GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS WITHIN JAILS AND PRISONS

By Lindsay M. Hayes

All correctional facilities, regardless of size, should have a comprehensive suicide prevention program that addresses the following critical components.

Staff Training

The essential component to any suicide prevention program is properly trained staff, who form the backbone of any correctional facility. Very few suicides are actually prevented by mental health, medical, or other professional staff because suicides are usually attempted in housing units, and often during late evening hours or on weekends when they are generally outside the purview of program staff. These incidents, therefore, must be thwarted by correctional staff who have been trained in suicide prevention and have developed an intuitive sense about suicidal inmates. Correctional staff are often the only personnel available 24 hours a day; thus, they form the front line of defense in preventing suicides.

All correctional, medical, and mental health personnel, as well as any staff who have regular contact with inmates, should receive 8 hours of initial suicide prevention training, followed by 2 hours of refresher training each year. The initial training should include administrator and staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, guiding principles to suicide prevention, inmate suicide research, why the environments of correctional facilities are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, components of the facility's suicide prevention policy, and liability issues associated with inmate suicide. The 2-hour refresher training should include a review of administrator and staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, predisposing risk factors, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, and review of any changes to the facility's suicide prevention plan. The annual training should also include general discussion of any recent suicides or suicide attempts in the facility.

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 for all staff.

Identification, Referral, and Evaluation

Intake screening and ongoing assessment of all inmates is critical to a correctional facility's suicide prevention efforts. It should not be viewed as a single event but as an ongoing process because inmates can become suicidal at any point during their confinement, including the initial admission into the facility; after adjudication when the inmate is returned to the facility from court; following receipt of bad news or after suffering any type of humiliation or rejection; confinement in isolation or segregation; and following a prolonged stay in the facility.

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. Research consistently reports that approximately two thirds of all suicide victims communicate their intent some time before death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt.

Intake screening for suicide risk may be contained within the medical screening form or as a separate form. The screening process should include inquiry regarding past suicidal ideation or attempts; current ideation, threat, or plan; prior mental health treatment or hospitalization; recent significant loss (e.g., job, relationship, death of family member or close friend); history of suicidal behavior by family member or close friend; suicide risk during prior confinement; and arresting/transporting officer belief that the inmate is currently at risk. Specifically, inquiry should determine the following:

- Was the inmate a medical, mental health, or suicide risk during any prior contact or confinement within this facility?
- Does the arresting or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates the inmate is a medical, mental health, or suicide risk now?
- Has the inmate ever attempted suicide?
- Has the inmate ever considered suicide?
- Is the inmate now being treated or has ever been treated for mental health or emotional problems?
- Has the inmate recently experienced a significant loss (e.g., relationship, death of family member or close friend, job)?
- Has a family member or close friend of the inmate ever attempted or committed suicide?
- Does the inmate feel there is nothing to look forward to in the immediate future (expressing helplessness or hopelessness)?
- Is the inmate thinking of hurting or killing himself/herself?

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 of being suicidal or having a history of mental illness and suicidal behavior, particularly when the inmate's behavior or actions or even previous confinement in the facility suggests otherwise.

The process should include reasonable privacy and confidentiality, as well as procedures for referral to mental health and/or medical personnel for a more thorough and complete assessment.

The intake screening process should be viewed as similar to taking a patient's temperature: it can identify a current fever, but not a future cold. Therefore, after the intake screening, should any staff hear an inmate verbalize a desire or intent to commit suicide, observe an inmate engaging in self-harm, or otherwise believe an inmate is at risk for suicide, a procedure should be in place that requires staff to take immediate action to ensure that the individual is constantly observed until appropriate medical, mental health, and/or supervisory assistance is obtained.

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

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

Communication

Certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and communicated to others, can reduce the likelihood of suicide. In addition, most suicides can be prevented by correctional staff who establish trust and rapport with inmates, gather pertinent information, and take action. There are essentially three levels of communication in preventing inmate suicides: between the arresting/transporting officer and correctional staff; between and among facility staff (including correctional, medical, and mental health personnel); and between facility staff and the suicidal inmate.

In many ways, suicide prevention begins at the point of arrest. At Level 1, what an arrestee says and how he or she behaves during arrest, transport to the facility, and intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the individual. Arresting officers should pay close attention to the arrestee 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 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.

At Level 2, effective management of suicidal inmates is based on communication among correctional personnel and other professional staff in the facility. Because inmates can become suicidal at any point during confinement, correctional staff 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 these inmates. Multidisciplinary teams (to include correctional, medical, and mental health personnel) should meet 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.

At Level 3, facility staff must 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. 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.

Poor communication between and among correctional, medical, and mental health personnel, as well as outside entities (e.g., arresting or referral agencies, family members) is a common factor found in the reviews of many custodial suicides. Communication problems are often caused by lack of respect, personality conflicts, and boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides.

Housing

In determining the most appropriate housing location for a suicidal inmate, correctional facility officials (with concurrence from medical and/or mental health staff) often tend to physically isolate (or segregate) and sometimes restrain the individual. These responses might be more convenient for staff, but they are detrimental to the inmate because isolation escalates the 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. Furthermore, removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, handcuffs, straitjackets) should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten depersonalizing aspects of confinement.

All cells designated to house suicidal inmates should be as suicide-resistant as is reasonably possible, free of all obvious protrusions, and provide full visibility. These cells should contain tamper-proof light fixtures, smoke detectors, and ceiling/wall air vents that are protrusion-free. The cells should not contain live electrical switches or outlets, bunks with open bottoms, any type of clothing hook, towel racks on desks or sinks, radiator vents, or any other object that provides an easy anchoring device for hanging. Each cell door should contain a heavy gauge Lexan (or equivalent grade) clear panel that is large enough to allow staff a full and unobstructed view of the cell interior. Finally, each housing unit in the facility should have an emergency response bag that contains, at a minimum, a first-aid kit, Ambu bag or

CPR mask, 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 Observation/Management

The promptness of the response to suicide attempts is often driven by the level of supervision afforded the inmate. The planning of and preparation for suicide can take several minutes; brain damage from strangulation caused by a suicide attempt can occur within 4 minutes, and death often within 5 to 6 minutes. 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 in a protrusion-free cell. Staff should observe such an inmate at staggered intervals not to exceed every 10 to 15 minutes (e.g., 5, 10, 7 minutes).

- *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. In some jurisdictions, an intermediate level of supervision is used with observation at staggered intervals that do not exceed every 5 minutes.

Other aids (e.g., closed-circuit television, cellmates) can be used as a supplement to, but never as a substitute for, these observation levels.

Because death from a suicide attempt can occur within a short period, observation of a suicidal inmate at intervals less frequent than continuous observation can be successful only if the observation is staggered and the cell is suicide-resistant.

In addition, mental health staff should assess and interact with (not just observe) the suicidal inmate on a daily basis. The daily assessment should focus on the current behavior, as well as changes in thoughts and behavior during the past 24 hours (e.g., “What are your current feelings and thoughts?” “Have your feelings and thoughts changed over the past 24 hours?” “What are some of the things you have done or can do to change these thought and feelings?”)

An individualized treatment plan (to include follow-up services) should be developed for each inmate on suicide precautions. The plan should be developed by qualified mental health staff in conjunction with not only the inmate but also medical and correctional personnel. The treatment plan should describe signs, symptoms, and the circumstances under which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the inmate and staff will take if suicidal ideation reoccurs.

Finally, due to the strong correlation between suicide and prior suicidal behavior, continuity of care for suicidal inmates must be ensured. All inmates discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health personnel until their release from custody. Although there is no national consensus as to the schedule for follow-up, a suggested assessment schedule after discharge from suicide precautions might be 24 hours, 72 hours, 1 week, and periodically until release from custody, unless the individual treatment plan specifies a different schedule.

Intervention

Following a suicide attempt, the degree and promptness of the staff’s intervention often foretells whether the victim will survive. National correctional standards and practices generally acknowledge that a facility’s policy regarding intervention should be threefold:

1. All staff who come into contact with the inmate should be trained in standard first aid procedures and CPR.
2. 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 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.
3. Correctional staff should never presume that the victim 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 equipment used in responding to an emergency is in working order on a daily basis.

Finally, although not all suicide attempts require emergency medical intervention, all suicide attempts should result in immediate intervention and assessment by mental health staff.

Reporting

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

Mortality-Morbidity Review/Sustainability

Every completed suicide and serious suicide attempt (i.e., requiring medical treatment or hospitalization) should be examined through a mortality-morbidity review. If resources permit, clinical review through a psychological autopsy is also recommended. Ideally, the mortality-morbidity review should be coordinated by an outside agency to ensure impartiality. The review, separate from other formal investigations that may be required to determine the cause of death, should include a critical inquiry into the following:

- The circumstances surrounding the suicide or serious suicide attempt
- Facility procedures relevant to the incident
- All relevant training received by involved staff
- Pertinent medical and mental health services and reports involving the victim
- Possible precipitating factors leading to the incident
- Recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures

Finally, the success of a suicide prevention program is not measured solely by the lack of suicides, but also on sound practices that mirror policies that are sustained by a fully transparent continuous quality improvement process.

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