVED BY (SIGNATURE): _____ **DATE:** _____ **TIME:** _____
(Qualified Mental Health Professional)

Attachment F

SUICIDE PRECAUTIONS OBSERVATION SHEET

Inmate's Name: _____ **I.D. Number:** _____
(Last) (First) (M.I.)

Start Date: _____ **Start Time:** _____ **Cell Location:** _____

Suicide Precaution Level:

- ❑ **CLOSE** (Physical checks at staggered intervals not to exceed every 15 minutes, e.g., 5, 12, 10 minutes)
- ❑ **CONSTANT** (Continuous, uninterrupted observation)
- ❑ **OTHER** (Specify) _____

Restraints: ❑Yes ❑No **Safety Smock:** ❑Yes ❑No

CODE FOR INMATE BEHAVIOR AND STAFF INTERVENTIONS

A. Self-Injurious Behavior	F. Quite/Seclusive	K. Sleeping	P. Yelling/Screaming
B. Assaultive Behavior	G Self-Contained Activity	L. Medical	Q. Telephone Call
C. Destructive Behavior	H. Social Activity/Program	M. Mental Health	R. Visit
D. Hyperactive	I. Medication	N. Eating	S. Incoherent
E. Active	J. Toilet/Shower	O. Crying	T. Other_____

Time	Codes	Staff Name	Time	Codes	Staff Name	Time	Codes	Staff Name

SHIFT SUPERVISOR SIGNATURE: _____ **DATE:** _____ **TIME:** _____

Developed by the NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES

Attachment G

MORTALITY REVIEW CHECKLIST

1) TRAINING

- Had all correctional, medical, and mental health staff involved in the incident received both basic and annual training in the area of suicide prevention prior to the suicide?
- Had all staff who responded to the incident received training (and were currently certified) in standard first aid and cardiopulmonary resuscitation (CPR) prior to the suicide?

2) IDENTIFICATION/REFERRAL/ASSESSMENT

- Upon this inmate's initial entry into the facility, were the arresting/transporting officer(s), as well as sending agency (if applicable) asked whether they believed the inmate was at risk for suicide? If so, what was the response?
- Had the inmate been screened for potentially suicidal behavior upon entry into the facility?
- Did the screening include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/ hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); and history of suicidal behavior by family member/close friend?
- If the screening process indicated a potential risk for suicide, was the inmate properly referred to mental health and/or medical personnel?
- Did the inmate receive a post-admission mental health screening within 14 days of his/her confinement?
- Had the inmate previously been confined in the facility/system? If so, had the inmate been on suicide precautions during a prior confinement in the facility/system? Was such information available to staff responsible for the current intake and post-admission screenings?

3) COMMUNICATION

- Was there information regarding the inmate's prior and/or current suicide risk from outside agencies that was not communicated to the correctional facility?
- Was there information regarding the inmate's prior and/or current suicide risk from correctional, mental health and/or medical personnel that was not communicated throughout the facility to appropriate personnel?
- Did the inmate engage in any type of behavior that might have been indicative of a potential risk of suicide? If so, was this observed behavior communicated throughout the facility to appropriate personnel?

4) HOUSING

- Where was the inmate housed and why was he/she assigned to this housing unit?
- If placed in a "special management" (e.g., disciplinary and/or administrative segregation) housing unit at the time of death, had the inmate received a written assessment for suicide risk by mental health and/or medical staff upon admission to the special unit?
- Was there anything regarding the physical design of the inmate's cell and/or housing unit that contributed to the suicide (e.g., poor visibility, protrusions in cell conducive to hanging attempts, etc.)?

5) LEVELS OF SUPERVISION

- What level and frequency of supervision was the inmate under immediate prior to the incident?
- Given the inmate's observed behavior prior to the incident, was the level of supervision adequate?
- When was the inmate last physically observed by correctional staff prior to the incident?
- Was there any reason to question the accuracy of the last reported observation by correctional staff?
- If the inmate was not physically observed within the required time interval prior to the incident, what reason(s) was determined to cause the delay in supervision?
- Was the inmate on a mental health and/or medical caseload? If so, what was the frequency of contact between the inmate and mental health and/or medical personnel?
- When was the inmate last seen by mental health and/or medical personnel?
- Was there any reason to question the accuracy of the last reported observation by mental health and/or medical personnel?
- If the inmate was not on a mental health and/or medical caseload, should he/she have been?
- If the inmate was not on suicide precautions at the time of the incident, should he/she have been?

6) INTERVENTION

- Did the staff member(s) who discovered the inmate follow proper intervention procedures, i.e., surveyed the scene to ensure the emergency was genuine, called for backup support, ensured that medical personnel were immediately notified, and initiated standard first aid and/or CPR?
- Did the inmate's housing unit contain proper emergency equipment for correctional staff to effectively respond to a suicide attempt, i.e., first aid kit, gloves, pocket mask, mouth shield, or Ambu bag; and emergency rescue tool?
- Were there any delays in either correctional or medical personnel immediately responding to the incident? Were medical personnel properly notified as to the nature of the emergency and did they respond with appropriate equipment? Was all the medical equipment working properly?

7) REPORTING

- Were all appropriate officials and personnel notified of the incident in a timely manner?
- Were other notifications, including the inmate's family and appropriate outside authorities, made in a timely manner?
- Did all staff who came into contact with the inmate prior to the incident submit a report and/or statement as to their full knowledge of the inmate and incident? Was there any reason to question the accuracy and/or completeness of any report and/or statement?

8) FOLLOW-UP/MORTALITY REVIEW

- Were all affected staff and inmates offered critical incident stress debriefing following the incident?
- Were there any other investigations conducted (or that should be authorized) into the incident that may be helpful to the mortality review?
- As a result of this mortality review, were there any possible precipitating factors (i.e., circumstances which may have caused the victim to commit suicide) offered and discussed?
- Were there any findings and/or recommendations from previous mortality reviews of inmate suicides that are relevant to this mortality review?
- As a result of this mortality review, what recommendations (if any) are necessary for revisions in policy, training, physical plant, medical or mental health services, and operational procedures to reduce the likelihood of future incidents?

Seeking Solutions to Self-Destruction

by
Dana Green

When he heard about the third suicide, Sheriff Dan Walsh felt a sinking feeling in his stomach. It was December 4, 2004 in Champaign County, Illinois, a racially mixed community of 186,000 people. 25-year-old Terrell Layfield, in jail for giving officers a false name during a drug arrest, had hung himself in his cell using his bed sheet. Walsh, elected county sheriff in 2002, oversees two jails in Urbana, a growing town 90 miles from Springfield. As many as 350 prisoners are housed in the separate facilities, with up to 30 prisoners entering its walls each day.

Two inmates had killed themselves earlier in the year — the first in June, the second in July. One inmate, Joseph Beavers, had managed to commit suicide only six hours after his intake interview, using a telephone cord to strangle himself in his booking cell. In six months, three young men were dead — with little explanation of why.

Only a mile from the Champaign County Jail, on Vine Street in Urbana, Sandra Ahten read about Layfield's suicide in the newspaper with a growing sense of outrage. Ahten, a local artist and diet counselor, had first-hand experience with incarceration at the county jail: the year before, her 22-year-old son had been arrested. Ahten thought about how isolated and scared her son had been as an inmate, cut off from family and friends. Ahten began to do research on how many suicides had occurred in Illinois county jails over the past year. The numbers surprised her.

Throughout the county jail system, there had been eight suicides in the state of Illinois — and three had been in Champaign County. "I didn't know if this was normal," Ahten said. "There was no press release...it was just reported as another death. It didn't look like there was going to be an investigation."

Ahten acknowledges that, for her, the deaths were a very personal matter. "Having had my son in the jail, it is a very real place — it is part of our community," Ahten said. "For most people, they just drive by. Inmates are a forgotten population."

Closer to home, Ravalli County (Montana) Sheriff Chris Hoffman is now grimly familiar with the Champaign County sheriff's predicament. On February 20, 2004, Mark Daniel Wilson was found hanging in his cell at the Ravalli County Detention Center in Hamilton. In September, detention officers found another inmate strangling himself with his bed sheets, but managed to lower him to the ground and transport him to the hospital.

Then in March, a sudden string of suicides, one after another, caught the attention of the community. On March 21, Bradley Palin, 42, a father of four, hanged himself only a week after being arrested under suspicion of starting two fires in a rural neighborhood south of Hamilton. In April, detention officers found Ryan Heath, a 27-year-old Hamilton High School graduate, dead in his cell. One month later, Scott Lewis, incarcerated on methamphetamine charges, was also found dead of an apparent suicide.

At a press conference on May 23, Hoffman expressed frustration at the string of deaths within his facility. He also pointed out that Ravalli County was not the only detention center facing a sudden rash of inmate suicide attempts. Hoffman cited Sheriff Walsh in Champaign County — he too had to explain to his community why a handful of young men had died under his watch. Hoffman promised that the National Institute of Corrections would send an expert consultant to assess the Ravalli County Detention Center for weaknesses in their suicide prevention policies.

But Hoffman told the grieving families gathered at the courthouse press conference that sometimes suicides were in the hands of only one person — the inmate. "They made choices that ended them in (jail)," Hoffman said. "We are reactive. They get the chance to do what they do first."

For Lindsay Hayes, jail suicides are a difficult problem — but they are also a preventable one. Literally and figuratively, Hayes has written the book on jail and prison suicides. A project director for the National Center on Institutions and Alternatives in Mansfield, Massachusetts, Hayes has conducted hundreds of jail suicide assessments across the country for the National Institute of Corrections. In 1980, he wrote the only national study on suicide in correctional facilities for the U.S. Department of Justice. Hayes now serves as editor for the NIC publication — ***Jail Suicide/ Mental Health Update***, a quarterly newsletter.

Inmate suicides are a problem every detention facility — large and small — must face, according to Hayes. According to the latest figures from the Justice Department's Census of Jails, suicide is the second leading cause of death in the nation's jails — second only to illnesses and other natural causes, and far exceeding death rates from AIDS, drug overdoses and injuries. However, if natural causes were broken down into separate illnesses, suicide would be the leading cause of death, Hayes said. "Every jail is susceptible to suicide — they are incarcerating people," said Hayes. But when jails experience a string of suicides over a short period of time, in Hayes' experience, there is usually a serious problem. The census figures agree: Only five percent of jails that reported suicides had more than one death occur in a one-year period.

When Hayes heard that four suicides have occurred at the 78-bed Ravalli County Detention Center, three since March, shock crept into his voice. "That's one of the largest ratios of suicides to number of beds that I've seen in 25 years of research (and consulting)," he said. "There's something very wrong at that jail."

But what is wrong can be fixed, in Hayes' opinion. After studying more than 1,500 cases of jail suicide nationwide in his career, Hayes has outlined eight factors that go into an effective detention suicide prevention program. Those eight factors include thorough officer training; careful intake screening; effective communication between law enforcement and mental health counselors; a safe environment to put suicidal prisoners; and rigorous observation techniques; as well as medical

intervention, reporting and assessment when a suicide attempt occurs.

These elements should be in place in every correctional institution: large or small, well-funded or not, according to Hayes. "It doesn't have much to do with the size of the jail or the resources available," Hayes said. Law enforcement officers can be trained to identify suicidal signs in prisoners. Inmates can be screened more closely during the intake process. Communication between officers and mental health staff can be improved, so that if an arresting officer sees telltale signs, that information is passed along effectively down the line to counselors.

It is easy for communication to break down between the numerous staff members that deal with each inmate, according to Hayes. "An arresting officer might have heard something on the scene at the arrest and didn't pass it along to mental health staff," Hayes said. Officers also must learn to recognize the type of inmate most at risk, Hayes said.

The typical suicide within the jail system is a young, white, single male, incarcerated for a nonviolent offense. Often, a suicide will occur within the first 48 hours after a prisoner is booked. Inmates who successfully commit suicide are often intoxicated or under the influence of drugs at the time they are arrested, Hayes said. "The level of intoxication plays a huge role," he said. Overwhelmingly — 92 percent, according to census figures suicide victims die by asphyxiation, using bed sheets or clothing.

After multiple suicides, local officials at smaller detention facilities often blame a lack of funding, or say that there's little they can do about suicide, according to Hayes. But that's simply not true, he said. "If they didn't have this problem two years ago, they need to evaluate their program," he said.

Whether a jail holds 78 beds or 5,000, officials need to make sure that all eight of those factors are in place — in practice, not just in an unopened policy manual, according to Hayes. "It's one thing to have a policy that looks good on paper, but then it (might) not be happening in practice," he said. Most of the program elements cost little to put into place — changing an intake screening form or training, for example, can be done with minimal cost, according to Hayes.

In the end, it becomes a matter of priorities. Top elected officials, from county commissioners to the sheriff, must have zero tolerance for suicides in their jail if the program is to be successful, says Hayes. "You don't have to accept inmate suicides in your jail system," Hayes said. "A lot of it has to do with attitude. You can't be 100 percent successful. But there are a lot of things a sheriff can do to prevent a completed suicide in their facility."

At Orange County Jail, suicide prevention has become a mantra from elected officials to rookie deputies. The vast jail system, five facilities known as the Orange County Complex, books an average of 60,000 prisoners a year. It is the 4th largest jail system in the state of California and the 13th largest in the nation, holding about 5,000 inmates each day. Despite its vast size, the jail system's low suicide rate reflects a commitment to prevention at every level.

As of this year, there have been only five successful suicides in the last decade, according to Kevin Smith, Administrative Manager for Correctional Mental Health for the Orange County jails. Smith credits the low suicide rates to a sense of teamwork between deputies, health care professionals and counselors. "It's truly a collaborative team," Smith said. "I feel that is one of the key ingredients. There has got to be leadership from the top down."

Mental health staff is on-site — if they determine the inmate to be at risk, preventative steps are implemented. The inmate is placed in a mental health center, guaranteeing more effective observation. The jail system has also designed a special smock so that at-risk prisoners cannot use clothing to strangle themselves. In addition, each deputy holds a laminated card in his or her uniform pocket, listing symptoms to look for, Smith said. The card represents each officer's commitment to prevent another suicide on his or her watch, according to Smith. "They touch that card every time they change their uniform," Smith said. "It's sort of a symbol that pulls the group together."

In Champaign County, Sandra Ahten had decided that three suicides were three too many. Ahten began to show up at county commission meetings. She argued that the jail's restrictive visitation and phone call policies were contributing to the escalating number of suicides. After an initial phone call, inmates had to pay collect to call outside — often as high as $6 for a 15-minute call, according to Ahten. Visits were also heavily restricted — the sheriff's department only allowed 50 visitors per day, and family members often had to wait hours trying to get in, according to Ahten. These restrictive policies left family members unable to detect warning signs of depression, according to Ahten.

In early March, Sheriff Walsh loosened visitation and phone call rules, allowing inmates more access to their families. Ahten and other members of Champaign-Urbana Citizens for Peace and Justice, a grassroots citizens group, also pushed for a National Institute of Corrections assessment to be conducted. The report, released in March, indicated that training for officers needed to be expanded, and that all inmates should go through a screening process, conducted by mental health professionals, within two weeks after intake. The report also recommended that prisoners at a high level of risk for a suicide attempt be monitored more closely.

In the wake of community activism, Sheriff Walsh turned to the Champaign County Board of Commissioners to help fulfill the report's goals. The county commissioners were committed to ending the cycle, according to Walsh.

Since the report came out, the detention center has tripled its clinical staff, and brought in a part-time in-house psychiatrist. Officers now do not have to take the security risk, as they did previously, of bringing prisoners off-site for mental health evaluations. "The county Board has been very supportive," Walsh said. "I said, 'I know money is tight, but we need to do this.'" Within his department, the attitude regarding inmate suicide has also changed significantly, according to Walsh. "The officers are much more vigilant," he said. "They're trying

to pay attention to even the small details about how an inmate is acting."

According to Sheriff Walsh, the changes have relieved a weight on the shoulders of his team, which includes about 185 full and part-time officers and support staff. After the third suicide, depression and anxiety had begun to affect the ranks of his department, according to Walsh. "From the officers to me, you know these people," Walsh said. "(These) are members of the community – they're just in a secure environment." Preventing suicides in the jail was important to the community — but also to the morale of detention staff, Walsh found. "We are hoping that by doing this, it will improve things for inmates — but also my employees," Walsh said. "They were under (enormous) stress."

When multiple suicides occur, bringing in the NIC to do a jail assessment is the right first step, according to Hayes. The National Institute of Corrections, under the auspices of the Justice Department, offers technical assistance, resources, and information to state and local correction agencies across the country. The NIC helps local detention facilities plan for expansion, provides information on mental health issues among inmate populations, and conducts operational assessments and inmate management reviews, said Jim Barbee, a correctional programs specialist with the NIC's jails division.

An NIC assessment is scheduled at the Ravalli County Detention Center this week, and that could help target policy problems, Barbee said. "Sometimes a set of fresh eyes helps," Barbee said. "Sometimes (officials) are so close to the forest they can't see the trees."

But for the Ravalli County Detention Center, a professional assessment is only the beginning, in Hayes' view. The NIC assessment is strictly non-regulatory — a consultant will be sent in only when requested by local law enforcement officials, and they have power only to make recommendations, not to enforce any changes. "This is not an investigation," Barbee said. "Our sole purpose is to provide technical assistance and problem solving."

Once the assessment is conducted, the community needs to remain vigilant to be sure elected officials are committed to making necessary changes, Hayes said. Sheriff's departments can — and should — be held responsible for suicides within their facilities, according to Hayes. "Ultimately, they are responsible for what goes on within those walls," he said.

But the community also can play a large role in tackling the root causes of inmate suicides. In Champaign County, Aaron Ammons, a CUCPJ co-founder and activist, says that the group's members have tried to take a hard look at the bigger social problems facing their community — of which jail suicides are just one symptom. Drug use, lack of mental health counseling, suicide rates among the general population and overzealous prosecutions can all play a role, Ammons believes. Ammons said that prosecutors in Champaign County have pursued felony convictions at a rate that leaves little hope for first-time and nonviolent offenders. Cuts in mental health funding have also played a role, Ammons added.

JAIL MENTAL HEALTH SERVICES INITIATIVE FROM THE NATIONAL INSTITUTE OF CORRECTIONS (JAILS DIVISION)

Nearly 6 to 8 percent of the more than 10 million annual commitments to jails are individuals with severe mental illnesses. Many sheriffs and jail administrators view the challenge of responding to the needs of this population as one of the major issues in jail management. In response, the National Institute of Corrections (NIC) has worked collaboratively with the National Institute of Mental Health for the past several years, and more recently, with the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services to increase and improve these services. As a result of these collaborations, the NIC Jails Division has developed a mental health initiative for jails.

An important component of the initiative is the offering of regional workshops conducted in collaboration with state, regional, and local jurisdictions. The 21-hour regional workshops will be provided upon request to help small and medium-sized jails enhance mental health services and service delivery for inmates. Several jurisdictions in a region can each send a three-person team consisting of a jail administrator, a representative of the jail's community mental health provider, and the person who coordinates mental health services for inmates. Each workshop will include: overview of the problem, planning principles, contract development, leadership and managing change, implementation strategies, staffing and cross-training, and coalition building. The workshops are conducted at the request of a host agency, which is responsible for furnishing the training rooms and equipment. The NIC Jails Division provides two trainers, the curriculum and training materials. Participants are responsible for their own expenses.

In addition to the workshops, the NIC Jails Division's mental health initiative includes the following services:

- **On-site Technical Assistance**: This assistance usually consists of an assessment of a jail system's mental health needs, *but also can be targeted at suicide prevention issues in the jail*;
- **Newsletter**: The NIC Jails Division funds the ***Jail Suicide/Mental Health Update***, a newsletter which is distributed free of charge on a quarterly basis;
- **Information Resources**: The NIC Information Center has compiled a jail mental health information resource order form that contains 22 items. The form is available at the mental health workshops held in Longmont, Colorado and at regional sites. It can also be obtained by calling the Information Center at (800) 877-1461.

For more information on the NIC Jails Division's mental health initiative, on-site technical assistance, and the mental health workshops, contact the agency at (800) 995-6429, or visit their website at: www.nicic.org

Ultimately, the community sets the priorities — and they have the choice of whether or not to take action. "(The community is) going to have to stay vigilant," Ammons said. "The elected officials are going to think you'll go away. But officials must know that the (public) is not going to go away." Ammons said that his organization's efforts to eliminate jail suicides go beyond merely protests — it is about shaping the kind of community where everyone is safe and protected, even those who have broken the law. "They can see we're not just out here protesting," Ammons said. "We want to be part of this process — to help them do their jobs better."

For Sheriff Walsh, that job now includes not just locking up prisoners, but also protecting them. "These people downstairs, they are almost like my children," he said. "I have a statutory duty to take care of them."

As for Ahten, she has become a tireless advocate for inmate rights, who has gained the grudging respect of local elected officials and community leaders in Urbana. Ahten is now working on a new goal to provide a library service for Champaign County inmates. Despite the fact that the jail is less than two blocks from the University of Illinois campus, inmates do not have access to books, according to Ahten. Her ultimate goal, Ahten says, is to get the community to see inmates as real people with problems — not just statistics in the daily newspaper. A recovering alcoholic, Ahten said she has compassion for individuals struggling to turn their lives around. In her view, community resources should go toward tutoring, job training, drug counseling and recovery — not just adding beds in the jail. "What I'm hoping to do is get the whole community thinking about the jail," she said. "As a community, we can start to think preventatively. These people are not put away and never coming back. They are community members. You can't pretend they don't exist."

In Ravalli County, the families of the inmates who committed suicide are just starting to ask questions — to try to find out why. Becky Rickman, Ryan Heath's maternal grandmother, lives in Portland. Rickman traveled to the Bitterroot to help her daughter, Linda Heath, Ryan's mother, when she heard the news that Ryan had been arrested for an alleged sexual assault. Trying to set aside visitation hours for other family members, Rickman was unable to see Ryan in the two weeks before his death.

Rickman still doesn't know why — why Ryan was so despondent, or whether his death could have been prevented. "I didn't get in to talk to him at all," she said. "Somewhere there was a breakdown in communication." Ryan was severely hearing impaired — but Rickman said she still doesn't know whether detention guards were aware of that fact. Mostly, Ryan's family simply wants answers, Rickman said. "The whole family feels his death was entirely needless," Rickman said. "Right now, all I can say is that there is a great deal of unanswered questions."

*The above article was written by Dana Green, a staff writer for the **Ravalli Republic** in Hamilton, Montana. It appeared in the June 8, 2005 edition of the newspaper and is reprinted with the permission of the **Ravalli Republic**.* ❑

JAIL SUICIDE/MENTAL HEALTH UPDATE

This technical update, published quarterly, is part of the National Center on Institutions and Alternatives (NCIA)'s continuing efforts to keep state and local officials, individual correctional staff, mental health/medical personnel, and interested others aware of developments in the field of jail suicide prevention and jail mental health services. Please contact us if you are not on our mailing list. Readers are encouraged to offer opinions and/or submit pertinent materials for inclusion into future issues.

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Unless otherwise noted, all articles appearing in this newsletter are written by Lindsay M. Hayes, Editor/Project Director.

AVAILABLE JAIL/PRISON/JUVENILE SUICIDE PREVENTION MATERIALS

And Darkness Closes In...National Study of Jail Suicides (1981)
National Study of Jail Suicides: Seven Years Later (1988)
Training Curriculum on Suicide Detection and Prevention in Jails and Lockups—Second Edition (1995)
Curriculum Transparencies—Second Edition (1995)
Prison Suicide: An Overview and Guide to Prevention (1995)
Juvenile Suicide in Confinement: A National Survey (2004)
Jail Suicide/Mental Health Update (Volumes 1-12)

For more information regarding the availability and cost of the above publications, contact either:

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(508) 337-8806 • (508) 337-3083 (fax)
Web Site: www.ncianet.org/cjjsl.cfm
E-Mail: Lhayesta@msn.com

or

NIC Information Center
1860 Industrial Circle, Suite A
Longmont, Colorado 80501
(800) 877-1461 • (303) 682-0558 (fax)
Web Site: www.nicic.org