

Guiding Principles to Suicide Prevention in Correctional Facilities

Lindsay M. Hayes

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More times than not, we do an admirable job of safely managing inmates identified as suicidal and placed on precautions. After all, very few inmates successfully commit suicide on suicide watch. 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 of *Night Falls Fast – Understanding Suicide* (1999), has better articulated the point by stating in her book that:

“If suicidal individuals were either willing or able to articulate the severity of their suicidal thoughts and plans, little risk would exist.”

With this mind, the following **GUIDING PRINCIPLES FOR 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 risk 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 direct care and health care personnel when determining whether the inmate might be at risk during their current confinement.

4. In addition to the heightened risk for suicide during the first 24 to 48 hours of confinement, recent research suggests that many suicides occur in close proximity to a court proceeding. We must begin to devise ways in which our housing unit staff is more attentive to this risk period. In some jurisdictions, a brief mental status exam is given to select inmates (e.g., those on a mental health caseload, those identified as having a prior history of suicidal behavior, etc.) each time they return from a court proceeding.
5. A disproportionate number of inmate suicides take place in “special housing units” (e.g., disciplinary/administrative segregation) 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, an avoiding lockdown due to staff shortages (and the resulting limited access of medical and mental health personnel to the units).
6. 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 than their words. For example: In any facility, the inmate is on suicide precautions for attempting suicide the previous day. He is now naked except for a suicide smock, given finger foods, and on lockdown status. The mental health clinician approaches the cell and asks the inmate through the food slot (within hearing distance of others on the cellblock): “How are you feeling today? Still feeling suicide? Can you contract for safety? “Will this inmate’s response be influenced by his current predicament? How would you respond?
7. We must provide meaningful suicide prevention training to our staff, 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/DVD, or web-based question-answer format, 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.
8. Many preventable suicides result from poor communication amongst direct care, medical and mental health staff. Other problem areas for communication include outside law enforcement agencies and concern expressed from family members. 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.

9. One 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. A clinician should never feel pressured, however subtle that pressure may be, to downward and/or discharge an inmate from suicide precautions because additional staff resources (e.g., overtime, post transfer, etc.) are required to maintain the desired level of observation. Although they would rarely admit it, clinicians have prematurely downgraded, discharged, and/or changed the management plan for a suicidal inmate based upon pressure from facility officials.
10. By far the most important decision in the area of suicide precaution is the determination to discharge an inmate from suicide precautions. That determination *must* always be made by a qualified mental health professional (QMHP) following a comprehensive suicide risk assessment. Decisions by non-QMHPs that result in bad outcomes incur unnecessary liability.
11. 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 garment, 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.
12. 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 gain a housing relocation, transfer to the local hospital, receive preferential staff treatment, or seek compassion from a previously unsympathetic family member. Some inmates simply use manipulation as a survival technique. Although there are no perfect solutions to the management of manipulative inmates 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 plan.
13. A lack of inmates on suicide precautions should not be interpreted as meaning 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 facilities are increasingly housing more mentally ill and/or other high risk inmates 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. A lack (or small number) of inmates on suicide precautions might be the result of inadequate identification practices.
14. We must avoid using the terms "WATCH CLOSELY" or "KEEP AN EYE ON HIM" when describing an inmate we are concerned about, but have not placed on suicide precautions. If we are concerned about them, then they should be on suicide precautions.

15. 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.
16. We must create and maintain a comprehensive suicide prevention program that includes the following essential components: staff training, intake screening/assessment, communication, housing, levels of observation/management, intervention, reporting, follow-up/morbidity-mortality review.