Suicide in Correctional Facilities

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Abstract

This paper addresses suicide prevention which is a very difficult problem that administrators in correctional facilities face on a daily basis. The substance of this policy paper analyzes that problem in depth. There are two alternative policies that this analyst researched. The first is the Hayes, Hunter, Moore, and Thigpen 1995 report on Elayn Hunt Correctional Center (EHCC): Suicide Prevention Plan. This facility is located in Louisville, Kentucky.

The final policy analyzed was a written article in 1991 by Marc Friedman. This program is used at Jefferson County Corrections Department. The program is entitled Inmate Watch Program Helps Prevent Suicide. This program is similar to other correctional systems, such as the Federal Bureau of Prisons who use inmates to observe other inmates who are placed under suicide watch. In 2000 the city and county governments had merged, and the name Jefferson County Corrections Department became “Louisville Metro Department of Corrections”.

In conclusion, these alternative policies were evaluated by using criterion such as technical feasibility, economic efficiency, political viability, and administrative operability. This analyst hopes that the ideation of these options substantiated by these reports will be beneficial for the problem of dealing with a very difficult dilemma in corrections, suicide prevention.

I. Introduction

Undeniably, it is a difficult task for any warden or superintendent to input a policy which would prevent or deter suicide by prisoners in any correctional facility. This analyst intends to investigate viable policies which would reduce factors and suicidal behavior statistically.

The National Center on Institutions and Alternatives (NCIA) reported that the research indicated that there were 419 jail suicides occurring in 1979. The NCIA report reflected that there were 453 suicides in 1985 and 401 in 1986. This research determined that the suicide rate committed at the county jail level is nine times higher than the general population. It was also reported by the NCIA that the recent national data has not been available. When looking at the jail suicide rate, data reflects stability over time. These suicides have created an increased stability with publicity, public awareness, and, ultimately, litigation against the facilities and their personnel, city governments and county commissioners (Hayes and Rowan, 1988, pp-X, 1).

In the National Study of Jail Suicides Seven Years Later, Hayes and Rowan reported that this study reflected the typical profile of the victim. This typical profile is consistent with a white and single male 22 years of age. This male is usually arrested for a charge of public intoxication. This charge would be the only offense leading to his arrest. He would be under the influence of alcohol and/or drugs upon his incarceration. The victim's arrest record would not have any significant history of his prior arrests. This study shows that in 3 hours or less, he would have committed suicide by hanging himself with his beddings (i.e. sheets, blanket and/or his pillow case). The study also indicated that this would happen on a Saturday evening taking place during the month of September between the hours of 12:00 midnight and 1:00 a.m. The jail staff would have discovered this suicide within 15 minutes after the act was carried out

by the victim. Lastly, the jail records would reflect that the victim had no history of mental illness or previous suicide attempts (Hayes and Rowan, 1988, pp-1-2).

The following Table 1 was taken from National Study of Jail Suicides Seven Years Later, which was illustrated by Hayes and Rowan. This table reflected characteristics, jail inmate profiles, and finally, the NCIA 1981 Suicide Victims' Profile (Hayes and Rowan, 1988, pp-8):

Table 1

CHARACTERISTICS	JAIL INMATE PROFILE	NCIA 1981 SUICIDE VICTIM PROFILE
SEX		
Male	92%	97%
Female	8%	3%
Race		
White	58%	67%
Black	41%	22%
Other	1%	11%
Age		
18-24	40%	(18-27) 54%
25-34	39%	(28-37) 27%
Other	21%	(Other) 19%
Marital Status		
Single	54%	54%
Married	21%	30%
Separated/divorce	25%	16%
Jail status		
Detained	53%	91%
Sentenced	47%	9%
Intoxication	31%	60%
Length of Incarceration(Average)	6-11 Days	24 hours (50%) 3 Hours (27%)
Offense		
Violent	30%	27%
Property	33%	22%
Alcohol/Drug Related	20%	30%
Minor Other	17%	21%

Inmates are very vulnerable to suicide under their first 24 hours in custody facing the reality of incarceration. This anxiety increases when they are charged for their first felony,

unable to post bail, and also coupled with their first time of being detained in a detention or lock-up facility. The environment that jail offers can epitomize fear, mistrust, and exclusion, to only mention a few. The hopelessness that the newly admitted inmate feels is overwhelming and the inmate can become so despondent that he or she can opt to escape by committing suicide (Tripodi and Bender, 2007, pp-1).

Unbeknownst to the correctional personnel in the jails or detention facilities, the offenders enter a jail environment bringing with them factors that pre-exist through alcohol or substance abuse problems. These individuals could also have mood disorders and a history of past suicide attempts (Tripodi and Bender, 2007, pp-1).

Between the years of 2001 and 2004, the Deaths in Custody Reporting Program (DCRP) released a nationwide report which recorded 12,129 state prisoner deaths. In this report, prison executions had been excluded from these numbers. Approximately 1 in 10 or (6%) of these deaths were the cause of suicide by prisoner. This data was collected from individual death records which were collected from the Death Custody Reporting Act of 2000 (Mumola, 2007, pp-1).

Shaw, Appleby, and Baker reported (2003):

> "They stated that in two years (1999-2000), 172 suicides occurred among prisoners; twelve prisons, including two young offender institutions, had five or more suicides. One hundred and nine (63%) were located in single cells (this includes 9% who were in a segregation unit); of those in double cells, the cellmate was absent in and around a half (Shaw, Appleby, & Baker, 2003, pp-4).

Shaw, Appleby and Baker, did a National Study from 1999-2000 on Safer Prisons in England and Whales and listed the following Key findings from their report (Shaw, Appleby, & Baker 2003, pp-4, 5, 6, and 7):

- Number of Suicides
    - In two years (1999-2000), 172 suicides occurred among prisoners; twelve prisons, including two young offender institutions, had five or more suicides.
    - The 172 deaths included five in the care of the Prison Escort Custody Service.

- Suicide method
    - One hundred and fifty-nine (92%) suicides were by hanging or self-strangulation.
    - The commonest ligature points were window bars; the commonest ligatures were bed clothes.

- Location and timing
    - Nineteen (11%) suicides occurred within 24 hours of reception into prison; 55 (32%) occurred within seven days.
    - Eighty-five (49%) of these individuals were on remand.
    - Nineteen (11 %) were on a vulnerable persons unit.
    - One hundred and nine (63%) were located in single cells (this includes 9% who were in a segregation unit); of those in double cells, the cellmate was absent in and around a half.

- Demographic features
    - One hundred and fifty-nine (92%) were male; the proportion of females was highest (14%) in suicides aged 21 and under.
    - Nineteen (11%) were from an ethnic minority.

- Offence
    - Forty-one (26%) had been charged with or convicted of a violent offence.
    - In 11 (6%) the offence was murder or manslaughter; 6 of these were serving life sentences.

- Prison experience
    - Thirty (21%) were known to have been victims of bullying in prison.
    - Thirty-two (21%) did not take part in any prison activities.
    - Fifty-seven (42%) had received no visits prior to death.
    - Nineteen (18%) had experienced a recent family bereavement or terminal illness in a family member.

- General health
    - Fifty-four (34%) were found to have a physical health problem or disability at reception.
    - The most common illnesses were epilepsy and asthma.

- Mental health at reception
    - One hundred and ten (72%) had at least one psychiatric diagnosis identified at reception.
    - The commonest diagnosis was drug dependence.
    - Forty-six (32%) had a second (co-morbid) diagnosis, indicating more complex treatment needs.
    - Ninety-five (62%) had a history of drug misuse; 43 (45%) were referred to a health professional in prison.
    - Forty-six (31%) had a history of alcohol misuse; 24 (52%) were referred to a health care professional in prison.
    - Seventy-eight (53%) had a history of self-harm; 41 (53%) of these were referred to a health care professional in prison.
    - Eighty-nine (57%) had symptoms of psychiatric disturbance on reception to prison; of these, 64 (72%) were referred to a health care professional in prison.
    - Forty-six (30%) had a history of contact with NIIS mental health services; of those 32 (70%) were referred to a health care professional in prison.
    - It was unusual for information to be requested from a GP or from mental health services (18 made contact with GP's and 17 with mental health professionals.

- Mental health in prison
    - Fifteen percent of prison suicides had no further contact with health care staff after reception.
    - Forty (25%) had an open F20 52SII at the time of death (indicating recognition of risk).
    - At final contact with health care staff, risk of self harm/suicide was thought to be low or absent in 141 (93%) cases.

- Prison Health Care Centre Inpatients
    - Twenty-seven (17%) suicides were prison health care centre inpatients at the time of death.
    - Eleven (6%) were under medium or high levels of observation at time of death.

- Post Discharge Suicides
    - Forty-five (29%) had been prison healthcare centre in-patients at some point during their prison term; 16 (9%) died within one week of discharge from the healthcare centre.
    - In twelve (27%) post-discharge suicides, no follow-up appointment was arranged.
- Prevention
    - Twenty-two (15%) suicides were seen by health staff as preventable.
    - Staff indicated that closer supervision, better training, and an increase in use of shared cells could have reduced risk.
- Young suicides
    - Thirty-one (18%) suicides were aged 21 or under.
    - Seven (23%) young suicides died in the first seven days following reception to prison.
    - Seven (23%) were located in an adult local prison or remand centre.
    - Twenty-one prisoners (68%) were located in a single cell at the time of death.
- Recently released prisoners
    - In a 4-year study period (1996-2000), 354 people were found to have committed suicide within 1 year of release from prison, i.e. 88 cases per year.
    - These deaths clustered immediately after release with 80 (23%) in the first month and 40 in the first week

This list of information provided by Shaw, Appleby and Baker can assist administrators in suicide prevention in any correctional or lock-up facility.

In the following section, we intend to delve into the problem of suicide by prisoner by defining them in depth and by analyzing the cause and effect of this problem.

II. Define the Problem

There are two primary causes for jail suicides theorized by Hayes, Hunter, Moore, and Thigpen (1995):

> First, jail environments are conducive to suicidal behavior and, second, the inmate is facing a crisis situation. From the inmate's perspective, certain features of the jail environment enhance suicidal behavior: fear of the unknown, distrust of the authoritarian environment, lack of apparent control over the future, isolation from family and significant others, shame of incarceration, and the dehumanizing aspects of incarceration. In addition, certain factors often found in inmates facing a crisis situation could predispose them to suicide: recent excessive drinking and /or use of drugs, recent loss of stabilizing resources, severe guilt or shame over the alleged offense, and current mental illness and/or prior history of suicidal behavior. These factors become exacerbated during the first 24 hours of incarceration, when the majority of jail suicides occur. Inmates attempting suicide are often under the influence of alcohol and/or drugs and placed in isolation. In addition, many jail suicide victims are young and generally have been arrested for non-violent, alcohol-related offenses. Although prison suicide victims share some of these characteristics, the precipitating factors in suicidal behavior among prison inmates are somewhat different and fester over time (Hayes, Hunter, Moore, and Thigpen, 1995, pp-2).

Different studies have analyzed intake and bookings into jails and lock-up facilities during the early going of these inmates' incarceration. They also reflect the importance of good intake procedures and just how vital they're for identifying suicidal characteristics.

A study in South Carolina that was completed in 1984 had paralleled NCIA's 1981 study. The suicide rate of inmates in police departments was found by researchers to be approximately 250 times higher than the state's general population rate. Additionally, it was determined that the suicide rate for city and county jails exceeded the state's general population by 14 times (Hayes, and Rowan, 1988, pp-4).

In the state of Ohio, a two-year evaluation was completed in 1983 analyzing 46 jail suicides. This evaluation by the researchers determined the following:

1. Suicides were found to be most prevalent in city/municipal detention facilities;

2. An overwhelming majority of victims chose hanging as the mode of death;

3. Over two-thirds of the suicides occurred within the first 24 hours of incarceration;
4. The most serious crime of the victim tended to be either a misdemeanor, property offense or alcohol/drug-related; and
5. The victims tended to be young, single, unskilled males (Hayes and Rowan, 1988, pp-4).

Finally, in California's Los Angeles County, the medical examiner completed a 10-year study in 1987 on jail suicides. This examination determined that there were interesting findings by the researchers on the 103 suicides regarding the length of incarceration prior to the suicide and the method of suicide used, as well as the time element spanned between cell checks and the suicide. Similarly, the NCIA's 1981 study reflected that 59% of the Los Angeles County suicides had occurred during the first 24 hours of incarceration, and 35% of these suicides had taken place within the first six hours. The method of suicide was hanging. Interesting enough were the findings by the researchers concerning the positions of the victim. In the suspended position, the victim was found 41%; fifty-nine percent of the time the victim was either slumped, sitting, or kneeling. Lastly, 2% of the victims had been found within 10 minutes since the last cell check, and 52% had been found between 20 and 60 minutes. An astonishing 37% were found between 2 and 4 hours (Hayes and Rowan, 1988, pp-5).

The American Jail procures very little data about the prisoner who is committed. The jail retains, if any, usable records and almost nothing is reported to higher authorities. The record keeping is geared at harsh criticism towards general practices on jail record keeping and their felicitous suicide prevention screening (Hayes and Rowan, 1988, pp-42).

The skepticism of the importance of the intake screening process can be fully realized by the experts. In 1982, there had been a survey conducted on 2,600 jails throughout the country. It

was reported by the National Sheriffs' Association that only 41% of these facilities engaged in screening the detainees medically. Then a survey of police departments, which was conducted in 1984, found in Massachusetts that 89% of the facilities that responded did not ask pertinent questions regarding suicidal behavior upon their booking into these facilities (Hayes and Rowan, 1988, pp-42-43).

Since 1978, screening was standardized by the (AMA)'s Standards for Health Services in Jails. It was later revised in 1981. Throughout the country it is broken down into two sections - booking officer's visual opinion and officer-inmate questionnaire. The design of this structured inquiry and observation can prevent newly arrived inmates who can pose a threat to their health or safety threat to themselves. This can prevent them from entering the jail population so they can be treated medically in a rapid fashion (Hayes and Rowan, 1988, pp-43).

The American Medical Association Standards in Prisons consisted of the first national standards that had addressed health care exclusively in the prison system. The first publication of these standards was published in 1979. Several suicide protocols were established by the AMA. The specific procedures were established for intake screening and identification which provided supervision for inmates who had suicidal tendencies. For example, Standard 144 communicated that it required the following interim health appraisal which required the following:

- Psychiatric problems identified either at receiving screening or after admission must be followed up by medical staff. The urgency of the problems determines the responses. Suicidal and psychotic patients are emergencies and require prompt attention.

- Inmates awaiting emergency evaluation should be housed in a specially designated area with constant supervision by trained staff (Hayes, Hunter, Moore, Thigpen, 1998, pp-11).

Standard 147 was established for all inmates who were isolated in a segregation unit. These inmates were to be seen and medically evaluated at least a minimum of three times weekly by a competent and qualified health care professional.

- Due to the possibility of injury and/or depression during such periods of isolation, health evaluations should include notation of bruises or other trauma markings, and comments regarding attitude and outlook.
- Carrying out this policy may help to prevent suicide or an illness from becoming serious (Hayes, Hunter, Moore, Thigpen, 1995, pp-11).

The following is from American Public Health Association Standards for Health Services in Correctional Institutions which became definitive in 1986 with the regulations for suicide prevention:

- Suicide is the major cause of death among detainees and prisoners. Health providers must be trained to recognize warning signs and must devise appropriate plans to safeguard life. Inmates are especially at risk for suicide when first admitted to a jail. Whereas correctional authorities have responsibility for safe custody, health staff possess the training and expertise to recognize signs of depression and aberrant behavior, which may include suicidal intent.

  A. Every correctional facility must institute a suicide prevention program which addresses the profile of inmates at greatest risk for suicide and details particular plans for intervention.
  B. Jail health providers must screen inmates for suicidal intent or ideation as part of the admission medical evaluation, since 50% of jail suicides occur in the first 24 hours and 27% occur during the first 3 hours.

  C. Prison health staff shall screen inmates for suicidal intent on admission to the institution or transfer to another facility.

  D. When an inmate at risk is identified by medical staff, the inmate must be referred to the Mental Health Unit for immediate evaluation. Upon psychiatric evaluation, any inmate considered to be an actual suicide risk shall be hospitalized on an emergency basis. All others shall be placed in a mental observation area with a suicide watch pending further evaluation by a psychiatrist.

  E. Isolation may increase the chance that an inmate will commit suicide and must not be used as a substitute for staff supervision, especially in jails, especially for intoxicated individuals. A drug and/or alcohol-intoxicated prisoner shall not be

> locked in an unobserved cell or holding unit. Observation of intoxicated inmates must be constant. If observation is carried out via TV monitor, staff must be able to gain access to the prisoner within three minutes (Hayes, Hunter, Moore, Thigpen, 1995, pp-11-12).

When looking at the Texas Department of Corrections (TDC), Kentucky prisons and, lastly, the Federal Bureau of Prisons (FBOP), these three systems represent the suicide prevention problems those administrators and their staff experience at their respective institutions.

Thirty-eight suicides in the (TDC) were examined by Anno (1985):

> Between 1980 and 1985 and determined that the suicide rate was 18.6 per 100,000 inmates. The research also revealed that the vast majority of victims (97%) were housed in single cells, 45 percent had a history of prior suicide attempts, 68 percent had a history of mental illness, and 58 percent had been convicted of a personal crime. The victims' case files also contained various behavioral and verbal cues:
>
> > In almost all of the TDC cases, there was some evidence available in the records or, more often, in the subsequent reports of the individuals' deaths that could have alerted an aware staff member to the fact that the inmate was suicidal. In some cases, the inmate told someone he had been thinking of suicide. In others, it was noted that the individual had just received some bad news (e.g., death of a family member). In still other instances, there were notations in the record of bizarre behavior or withdrawn, depressed behavior or expressions of extreme shame and remorse regarding their crime ((Hayes, Hunter, Moore, Thigpen, 1995, pp-3).

Jones stated in (1986):

> A study of 19 suicides in Kentucky prisons between 1973 and 1986 found that, although most victims' characteristics paralleled those of the general inmate population, 79 percent of the suicides occurred in special housing units and 53 percent of victims had a history of serious mental illness in one or more prior suicide attempts ((Hayes, Hunter, Moore, Thigpen, 1995, pp-3).

A most interesting finding that was reported was several environmental and operational factors that could have contributed to the suicides:

1. Inadequate or unavailable psychological services at initial intake and during incarceration,

2. Poor communication among staff,

3. Perception of self-injurious behavior as a means of manipulation,

4. Basic elements of the institutional environment that constrain personal efficacy and control,

5. Limited staff training and direction in suicide prevention,

6. Limited staff direction in responding to suicide incidents, and

7. Investigation directed primarily toward establishing an appropriate response by staff without the accompanying thorough investigation of the causes of the suicide (Hayes, Hunter, Moore, Thigpen, 1995, pp-3).

White and Shimmel provided a thorough review of the Federal Bureau of Prisons (FBOP) in which they analyzed 86 suicides between 1983 and 1992. It was determined that the researchers found that 49 % of the victims had a history that had been documented. It was discovered that these victims had previously been diagnosed with mental illness or treatment, and 46 % of those committed suicide. In the past, these same individuals had previously made gestures or attempted suicide. It was also found that 68 % of these inmates had committed suicide in “special housing units” (e.g. segregation, administrative detention, or in a psychiatric seclusion unit). There was one major exception noted. All of the victims were housed in a single cell at the time of their death (Hayes, Hunter, Moore, and Thigpen, 1995, pp-4).

The following section will randomly look at the Okalahoma and Pennsylvania Department of Corrections purpose and their goals in suicide prevention and intervention.

III. Goals and Objectives

The main objective for any correctional facility is Care, Custody and Control. When approaching the goal of suicide prevention, each correctional institution's approach may differ, but their focus is always on prevention.

Oklahoma's Department of Correction's purpose for suicide prevention is stated as follows:

> Purpose:
>
> The Oklahoma Department of Corrections recognizes that the prevention of suicide by offenders is a critical issue to be addressed at all correctional facilities by all correctional staff. Suicide risk management is an on going process, not a single event or series of events. All correctional personnel with responsibility for offender supervision will identify and report at-risk offenders to the appropriate qualified mental health professional (QMHP) and/or shift supervisor. The purpose of this procedure is to provide a comprehensive set of suicide prevention principles and guidelines for correctional staff and administrators. (4-4373M, 4-ACRS-4C-16M) (Jones, 2008, pp-1-2)

Oklahoma's (DOC) policy is to have each individual correctional facility write an individual suicide prevention plan, which suits that individual institutions needs. These prevention plans are developed by each of the facilities Mental Health Departments. The most significant components of the Suicide Prevention Plan are the following:

- Suicide prevention training,
- The process for implementing safety measures to prevent suicides,
- Responses to and evaluation of attempted and actual suicides,
- Development of continuous quality improvement mechanisms to evaluate the efficacy and improve upon suicide prevention efforts (Jones, 2008, pp-2).

Jones states (2008):

> One critical element of a comprehensive suicide prevention plan is the identification of and appropriate response to suicide warning signs. To facilitate appropriate identification of and response to potentially suicidal offenders, all staff who interact with offenders will

> wear a card containing a listing of potential suicide warning signs and suggestions for appropriate crisis response (Jones, 2008, pp-2).

Since 1995, the Pennsylvania Department of Corrections had a sharp increase rate in suicides among their inmates. Therefore, they significantly intensified their suicide prevention program with positive results. They provide videotapes and brochures to the inmates and the staff. Training has increased in this area. Officials for the department have developed a risk indicator checklist. This checklist is administered to all offenders who enter their prison system. These initiatives have had positive results. Since the increase in the inmate population, suicide has been in the decline. A comparative study was done. The comparison consisted of a U.S. population that was similar in size. This was adjusted for age, gender and race distribution in the community. This comparison faired relatively well and was measured comparably to an unincarcerated U.S. population. This factual data proved that the PA DOC suicide rate was in fact lower (Eisenhower, Johnson and Richman, 2005, pp-33).

Strategies to Reduce DOC Suicides:

- Training: Required that all staff receive at least 2 hours of initial training followed by 1 hour of annual refresher training
- Updating policies and procedures
- Expand mental health treatment for inmates
- When possible, divert inmates with mental illness from placement in administrative segregation
- Disseminate suicide prevention and mental health information to the inmate population
- Increase the comprehensiveness of clinical reviews conducted following all suicides and frequency of reviews following serious gestures
- Enhance services for non-mentally ill inmates: programs on substances abuse (Alcoholic Anonymous, (AA), Narcotics Anonymous (NA), etc...) sex offender treatment, children's visitation centers, etc. (Eisenhower, Johnson and Richman, 2005, pp-33-34).

IV. Establish The Evaluation Criteria

The following are evaluation criterion that policy analysts use to evaluate policies. They are technical feasibility, economic efficiency, political viability, and administrative operability. The technical feasibility criterion is used as a measure for a specific program as to whether it will be able to work or not, and if the program will be effective. The political viability of the specific program will be measured as acceptable to relevant political groups. Administrative operability measures the bureaucracy of specific program implementation. Finally, economic efficiency is a cost benefit analysis which determines when the program is rendered whether the benefits outweigh the costs incurred to produce the program (Gaynor, 2001, pp-5).

V. Evaluating Alternative Policies

Alternative Policy One: Elayn Hunt Correctional Center (EHCC): Suicide Prevention Plan

The first policy that will be evaluated is the Elayn Hunt Correctional Center which is located in St. Gabriel, Louisiana. This institution opened in 1979. This correctional institution is the second largest in the state with a capacity of 1,875 inmates. (EHCC) has two main functions:

1. To serve as the intake point for male offenders committed to the Louisiana Department of Public Safety and Corrections, and
2. To provide housing for approximately 1,475 sentenced prisoners. All newly sentenced male inmates committed to the Louisiana Department of Public Safety and Corrections are initially processed into the system through (EHCC)'s 400-bed Adult Reception and Diagnostic Center (ARDC) (Hayes, Hunter, Moore, and Thigpen, 1995, pp-34).

There is a 14-day period where inmates receive a thorough and complete medical examination and a very comprehensive psychological assessment with a complete classification review. After this classification review, the inmates are then slated and relocated to one of 11 prison facilities within the state (Hayes, Hunter, Moore, and Thigpen, 1995, pp-34).

(EHCC) holds a variety of inmates from general population status to disciplinary custody status transfers from other institutions. (EHCC) is designated by Louisiana Department of Public Safety and Corrections as the central mental health facility and medical center for minimum and medium security inmates who are seriously and chronically ill. The (EHCC) has a complete staff with 4 full-time physicians and 2 part-time specialists, 2 physician assistants, 26 nurses, 1 full-time psychologist, 2 part-time psychiatrists, 6-psychological associates, 9 clinical social workers, and 1 substance abuse counselor. This staff also assists the Louisiana Correctional Institution for Women with their intake procedure. The women's institution is located nearby (EHCC) (Hayes, Hunter, Moore, and Thigpen, 1995, pp-34).

Staff Training:

The staff training at (EHCC) provides two hours of potential suicide recognition and intervention each year for administrative, managerial, correctional, mental health, and medical personnel. The sessions take place on Fridays and the instruction is on how to identify suicidal behavior and review the components of the facility's suicide prevention. There are also 4-hours of first aid and CPR training annually (Hayes, Hunter, Moore, and Thigpen, 1995, pp-36).

Housing:

The (EHCC) has two locations which hold inmates who are placed on suicide watch. These locations are D-1 Cellblock and the prison's infirmary 24-hour unit. There are six cells in the D-1 Cellblock used for standard suicide watch. Two cells allow the officers a higher visibility of precaution with an extreme suicide watch for the inmates housed in those cells, and for extra measures, these cells contain (CCTV) closed circuit televisions. These televisions add a secondary secure method of observation. Due to the higher incidence of suicide, an inmate housed in a single cell poses a higher probability of suicide. The (EHCC) attempts to house two inmates in these cells versus one. If the only option is one, then the officers are trained to frequently have conversations with the inmate who is placed in a single cell. In the infirmary's 24-hour unit, there is a 30 bed reserve for inmates who are placed on extreme suicide watch. They might be required to be placed in four-point restraints where the mental health or the medical staff for each inmate decides what type of clothing they will be issued during their time on suicide watch (Hayes, Hunter, Moore, and Thigpen, 1995, pp-36).

Levels of Supervision:

When a standard suicide watch is ordered at (EHCC), it is used for inmates who presently are not actively suicidal, but have a history of suicide and, in the past, has expressed thoughts

of suicide. When an extreme suicide watch is ordered, inmates have showed a continual risk of self destructive suicidal behavior. These inmates create a clear and present danger of past behavior of banging their heads off of walls or cell bars, or making threats to do so. In some cases, they have even tied linens to themselves and the cell bars. The observation time can vary from a 15-minute waiting period between intervals to, in an extreme watch situation, an average of 5 minutes. One correctional officer will document each observation made on an Inmate's Suicide Watch Log Sheet. There are even additional observations made to hinder any attempt of a self-destructive act. For the six designated suicidal cells in D-1 Cellblock, the 24-hour Unit has supervision by correctional and medical personnel around the clock to observe the inmates who are placed on suicide watch. The inmates that are placed in restraints have their restraints checked by the medical staff every two hours. Within a time span of 12 hours the inmates who are placed under extreme suicide watch are scrutinized by the mental health staff who will confer with the psychiatrist and the physician about the treatment plan to continue the suitability of the watch treatment plan for the inmate(s) (Hayes, Hunter, Moore, and Thigpen, 1995, pp-36).

Intervention:

When a suicide attempt occurs, (EHCC) practices an excellent intervention procedure. The staff has been trained in first aid and CPR. In the three housing compounds in the facility there are assigned at least two correctional officers who have been certified as "first responders" (i.e. they have been trained in advance first aid). Even the (EHCC) facility has an ambulance that can transport the patients to the local hospital in Baton Rouge. Also, you will find located at each control desk in every housing unit the following equipment: Oxygen tanks and a fully stocked "suicide prevention kit". In addition, there is a tool kit that is shaped like a

carpenter's box with the following equipment: paramedic shears, large and regular gauze bandages, ace bandages, an elastic roll, cloth tape, a disposable pocket mask, latex gloves, a bite block, and a specially designed tool that can cut a variety of materials that the inmate could use to hang their selves (Refer to Appendix D for an illustration of an example of this type of cutting rescue tool).

Correctional officers in the Louisiana Department of Public Safety and Corrections have been trained for immediate response in case of emergencies. They have also been trained to initiate first aid and CPR procedures, if necessary, and they would then transport the victim to the medical facility (Hayes, Hunter, Moore, and Thigpen, 1995, pp-38).

Administrative review:

When a suicide is committed at (EHCC), their policy requires that they launch a formal post-suicide investigation. A team is then formulated consisting of a mental health worker, a correctional investigator and a security supervisor from the housing unit where the suicide has occurred. There will also be a medical staff member who will either be a physician, registered nurse or a paramedic. This team will conduct the investigation by interviewing the staff and the inmates. These documents will be compiled and submitted to the warden/superintendent as well as the secretary of the department.

Finally, Elayn Hunt Correctional Center's suicide prevention plan is not a perfect one. Some correctional professionals could argue that the suicide prevention policy should be revised to include more hours of training which would include more pre-service for a clearer procedure for a more vigilant extreme suicide watch. Although, a disagreement exists with the application of automatic restraints for those inmates placed under the extreme watch. Some believe it is not necessary. This particular institution has a successful track record over a

period of 12 years where they experienced only 1 suicide. During that time, there have been 57,091 admissions (Hayes, Hunter, Moore, and Thigpen, 1995, pp-41).

Warden Lensing, who summarized his approach to suicide prevention at (EHCC) (1995):

> "We fail when we have fatalities based on unnatural causes....I don't wait and react. I don't like crisis management. You need to stay one step ahead of the game. When you put suicide prevention kits in each housing unit, place social workers in the cellblocks to assess suicidal inmates every day, and schedule suicide prevention training every Friday, you symbolize to all staff the commitment we have to suicide prevention (Hayes, Hunter, Moore, and Thigpen, 1995, pp-41).

Alternative Policy Two: Jefferson County Corrections Department Inmate Watch Program Helps Prevent Suicides

Another method which some correctional institutions are using to prevent inmate suicides is the use of inmates who are incarcerated there to watch over the inmates who are placed under a suicide watch. There is such a program called "Inmate Watch Program Helps Prevent Suicides". One such program is being operated in the Jefferson County Corrections Department.

Louisville Kentucky has a population of 900,000. At the time of this article, it was reported that their five correctional facilities have a daily jail census report which averages in excess of 1,600. The Hall of Justice correctional facility holds more than 600 beds and is the site of the suicide prevention watch program.

Screening Process:

Jefferson County Corrections Suicide Prevention Program initiates on their booking floor. A new actor entering the institution is searched by a corrections officer. After the completion of the search, the newly admitted inmate goes through a suicide risk checklist with values that are weighted. This is administered by a nurse and documented on a health screening form. The nurse also conducts a brief mental health status examination. If the newly admitted inmate fits a certain criteria by his or her responses, this indicates that the individual(s) is in acute psychological distress. The jail's psychologist is then notified immediately by the interviewer (Friedman, 1991, pp-13).

If the psychologist assesses that the newly admitted inmate poses a suicide risk, the shift sergeant or appropriate supervisor is notified and briefs the supervisor that the individual needs to be placed in an observation single cell for precautionary reasons. The psychologist's recommendations are contingent of the severity of the suicide risk. The appropriate intervals of time between observations are then ordered. The psychologist also has the authority to place the

inmate in question in a paper gown and restrict the items that the inmate is permitted to have in his or her cell which could expedite the suicide attempt (Friedman, 1991, pp-13).

These precautionary measures that have been documented are now assessed by either the psychologist or a psychiatric registered nurse. This assessment could be modified for the future of the placement of what type of housing the inmate will require. If this individual has a recent history that consists of psychological or psychiatric treatment, the recommendation by the psychologist deems that this individual poses an immediate status for pending psyche classification of potential risk and harm to themselves or others. This assists the staff by identifying just what type of classification is recommended by the psychologist (Friedman, 1991, pp-13).

There is a psychiatric section in the jail constructed with two single-cell walks and two walks that are open. This psychiatric unit has thirty-four cells. This unit holds those inmates who are psychotic and chronically mentally ill.

Inmate Volunteers

Jefferson County's Suicide Prevention Plan has a unique wrinkle to it. It puts into practice the use of inmates to observe other inmates who display suicidal tendencies. Inmates selected for this suicide prevention program volunteer their services. How the selection process is conducted is from a group of specific inmates.

This group is chosen from the jail's psychologist, members of correctional personnel and a shift sergeant who make that selection from a criterion which consists of a good jail disciplinary record of inmates who have demonstrated the following qualities:

- Maturity
- Emotional stability
- The inmates have to commit to the goals and objectives of the program

- There is an approved watcher list kept by the sergeant. If one inmate can't perform their duties, another inmate from this list is selected to fill this vacancy (Friedman, 1991, pp-13).

There are several housing areas that are key and monitored by the watch teams. These teams are deployed nightly with a schedule that is structured on a rotating basis. The following housing areas are observed by the teams. You have the psychiatric unit, the basement, three walks on the sixth floor, and the observation cells on the female residential unit. The inmate watch team accompanies the correctional officers on their security and observation checks which is targeted in the residential areas between 10:30 p.m. and 7:00 a.m. (Friedman 1991, pp-13-14).

The inmate watcher volunteers have been trained to expand the ability of the correctional officers in the prevention of suicides.

According to Friedman (1991):

> Inmate watchers expand the ability of correctional officers to prevent suicides. Volunteers have been instructed by the corrections staff that they should immediately notify the officer on duty if they observe an inmate who appears to be in psychological distress. The corrections officer then assumes full responsibility for coordinating emergency or precautionary measures ((Friedman, 1991, pp-14).

Inmates who are participants of the watcher program receive two-hours of training orientation from the jail psychologist on issues that deal with mental health including suicide and depression. These watchers are also instructed by the correctional officers on basic emergency response (Friedman, 1991, pp-14).

Program Benefits

Jefferson County Correction's Inmate Watcher Program gives the inmate participants an important opportunity to assist in the inmate welfare of their peers. This program has been instrumental in preventing a number of inmate's suicides at the jail. There have been letters of commendation bestowed on several inmates by correctional administrators for their accountable

and quick responsive actions in a potentially life threatening circumstance. This program began as a duration holiday season program beginning on Thanksgiving and ending in mid-January. The program's expanded success warranted a year round program. It is an integral part of Jefferson County Correction's mental health delivery system (Friedman, 1991, pp-14).

VI. Distinguishing Among Alternatives

Alternative Policy One: Elayn Hunt Correctional Center Suicide Prevention Plan

This analyst has chosen the following criterion for its evaluation of: technical feasibility, economic efficiency, political viability, and administrative operability.

The technical feasibility of this plan is rated high. Hayes, Hunter, Moore, and Thigpen, who reported on this institution in 1995, stated that this particular institution had a successful track record ranging from January, 1983 through October, 1994, which spanned over a 12 year period. During this time, they had experienced only 1 suicide over the 12 year period. During that time there had been over 57,091 admissions.

They don't like crisis management at this institution. They prefer to stay one step ahead of the game. There are suicide kits placed on every housing pod in this institution. They also station social workers on the housing pods to access inmates who are suicidal. This institution is very proactive with suicide prevention and they also schedule training sessions on a weekly basis (Hayes, Hunter, Moore, and Thigpen, 1995, pp-35 and 41).

When analyzing the economic efficiency criteria, we can look at the following data provided by the following:

Stephan Reported in (2004):

> The average annual operating cost per State inmate in 2001 was $22,650, or $62.05 per day. Among facilities operated by the Federal Bureau of Prisons, it was $22,632 per inmate, or $62.01 per day (Stephan, J.J., 2004, June, pp-1).

In a comparison in prison spending in 1996, which was compared to 2001, the revelation of this comparative study indicated that there had been a much more significant emphasis on the facility operation. This study divulged that over ¾ of the states had spent over 96% on salaries, wages, benefits, supplies, maintenance, and contractual services, which consisted of more prison funds on those current operations. Total expenditures accounted for spending by the State in 1996 (Stephan, 2004, pp-1 and 4).

It was also stated that in the following five states they listed their annual medical costs per inmate which exceeded $4,000: Maine ($5,601), New Mexico ($4,665), California ($4,394), Massachusetts ($4,049), and Alaska ($4,047). Three of the following states spent less than $1,000 per inmate: Louisiana ($860), Montana ($922), and Kentucky ($960) (Stephan, 2004, pp-6).

At the (EHCC), they have a complete staff to deal with their very successful suicide prevention plan at their institution. They have 4 full-time physicians and 2 part-time specialists, 2 physician assistants, 26 nurses, 1 full-time psychologist, 2 part-time psychiatrists, 6 psychological associates, 9 clinical social workers, and 1 substance abuse counselor.

The following figures are a cost benefit analysis of these health care professionals which was used for the calculation of their annual salaries. The only exception that was not integrated with these figures was the positions of the 2 part-time specialists that had not been identified in the report. Two measurements were used, a high and low end salary position. This analyst used the high end for the cost benefit analysis bottom line. Also calculated into the staffing needs were the correctional officers that were used in the suicide watch section D-1 cell block, mentioned in the (EHCC) report (Hayes, Hunter, Moore, and Thigpen, 1995, pp-34 and 37).

These officers maintained three shifts. A staffing multiplier of 1.7 was calculated into the equation. Five officers would have to be hired to fill those three positions to cover all of the relief factors. Closed Circuit Television Camera (CCTV) equipment was also calculated into these figures for extra control and countermeasures in the suicide prevention plan.

Lastly, training should also be calculated between two hours of potential suicide recognition training annually for your correctional personnel. This will have to be quantified and based on each institution's compliment of staff.

This analyst calculated the following information by basing it on the staffing numbers used at (EHCC) and using the information provided by the Occupational Outlook Handbook of the 2008-09 Edition. These figures could be very beneficial for other institutions to use this type of matrix design as a staffing guide. You will find this information listed in Table-3. Please refer to the following page (Hayes, Hunter, Moore, and Thigpen, 1995, pp-34).

Benefit Cost Analysis on Staffing Salaries

Information Provided By The Following:

Occupation Outlook Handbook-2008-09 Edition

Table-2

Total Positions Required	Title Of Those Positions	High End Salaries	Low End Salaries	Based On High End Salaries
Four	Physicians	$156,000	$137, 119	$624,000
Two	Physicians Assistant	$80, 960	$74,160	$161,920
Twenty-six	Nurses, RN	$83,440	$40,250	$2,169,440
One	Psychiatrist(full-time)	$180,000	$173,992	$180,000
Two	Psychiatrist(part-time)	$90,000	$86,996	$180,000
Six	Psychological Associates in Pennsylvania [1]	$75,000	$40,000	$450,000
Nine	Clinical Social Workers	$43,500	$39,000	$391,500
One	Substance abuse counselor	$55,650	$23,780	$55,650
Five	Correctional Staffing for suicide watch for D-1 cell block	$58,580	$23,780	$292,900
Two	Sony Security System 1 Closed Circuit Television Camera package	$694.00 [2]	$399.00 [3]	$1,388
Total				$4,506,798

[1] Indeed Search all Jobs, Psychological Associates Salaries of Pennsylvania

[2] Complete Sony Single Color Complete System, http://www.123securityproducts.com/sonsecsyscam.html#option (personal communication with K. Rogers, February 25, 2009)

[3] Sony Security System 1 Camera Complete Hi-Res Package, http://www.123securityproducts.com/sonsecsyscam.html#option (personal communication with K. Rogers, February 25, 2009)

The political viability criterion was used for Alternative Policy One. It was also measured high. A very successful program of this nature would have a very positive outlook for the political and prison advocacy groups who can become a very negative force with press releases, media and support with inmate litigation. A track record of one suicide being committed within a span of 12 years is a tremendous accomplishment for any correctional facility to achieve. This kind of successful model instills confidence by the community for those family members who are incarcerated there.

The executive branch for that jurisdiction can be very beneficial and will be more likely to provide federal or state funding, especially for the institution that has created a positive environment as (EHCC) has done with their suicide prevention plan.

In regard to the administrative operability, this analyst has also rated this institution to be high. When using administrative operability criterion, this criterion is generated from the top of the organizational chart. The chain of command is initiated at the warden or the superintendent's level. Policies are communicated down the chain of command. In the case of (EHCC) the following statement is very important to reiterate.

Warden Lensing summarized his approach to suicide prevention at (EHCC) (1995):

> "We fail when we have fatalities based on unnatural causes....I don't wait and react. I don't like crisis management. You need to stay one step ahead of the game. When you put suicide prevention kits in each housing unit, place social workers in the cellblocks to assess suicidal inmates every day, and schedule suicide prevention training every Friday, you symbolize to all staff the commitment we have to suicide prevention (Hayes, & Hunter, & Moore, & Thigpen, 1995, pp-41).

Any weak link in this chain can have devastating results. It is very important to have strong leadership qualities to set and enforce all the right policies that are in place. These administrators can have a large inmate population and a large compliment of staff that they have to manage daily. Along with this responsibility, as in the state-level, for example, the

superintendents have the higher echelon like the Commissioner of Corrections who are their bosses. Or, on the county level, the warden there takes his or her orders from the prison board which can consist of judges, the sheriff, and other community leaders with political leverage. The chair who oversees the Prison Board could either be the county executive or the county commissioner(s). These head administrators have to deal with these individuals who might have their own agendas, and if listened to on certain issues, could jeopardize the security of the institution.

Alternative Policy Two: Jefferson County Corrections: Inmate Watch Program Helps Prevent Suicides

In this policy, technical feasibility and administrative operability was used to measure this policy. The criterion for technical feasibility was rated medium. In this policy, the inmate watchers are selected from a volunteer list. This group must have a good jail disciplinary record and need to demonstrate the following qualities:

- Maturity
- Emotional stability
- These inmates have to commit to the goals and objectives of this program
- There is an approved watcher list kept by the sergeant. If one inmate can't perform their duties, another inmate from this list is selected to fill this vacancy (Friedman, 1991, pp-13)

According to Friedman (1991):

> Inmate watchers expand the ability of correctional officers to prevent suicides. Volunteers have been instructed by the corrections staff that they should immediately notify the officer on duty if they observe an inmate who appears to be in psychological distress. The corrections officer then assumes full responsibility for coordinating emergency or precautionary measures (Friedman, 1991, pp-14).

Another good component of this program is that the participating inmates receive two-hours of training orientation from jail psychologists on the issues that are pertinent to mental health issues, including suicide and depression. The inmate watchers are also instructed by the

correctional officers on basic emergency response. According to Friedman, this program has been instrumental in preventing a number of suicides at the jail (Friedman, 1991, pp-14).

Because the program uses inmates, the dependability of the inmate has to come into question, and because of this accountability issue, the criterion for administrative operability was also measured to be medium.

VII. Distinguishing Among Alternative Policies

To distinguish between the alternatives, this analyst will use the ***Satisficing Method*** developed by the late Professor Dr. Herbert Simon, Nobel Laureate from Carnegie Mellon University. This University is located in Pittsburgh, Pennsylvania. What is the accepted satisfactory level by the decision maker in Table-3?

Application of the Satisficing Method – Table 3

Dr. Herbert Simon

Alternatives	**Technical Feasibility**	**Economic Efficiency**	**Political Viability**	**Administrative Operability**
Alternative One: **Elayn Hunt Correctional Center Suicide Prevention Plan**	**High Medium Low** *****	**High Medium Low** *****	**High Medium Low** *****	**High Medium Low** *****
Alternative Two: **Jefferson County Corrections: Inmate Watch Program Helps Prevent Suicides**	**High Medium Low** *****			**High Medium Low** *****

VIII. Monitoring and Implementation of Policies

These two policies can be easily integrated. In corrections, our mission's bottom line is care, custody and control. We have the duty to protect the public trust. We have to ensure that our policies are carried out to the fullest for the protection of our correctional employees and inmates alike.

In the Elayn Hunt Correctional Center (EHCC) report presented by Hayes, Hunter, Moore, and Thigpen in 1995, it was documented this institution in St. Gabriel, Louisiana Department of Public Safety and Corrections has a very successful track record which reflected a very significant statistic of only one suicide that had been committed by an inmate over a span of 12 years.

This policy can be used in other institutions. The monitoring and implementation of this policy has to be a budgetary commitment for staffing needs and administratively implemented effectively.

Training is another very important component of the effectiveness of this policy's implementation. The national average of suicide training is between two to four hours in-service annually. Training is paramount for an efficient suicide prevention plan, as reflected in the (EHCC) plan.

Finally, in an extreme suicide watch scenario, as in (EHCC), a designated area like D-1 cell block has to be equipped with (CCTV) for extra precautionary steps for part of this policy's implementation. If the revenues are available, the following is a construction estimate on a supermax cell. The cost per cell is $150,000 each (Smykla and Scmalleger 2009, pp-514).

These Special Needs Units or (SNUs) is the end that justifies the means for a very effective suicide prevention plan monitoring and implementation of that suicide prevention

policy. These units are much more effective, because they are smaller and staffed with a concentration of mental health professionals. These units are smaller and less intimidating for the inmates who have been evaluated as a suicide risk and placed on this unit.

Lastly, regarding the second alternative policy at Jefferson County Corrections facility (Inmate Watch Program Helps Prevent Suicides), this program can be easily monitored and implemented. Treatment and security worked hand-in-hand for a program that is beneficial for that institution. With the economy in a downturn, and fiscally speaking, federal, state, and local governments are slicing their budgets for correctional facilities. This places institutions into a vicarious position of finding ways of cutting labor costs.

This practice of using inmates in an accountable and responsible position is being put into practice by more correctional facilities such as the Federal Bureau of Prisons (FBOP), New York Rikers Island jail, and the Maryland prison system to only mention a few that are using inmate aides for around the clock suicide observation (Fenton, 2008, June, pp-2).

It was reported by Fenton of the Baltimore Sun that inmates are being hired as aides to monitor at-risk detainees in Maryland prisons (2008).

> Officials with the state Department of Public Safety and Correctional Services say the practice, launched last year after a spike in suicides, enlists only the most trustworthy of inmates. But some critics say it's a shortcut for staff-strapped institutions, and a report last fall recommended that one area jail discontinue the practice after finding that prisoners can agitate their suicidal peers (Fenton, 2008, June, pp-2).

IX. Summary

These two alternative policies have been analyzed by exhibiting some favorable results. Suicide prevention is a major obstacle with which any warden or superintendent must contend. These policies have been examined and can give any correctional facility more options in suicide prevention.

(EHCC) has shown that commitment to their suicide prevention plan has been very successful. Their facility's criterion was evaluated high by this analyst in all four categories. This is an amazing accomplishment with suicide prevention in a correctional setting.

The final policy, Jefferson County Corrections facility (Inmate Watch Program Helps Prevent Suicides), showed success through the prevention of some suicides through the inmate watchers. This program has been successful in preventing some inmates from committing suicides as indicated in the article by Marc Friedman which was published in 1991.

On January 6, 2009, I contacted Ms. Laura Mc Kune, Deputy Director of Louisville Metro Department of Corrections. I telephoned her to inquire about Marc Friedman's article in 1991 regarding their institution (Inmate Watch Program Helps Prevent Suicides).

Ms. Mc Kune stated (2009):

> At the time of his publication, we were referred to as "Jefferson County Corrections Department." In 2000, the City and County Governments merged and we became "Louisville Metro Department of Corrections".
> In addition to regular one-on-one details, we expand the service during the Holiday seasons, beginning around Thanksgiving and running through Christmas. These specially trained work aids provide an extra set of eyes in the single cell/segregation units when the risk for depression and attempted suicide tends to increase. This unique program has assisted the department in greatly reducing the number of successful suicides. Also, we did not build a new "mental health facility," but rather dedicated an entire housing unit (79 beds) to our mentally ill inmates with the opening of our new facility in 2000.[4]

Mr. Lee Zellars is the Director of Mental Health at Louisville Metro Department of Corrections stated in (2009):

> The Suicide Watchers are utilized as a mechanism to just visually watch the inmates placed on suicide watch. Their primary responsibility is to sit outside the inmate's cell and visually observe the inmate. They are provided training on what to look for when observing the inmates such as crying, climbing, tying items around neck, banging head, etc…. These observations are reported to the security staff. During the training, it is also explained to the watchers what their expectations are such as staying at post, not harassing the inmates on the unit, not passing anything on the unit, etc….. The Watchers do not take the place of the Security staff, Mental Health, and Medical staff

[4] L. Mc Kune, (personal communication, January 6, 2009)

> responsibilities. They are only used to enhance the chances of preventing acts of self harm. [5]

Another program of this type was documented in the following study by Bates, Beeler, and Junker who examined the Inmate Observer Program (IOP) at the Federal Bureau of Prisons in a mental health setting where they reported the impact of using inmate observers. These inmates observe other inmates who are on suicide watch. In this setting, suicidal inmates are placed in observation rooms. The inmates are watched by inmates who have been selected as observers. The inmates are carefully selected and trained for the observation of those inmates that are placed on suicide watch. They are trained in a 4-hour initial session. This session includes the inmate observers' job assignment and how to observe their peers by documenting entries in a log every 15 minutes. This study showed that an inmate who is on suicide watch can identify more with someone of their own peer group than a figure who is in authority. The stressful environment in a prison setting can be more of a suicidal ideation. The Inmate Observer Program (IOP) has saved the Federal Bureau of Prisons $300,000 in overtime pay (Bates, Beeler, and Junker, 2005, pp-20, 21, 23, 25 and 26).

These programs reported that they have had some very successful results.

There are opposite perspectives when using inmates in a responsibility position of this nature. Daniel Malloy, a reporter from the Pittsburgh Post Gazette, reported that Lindsey M. Hayes, a Massachusetts criminologist, has studied jail suicides at the National Center on Institutions and Alternatives and has stated the following (2008):

> He doesn't see any particular harm in inmate watch, but he is skeptical of the benefits. "An individual is an inmate because they are unreliable and were arrested and/or convicted of a crime," Mr. Hayes said. "To put them in a position of responsibility or reliability is contrary to the reasons why they're in there." Mr. Hayes said the best way to prevent suicides is to identify unstable inmates when they enter the jail and monitor them (Malloy, 2008, December 28, pp-A-7).

[5] L. Zellars, (personal communication, February 10, 2009)

Finally, this analyst retired in 2004 after 30 years of service as a Captain from the Allegheny County Bureau of Corrections, located in Pittsburgh, Pennsylvania. There have been many occasions that I can recollect when inmates have actually saved correctional personnel and inmates' lives. Actually, I fall in that category when a psychotic inmate who was later convicted of brutally killing his wife, assisted me in restraining a very recalcitrant inmate who had just assaulted me when I was a correctional officer. This assault happened in the Mental Health Unit in our old facility. Some inmates, just like this one, have actually placed themselves in harm's way to achieve this undertaking.

Unfortunately, when dealing with inmates who are placed in a position with this type of responsibility, there always has to be a caveat in place. There are unforeseen variables that can fit into the inmates own agendas which could have adverse ramifications for the administration. This could present a potential problem from a legal standpoint. For example, if a suicide would occur, the family of that victim could file a wrongful death suit and attempt to hold the jail responsible by attempting to place the culpability of that suicide square on the shoulders of the administration for involving inmates with this serious responsibility.

In a leadership capacity, I was involved with many suicides during my career. There is nothing more horrific then finding an inmate who has committed suicide.

In the late 1970's the design of our old facility was the old linear style. This style by today's standards is archaic. The design consisted of cell blocks with those long corridors called ranges. This is where the inmates were housed in their individual cells. I remember as a young correctional officer patrolling the ranges at night in the darkness on the 12-8 shift armed with a flashlight and a two-way radio. In each cell your flashlight scans the darkness looking for skin and to make sure that the inmate is still breathing. Then, it happens, and you discover a young

male inmate hanging from his bars. You never forget that vivid, haunting picture which will forever be etched in your mind.

In the Appleby, Baker, and Shaw report, which was a comprehensive national study based on prison suicides in England and Wales, a sample on suicides or suspected suicides data was collected in this study from January,1999 to December, 2000(Appleby, Baker, and Shaw, 2003, pp-4).

The same problems exist for administrators of correctional facilities here, as well as, abroad. They experience the same identical problems which transcends globally to administrators in their prison systems.

This is why correctional professionals have this important task at hand to use every resource at their disposal to help prevent suicides from occurring. These policies might be helpful in assisting us to succeed as administrators in suicide prevention in any correctional facility that is under our direction.

Reference

Bates, J. & Beeler, A. & Junker, G. (2005). Using trained inmate observers for suicide watch in a federal correctional setting: A win-win solution, Vol. 2, No. 1, 20-21, 23, 25-26, Retrieved on, February 4, 2009, http://www.apa.org/journals/features/ser2120.pdf

Complete Sony Single Color Complete System, Retrieved on, January 24, 2009, http://www.123securityproducts.com/comsonsincol.html

Eisenhower, N.D., Johnson, C.B., & Richman, E. (2005). Pennsylvania adult suicide prevention plan, 33-34, Retrieved on, February 7, 2009 http://www.dpw.state.pa.us/Resources/Documents/Presentations/PaStrategyForAdultSuicidePrevention.pdf

Fenton, J. (2008, June 29**).** Help for suicidal prisoners inmates being hired as aides to monitor at-risk detainees, Baltimore Sun, Retrieved on, January 30, 2009, http://www.publicjustice.org/news/index.cfm?newsid=255

Friedman, M. (1991). Inmate watch program helps prevent suicides, Large Jail Network Bulletin, 2, (3), 13-14, Retrieved on December 5, 2009, http://www.nicic.org/pubs/1991/period86.pdf

Gaynor, M. (2001) School Violence, Evaluation Criteria, University of Pittsburgh, Graduate School of Public and International Affairs, 5

Hayes, L.M. & Hunter, S.M. & Moore, J.E. & Thigpen, M.L. (1995). Prison suicide: An overview and guide to prevention, pp-2-3, 11-12, 34-38, 41, Retrieved, December 26, 2008, http://www.nicic.org/pubs/1995/012475.pdf

Reference

Hayes, L. M., & Rowan, J. R, (1988). National study of jail suicides seven years later, pp-X, 1-5, 8, 42-43, Retrieved December 26, 2008, http://www.nicic.org/pubs/pre/006540.pdf,

Indeed Search all Jobs, Psychological Associates Salaries of Pennsylvania, Retrieved on January 24, 2009, http://www.indeed.com/salary?q1=psychologists+licensed+and+psychological+associate&l1

Jones, J (2008). Oklahoma Department of Corrections: Suicide Prevention, 1-2 Retrieved on, January 2, 2009, http://www.doc.state.ok.us/Offtech/op140129.pdf

Malloy, D. (2008, December 28). County jail expands monitoring program, Pittsburgh Post Gazette, p. A7

Mumola, C. (2007, January). Medical causes of death in state prison, U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics Data Brief, 1, Retrieved on, December 11, 2008, http://www.ojp.usdoj.gov/bjs/pub/pdf/mcdsp04.pdf

Occupational Outlook Handbook, 2008-09 Edition, Retrieved on, January 24, 2009 http://www.bls.gov/oco/ocos156.htm#earnings

Shaw, J, Appleby, L, & Baker D. (2003), Safer Prisons: A national study of prison suicides 1999-2000 by the national confidential inquiry into suicides and homicides by people with mental illness, 4-7.Retrieved on, February 14, 2009, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4034301.pdf

Reference

Smykla, J. & Scmalleger, F. (2009). Corrections in the 21st century, fourth edition, McGraw Hill, New York, New York, pp-514

Simon, H (1955) A Behavioral Model of Rational Choice, Quarterly Journal of Economics Volume 69, pp-99-118

Sony security system 1 camera complete hi-res package, Retrieved on, January 24, 2009, http://www.123securityproducts.com/sonsecsyscam.html#option

SP Services, Res-Q-Hook Rescue Knife [AR/044], Retrieved on, January 30, 2009, http://www.spservices.co.uk/product_info.php/cPath/266/products_id/3193

Stephan, J.J. (2004), Bureau of justice statistics special report: State prison expenditures, 2001, pp-1, 4 and 6, Retrieved on, January 7, 2009 http://www.ojp.usdoj.gov/bjs/pub/pdf/spe01.pdf

Tripodi, S & Bender, K. (2007). Inmate Suicide: Prevalence, Assessment, and Protocols, pp-1 and 4, Retrieved on January 31, 2009, http://brief-treatment.oxfordjournals.org/cgi/content/full/7/1/40

Appendix A

Table 1		
CHARACTERISTICS	JAIL INMATE PROFILE	NCIA 1981 SUICIDE VICTIM PROFILE
SEX		
Male	92%	97%
Female	8%	3%
Race		
White	58%	67%
Black	41%	22%
Other	1%	11%
Age		
18-24	40%	(18-27) 54%
25-34	39%	(28-38) 27%
Other	21%	(Other) 19%
Marital Status		
Single	54%	54%
Married	21%	30%
Separated/divorce	25%	16%
Jail status		
Detained	53%	91%
Sentenced	47%	9%
Intoxication	31%	60%
Length of Incarceration(Average)	6-11 Days	24 hours (50%) 3 Hours (27%)
Offense		
Violent	30%	27%
Property	33%	22%
Alcohol/Drug Related	20%	30%
Minor Other	17%	21%

(Hayes and Rowan, 1988, pp-8)

Appendix B

Occupation Outlook Handbook-2008-09 Edition

Table-2

Total Positions Required	Title Of Those Positions	High End Salaries	Low End Salaries	Based On High End Salaries
Four	Physicians	$156,000	$137, 119	$624,000
Two	Physicians Assistant	$80, 960	$74,160	$161,920
Twenty-six	Nurses, RN	$83,440	$40,250	$2,169,440
One	Psychiatrist(full-time)	$180,000	$173,992	$180,000
Two	Psychiatrist(part-time)	$90,000	$86,996	$180,000
Six	Psychological Associates in Pennsylvania [6]	$75,000	$40,000	$450,000
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One	Substance abuse counselor	$55,650	$23,780	$55,650
Five	Correctional Staffing for suicide watch for D-1 cell block	$58,580	$23,780	$292,900
Two	Sony Security System 1 Closed Circuit Television Camera package	$694.00 [7]	$399.00 [8]	$1388.
Total				$4,506,798

[6] Indeed Search all Jobs, Psychological Associates Salaries of Pennsylvania

[7] Complete Sony Single Color Complete System http://www.123securityproducts.com/sonsecsyscam.html#option (personal communication with K. Rogers, February 25, 2009)

[8] Sony Security System 1 Camera Complete Hi-Res Package http://www.123securityproducts.com/sonsecsyscam.html#option (personal communication with K. Rogers, February 25, 2009)

Appendix C

Application of the Satisficing Method - Table-3

Dr. Herbert Simon

Alternatives	Technical Feasibility	Economic Efficiency	Political Viability	Administrative Operability
Alternative One: **Elayn Hunt Correctional Center Suicide Prevention Plan**	**High Medium Low ***	**High Medium Low ***	**High Medium Low ***	**High Medium Low ***
Alternative Two: **Jefferson County Corrections: Inmate Watch Program Helps Prevent Suicides**	**High Medium Low ***			**High Medium Low ***

Appendix D

Res-Q-Hook Rescue Knife
[AR/044]

Use of Picture and Companies Web-site Authorized by Mr. Steve Bray, CEO of SP Services (UK) Ltd[9]

[9] S. Bray, , (personal communication, February 19, 2009)