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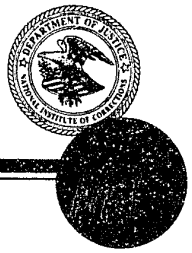

Prison Suicide: An Overview and Guide to Prevention

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Prison Suicide: An Overview and Guide to Prevention

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June 1995

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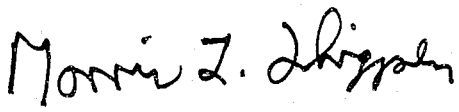
FOREWORD

While suicide is recognized as a critical problem within the jail environment, the issue of prison suicide has not received comparable attention. Until recently, it has been assumed that suicide, although a problem for jail inmates as they face the initial crisis of incarceration, is not a significant problem for inmates who advance to prison to serve out their sentences. This assumption, however, has not been supported in the literature. Although the rate of suicide in prisons is far lower than in jails, it remains disproportionately higher than in the general population. To date, little research has been done or prevention resources offered in this critical area.

This monograph was produced by the National Center on Institutions and Alternatives in an effort to fill a critical void in the knowledge base about prison suicide. In addition to a thorough review of the literature and of national and state standards for prevention, the document offers the most recent national data on the incidence and rate of prison suicide, effective prison suicide prevention programs, and discussion of liability issues. The National Institute of Corrections hopes that this document will encourage continued research, training, and development of comprehensive prevention policies that are imperative to the continued reduction of prison suicides throughout the country.



Morris L. Thigpen, Director
National Institute of Corrections

June 1995

PREFACE AND ACKNOWLEDGMENTS

In April 1993, I embarked on the task of developing a comprehensive monograph on prison suicide. Having devoted more than 15 years to the study and prevention of jail suicide, I was not only well aware of the problem of suicide in custody, but also had developed the strong bias that we should be directing much more energy toward the issue. My feeling then and now is that while the number of suicides in jails far exceeds the number in prison, that fact certainly should not lessen our responsibility to identify and prevent as many of these prison deaths as we can. It is always difficult, however, to preach prevention without first identifying the parameters of the problem. The intent of this document is not only to detail what is now known about prison suicide, but also to describe how far we have come in our prevention efforts and the work that still lies ahead. Only by continuing to examine the problem of prison suicide and transmitting what is learned to those entrusted with the custody and care of inmates will we be in the best possible position to reduce the likelihood of prison suicide. It is my hope that this monograph provides the appropriate vehicle for disseminating such information.

Many individuals are involved in a project of this scope. First, I would like to thank Susan M. Hunter, chief, NIC Prisons Division, and John E. Moore, program monitor, for their positive response to my initial concept proposal and support in the project, as well as Nancy Sabanosh for her diligence in pushing the document through the publication process. Second, the assistance from each department of correction throughout the country, resulting in a 100 percent survey response, is greatly appreciated and thanks are also due to those jurisdictions that granted permission for various suicide prevention protocols to be reprinted in the appendices. Third, I would like to especially thank staff at both the Elayn Hunt Correctional Center (EHCC) in St. Gabriel, Louisiana, and State Correctional Institution (SCI) at Retreat in Hunlock Creek, Pennsylvania, for allowing me to conduct onsite case studies of the suicide prevention programs that are presented in Chapter 4. At EHHC, Warden C.M. Lensing and Mental Health Coordinator Nancy Gautreau provided invaluable assistance and insight during my visit. At SCI Retreat, Superintendent Dennis R. Erhard, Inmate Program Manager John G. Mack, Psychologist James P. McGraw, Jr., and Chief of Psychological Services for the Pennsylvania DOC Dr. Lance Couturier were equally as helpful to developing the case studies.

Finally, this monograph could not have been written without the assistance and support of several other individuals. Thanks go to Thomas W. White, Ph.D., and Dennis J. Schimmel, Ph.D., for writing the article on suicide prevention efforts within the Federal Bureau of Prisons that appears as Chapter 5; and William C. Collins, Esq., for writing the article on prison suicide liability that appears as Chapter 6. In addition, Ronald L. Bonner, Ph.D., James T. Sprowls, Ph.D, and Chris Cormier Hayes reviewed earlier drafts and provided invaluable assistance, while Alice Boring brought it all together.

Lindsay M. Hayes
June 1995

Chapter 1

INTRODUCTION AND LITERATURE REVIEW

Writing about "difficult prisoners" in his autobiography *Fifty Years of Prison Service,* Zebulon R. Brockway appeared perturbed by the prospect of managing suicidal inmates and by the resulting publicity in the event of their deaths. As superintendent of Elmira Reformatory (often described as the original model from which progressive penology evolved) from 1876 to 1900, Warden Brockway described his experience with three prison suicides:

> One, a prisoner on parole in New York City who violated his obligations, was taken for kindly investigation to the secretary of the Prison Association, at the rooms then situated in the third story of the Bible House. While awaiting the secretary's convenience the young man suddenly dashed through an open window to his death on the pavement below. The newspapers made a sensational account of it and inquired why, if the reformatory was as it should be, a paroled man should voluntarily go to his death rather than be returned to treatment there. Another, a resident prisoner under a definite sentence, hanged himself in his cell. The coroner's jury absolved the reformatory management from any blame, but the hungry newspapers magnified the incident. Hughes, a prisoner from Albany, of feeble intellect, hanged himself by his suspenders in his cell. The remains were forwarded to his parents, working people in Albany. The condition of the remains on arrival, by reason of the manner of the death and the futile extraordinary efforts by our physician, Dr. Wey, for his resuscitation, led to the mistaken opinion that he suffered ill treatment at the reformatory — an opinion which, though contrary to the coroner's verdict, was entertained by his parents and was mentioned sensationally in the newspapers of Albany (Brockway, 1969, pp. 191-92).

Of course, Warden Brockway had his own theory about suicidal behavior among his prisoners: "I traced the abnormal activity to (a) instinctive imitation, (b) craving curiosity, (c) mischievous desire to excite alarm, (d) intent to create sympathy and obtain favors, (e) a certain subjective abnormality induced by secret pernicious practices." His solution: "Suicide attempts were completely stopped by notice in the institution newspaper that thereafter they would be followed in each case with physical chastisement" (Brockway, 1969, p. 192).

Fortunately, our current understanding of both the causes and prevention of suicide within the correctional environment has survived Warden Brockway's questionable wisdom. But while suicide is recognized as a critical problem within jails, the issue of **prison** suicide has not received comparable attention — primarily because the number of jail suicides far exceeds the number of prison suicides. Suicide continues to be the leading cause of death in jails, where over 400 inmates take their lives each year; the suicide rate in detention facilities

is approximately nine times greater than that of the general population (Hayes and Rowan, 1988). On the other hand, suicide ranks third as a cause of death in prisons (Bureau of Justice Statistics, 1993a), and, as will be shown in Chapter 3, the number and rate of suicides in prison are considerably lower than in jails. While two comprehensive national studies of jail suicide have been completed (Hayes and Kajdan, 1981; Hayes and Rowan, 1988), a comparable national examination of prison suicides has not occurred to date.

Historically, little is known about the risk of suicide in prison, a research topic that has been characterized as a victim of relative neglect in criminology and corrections (Austin and Unkovic, 1977). Before 1973, most research on prison suicides was concentrated on attempted suicide (e.g., Reiger, 1971), self-mutilation (e.g., Johnson, 1973), or deaths in the European correctional system.* More recent research offers limited insight through its exclusive focus on prison suicide rates (e.g., Batten, 1992; Lester, 1990); victim profiles (e.g., Austin and Unkovic, 1977); absence of discussion regarding precipitating factors; and failure to differentiate prison and jail suicides (e.g., Salive, Smith, and Brewer, 1989). Other observers are simply unimpressed with prison suicide rates and are not convinced that the issue bears significant attention (e.g., Payson, 1975). These same observers assume that, while the risk of suicide looms large in jail among inmates facing the initial stages of confinement, such risk dissipates over time in prison as individuals become more comfortable or tolerant of their predicament and develop coping skills to effectively handle life behind bars. This assumption, of course, has not been empirically studied, is far too simplistic, and ignores both the process and individual stressors of prison life.

The precipitating factors of suicidal behavior in jail are well established (Rowan and Hayes, 1995). It has been theorized that there are two primary causes for jail suicide — 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.

*Research on prison suicides in foreign countries was purposely excluded from this literature review, primarily because correctional systems in other countries are operated quite differently from those in the United States. For example, the word "prison" has different meanings throughout Europe, and many foreign prison systems hold both pretrial (remand) and sentenced inmates. The most comprehensive and enlightening research on prison suicide from Europe to date is Liebling, *Suicides in Prison*, London, England: Routledge Publishing, 1992.

An Englishman named J.M. Wooley was one of the first researchers to address these issues over 80 years ago. Studying the topic of prison suicide when transportation was a common method of excluding criminals from society, Wooley (1913) reviewed specifically the suicides of Indian prisoners from 1902 through 1911 who were placed in solitary confinement before being transported to settlement camps. The research indicated that 43 percent of the suicides occurred during the first 18 months of incarceration, 90 percent were by hanging, and inmates sentenced for murder committed suicide five times more frequently than non-murderers. Wooley cautioned, however, that the data became less significant unless certain institutional factors were addressed: prison discipline, hard labor, solitary confinement, overcrowding, homosexual attacks, and staff brutality.

More recently, Anno (1985) examined 38 suicides in the Texas Department of Corrections (TDC) 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 (Anno, 1985, p. 90).

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 and one or more prior suicide attempts (Jones, 1986). Most interesting was the finding that several **environmental** and **operational** factors might 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) investigations directed primarily toward establishing an appropriate response by staff without the accompanying thorough investigation of the causes of the suicide.

Based on 37 prison suicides between 1979 and 1987, Salive et al. (1989) projected a suicide rate in the Maryland prison system of almost three times that of the general population. Although precipitating factors were not offered, the study found higher suicide rates among white inmates and those aged 25 to 34, convicted of personal crimes, and housed in a maximum security facility. In addition, while the length of actual time served by inmates who committed suicide varied widely,

only 22 percent of the victims had sentences under eight years, and almost 25 percent of all victims were serving life sentences.

Two states with large prison populations — California and New York — recently collected data on inmate suicides within their prison systems. In a review of 15 suicides that occurred in its prison facilities during 1990, the California Department of Corrections (1991) found that 60 percent of victims had been diagnosed with a serious mental disorder and that 53 percent had a history of substance abuse. All but one of the victims were housed in a single cell, and 40 percent were confined in administrative segregation units. A subsequent analysis by the California Department of Corrections (1994) determined that the rate of suicide in its prison facilities decreased from 17 per 100,000 inmates in 1990 to 14 per 100,000 in 1992, but dramatically and inexplicably rose to 25 per 100,000 in 1993.

The New York State Department of Correctional Services (1994) analyzed 52 suicides in its prison facilities between 1986 and mid-1994 and compared the data to the general inmate population. White inmates represented 18 percent of the prison population but 42 percent of the suicides, whereas black inmates represented 50 percent of the prison population but only 20 percent of the suicides. Further, although inmates convicted of a violent felony represented 56 percent of the prison population, they accounted for 80 percent of the suicides. Regarding length of incarceration, 64 percent of all victims committed suicide within 2 years of entering the prison system, and 66 percent of the victims had mandatory minimum sentences of at least 4 years, with 23 percent serving life sentences.

Finally, in a study provided in Chapter 5, White and Schimmel discuss one of the most thorough reviews to date of suicides in federal prisons. In their analysis of 86 suicides that occurred within the Federal Bureau of Prisons (FBOP) system between 1983 and 1992, the researchers found that 49 percent of the victims had a documented history of diagnosed mental illness or treatment and that approximately 46 percent of those who committed suicide had attempted it or made gestures in the past. In addition, approximately 68 percent of the inmates who committed suicide were on "special housing status" (e.g., segregation, administrative detention, or in a psychiatric seclusion unit) and, with only one exception, all victims were in single cells at the time of their deaths.

Of special interest was the fact that although pretrial inmates and Mariel Cuban detainees represented only 6 percent and 4 percent of the total FBOP population, respectively, these two groups combined accounted for 42 percent of all suicides. In addition, although inmates serving sentences of over 20 years represented only 12 percent of the inmate population, they accounted for 28 percent of all suicides. Generally, long-term prisoners committed suicide after serving approximately 5 years of their sentences. Finally, with access to FBOP-authorized psychological autopsies on each suicide, White and Schimmel speculated about several precipitating factors: "new legal problems" for the inmate in 28 percent of the suicides, "marital or relationship difficulties" in 23 percent, and "inmate-related conflicts" in 23 percent.

Despite the consistent findings in all of this recent research, its general use is somewhat limited. Research to date in the area of custodial suicide has generally been retrospective and descriptive. The descriptors have been gathered after the fact, and their etiological and/or developmental role in the process of suicide is therefore unclear. Most important, this research has perhaps unknowingly conceptualized suicide as a static, isolated event that is simply associated with other static factors (e.g., demographics). Such an approach, however, cannot explain or account for the process by which certain prison inmates decide to end their lives at a given time within a particular condition (Bonner, 1992a).

This process can be better explained in the general literature on suicidology. Efforts to correlate suicide to socio-demographic variables and psychiatric categories (e.g., depression) will have a negligible impact unless the individual's "psychache" (intolerable psychological pain) is addressed (Shneidman, 1993). "Suicide is not a bizarre and incomprehensible act of self-destruction. Rather, suicidal people use a particular logic, a style of thinking that brings them to the conclusion that death is the only solution to their problems. This style can be readily seen, and there are steps we can take to stop suicide, if we know where to look" (Shneidman, 1987, p. 56). In applying this doctrine to prison suicide, Bonner (1992a) offers the "stress-vulnerability model," the theory that suicide must be viewed in the context of a process by which an inmate is (or becomes) ill-equipped to handle the common stresses of confinement. As the inmate reaches an emotional breaking point, the result can be varying degrees of suicidal intention, including ideation, contemplation, attempt, or completion. Initially, these stressors mirror those of jail suicide victims, such as fear of the unknown and isolation from family, but over time:

> ...incarceration may bring about added stressors, such as loss of outside relationships, conflicts within the institution, victimization, further legal frustration, physical and emotional breakdown, and a wide variety of other problems in living. Coupled with such negative life stress, individuals with psychosocial vulnerabilities (including psychiatric illness, drug/alcohol intoxication, marital/ social isolation, suicidal coping history, and deficiencies in problem-solving ability) may be unable to cope effectively and in time may become hopeless (Bonner, 1992a, p. 407).

In addition to hopelessness, the general literature on suicidology identifies other risk factors for suicidal behavior: current degree of suicidal ideation and previous attempts, dysfunctional assumptions, dichotomous (all-or-nothing) thinking, inability to solve problems and a view of suicide as the desirable solution to one's problems, psychiatric disorders, substance abuse, and availability of something to use to commit suicide (Weishaar and Beck, 1992). Such factors, in combination or interaction with the common stresses of confinement, could break down the ability to cope and create the emotional avenue for suicidal behavior. With few exceptions, however (most notably Bonner and Rich, 1992; Ivanoff and Jang, 1991; Ivanoff, Smyth, Grochowski, Jang, and Klein, 1992), these factors have not been empirically tested in a correctional setting. Yet, although research has not sufficiently addressed the psychosocial process of prison suicide, court decisions and developing national standards have, to a degree, filled the void by advocating the view that suicide is a process that typically displays observable signs of maladaptive coping and suicidal intention. If identified in time, the process can be reversed or prevented in most cases (Bonner, 1992b).

A discussion of prison suicide would be incomplete without a few words about suicide and the manipulative inmate. Few issues challenge prison officials and staff more than the management of manipulative inmates. It is not unusual for inmates to call attention to themselves by threatening suicide or feigning an attempt to avoid a court appearance, bolster an insanity defense, be relocated to a different cell, be transferred to the prison infirmary or a local hospital, receive preferential staff treatment, or seek compassion from a previously unsympathetic spouse or other family member.

Although the prevailing theory is that any inmate who would go to the extreme of threatening suicide or engaging in self-injurious behavior is suffering from at least an emotional imbalance that requires special attention, too often prison officials (with the support of mental health staff) conclude that the inmate is not dangerous and simply attempting to manipulate his or her environment. They often suggest such behavior be ignored and not reinforced through intervention. In fact, it is not unusual for mental health professionals to resort to labeling, with inmates engaging in "deliberate self-harm" termed "manipulative" or "attention seeking," and "truly suicidal" inmates seen as "serious" and "crying for help." Clinicians routinely differentiate between behavior they regard as genuine suicide attempts and other self-injurious behavior they label, variously, as self-mutilation, suicidal gestures, parasuicide, manipulation, or malingering (Haycock, 1989a).

A study of self-injury among prison inmates, for example, found that acts of self-mutilation often signify increased tension in the inmates' lives caused by situations they sense are beyond their direct control (Thorburn, 1984). Use of violence for control is common in prison, and self-directed violence as in self-mutilation can provide a distorted sense of control. A study of parasuicide (intentional self-harm) among prison inmates found that psychiatric history and parasuicide records of the inmates' group of significant others (i.e., other prisoners) were the best predictors of intentional self-harm (Ivanoff, 1992). In any event, at a minimum, **all** acts of self-injury can be said to reflect personal breakdowns resulting from crises of self-doubt, poor coping and problem-solving skills, hopelessness, and fear of abandonment (Toch, 1975). It has been argued that there are no false suicidal acts:

> Correctional, medical, and mental health staff should abandon the effort to classify suicidal behavior according to expressed or presumed intent, particularly since the tendency of persons to minimize the seriousness of their suicidal intent after the fact is well-known across community, hospital, and other settings. There are no reliable bases upon which we can differentiate "manipulative" suicide attempts posing no threat to the inmate's life from those true "non-manipulative" attempts which may end in a death. The term "manipulative" is simply useless in understanding, and destructive in attempting to manage, the suicidal behavior of inmates (or of anybody else) (Haycock, 1992, pp. 9-10).

Other clinicians disagree and argue that self-injurious behavior displayed by "truly suicidal" or "manipulative" inmates should result in different interventions. For suicidal inmates, intervention that promotes close supervision, social support, and access to or development of psychosocial resources is crucial. For manipulative inmates, intervention that combines close supervision with behavior management is crucial in preventing or modifying such behavior. Historically, the problem has been that manipulative behavior was ignored or resulted in punitive sanctions, including isolation. Often, manipulative inmates escalate their behavior and die, either by accident or miscalculation of the staff's responsiveness. Therefore, these clinicians stress, the problem is not in how we "label" the behavior, but how we react to it — and the reaction should not include isolation.

Finally, the literature is replete with recommendations on how to reduce incidents of suicidal behavior among prison inmates, a problem that many believe is the most preventable cause of death in prisons (Anno, 1991; Salive et al., 1989). A primary recommendation, based chiefly on overwhelmingly consistent research, is that isolation should be avoided whenever possible. Whether its use is disciplinary or observational, isolation can pose a special threat to inmates who have limited abilities to cope with frustration. Further, while some inmates are initially placed in administrative segregation for reasons unrelated to risk of suicide, they can injure themselves as a result of the isolation. As one inmate offered: "The Hole and Segregation cells are depressing enough to drive many men to take their lives in order to escape. For some it would appear to be the only way out. After years of living in the cramped confines of a segregation cell with no hope of getting out, it is easy to see why a man would prefer death" (Cardozo-Freeman, 1984, p. 430). Death row inmates are preoccupied with thoughts of suicide (Johnson, 1981) and exhibit an unusually high rate of suicide (Lester, 1990). A psychiatrist who investigated the use of isolation in several prison systems throughout the country attributed prolonged social isolation and lack of stimulation in segregation to a solitary confinement syndrome," where inmates become "floridly psychotic and subject to uncontrollable impulses, including random violence, self-mutilation, and suicidal behavior" (Murphy, 1994, p. 4).

And while few prison officials today would support Warden Brockway's suggestion of "physical chastisement" as a tool for suicide prevention, the use of segregation for self-injurious inmates can be said to be the modern equivalent, and it should be met with the same disapproval. As observed by one federal court:

> ...The Court finds the treatment of seriously mentally ill inmates to be appalling. Rather than providing treatment for serious mental illnesses, ADOC punishes these inmates by locking them down in small, bare segregation cells for their actions that are the result of their mental illnesses. These inmates are left in segregation without mental health care. Many times the inmates, such as H.B. are in a highly psychotic state, terrified because of hallucinations, such as monsters, gorillas or the devil in her cell....This use of lockdown as an alternative to mental health care for inmates with serious mental illnesses clearly rises to the level of deliberate indifference to the serious mental health needs of the inmates and violates their constitutional rights to be free from cruel and unusual punishment (*Casey* v. *Lewis*, 1993, p. 1477).

Other recommendations found in the literature include suicide prevention training for both correctional and mental health staff (Anno, 1985; Sperbeck and Parlour, 1986); preventive intervention for long-term inmates (Salive et al., 1989); better communication between correctional, medical, and mental health staff (Jones, 1986); and comprehensive suicide prevention policies that include screening procedures, architectural considerations, monitoring/ observation patterns, and interaction techniques (Anno, 1991). The success of efforts to prevent suicide in prisons will depend on our ability and willingness to identify the vulnerable inmate, provide the necessary supervision, and offer alternative ways of coping and reducing emotional distress (Bonner, 1992b).

Chapter 2

NATIONAL AND STATE STANDARDS FOR PRISON SUICIDE PREVENTION

Beginning in the early 1960s, various legislative bodies and agencies have examined prison systems in an effort to fashion standards for the efficient operation of correctional facilities. From these efforts, two basic types of standards emerged to measure the adequacy of prison conditions: 1) the minimum standards of constitutional decency devised and refined by federal courts in decisions challenging the conditions of confinement, and 2) the growing body of self-regulatory standards and accreditation procedures promulgated by professional and federal agencies to stimulate improvement of the facilities through voluntary, administrative action (National Institute of Justice, 1980).

The courts have taken an active role in measuring the adequacy of prison conditions. As of January 1995, 39 states plus the District of Columbia, Puerto Rico, and the Virgin Islands were under court order or a consent decree to limit the number of inmates and/or improve conditions of confinement in either the entire state prison system or its major facilities (National Prison Project, 1995). Of these, 33 jurisdictions were under court order for overcrowding or conditions of confinement in at least one of their major prison facilities, while 9 jurisdictions were under court order for their entire system. Only 3 states (Minnesota, New Jersey, and North Dakota) have never been involved in major litigation challenging prison overcrowding or conditions.

Although correctional standards are not legally binding and do not set constitutional requirements (see *Rhodes* v. *Chapman*, 1981), the U.S. Supreme Court has stated that such standards have the ability to serve as guidelines or benchmarks in assessing the "duty of care" or "reasonable conduct" (see *Bell* v. *Wolfish*, 1979). Correctional standards are also seen by experts as: 1) promoting humane conditions of confinement; 2) reducing liability in the event of a lawsuit; and 3) increasing organizational efficiency, including the desire to professionalize the field of corrections. According to one federal court monitor, "The move toward professionalism in the field has been going on for many years, but comprehensive standards were not forthcoming until the early 1960s. Standards then represent a quantum leap in the move toward professionalism, and cover such topics as personnel, administration, and operations" (Lonergan, n.d.).

Correctional standards have become a yardstick for measuring conditions of confinement. As noted several years ago, "The new judicial activism has added a sense of urgency to the development of increasingly specific **self-regulatory standards** by executive and professional organizations. In turn, the availability of these standards promises to introduce a new level of objectivity to litigation challenging the conditions of confinement" (National Institute of Justice, 1980, p. 39). In 1990, the American Correctional Association (ACA) commissioned a study to determine the impact of its correctional standards on court rulings and found that 1) courts often consult ACA standards when attempting to determine appropriate expectations in a correctional setting, 2) courts sometimes cite ACA standards as the basis for establishing a court standard or a requirement in a decision, and 3) courts have sometimes used ACA standards and accreditation as a component of a continuing order or consent decree (Miller, 1992). Not

all courts use standards (ACA or otherwise) to measure conditions of confinement, however, because in "many instances a lower requirement is adopted consistent with the court's view of the constitutional or statutory requirement. In others, a higher standard might be established by the court given the circumstances of the case. And often the court prefers to take a totality of conditions perspective instead of relying on specific standards" (Miller, 1992, p. 60).

In attempting to manage a correctional facility, the prison administrator is faced with two dilemmas: what constitutes sound correctional practices and what represents the "state of the art." Standards, whether national or state, can provide guidance for the administrator. When devising a strategy to reduce liability, for example, the administrator can cite compliance with national and/or state standards as part of a good faith defense. Because standards reflect the state of the art, they provide reasonable and minimal guidelines on which the administrator can base policies and procedures. By promoting professionalism, standards "provide administrators with the opportunity to develop a planned program for upgrading facilities and procedures in accordance with a nationally recognized and respected format. The standards can assist administrators in working effectively with the courts and legislatures" (ACA, 1981, p. vii).

Reviewing the National Standards

Although initially created a decade earlier, correctional standards gained prominence in the late 1970s. In 1966, ACA published its *Manual of Correctional Standards,* followed by *Manual of Standards for Adult Correctional Institutions* in 1977. These standards were again revised and published as *Standards for Adult Correctional Institutions* in 1981. The American Public Health Association (APHA) published *Standards for Health Care in Correctional Institutions* in 1976, revised and reissued 10 years later as *Standards for Health Services in Correctional Institutions.* In 1979, the American Medical Association (AMA) published *Standards for Health Services in Prisons.* During the 1980s, the U.S. Department of Justice published *Federal Standards for Prisons and Jails* (1980); the National Commission on Correctional Health Care (NCCHC) revised the AMA's 1979 standards and published *Standards for Health Services in Prisons* (1987); and the American Psychiatric Association (APA) published a task force report and guidelines manual entitled *Psychiatric Services in Jails and Prisons* (1989). In 1990, ACA issued the third, revised edition of *Standards for Adult Correctional Institutions*, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) published *Ambulatory Health Care Standards.* Finally, NCCHC issued the third, revised edition of *Standards for Health Services in Prisons* in 1992.

The relationship between suicide prevention and correctional standards is a fairly recent phenomenon. While the 1970s and 1980s witnessed a plethora of national correctional standards, the standards greatly varied in their specificity regarding prevention of prison suicides. In fact, several standards failed to even address the issue.*

*Because neither the APA nor U.S. Department of Justice or JCAHO standards address basic suicide prevention protocols, they will not be reviewed here. Appendix E of Anno (1991) contains an excellent comparative analysis of national prison health care standards.

American Correctional Association Standards

ACA's *Standards for Adult Correctional Institutions* are the most widely recognized national prison standards, but, because their primary emphasis is on the operation and administration of prisons, the early editions did not fully address health care. For example, with two minor exceptions,* the 1981 ACA standards did not specifically address the issues of suicide prevention and handling suicidal inmates, the components of the special health program, or the frequency or type of supervision for suicidal inmates.

In August 1983, standard 2-4182-3 was created:

> Written policy and procedure require that all special management inmates are personally observed by a correctional officer at least every 30 minutes, but on an irregular schedule. More frequent observation is required for those inmates who are violent or mentally disturbed or who demonstrate unusual or bizarre behavior; suicidal inmates are under continuing observation.

The following year, the issue of suicide prevention was again addressed in standard 2-4285-1 with some of the strongest commentary to date:

> Added August 1984. There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with responsibility for inmate supervision are trained in the implementation of the program.
>
> **Discussion.** Staff have a responsibility for preventing suicides through intake screening, identification, and supervision of suicide-prone inmates. They should receive special training in the implementation of a suicide prevention program.

In January 1989, standard 2-4092 was revised to require that the topics "signs of suicide risk" and "suicide precautions" be included in the training curriculum for new correctional officers. The following year, ACA issued the third edition of *Standards for Adult Correctional Institutions.* With one exception, it contained no further revisions to suicide prevention protocols. Standard 2-4092 was renumbered as 3-4081, standard 2-4182-3 was renumbered as 3-4245, standard 2-4289 was renumbered as 3-4343, standard 2-4304 was renumbered as 3-4355, and standard 2-4285-1 was renumbered as 3-4364. While standard 2-4285-1 had contained ACA's strongest commentary about preventing suicide, emphasizing that "staff have a

*Standard 2-4289, requiring that all inmates except intrasystem transfers be medically screened, including inquiry into "past and present treatment or hospitalization for mental disturbance or suicide"; and standard 2-4304, requiring a special medical program for inmates needing close medical supervision because they could be suicidal.

responsibility for preventing suicides," that language was removed from the third edition and the standard (renumbered as 3-4364) simply reads, "The program should include specific procedures for intake screening, identification, and supervision of suicide-prone inmates."

American Medical Association Standards

AMA's *Standards for Health Services in Prisons* contained the first national standards developed exclusively for prison facilities that specifically addressed health care. First published in 1979, the AMA standards included several suicide prevention protocols. For example, standard 144 addressed the need for an "interim health appraisal," requiring that:

> 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....

In addition, standard 147 required a medical evaluation of all inmates housed in segregation at least three times weekly by qualified health care personnel:

> 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.

Finally, AMA's standards required a "special medical program" for inmates with "a broad range of health problems, e.g., seizure disorders, diabetes, potential suicide, chemical dependency, psychosis."

American Public Health Association Standards

Although APHA's *Standards for Health Services in Correctional Institutions* did not distinguish the sometimes subtle differences in health care for jail and prison inmates, the 1986 regulations were definitive about the issue of 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.

National Commission on Correctional Health Care Standards

NCCHC's *Standards for Health Services in Prisons*, published in January 1987, was a substantially revised version of AMA's 1979 standards. For example, unlike the AMA regulations, the NCCHC standards highlighted the relationship between "receiving screening" (standard P-30) and the identification of suicidal inmates:

> It is extremely important for screeners to explore fully the inmate's suicide and withdrawal potential. Reviewing with an inmate any history of suicidal behavior, and visually observing the inmate's behavior (delusions, hallucinations, communication difficulties,

speech and posture, impaired level of consciousness, disorganization, memory defects, depression or evidence of self-mutilation) are recommended. This approach, coupled with the training of the staff in all aspects of mental health and chemical dependency, should enable facilities to intervene early to treat withdrawal and to prevent most suicides.

More important, the NCCHC standards offered the most comprehensive and practical suicide prevention regulations to date because they not only required that prisons develop a written plan but also listed the essential components of a suicide prevention program:

P-58: Suicide Prevention

The prison has a written plan for identifying and responding to suicidal individuals.

Discussion. While inmates may become suicidal at any point during their stay, high-risk periods include the time immediately upon admission to a facility; after adjudication, when the inmate is returned to a facility from court; following the receipt of bad news regarding self or family (such as serious illness or the loss of a loved one); and after suffering some type of humiliation or rejection. Individuals who are in the early stages of recovery from severe depression may be at risk as well. The facility's plan for suicide prevention should include the following elements:

a. **Identification.** The receiving screening form should contain observation and interview items related to the inmate's potential suicide risk.

b. **Training.** All staff members who work with inmates should be trained to recognize verbal and behavioral cues that indicate potential suicide.

c. **Assessment.** This should be conducted by a qualified mental health professional, who designates the inmate's level of suicide risk.

d. **Monitoring.** The plan should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular, documented supervision should be maintained.

e. **Housing.** A suicidal inmate should not be placed in isolation unless constant supervision can be maintained. If a sufficiently large staff is not available that constant

supervision can be provided when needed, the inmate *should not be isolated.* Rather, s/he should be housed with another resident or in a dormitory and checked every 10-15 minutes. The room should be as nearly suicide-proof as possible (that is, without protrusions of any kind that would enable the inmate to hang him/herself).

f. **Referral.** The plan should specify the procedures for referring potentially suicidal inmates and attempted suicides to mental health care providers or facilities.

g. **Communication.** Procedures for communication between health care and correctional personnel regarding the status of the inmate should exist, to provide clear and current information.

h. **Intervention.** The plan should address how to handle a suicide in progress, including how to cut down a hanging victim and other first-aid measures.

i. **Notification.** Procedures for notifying prison administrators, outside authorities, and family members of potential, attempted, or completed suicides should be in place.

j. **Reporting.** Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide.

k. **Review.** The plan should specify the procedures for medical and administrative review if a suicide does occur.

In 1992, the NCCHC standards were again revised and although standard P-58 was renumbered as P-54, it remained intact. In addition, the revised NCCHC standards offered a four-level suicide prevention protocol for the assessment, housing, and observation of suicidal inmates.* Briefly, Level 1 is reserved for the inmate who recently attempted suicide. The inmate should be housed in either a "safe room" or the health clinic, with health care staff

*Titled "Sample Suicide Precaution Protocols," this section of NCCHC's 1992 *Standards for Health Services in Prisons* is reprinted in Appendix A.

providing one-on-one constant observation of the inmate while he or she is awake, and visual checks every 5 to 10 minutes while the inmate is asleep. Level 2 is reserved for the inmate who is considered a high suicide risk. The inmate should be housed in either a "safe room" or the health clinic, with health care staff providing visual observation of the inmate every 5 minutes while awake and every 10 minutes while asleep. Level 3 is reserved for the inmate who is assessed as a moderate suicide risk, who might previously have been on either Level 1 or 2. The inmate should be observed every 10 minutes while awake and every 30 minutes while asleep. Level 4 is reserved for the inmate who, perhaps based on past history, could be at risk of becoming severely depressed and/or suicidal. The inmate should be observed every 30 minutes while awake and asleep.

Conclusion

Historically, national correctional standards have been viewed with some skepticism, referred to as too general or vague, lacking in enforcement power, and often politically influenced. "Courts and correctional administrators seeking specific guidelines as to what constituted 'adequate' provisions for health care were not likely to derive much satisfaction from the early standards" (Anno, 1991, p. 18). And formal adoption of current national correctional standards by a prison system does not necessarily ensure that individual facilities have put those procedures into operation. There are numerous examples of accredited prison facilities that are under court order for inadequate conditions of confinement.

Most of the national standards were developed as recommended procedures rather than regulations that measured **outcome**. For example, current ACA standards require a "written suicide prevention and intervention program" but offer no guidance as to what components should be included in such a program. The potential result is that two prison systems could be in compliance with this standard yet have dramatically different procedures. It must be noted, however, that management of prisons and conditions of confinement have improved since correctional standards were first promulgated in the early 1960s. "Most state departments of correction have ... a system of health care in place: some because they were mandated to do so by federal courts, others because they chose to follow the recommendations of the health professional associations" (Anno, 1991, p. 1).

Once a footnote in medical care standards, suicide prevention is now addressed separately and distinctly in most national correctional standards. Several national organizations and other influential bodies recognized that, because suicide remains a leading cause of death in prisons, standards were needed to specifically address suicide prevention. Perhaps best exemplified by the NCCHC standards, national guidelines for suicide prevention have provided the opportunity and framework for departments of correction to create and build upon their policies and procedures for the prevention of suicides.

Reviewing State Standards

Most states adopted prison standards in the 1970s. The call for standards came from many fronts, including the federal courts. In what has been described as the first federal court decision devoted entirely to the adequacy of a state's prison health care services, a federal

appeals court upheld a lower court ruling in *Newman* v. *Alabama* (1974) that the state's correctional system was unconstitutional for its failure to provide sufficient and adequate medical care to its inmates. The court ordered the state to develop immediate remedies for the deficient health care, including comprehensive policies and procedures for the delivery of medical services to inmates. This case precipitated other courts becoming more involved in conditions of confinement, resulting in the landmark *Estelle* v. *Gamble* (1976), in which the U.S. Supreme Court ruled that:

> Deliberate indifference to the serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain...proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with treatment once prescribed. Regardless of how evidenced, deliberate indifference to [a] prisoner's serious illness or injury states a cause of action (*Estelle* v. *Gamble*, 1976, pp. 104-105).

Estelle's result was the coining of a legal yardstick — "deliberate indifference" — that led to the filing of numerous class-action lawsuits challenging the adequacy of medical care in prisons.

The call for improved conditions of confinement and prison standards did not come from the courts alone, however, but also from professional groups like AMA and ACA and with the financial and technical assistance of the federal government. Through the U.S. Justice Department's Law Enforcement Assistance Administration (LEAA), the development, promulgation, and enforcement of standards became a significant part of a state's responsibility for maintaining and improving the conditions of its prisons during the 1970s. Ensuring adequate prison health care was of growing concern outside the legal arena (Anno, 1991). Both state and national correctional and medical officials were searching for solutions — either through implementation of specific programs designed to improve health care in certain facilities or by the development of standards for prison health care. Twenty years later, prison health care has improved notably:

> While both litigation and the assistance offered by the health care professional associations have resulted in significant improvements in the status of prison health care in the various states, some problems remain. Nonetheless, it is refreshing to note that the pressing problems of today are not the same as those of the 1970s. That, in and of itself, represents growth....The challenges for the 1990s include how to fine-tune those systems so that the quality of care offered will mirror that of the community...how to cope with population increases that put pressure on existing delivery systems, and how to control burgeoning health care costs (Anno, 1991, p. 21).

Suicide Prevention Programs

One example of fine-tuning in health services is the development of written policies and procedures for suicide prevention in state departments of correction. To determine the degree to which prison standards address suicide prevention, the National Center on Institutions and Alternatives (NCIA) recently surveyed all 50 state departments of correction (DOCs), the District of Columbia, and the Federal Bureau of Prisons. Each was asked whether its agency and/or individual facilities had developed any policies and procedures regarding prison suicide and, if so, to forward a copy of the procedures.* Determining what constituted a suicide prevention policy during the review of responses was predicated on two conditions: 1) that the policy followed the spirit of standard 3-4364 (ACA, 1990) — "a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional" and 2) that the policy was a separate directive within a DOC's operational procedures or was contained in a separate section of another DOC administrative directive (e.g., medical or mental health).

As shown in Table 2-1, 41 DOCs (79%) had a suicide prevention policy, 8 DOCs (15%) had no suicide prevention policy but had varying numbers of protocols contained in other agency directives, and 3 DOCs (6%) did not address the issue of suicide prevention in any written policy or directive.

ACA (1990) standard 3-4364 and NCCHC (1992) standard P-54 were used as yardsticks to measure the comprehensiveness of a DOC's suicide prevention policy. For this analysis, NCIA combined the requirements of both standards and identified the six most critical components of a suicide prevention plan: staff training, intake screening/assessment, housing, levels of supervision, intervention, and administrative review (see Hayes, 1994a).

NCIA's analysis found that only three departments of correction (California, Delaware, and Louisiana) had suicide prevention policies that addressed **all** six critical components and that an additional five departments of correction (Connecticut, Hawaii, Nevada, Ohio, and Pennsylvania) had policies that addressed all but one critical component. Thus, only 15 percent of all departments of correction had policies that contained either all or all but one critical component of suicide prevention. In contrast, 14 departments of correction (27%) had either no suicide prevention policies or limited policies — 3 with none, and 11 with policies that addressed only one or two critical components. The majority (58%) of DOCs had policies that contained three or four of the critical components.

Staff Training

The key to any suicide prevention program is properly trained correctional staff, who form the backbone of any prison facility. Very few suicides are actually prevented by mental health, medical, or other professional staff because suicides usually are attempted in inmate housing units and often during late evening and on weekends when inmates are outside the purview of program staff. These incidents must therefore be thwarted by correctional staff

*Responses were received from all jurisdictions.

who have been trained in suicide prevention and have developed an intuitive sense about the inmates under their care. Correctional officers are often the only staff available 24 hours a day; thus, they form the front line of defense in preventing suicides.

Both ACA and NCCHC standards stressed the importance of training as a critical component of the suicide prevention plan. ACA standard 3-4081 required that all new correctional staff receive training in the "signs of suicide risk" and "suicide precautions," while

TABLE 2-1
SUICIDE PREVENTION PROTOCOLS WITHIN DEPARTMENTS OF CORRECTION

DOC	Prevention Policy	Training	Screening/ Assessment	Housing	Suicide Watch Levels (in minutes)	Intervention	Admin. Review	Last Revision
Alabama				x	15			5/93
Alaska		x	x		15, 30, 60			2/93
Arizona	x		x	x	10			8/89
Arkansas								
California	x	x	x	x	constant/unspecified	x	x	no date
Colorado	x	x		x	30, 60			9/93
Connecticut	x	x	x	x	constant, 15		x	7/92
Delaware	x	x	x	x	15	x	x	7/93
District of Col.	x		x		15, 30, 60		x	6/93
Florida	x			x	constant, 15, 30			10/93
Georgia			x			x		1/91
Hawaii	x	x	x	x	constant, 15	x		2/93
Idaho	x		x			x	x	11/93
Illinois	x			x	10, 15			5/91
Indiana								
Iowa	x				15, 30			3/90
Kansas	x	x		x	10-15			3/93
Kentucky								
Louisiana	x	x	x	x	5-15	x	x	9/93
Maine		x	x		constant, 15			Draft/94
Maryland	x			x				2/92
Massachusetts			x	x				5/93
Michigan	x	x	x	x	10			12/91
Minnesota	x		x	x	15, 30			5/92
Mississippi	x			x	5			11/93
Missouri	x		x	x	15			6/92
Montana	x	x	x	x	15			5/93
Nebraska	x	x						12/93
Nevada	x	x	x	x	constant, 15			8/93
New Hampshire	x		x	x	15, 30, periodic	x	x	8/93
New Jersey	x				15	x		7/92
New Mexico	x			x	constant	x		1/92
New York		x		x	constant, 5, 15		x	9/92
North Carolina	x	x	x	x	constant, 15			7/93
North Dakota		x		x	15, 30			9/93
Ohio	x	x	x	x	5, 15		x	12/92
Oklahoma	x		x	x	15		x	5/92
Oregon	x	x	x	x	10-15			no date
Pennsylvania	x	x	x	x	constant, 15, 30		x	4/94
Rhode Island	x			x	15	x	x	4/88
South Carolina	x	x	x					3/86
South Dakota	x	x	x		15		x	6/91
Tennessee	x	x		x				11/92
Texas	x			x	15	x		10/93
Utah	x			x	15			2/94
Vermont	x		x	x	constant, 10-15			4/82
Virginia	x	x		x	constant, 15			2/92
Washington	x	x		x	constant, 15			6/84
West Virginia	x	x	x	x	15			5/87
Wisconsin				x	15			4/90
Wyoming	x	x	x	x	constant, 15	x		10/92
Federal Bureau of Prisons	x	x	x	x			x	4/90

standard 3-4364 required that staff be trained in the implementation of the suicide prevention program. NCCHC standard P-54 stressed that "all staff members who work with inmates should be trained to recognize verbal and behavioral cues that indicate potential suicide."

NCIA's analysis found that only 27 departments of correction (52%) addressed the issue of training in their suicide prevention policy or other administrative directive. Further, few DOCs were specific about the length, frequency, and areas of training. For example, one DOC procedure stated, "Wardens should ensure that appropriate staff are trained with the skills and knowledge to recognize and initially manage suicidal behavior." Another procedure simply stated that the "training director shall ensure that appropriate training is provided." Some DOCs were notable exceptions, however, including the Nevada Department of Prisons, whose suicide prevention training procedure stated:

> 1. Pre-Service Training (PST) — All new employees are required to complete classes in the identification, recognition, and mental health referral of suicidal and mentally disordered or developmentally disabled inmates.
>
> 2. In-Service Training (IST) — At least yearly, the mental health staff should conduct an advanced class at each institution on suicide prevention. Areas covered include signs [and] symptoms to predisposing factors of potentially suicidal inmates; risk factors in the evaluation of suicidal potential; [management] of potentially suicidal inmates; levels of suicide prevention; and AR concerning mental health issues. This will be for custody, programs, and medical staff.

Intake Screening/Assessment

Screening and assessment when inmates enter a facility are critical to a correctional facility's suicide prevention program. Although the psychiatric and medical communities disagree about which factors can be used to predict suicide in general, research on jail and prison suicides has identified a number of characteristics that are strongly related to suicide, including intoxication, emotional state, family history of suicide, recent significant loss, limited prior incarceration, lack of a social support system, psychiatric history, and various stressors of confinement. Most important, prior research has consistently reported that at least 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 (Clark and Horton-Deutsch, 1992). The key to identifying potentially suicidal behavior in prison inmates is through inquiry during intake screening/assessment and other high-risk periods of incarceration. An inmate can attempt suicide at any point during incarceration.

Both ACA and NCCHC standards addressed the issue, with the latter stating that the screening form should contain observations about an inmate's potential suicide risk and that a qualified mental health professional should conduct the screening and designate the inmate's risk of suicide. As shown in Table 2-1, only 29 departments of correction (56%) address the

issue of intake screening and assessment in their suicide prevention policy or other administrative directive. Procedures at the Connecticut Department of Corrections perhaps best exemplified this critical component:

> All newly admitted inmates will be screened by Health Services staff within 24 hours of admission to the facility for both obvious and subtle signs of potential for suicide.
>
> - Designated Health Services staff administer an Intake Screening Form to all newly admitted inmates.
>
> - Indication of potential suicide will result in an immediate referral to [mental health staff] and a screening by administration of the Mental Health Suicide Intake Screening Form. Following completion of this form, appropriate disposition regarding housing, coordination, and referrals will be recommended by the mental health staff or medical supervisor.
>
> - Staff should never take lightly any suicidal threats, attempts, or hints from other inmates about a potentially suicidal inmate.
>
> - To assist in the identification of potential suicidal inmates, a Guideline for Suicidal Risk is provided to staff. These questions are designed to elicit and formulate information as part of the assessment process.

Housing

In determining the most appropriate housing location for a suicidal inmate, prison officials often tend to physically isolate and restrain the individual. These responses might be more convenient for staff, but they are detrimental to the inmate, as the use of isolation escalates the inmate's sense of alienation and further removes the individual from proper staff supervision. National correctional standards stress that, to every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. Further, removal of an inmate's clothing (except belts and shoelaces) and the use of physical restraints (e.g., leather straps, straitjackets) should be avoided whenever possible and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Handcuffs should never be used to restrain suicidal inmates. Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten the depersonalizing aspects of incarceration.

Most DOC policies reflected the importance of housing to a suicide prevention program. NCIA's analysis found that 39 departments of correction (75%) addressed the issue of housing in their suicide prevention policy or other administrative directive. But while most procedures

addressed the issues of inmate clothing and the use of restraints as a last resort, few specifically prohibited the use of isolation or seclusion and many did not address the removal of obvious protrusions in cells. In addition, few procedures were tailored to the level of an inmate's suicide risk. One notable exception was the Virginia Department of Corrections' housing procedure for inmates at "imminent" risk of suicide:

> Inmates on Suicide Precautions Status with One-to-One Supervision ("Constant Watch") may be housed in a stripped cell, i.e., an empty cell furnished only with a mattress. Inmates will receive undergarments to wear, and a blanket in cool weather. Clothing or blankets may be removed upon the order of a QMHP (Qualified Mental Health Professional) if warranted by the inmate's condition.
>
> Stripping the inmate of all clothing should be avoided if possible and used only as a last resort. If available, a paper gown should be provided to the inmate on the recommendation of the QMHP. In the event that the stripping of an inmate of all clothing is viewed as necessary and continues to be necessary for more than forty-eight (48) hours, transfer to an acute care mental health unit should be considered.

Levels of Supervision

Prompt, effective emergency medical service can save lives. Research indicates that the overwhelming majority of suicide attempts in custody are by hanging. Medical experts warn that brain damage from strangulation can occur within 4 minutes, death often within 5 to 6 minutes. In prisons, the promptness of the response to attempted suicide is often driven by the level of supervision afforded the inmate. While both ACA and NCCHC standards addressed levels of supervision, the degree of specificity varied. ACA standard 3-4245 required only that suicidal inmates be under continuing observation, while NCCHC standard P-54 required observation ranging from constant supervision to physical checks every 10 to 15 minutes by correctional staff. Consistent with national standards, 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 and/or has a recent prior history of self-destructive behavior. Staff should observe such an inmate at staggered intervals not to exceed every 15 minutes. Constant observation is reserved for the inmate who is actively suicidal, either threatening to or engaging in the act of suicide. Staff should observe such an inmate on a continuous, uninterrupted basis. Other aids (e.g., closed-circuit television, inmate companions/watchers) can be used as a supplement to, but never a substitute for, such observation (see Hayes, 1994a).

As shown in Table 2-1, although 41 departments of correction (79%) addressed the issue of supervision levels in their suicide prevention policy or other administrative directive, the highest level of observation afforded suicidal inmates within these prison systems varied considerably. For example, of the 41 DOCs, only 14 (34%) had procedures for constant supervision; 18 DOCs (44%) used 15-minute watches as the highest level; 8 DOCs (20%) had

only 5- to 10-minute watches; and 1 DOC (2%) had only 30-minute watches. In addition, many of the policies from the remaining 11 DOCs that did not specifically address the issue of supervision levels were vague. For example, the only reference to observation of suicidal inmates in one policy was:

> Arrangements shall be made for an inmate identified as a potential suicide to be maintained under frequent observation. Other maintenance methods may include reassignment of housing, increased contact with those staff members with whom the inmate has developed a positive relationship, or the provision of treatment services. Prognosis is good if immediate prevention measures are taken. The acute suicide period is usually of short duration; if the person can be talked through the crisis, the likelihood of an actual suicide is significantly reduced.

Several departments of correction had policies that allowed either closed-circuit television or inmate companions/watchers to be used as a substitute for staff in the supervision of suicidal inmates requiring constant observation. In NCIA's analysis, these policies were not grouped with those from other DOCs that exclusively used staff for constant observation of suicidal inmates because such a directive was contrary to national correctional standards and practices.* In contrast, the suicide prevention policy from the Connecticut Department of Corrections provided a precise definition of supervision levels for suicidal inmates:

> **SUICIDE WATCH**: A suicide watch is defined as supervisory precautions taken for suicidal inmates that require frequent observation. Suicide watch has two levels of observation.
>
> (a) *15-Minute Watch* — for those not actively suicidal, but have expressed thoughts of suicidal ideation and/or have a prior history of suicidal behavior. Such inmates are to be physically observed by an officer at staggered intervals not to exceed 15 minutes. This involves observing living, breathing flesh and entering the cell to do so if necessary. A TV monitoring system is not to be utilized as a substitute for an active 15-minute watch.
>
> (b) *Continuous Observation 1:1* — for those actively suicidal, either by threatening or engaging in the act of suicide. Such inmates shall be physically observed on a continuous and

*Departments of correction in Kansas, Minnesota, New Jersey, and Tennessee allowed for the use of closed-circuit television as a substitute for staff supervision; West Virginia and the Federal Bureau of Prisons allowed for inmate companions/watchers as a substitute for staff supervision.

> uninterrupted basis. The officer shall maintain a clear [un]obstructed view of the inmate at all times. A TV monitoring system shall not be utilized [as a substitute for] constant supervision. TV monitoring is a supplement, not a substitute. The officer shall document the suicide watch for each inmate utilizing the "Observation, Seclusion, Restraint Checklist Form."

Intervention

Following a suicide attempt, the degree and promptness of the staff's intervention often foretell whether the victim will survive. National correctional standards generally acknowledge that a facility's policy regarding intervention should be threefold. First, all staff who come in contact with inmates should be trained in standard first aid procedures and cardiopulmonary resuscitation (CPR). Second, any staff member who discovers an inmate attempting suicide should immediately survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin standard first aid and/or CPR. Third, staff should never presume that the inmate is dead but rather should initiate and continue appropriate life-saving measures until relieved by arriving medical personnel.

The federal courts have addressed the issue of intervention in attempted inmate suicide. In March 1992, a federal appeals court upheld a lower court's finding in *Heflin* v. *Stewart County* (1992) that the proximate cause of an inmate's death was both an inadequate, contradictory policy and the correctional staff's inaction in attempting to save his life:

> ...The defendants assert that there was no evidence that the county had a policy or custom requiring officers on the scene of a suicide attempt at a jail to leave an inmate found hanging while pictures were taken and until the medical examiner arrived. Furthermore, the county had sent Deputy Crutcher for training at the Tennessee Corrections Institute. If he failed to follow required procedures as instructed at the Institute — or forgot his instructions — the county cannot be held liable for his derelictions.
>
> This argument overlooks the fact that Sheriff Hicks was the sole policy maker for the conduct of jail officials. Deputy Crutcher testified that he followed jail policy in not cutting Heflin down and attempting to revive him....
>
> Both Crutcher and Hicks were trained in CPR. Furthermore, after the sheriff arrived at the jail he did nothing other than follow the same policy or custom described by Crutcher. In fact, after Dr. Lee arrived and directed that Heflin be cut down, Sheriff Hicks delayed that procedure until photographs could be taken of the hanging body....

> There clearly was evidence from which the jury could find that Heflin died as a proximate result of the failure of Sheriff Hicks and Deputy Crutcher to take steps to save his life (*Heflin* v. *Stewart County*, 1992, pp. 714, 720).

Although both ACA and NCCHC standards addressed the issue of intervention, neither offered specific protocols. For example, ACA standard 3-4351 required that "personnel are trained to respond to health-related situations within a four-minute response time. The training program ... includes the following: recognition of signs and symptoms, and knowledge of action required in potential emergency situations; administration of first aid and cardiopulmonary resuscitation (CPR)." NCCHC standard P-54 stated, "Intervention: The plan should address how to handle a suicide in progress, including appropriate first-aid measures."

NCIA's analysis found that only 12 departments of correction (23%) addressed the issue of intervention in their suicide prevention policy or other administrative directive. Of these DOCs, perhaps the Louisiana Department of Public Safety and Corrections' procedures best exemplified this critical component:

Suicide Attempt/Postsuicide Procedures:

Duties

a. First officer on scene
   - Notify other staff (call for help, activate beeper, etc.);
   - Get the victim down if hanging (using C-spine stabilization) (IMMEDIATE ACTION IS REQUIRED! SECONDS MAY SAVE A LIFE!);
   - Initiate first aid (control bleeding, begin CPR, etc.);
   - Policy permits single-officer cell entry to save life.

b. Second officer on scene
   - Request ambulance or medical assistance;
   - Assist with first aid as necessary;
   - Maintain security and preserve scene as much as possible.

c. Supervisor
   - Ensure that ambulance or medical response team has been called and is enroute;
   - Supervise and assist with first aid/CPR, as necessary, until medical assistance arrives;
   - Ensure that scene is preserved as much as possible;
   - Notify duty warden, institution's investigator, and mental health treatment staff so that the supervisor then can focus his full attention on the suicide incident. The duty warden is then to be responsible for notifying other appropriate institutional personnel;

- Ensure that staff cooperate with medical team's speedy entry of area and evacuation of victim.

d. EMTs, paramedics, or medical response team
   - Initiate advanced life support care, resuscitation, or other necessary life recovery treatment, commensurate with their training level;
   - Transport victim to the appropriate medical facility;
   - If death occurs, request that an autopsy be performed.

Equipment

Each single-cell lockdown cellblock housing unit shall have the following equipment immediately available to the officers on duty to be used in responding to suicide events:

a. An airway protection service
b. Surgical gloves
c. Blood stopper compression bandage
d. Large paramedic shears
e. Hoffman design 911 rescue tool
f. Pocket mask
g. Bite block.

Administrative Review

An administrative review is the final critical component of a comprehensive suicide prevention program. National correctional standards recommend that such reviews include 1) a critical review of the circumstances surrounding the incident; 2) a critical review of prison procedures relevant to the incident; 3) a synopsis of all relevant training received by involved staff; 4) a review of pertinent medical and mental health services involving the victim; and 5) any recommendations for changes in policy, training, physical plant, medical or mental health, and operational procedures.

The issue of administrative review was covered in two NCCHC standards. NCCHC standard P-54 stated that a suicide prevention policy should specify the procedures for medical and administrative review if a suicide does occur; standard P-09 stated:

> A mortality review, involving physicians, nurses, and others, seeks to determine if there was a pattern of symptoms [that] might have resulted in earlier diagnosis and intervention. Additionally, the review examines events immediately surrounding a death to determine if appropriate interventions were undertaken. Each inmate death should be compared with other inmate deaths to determine if it is part of an emerging pattern.

As shown in Table 2-1, NCIA's analysis found that only 14 departments of correction (27%) addressed the issue of administrative review in their suicide prevention policy or other administrative directive. The Pennsylvania Department of Corrections' policy on clinical review provided an excellent example:

> It is the policy of the Department of Corrections that the superintendent of a department facility shall cause a clinical review, of all successful suicides, to be conducted by appropriate staff. In cases of attempted suicide, it will be up to the discretion of the superintendent as to whether or not a critical review shall be conducted....The focus of the review should be twofold: what happened in the case under review and what can be learned to help prevent future incidents....
>
> The clinical review shall be a learning experience and, as such, shall be conducted in an open and honest manner with contributions encouraged from all staff in order to sharpen staff detection skills and help prevent unnecessary loss of life due to suicide. All information gathered as a result of the clinical review shall be confidential.
>
> ...Appropriate information, not the confidential report, will be shared with the institutional training coordinator, who in turn will present an annual in-service training seminar for all staff on recognition and prevention of suicide based on information gathered by the clinical review team.

Conclusion

With a few notable exceptions, most prison systems have not developed comprehensive suicide prevention programs as promulgated in either ACA or NCCHC standards. Although many DOCs had a suicide prevention policy, most were not comprehensive because they failed to adequately address the six critical suicide prevention protocols. Why the necessity for such scrutiny? Because, as one observer noted, while inmates do not always exhibit clearly visible signs and symptoms of suicidal behavior, comprehensive suicide prevention programming "will reduce the opportunity for suicide and should reduce the prison's potential liability as well" (Anno, 1991, p. 151).

Chapter 3

PRISON SUICIDE RATES: A 10-YEAR REVIEW

Suicide ranks third, behind natural causes and AIDS, as the leading cause of death in prisons (Bureau of Justice Statistics, 1993a). To measure the severity of the problem, researchers calculate the rate of suicide within individual prison systems, but to date few national studies of prison suicide rates have been conducted. The knowledge base is therefore limited to research on individual state prison systems. The state systems report widely disparate findings — 18.6 per 100,000 inmates in the Texas prison system (Anno, 1985); 39.6 for male prison inmates in Maryland (Salive et al., 1989); and 53.7 in the Oregon prison system from 1963 through 1987 (Batten, 1992). In addition, rates of suicide within the same prison system can vary widely from year to year — from 17 per 100,000 inmates in 1990 to 14 in 1992 to 25 in 1993 in California, for example (California Department of Corrections, 1994).

The limited research that is available on national prison suicide rates is both dated and plagued by inconsistent reporting. Previous calculations of national prison suicide rates for 1978 to 1979 and 1980 to 1983 found the rate for male inmates was 24.6 and 24.3, respectively (Lester, 1982, 1987). The calculations, however, were based on Bureau of Justice Statistics (BJS) data that was under-reported. For example, the most recent data available from BJS (1993a) reported a total of 89 prison suicides throughout the United States during 1991. That total, however, does not include data from "non-reporting" jurisdictions (the Federal Bureau of Prisons, Connecticut, the District of Columbia, Louisiana, Texas, and New Mexico) or reflect that an unknown number of suicides could be contained within the 17 percent of deaths reported to BJS as "unspecified causes." Excluding non-reporting jurisdictions, the national prison suicide rate, based on BJS data of 639,281 inmates in custody as of December 31, 1991, would be 13.9 suicides per 100,000 inmates. This rate is low, however, compared to other data. For example, an analysis of annual survey data from the Criminal Justice Institute (1992) and CEGA Publishing (1992), followed up by telephone calls to several jurisdictions, verified 127 prison suicides for all state and federal prisons during 1991. Thus, a more accurate national prison suicide rate for 1991 would be 16.4 per 100,000 inmates, based on 774,198 inmates in custody.*

NCIA Survey Findings

In its survey of DOCs in all 50 states, the District of Columbia, and the Federal Bureau of Prisons, NCIA asked each to supply the total number of suicides in its prison facilities and the total number of inmates in the prison facilities (in each case excluding state inmates held in county jails or other non-state facilities) as of December 31, 1993.

*The 1991 survey conducted by the Criminal Justice Institute received responses from all jurisdictions except Louisiana, resulting in the reporting of 120 prison suicides for that year. NCIA verified 7 additional suicides in Louisiana, Nebraska, Ohio, Vermont, and Virginia.

As shown in Table 3-1, NCIA was able to verify 158 suicides in state and federal prisons during 1993, excluding suicides that occurred outside the prison (i.e., while on work release or escape status, for example). Based on a total prison population of 889,836 inmates, the national suicide rate for 1993 was 17.8 per 100,000 inmates. Thus, the rate of suicide in U.S. prisons during 1993 was almost 50 percent greater than in the general population, calculated as 12.2 by the National Center for Health Statistics (1993). Reflecting its large prison population, California led all states with 29 suicides. Six jurisdictions (California, Michigan, New York, Ohio, Texas, and the Federal Bureau of Prisons) accounted for over 50 percent of all suicides and had a combined suicide rate of 19.9. Twelve states reported no prison suicides during 1993. Although 19 states had prison suicide rates above the national average of 17.8 (including extremely high rates in Alaska, Rhode Island, Vermont, and Wyoming), caution should be used in interpreting rates based solely on data from one year.

In an effort to review historical trends in the rate of prison suicides throughout the country, NCIA analyzed data from 1984 through 1992 (see Appendix B for a list of total prison suicides and rates by jurisdiction for that time period).*

Table 3-2 presents the aggregate 9-year total of prison suicides and rates combined with NCIA's 1993 data. As indicated, 1,339 suicides occurred in state and federal prisons throughout the country from 1984 through 1993, resulting in a 10-year suicide rate of 20.6. California led all states with 176 prison suicides, while New Mexico reported only 2 suicides during the 10-year period. New Mexico also had the lowest suicide rate (7.1), while North Dakota had the highest (101.7) — a misleading statistic since this prison system has not experienced an inmate suicide since 1988. In addition, 10 large jurisdictions (Arizona, California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, Texas, and the Federal Bureau of Prisons) accounted for almost 50 percent of all suicides, yet had a combined suicide rate **below** the national rate (17.8 vs. 20.6).

Table 3-2 also indicates that 31 jurisdictions had suicide rates above the national rate (including extremely high rates in Alaska, Minnesota, Montana, and North Dakota). At first glance it would appear that the seven jurisdictions operating dual systems of confining both pretrial and sentenced inmates had suicide rates that far exceeded the national average. From a low of 15.6 in the District of Columbia to a high of 87.3 in Alaska, these seven dual-system jurisdictions had a combined suicide rate of 34.4. Given the fact that pretrial inmates appear more vulnerable to suicide and the suicide rate in local jails is estimated to be more than nine times greater than in the community, the rate of suicide within dual prison systems is not surprising. It also appears, however, that the distinctiveness of jurisdictions with dual systems is **not** the sole cause of high suicide rates in prison systems throughout the country. As shown in Table 3-3, the seven smallest prison systems (excluding dual systems) had a combined suicide rate of 53.8 — more than two and one-half times greater than the national average.†

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*NCIA used the Criminal Justice Institute's *Corrections Yearbook* for each year from 1985 through 1993 and CEGA Publishing's *Corrections Compendium* for November 1992, June 1991, July/August 1989, September 1987, and February 1986. These two data sources were inconsistent. For example, the *Corrections Yearbook* for 1990 reported 145 prison suicides for 1989, while *Corrections Compendium* (June 1991) reported 120 suicides and BJS reported 113 prison suicides for that year. When it found inconsistencies, NCIA contacted the jurisdictions in dispute and was thus able to verify 146 prison suicides for 1989.

†West Virginia is included among the seven smallest states only because the smaller dual system of Vermont was excluded from the table. If Vermont replaced West Virginia in Table 3-3, the combined suicide rate of the seven smallest states would be 59.7.

TABLE 3-1
TOTAL PRISON SUICIDES AND RATES BY STATE, 1993

State	Suicides	Total Inmate Population	Rate
Alabama	1	16,363	6.1
Alaska*	2	2,703	74.0
Arizona	6	17,674	33.9
Arkansas	1	7,928	12.6
California	29	112,370	25.8
Colorado	2	7,877	25.4
Connecticut*	1	13,384	7.5
Delaware*	2	3,669	54.5
District of Columbia*	4	10,787	37.1
Florida	5	53,048	9.4
Georgia	3	27,722	10.8
Hawaii*	0	2,792	—
Idaho	0	2,266	—
Illinois	4	34,495	11.6
Indiana	2	14,470	13.8
Iowa	0	4,898	—
Kansas	0	5,664	—
Kentucky	1	8,622	11.6
Louisiana	2	16,067	12.4
Maine	0	1,545	—
Maryland	3	20,177	14.9
Massachusetts	1	9,652	10.4
Michigan	7	36,743	19.1
Minnesota	0	4,059	—
Mississippi	2	8,574	23.3
Missouri	1	15,409	6.5
Montana	0	1,254	—
Nebraska	1	2,453	40.8
Nevada	1	6,153	16.3
New Hampshire	0	1,846	—
New Jersey	3	20,500	14.6
New Mexico	0	3,510	—
New York	8	64,575	12.4
North Carolina	3	22,233	13.5
North Dakota	0	501	—
Ohio	8	40,253	19.9
Oklahoma	3	11,190	26.8
Oregon	3	6,545	45.8
Pennsylvania	3	26,060	11.5
Rhode Island*	2	2,700	74.1
South Carolina	1	17,263	5.8
South Dakota	1	1,507	66.4
Tennessee	2	11,474	17.4
Texas	17	66,664	25.5
Utah	1	2,621	38.2
Vermont*	1	875	114.3
Virginia	4	18,247	21.9
Washington	0	9,528	—
West Virginia	0	1,964	—
Wisconsin	3	8,783	34.2
Wyoming	3	1,048	286.3
Federal Bureau of Prisons*	11	81,131	13.6
TOTAL	**158**	**589,836**	**17.8**

*Dual system of both pretrial and sentenced inmates.

TABLE 3-2
TOTAL PRISON SUICIDES AND RATES BY STATE, 1984 THROUGH 1993

State	Suicides	Total Inmate Population	Rate
Alabama	17	122,117	13.9
Alaska*	20	22,921	87.2
Arizona	38	125,059	30.4
Arkansas	13	59,459	21.9
California	176	779,724	22.6
Colorado	17	54,005	31.5
Connecticut*	32	85,857	37.3
Delaware*	7	30,625	22.9
District of Columbia*	13	83,309	15.6
Florida	43	385,035	11.2
Georgia	34	205,828	16.5
Hawaii*	7	22,416	31.2
Idaho	7	16,763	41.8
Illinois	38	242,998	15.6
Indiana	20	117,613	17.0
Iowa	6	37,667	15.9
Kansas	12	53,604	22.4
Kentucky	14	66,357	21.1
Louisiana	28	128,667	21.8
Maine	9	13,325	67.5
Maryland	30	154,341	19.4
Massachusetts	26	79,177	32.8
Michigan	43	258,742	16.6
Minnesota	27	30,584	88.3
Mississippi	17	70,443	24.1
Missouri	25	129,297	19.3
Montana	10	12,076	82.8
Nebraska	10	22,024	45.4
Nevada	21	49,989	42.0
New Hampshire	3	11,612	25.8
New Jersey	26	150,391	17.3
New Mexico	2	28,134	7.1
New York	53	482,915	11.0
North Carolina	25	184,832	13.5
North Dakota	5	4,917	101.7
Ohio	49	286,364	17.1
Oklahoma	32	93,380	34.3
Oregon	13	51,497	25.2
Pennsylvania	49	189,297	25.9
Rhode Island*	12	20,410	58.8
South Carolina	21	130,515	16.1
South Dakota	6	12,078	49.7
Tennessee	23	83,624	27.5
Texas	89	451,677	19.7
Utah	13	21,834	59.5
Vermont*	3	7,468	40.2
Virginia	28	136,814	20.5
Washington	22	72,394	30.4
West Virginia	3	15,175	19.8
Wisconsin	10	66,509	15.0
Wyoming	6	8,821	68.0
Federal Bureau of Prisons*	86	528,541	16.3
TOTAL	**1,339**	**6,499,221**	**20.6**

*Dual system of both pretrial and sentenced inmates.

TABLE 3-3
TOTAL PRISON SUICIDES AND RATES IN THE SEVEN SMALLEST STATE PRISON SYSTEMS, 1984 THROUGH 1993

State	Suicides	Total Inmate Population	Rate
Maine	9	13,325	67.5
Montana	10	12,076	82.8
New Hampshire	3	11,612	25.8
North Dakota	5	4,917	101.7
South Dakota	6	12,078	49.7
West Virginia	3	15,175	19.8
Wyoming	6	8,821	68.0
TOTAL	**42**	**78,004**	**53.8**

Although it might be assumed that prison systems with high suicide rates would mirror the suicide rate in their respective communities, current data does **not** support this proposition. According to National Center for Health Statistics (1993) data, with the exceptions of Montana and Wyoming, all of the seven smallest and dual-system jurisdictions with high prison suicide rates had general population suicide rates comparable to the national average of 12.2.* Perhaps a better explanation for the high prison suicide rates in these states is that, although all prison systems are plagued by limited resources, the strain is more acute in smaller jurisdictions.

The most encouraging finding from NCIA's survey is the gradual **decrease** in the rate of prison suicides throughout the country during the past 10 years. As shown in Table 3-4, after a high of 27.2 in 1985, the prison suicide rate in subsequent years declined steadily, to a low of 16.1 in 1992. Although the rate of prison suicides rose nationally to 17.8 in 1993, the

TABLE 3-4
TOTAL PRISON SUICIDES AND RATES, 1984 THROUGH 1993

Year	Suicides	Total Inmate Population	Rate
1984	121	446,212	27.1
1985	132	485,301	27.2
1986	126	522,780	24.1
1987	139	554,654	25.1
1988	139	598,239	23.2
1989	146	672,193	21.7
1990	118	730,486	16.2
1991	127	774,198	16.4
1992	133	825,322	16.1
1993	158	889,836	17.8
TOTAL	**1,339**	**6,499,221**	**20.6**

*The following distribution indicates suicide rates in the general population in small and dual-system jurisdictions: Alaska (12.8), Connecticut (10.0), Delaware (11.6), District of Columbia (5.6), Hawaii (9.4), Maine (14.3), New Hampshire (11.7), North Dakota (11.6), Rhode Island (8.2), South Dakota (13.5), Vermont (16.2), West Virginia (13.3), Wyoming (18.9). In addition, Minnesota's 10-year suicide rate was 88.3, yet its suicide rate for the general population was only 11.5.

increase could indicate an upward trend or merely an aberration. In addition, the declining prison suicide rate nationwide during the past 10 years is punctuated by a dramatic drop from 21.7 in 1989 to 16.2 in 1990. In fact, from 1984 through 1989, the rate of prison suicides throughout the country was 24.5, but from 1990 through 1993, the rate dropped to 16.6.

Although the reason behind this reduction is unknown, several jurisdictions were primarily responsible for the decline. As shown in Table 3-5, suicide rates in 14 state prison systems decreased 50 percent or more from 1984 to 1989 compared to 1990 to 1993. During 1990 to 1993, these 14 states had a combined suicide rate of 13.5 — a decline of more than 60 percent from the 1984 to 1989 rate of 34.6. Only three states (Delaware, Vermont, and Wyoming) experienced increases of more than 50 percent during these periods.

It is noteworthy that three other states experienced substantial reductions in prison suicide rates from 1984 to 1991 compared to 1992 and 1993: an 82 percent reduction in Connecticut (48.9 versus 8.9), 58 percent in Missouri (22.5 to 9.5), and 54 percent in Pennsylvania (30.2 to 13.9).

TABLE 3-5
STATES WITH DECLINING PRISON SUICIDE RATES OF 50% OR MORE

State	1984-1989	1990-1993
Georgia	23.3	9.1
Hawaii	41.2	19.6
Idaho	57.7	23.8
Indiana	23.4	9.4
Kansas	29.4	13.0
Maryland	26.3	12.1
Minnesota	118.3	55.1
Montana	123.7	35.7
New Hampshire	59.9	—
New Jersey	24.7	9.5
North Dakota	177.4	—
Rhode Island	81.9	37.6
Washington	42.7	17.2
West Virginia	35.4	—
TOTAL AVERAGE	**34.6**	**13.5**

Conclusion

What is the significance of these findings? While the current data does not allow for a comparative analysis of prison suicide rates and prevention programs, the data does provide several interesting findings. First, the rate of suicide in prisons throughout the country during the past 10 years was 20.6 deaths per 100,000 inmates — a rate more than 50 percent greater than that of the general population yet far below the rate of jail suicides. Second, states with small prison populations appear to have exceedingly high rates of suicide — often more than two and one-half times greater than the national average. Third, apart from 1993, the rate of prison suicides has gradually and steadily declined throughout the country since 1985, punctuated by a dramatic decline after 1989. In fact, rates have decreased 50 percent or more in 14 state prison systems since 1989.

Finally, the prison suicide rate for 1993 — 17.8 — could indicate an upward trend or merely an aberration. Significant, however, is that 15 states experienced higher rates of prison suicide during 1993 compared to their 9-year averages (1984 to 1992).[6] Haycock (1991) has written that several recent developing characteristics of prisons suggest higher suicide rates in the future: mandatory sentencing laws, dramatic increases in death penalty and life sentences, overcrowded prison systems, increased cases of AIDS, and the graying of the inmate population could instill despair and hopelessness in inmates. Only time will determine whether 1993 was an aberration or a sign of an upward trend.

[6]For example, from 1984 through 1992, California paralleled the rest of the country with a gradually declining prison suicide rate — from a high of 43.1 in 1984 to a low of 14.4 in 1992. In 1993, however, 29 suicides occurred, resulting in a rate of 25.8. The other 14 jurisdictions experiencing varying rates of increase during 1993 were Arizona, Delaware, District of Columbia, Michigan, New York, Ohio, Oregon, Rhode Island, South Dakota, Texas, Vermont, Virginia, Wisconsin, and Wyoming.

Chapter 4

EFFECTIVE SUICIDE PREVENTION PROGRAMS IN STATE PRISONS

While most state prison systems have developed basic suicide prevention policies, few are comprehensive. A handful of effective programs operating in state prisons throughout the country, however, have reduced incidents of inmate suicide. In its survey, NCIA asked whether DOCs could identify any model suicide prevention programs and, if so, send information about them. Through this solicitation, NCIA received affirmative responses from 10 DOCs and subsequently began a preliminary evaluation of the nominated programs.

The determination of what constituted a model suicide prevention program was predicated on two conditions: 1) the prison facility adhered to each of the six critical components of a **written** suicide prevention policy (staff training, intake screening/assessment, housing, levels of supervision, intervention, and administrative review), and 2) the facility had an extended suicide-free period. Although responses from many of the nominated programs reflected adequate suicide prevention procedures, the programs were ultimately removed from final consideration because they lacked more than one of the six critical suicide prevention components and/or had experienced a recent suicide. And although none of the 10 prisons could be said to operate model programs, two facilities — Elayn Hunt Correctional Center in St. Gabriel, Louisiana, and the State Correctional Institution-Retreat in Hunlock Creek, Pennsylvania — were selected as best exemplifying highly effective prison suicide prevention programs. An onsite visit was made to both facilities to develop case studies.

Elayn Hunt Correctional Center

Opened in 1979, the Elayn Hunt Correctional Center (EHCC) is a multi-security-level adult institution in St. Gabriel, Louisiana. As the second largest prison in the state with a capacity for 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). During a 14-day period, inmates receive a complete medical examination, thorough psychological assessment, and in-depth classification review. Inmates are then assigned and transferred to one of 11 prison facilities in the state.

EHCC receives and holds a variety of inmates, including those assigned to the general prison population, disciplinary transfers from other facilities, prisoners with mental health problems and those at medical risk, participants in boot camp, those serving life sentences, and trustees assigned to work crews. In addition to offering normal institutional programming (education, employment, boot camp, for example), EHCC serves as the department's central mental health facility and medical center for all seriously or chronically ill minimum- and medium-security inmates. The institution is staffed 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. These personnel also assist with intake procedures for the Louisiana Correctional Institution for Women, located nearby. In addition to providing a full array of medical services, EHCC offers a comprehensive mental health program, including a variety of individual and group counseling sessions covering transitional adjustment for newly incarcerated inmates, HIV/AIDS, substance abuse, problem-solving, and crisis intervention programs (including suicide prevention).

The Louisiana prison system has not always been known for comprehensive programming and constitutionally adequate conditions of confinement. Since the 1970s, the entire prison system has been under litigation for overcrowding and a variety of other unconstitutional conditions. In 1975, one federal judge found that conditions at Louisiana State Penitentiary in Angola (the largest prison in the state and the primary focus of litigation) "shocked the conscience." In June 1989, another federal judge declared a state of emergency at Angola, citing a rash of stabbings, escapes, murders, and other deaths, including five inmate suicides in one year. In February 1991, conditions in the Angola prison improved and the state of emergency was lifted (see *Williams* v. *McKeithen*, 1991). In January 1992, Richard L. Stalder was appointed secretary of the Louisiana Department of Public Safety and Corrections. As a career professional who rose from the ranks of correctional officer to warden, he set as first priorities improvement of confinement conditions within the prisons and obtaining ACA accreditation, thereby working toward removing the 11 facilities from the federal courts' jurisdiction. To date, most of the state prisons have been accredited by ACA, and 8 of the 11 facilities have been released from federal court oversight.

Formal adoption of correctional standards through accreditation does not always ensure that a prison has put those standards into operation. Under the leadership of Warden C.M. Lensing, however, the Elayn Hunt Correctional Center not only has been accredited by ACA, but also operates a highly successful suicide prevention program. EHCC's suicide prevention program is detailed in Institutional Policy No. 400-B1, Suicide Prevention and Intervention, which addresses the six critical components of such a program. As indicated in Table 4-1, 57,091 inmates were processed through the ARDC from January 1983 through October 1994

TABLE 4-1
TOTAL ANNUAL ADMISSIONS VERSUS TOTAL ANNUAL SUICIDES, 1983 THROUGH 1994

Year	ARDC/EHCC Admissions	Total Suicides
1983	3,719/including 854 at EHCC	1
1984	3,702/809	0
1985	3,874/870	0
1986	3,672/976	0
1987	4,616/1,304	0
1988	4,337/1,164	0
1989	4,826/1,125	0
1990	5,147/1,019	0
1991	5,523/846	0
1992	6,946/850	0
1993	6,188/767	0
1994 (through October)	4,541/450	0
TOTAL	**57,091/11,034**	**1**

(including 11,034 prisoners assigned to EHCC for housing). During this approximate 12-year period, only one inmate committed suicide at EHCC (in 1983).

Staff Training

All EHCC staff providing direct care (including administrative, managerial, correctional, mental health, and medical personnel) receive two hours of training in potential-suicide recognition and intervention **each** year. The training sessions, held each Friday morning throughout the year, include instruction on how to identify suicidal behavior and the components of the facility's suicide prevention policy. In addition, all staff receive four hours of instruction in first aid and four hours of training in CPR annually.

Intake Screening/Assessment

Upon admission to the ARDC, all inmates receive Preliminary Health Screening by the medical staff, which includes questions about current and prior suicide risk.* They also are screened for assessment and intervention by mental health staff during processing, providing more information about risk of suicide. Although medical and mental health staff can often identify suicide risk during the 14-day process, other direct-care staff (including supervisory and correctional line officers) are also in a position to identify an inmate's suicidal behavior and report the potential risk through the Mental Health Behavior Checklist. This form lists various factors that are commonly displayed by suicidal inmates: self-destructive acts, suicidal/homicidal ideation, critical changes in one's life, depression, mood changes, agitation, hostility, insomnia/hypersomnia, bizarre behavior, for example. The Mental Health Behavior Checklist is used not only to identify suicidal behavior, but also to communicate the concerns of the direct-care staff to mental health and medical staff for initiation of suicide prevention procedures.

When an inmate is identified as potentially suicidal, mental health staff assess the situation and, if warranted, authorize the inmate to be placed on **standard** or **extreme** suicide watch. (In the absence of mental health staff, medical staff can authorize a suicide watch.) The Mental Health Management Order designates the location of housing, restrictions in personal property, and level of supervision. Mental health staff reassess all inmates placed on suicide watch every 24 hours. Only mental health staff (or an attending physician) may upgrade, downgrade, or discontinue a suicide watch.

Housing

Although more than 15 years old, the EHCC physical plant is in impeccable condition. The facility houses suicidal inmates in two locations: D-1 Cellblock, and the infirmary's 24-Hour Unit. The D-1 Cellblock contains six cells designated for inmates placed on standard suicide watch. Two of the cells allow high visibility of inmates on extreme watch. Each cell contains closed-circuit television (CCTV), which provides supplemental observation of the

*Reformatted copies of all suicide prevention protocol forms used at EHCC are shown in Appendix C.

inmate. Whenever possible, two inmates are assigned to a cell to avoid isolation. If an inmate must be placed alone in a cell, security officers are encouraged to attempt frequent conversations with the inmate. The infirmary's 24-Hour Unit contains 30 beds, three of which are reserved for inmates placed on extreme suicide watch who might require four-point restraints and have accompanying medical problems. Mental health or medical staff decide what clothing and bedding to issue each inmate on suicide watch.

Levels of Supervision

Standard suicide watch is used for inmates who are not actively suicidal but have expressed thoughts of suicide and/or have a prior history of suicidal behavior. **Extreme** suicide watch is used for inmates who present a clear and/or continual risk of self-destructive behavior — banging their heads against a wall or cell bars, threatening to do so, or tying linen to themselves and the cell bars. The frequency of observation for both watch levels varies from 15-minute intervals to continual observation, with each observation (particularly for extreme watch) normally averaging every 5 minutes. Correctional staff document each observation on the inmate's Suicide Watch Log Sheet. Further, within the prescribed interval, additional observations are made occasionally and randomly to thwart the planning of self-destructive acts.

One correctional officer is assigned to the six cells reserved for suicidal inmates in the D-1 Cellblock. The 24-Hour Unit, in addition to supervision by correctional staff, is staffed around the clock by medical personnel who observe inmates on suicide watch. Medical staff monitor all inmates placed in restraints every two hours. In addition, within 12 hours of starting extreme watch, mental health staff confer with both the psychiatrist and physician about the continued suitability of the watch level and the treatment plan for the inmate.

The following recent case history of inmate John Doe illustrates the suicide prevention assessment, housing, and supervision protocols at EHCC.

> John Doe arrived at the facility's ARDC on Thursday, July 7, 1994. Medical staff performed a preliminary health screening, and a psychological associate administered an assessment and intervention screening. The assessment revealed that Doe had a recent history of mental health problems and had been admitted to a psychiatric hospital in 1993. It also determined that he currently was taking psychotropic medication and participated in out-patient therapy for depression. Doe admitted to a significant history of substance abuse with cocaine addiction and reported a history of numerous suicidal gestures, the most recent of which had occurred in November 1993. During the interview, Doe showed significant depression and anxiety and reported some thoughts of suicide in the recent past, although he denied any current thoughts.
>
> Based on the assessment, Doe was placed on standard suicide watch with supervision at 5-minute intervals. He was assigned to

the D-1 Cellblock and placed in a cell with closed-circuit TV. He was issued a paper gown and mattress but deprived of all other property. Mental health staff saw Doe the following day and reported "passing suicidal thoughts with some depression." The suicide watch was continued. Doe was seen again on July 9, when he claimed he was "feeling better" and denied having thoughts or plans of suicide. Staff noted, however, that he still exhibited depression with anxiety and kept him on suicide watch. The following day, he continued to deny suicidal thoughts but continued to display depression and mental anguish; as a precaution, he remained on suicide watch an additional day. On July 11, Doe's mood was found to be more appropriate, with no significant depression. He continued to deny having suicidal thoughts and did not display any distress. Based on his improved condition, Doe was removed from standard suicide watch and placed on mental health observation; his clothes were returned and supervision was downgraded to 15-minute intervals. The following day, Doe told the social worker he was feeling safe and in good spirits. The psychiatrist saw him on July 13 and subsequently removed him from mental health observation.

Doe was transferred to a general population housing unit at EHCC, scheduled to see a psychiatrist during the following month, and provided with routine services and psychiatric counseling as needed until discharge from prison.

Intervention

EHCC follows excellent intervention procedures in the event of a suicide attempt. In addition to staff trained in first aid and CPR, each of the three housing compounds at the facility is assigned at least two correctional officers certified as "first responders" (i.e., with advanced first aid training). The facility also has a fully operational ambulance for transporting patients to the local hospital in Baton Rouge, and the control desk in each housing unit is equipped with oxygen tanks and a fully stocked "suicide prevention kit." Shaped like a carpenter's tool box, the kit contains first aid items (e.g., 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 tool designed to cut a variety of materials that could be used in attempted hangings. Correctional officers in the Louisiana Department of Public Safety and Corrections are trained to respond promptly to emergencies, call for assistance, initiate first aid and CPR if necessary, and transport the victim to a medical facility.

*A less formal review is also made by the team for all serious suicide attempts.

Administrative Review

Following a suicide, EHCC policy requires that a formal post-suicide investigation be conducted by a four-member team comprised of a mental health worker, a correctional investigator, a security supervisor (from the housing unit where the incident occurred), and a medical staff member (physician, registered nurse, or paramedic).* The team interviews staff and inmates, reviews pertinent documents, and prepares and forwards a report to the warden and the secretary of the Department.

Following his appointment in 1992, Secretary Stalder established a departmental Suicide Review Committee to better coordinate comprehensive suicide prevention practices across all 11 prison facilities and to supplement internal investigations. The committee is comprised of correctional, mental health, and medical personnel from each facility. Chaired by the EHCC mental health director, the committee meets at least twice yearly as well as following an incident to review the circumstances surrounding all serious suicide attempts or suicides and, when appropriate, recommend revisions to operational procedures. Since 1992, the committee has recommended more than 72 changes to procedures at individual facilities, based on 6 suicides and 17 serious attempts throughout the state prison system. The following excerpts are from 10 of those recommendations.

- Intensified staff training in suicide prevention, training in the use of emergency life support techniques and procedures, and enhanced efforts to increase security observation rounds in high-risk areas for suicide attempts are considered crucial elements in recognizing and preventing suicide.

- Enhance efforts TO KEEP AN INMATE UNDER CONSTANT SURVEILLANCE following a suicide threat until the inmate is under a suicide watch.

- Initiate institutional systems to ensure that all concerned personnel (security, classification, clergy, mental health, and medical staff) are immediately alerted if an inmate indicates he is thinking about suicide. An exchange of pertinent information in this regard can aid in the prevention of suicide.

- Security staff should thoroughly shake down suicide observation cells to ensure the total removal of potential suicide apparatus.

- Periodically check vent plates in cells used for suicide watches to guard against using the vent plate as apparatus in attempted hangings.

- Security, medical, and mental health staff should make a concerted effort to intensify and expand the frequency of [their]

time spent in high-risk areas (cell blocks, administrative lockdown, isolation, protective custody, etc.) to identify and prevent suicide attempts.

- Detailed information should be included in the inmate's record as to the reason(s) the suicide watch was initiated, continued, and discontinued.

- When indicated, mental health staff should continue follow-up of an inmate who has experienced the recent death of a family member.

- In view of the trauma experienced from capture and rearrest, prison escapees should be closely and frequently monitored.

- Staff should make a more comprehensive effort to transfer all of a prisoner's pertinent mental health data to and from all facilities with a transfer (including transfer of information via telephone from mental health staff at the sending facility to mental health staff at the receiving facility).

According to the committee chairperson, Nancy Gautreau, "One of the most tragic, debilitating events that can happen to a prison is an inmate suicide. It will shake your structure. The initial response is always — 'What happened? Who was making the rounds? Did the inmate need mental health services?' We try to instill the attitude that there must have been something we could have done to prevent that suicide."*

The actions adopted systemically by the Louisiana Department of Public Safety and Corrections (symbolized through the efforts of the Suicide Review Committee) have resulted in a comprehensive suicide prevention policy and a recent reduction in the number of prison suicides throughout the state. As indicated in Table 4-2, during the 9 years from 1984 through 1992, the department experienced 26 prison suicides, reflecting a rate of 23.1 suicides per 100,000 inmates; during several of those years, the state's prison suicide rate was almost twice the national average. During 1993, however, the rate dropped to 12.4 suicides per 100,000 inmates — a reduction of almost 50 percent from the 9-year rate. And as of October, the entire state prison system had not experienced an inmate suicide during 1994.

*Interview with author, June 2, 1994.

TABLE 4-2
ANNUAL PRISON SUICIDE RATES IN LOUISIANA
1984 THROUGH 1994

Year	Total Suicides	Total Inmate Population	Rate
1984	1	10,575	9.5
1985	2	10,637	18.8
1986	5	10,684	46.8
1987	—	11,206	—
1988	4	11,895	33.6
1989	5	12,896	38.8
1990	3	13,849	21.7
1991	2	14,508	13.8
1992	4	16,350	24.5
1993	2	16,067	12.4
1994 (through October)	—	15,594	—
TOTAL	28	144,261	19.4

Conclusion

The suicide prevention program at the Elayn Hunt Correctional Center is not perfect, and observers could argue that the policy should be revised to include additional hours for pre-service training in suicide prevention, clearer procedures for constant observation of extreme watch inmates, and that automatic restraints for inmates on extreme watch are not necessary. Few observers, however, could argue with the program's overall success: 1 suicide in almost 12 years and 57,091 admissions. Warden Lensing summarizes his approach to suicide prevention at EHCC: "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."*

State Correctional Institution at Retreat

The State Correctional Institution (SCI) at Retreat is located in Hunlock Creek, Pennsylvania. In 1878, an almshouse was established at the site to provide care for indigents. In the 1880s, a hospital for the insane was added to treat those with mental illness. During the first part of this century, the facility was known as the Retreat Hospital for the Insane and Almshouse. It was converted to the Retreat State Mental Hospital in the late 1940s, closed in 1981, and reopened as SCI-Retreat in January 1988.

SCI-Retreat is a medium-security institution with the capacity for 480 male inmates (although it now houses more than 820 inmates). In contrast to Louisiana's EHCC, it does not provide comprehensive reception and diagnostic services, and it is not designed for long-term

*Interview with author, June 2, 1994.

mental health care. SCI-Retreat's professional staff include a full-time psychologist, social worker, part-time psychiatrist, part-time physician, and 15 nurses providing 24-hour onsite medical care.

According to Lance Couturier, Ph.D., chief of psychological services for the Pennsylvania Department of Corrections, "1989 was a bad year: SCI-Camp Hill was hit with a riot and burned down, SCI-Graterford was locked down, and a disturbance occurred at SCI-Huntingdon. And by the end of the year, the department ranked fourth in the country in the number of inmate suicides."* In November 1990, a class-action lawsuit alleging overcrowded conditions, poor health care, violence, and inadequate programming (*Austin* v. *Pennsylvania Department of Corrections, et al.*, 1990) was filed against 13 of 22 DOC facilities.

In January 1990, Joseph D. Lehman was appointed commissioner of the Pennsylvania DOC. He immediately began to focus on relieving overcrowding, improving conditions of confinement, and addressing the other issues raised in *Austin*.† The DOC began analyzing incidents of suicidal behavior and found high concentrations of self-destructive conduct and mental illness in inmates confined to administrative segregation, referred to as "restrictive housing units" (RHUs). As alleged in the *Austin* lawsuit, many inmates were confined in the RHUs for prolonged periods without ongoing mental health services.

In an effort to provide more comprehensive mental health services, the DOC's Psychological Services Division created a psychiatric review team (PRT) in each prison. Each PRT, comprised of the facility's chief psychologist, a psychiatrist, the inmate program manager, and selected unit managers, meets regularly to review case files of inmates who have difficulty adjusting or whose behavior is related to emotional problems and require more in-depth evaluation, closer monitoring, and support. One of the PRT's goals is to reduce a mentally ill inmate's confinement in an RHU through prompt intervention, continuing care, and, when appropriate, transfer to one of four DOC mental health units or state Department of Public Welfare (DPW) forensic units. For example, according to Dr. Couturier, "If a suicidal inmate needs to be under constant watch for more than 24 hours, he probably will require commitment to a mental health unit."††

As a result of chronic overcrowding throughout most of the prison system and to protect against inmates who need mental health services from slipping through the cracks, each PRT keeps an active roster of inmates with mental illness and/or mental retardation and tracks their movements to and from DOC mental health units, DPW forensic units, and SCIs. Inmates tracked through the PRT roster include those having a serious psychiatric problem, found guilty but mentally ill, receiving psychotropic medication, having a history of psychiatric hospitalization, suffering from mental retardation, and exhibiting suicidal behavior within the past two years.

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*Behind California, New York, and the Federal Bureau of Prisons. Interview with author, June 28, 1994.

†On August 1, 1994, both parties in *Austin* signed an 87-page "proposed settlement agreement" to end further litigation of the suit.

††Interview with author, June 28, 1994.

In March 1991, the DOC introduced unit management to all state correctional institutions, with decisions regarding inmate control, programming, and overall operation of housing units decentralized and delegated to a unit team. The goal of unit management is to instill teamwork and facilitate communication and interaction between staff and inmates. A side benefit is that, through frequent interaction with inmates, the unit's staff are in a better position to identify potentially self-destructive behavior and thwart suicide attempts.

As indicated in Table 4-3, the number of inmate suicides in the Pennsylvania DOC has declined markedly since 1991, coinciding with the introduction of unit management and a comprehensive suicide prevention policy. During the 7 years from 1984 through 1990, 39 suicides occurred, reflecting a rate of 33.6 suicides per 100,000 inmates. (The 8 suicides during 1989 represented a rate of 41.6 suicides per 100,000 inmates.) During the 3 years from 1991 through 1993, however, only 10 suicides occurred, with a rate of 13.7 suicides per 100,000 inmates — a reduction of more than three times the previous 7-year rate and well below the national average.

TABLE 4-3
ANNUAL PRISON SUICIDE RATES IN PENNSYLVANIA
1984 THROUGH 1993

Year	Total Suicides	Total Inmate Population	Rate
1984	5	13,126	38.1
1985	2	14,260	14.0
1986	7	14,824	47.2
1987	3	15,877	18.9
1988	7	17,494	40.0
1989	8	19,236	41.6
1990	7	21,399	32.7
1991	3	22,794	13.2
1992	4	24,227	16.5
1993	3	26,060	11.5
TOTAL	**49**	**189,297**	**25.9**

Dr. Couturier cites several reasons for the reduction in inmate suicides: the commissioner's leadership, the introduction of unit management, and a generally increased awareness of suicide prevention. According to Dr. Couturier, "SCI-Retreat is a good example of what we have tried to accomplish with our suicide prevention policy. Both the administrative and unit staff at Retreat know all the inmates under their custody, they try to provide a continuum of care so that behavior does not escalate into a crisis, and they don't particularly like to use the restrictive housing unit — all key factors in suicide prevention."* SCI-Retreat's suicide prevention program is based on Chapter 9 of the DOC's *Mental Health Procedures Manual*, "Procedures for Dealing with Potentially Suicidal Inmates and Inmates Who Attempt Suicide."† The policy addresses all six critical components of a suicide prevention program.

*Interview with author, June 28, 1994.

†A reformatted copy of Chapter 9 is shown in Appendix D.

Staff Training

All staff who have contact with inmates are trained annually on the signs and symptoms of suicidal behavior and on DOC procedures for preventing suicide. New employees receive 1.5 hours of suicide prevention training and 1.5 hours of mental health training at the DOC Training Academy. Thereafter, 2-hour training sessions in suicide prevention/mental health and in first aid and CPR are held annually at the facility.

Intake Screening/Assessment

Before admission to SCI-Retreat, inmates are processed at one of three DOC Diagnostic and Classification Centers, where they receive a full medical and psychological examination and are assessed for suicide risk. Upon entering SCI-Retreat, all inmates are administered a Receiving Screening Form by medical and mental health staff, which includes queries about current and prior suicide risk. The initial reception committee (comprised of the inmate program manager and psychologist) also assesses inmates to determine housing and work assignments and identify any special needs, including the potential for suicide.

In addition, if a correctional officer observes an inmate displaying any signs of suicidal behavior, such as threats, depression, or self-mutilation, the unit manager is notified and the inmate is immediately referred to the mental health staff. The psychologist meets with the inmate and evaluates the level of suicide risk using the Suicide Potential Checklist (see Table 4-4). If warranted,

TABLE 4-4
SUICIDE POTENTIAL CHECKLIST AT SCI-RETREAT

- ☐ Has the inmate sustained a recent loss (loved one, friend, home, job) or a series of losses?
- ☐ Is the inmate depressed?
- ☐ Does he have a religious and/or philosophical background that supports suicide?
- ☐ Does he believe that suicide is an acceptable release (from prison, life)?
- ☐ Is he socially isolated from other inmates and staff (without friends and other social support systems)?
- ☐ Is this the first time in prison?
- ☐ Does he seem overly embarrassed, ashamed, or guilty about the crime committed?
- ☐ Has inmate been previously treated for mental illness, emotional disturbance?
- ☐ Does inmate have a history of self-destructive acts?
- ☐ Has a member of his family attempted suicide?
- ☐ Does he think about suicide at this time?
- ☐ Is he psychotic?
- ☐ Is he hearing voices telling him to kill himself?
- ☐ Has inmate expressed wish to die or failed to perform life-saving acts?
- ☐ Does inmate have terminal medical condition?
- ☐ Does inmate talk or think about giving possessions away or writing a will?
- ☐ Does inmate talk about a particular method/plan for killing himself?
- ☐ Is that method/plan available?

the inmate is placed under suicide watch. In the absence of mental health staff, the medical staff or shift commander may initially authorize a suicide watch, with the psychologist conducting a formal evaluation the following day. All inmates placed on suicide watch are reassessed by mental health staff every 24 hours. Only mental health staff, including the psychiatrist, may upgrade, downgrade, or discontinue a suicide watch. In addition, if the psychiatric review team determines, during its review of an inmate placed on suicide watch, that the inmate needs extensive mental health services, the PRT attempts to commit the inmate to a DPW forensic unit or transfer the individual to another SCI with a mental health unit.

Housing

Pursuant to DOC policy, the restrictive housing unit is **not** used for suicide watch at SCI-Retreat. All inmates placed on suicide watch are housed in the medical infirmary. The unit has four cells — two four-bed wards, one medical isolation cell, and one suicide observation cell directly next to the officers' station. Mental health and medical staff decide case by case whether to issue clothing and bedding and, if so, which articles. Restraints are used only as a last resort when the inmate is engaging in self-destructive behavior.

Levels of Supervision

Close watch is used for inmates who are not actively suicidal but have the potential for self-injury (e.g., an inmate who cannot give a firm commitment not to harm himself). The officer assigned to the infirmary visually checks inmates on a staggered 15-minute basis. **Constant watch** is reserved for actively suicidal inmates who threaten or engage in self-injury. The infirmary officer observes such inmates continuously and without interruption. **Regular watch**, the third level of supervision, requires observation at 30-minute intervals and is used to de-escalate inmates from higher watch levels. Observations during close and regular watch are documented on the inmate's Suicide Watch Checklist as the checks occur; observations during constant watch are documented at 15-minute intervals. In addition, nursing staff also observe all suicide watch inmates at 15-minute intervals, and the psychologist (or psychiatrist) monitors inmates daily.

Intervention

Each of the four general population housing units, the restrictive housing unit, and the infirmary contain a first aid kit, disposable pocket masks, and a tool for cutting materials used in attempted hangings. In addition to annual staff training in first aid and CPR, correctional officers are trained to respond promptly to emergencies, call for assistance, and initiate first aid and CPR if appropriate. When necessary, inmates who have attempted suicide are transported to Wilkes-Barre General Hospital by privately contracted ambulance personnel.

Administrative Review

Following a suicide or serious attempt, all SCI-Retreat staff who came into contact with the inmate before the incident are required to submit a factual statement of the

circumstances leading to the event. In addition, a "clinical review of suicide" is conducted within five days of the incident.* At SCI-Retreat, a Clinical Review Team (CRT) comprised of mental health, medical, and correctional personnel interviews staff and inmates and reviews written records of the incident to determine what factors precipitated the suicide or attempt and what action, if any, is necessary to reduce the likelihood of future incidents. According to DOC policy, the clinical review is to be a learning experience and is to be conducted openly and honestly. Contributions are encouraged from all staff to sharpen their detection skills and to help prevent unnecessary loss of life. All information gathered during a clinical review is confidential.

At the conclusion of the clinical review, the CRT chair (the SCI-Retreat psychologist) writes a report to the superintendent covering the team's findings and recommendations. A copy of the report is forwarded to the DOC regional office and then to the central office. The report may subsequently be used to correct action within the facility, revise DOC policy, and/ or as a tool for annual training.

Conclusion

Although it lacks written intervention procedures and staff would benefit from additional hours of suicide prevention training, the suicide prevention program at SCI- Retreat exemplifies a highly effective approach to the problem of suicide among prison inmates. From its opening in 1988 to 1994, the facility had not experienced an inmate suicide, despite 3,477 admissions.

*A reformatted copy of DOC Policy Statement 7.3.5, "Clinical Review of Suicide," is included in Appendix D. Although clinical reviews are required for all completed suicides, prison superintendents can decide whether a clinical review is warranted in cases of attempted suicide. At SCI-Retreat, the superintendent authorizes clinical reviews for all serious suicide attempts.

Chapter 5

SUICIDE PREVENTION IN FEDERAL PRISONS: A SUCCESSFUL FIVE-STEP PROGRAM

by

*Thomas W. White, Ph.D., and Dennis J. Schimmel, Ph.D.**

Although suicide is a relatively infrequent occurrence, it is a leading cause of death in jails (Bureau of Justice Statistics, 1993b) and prisons (Salive et al., 1989). While the rate of suicide for incarcerated offenders varies among local, state, and federal jurisdictions and among types of institutions, it is now generally accepted that suicide occurs more frequently in prisons and jails than in the general population (Hayes and Rowan, 1988). Given the high risk for offenders, courts have frequently held correctional administrators and practitioners to a high standard of accountability for the management of suicidal and potentially suicidal offenders. Consequently, national organizations like ACA and NCCHC have developed standards for evaluating suicide prevention programs in correctional and detention facilities. The standards, however, are often inconsistent and, without an accepted mechanism for enforcement, implementation must rely on voluntary compliance. Nevertheless, correctional administrators would be wise to establish suicide prevention programs in all detention and correctional facilities (O'Leary, 1989). Before it can be done efficiently and cost effectively, however, the long-term effectiveness of existing suicide prevention programs must be evaluated to determine which policies offer the most successful strategies for dealing with the problem. To this end, the study discussed in this chapter was undertaken to review the overall effectiveness of one such program — the Federal Bureau of Prisons' (FBOP) suicide prevention program.

In 1982, FBOP issued its first formal policy covering suicide prevention. The policy, implemented in all federal institutions, outlines a full range of procedures to be followed pertaining to the assessment, management, and treatment of suicidal inmates. The suicide prevention program includes five basic components: 1) initial screening of all inmates; 2) treatment and housing criteria for suicidal inmates; 3) development of standardized record keeping, follow-up procedures, and systematic data collection; 4) staff training; and 5) periodic reviews and audits. After the first 5 years of the program's implementation, FBOP's Psychology Services Division — which is directly responsible for program management — established a work group to review the program and, if necessary, recommend procedural changes. The work group used both psychological autopsies and staff interviews to analyze inmate suicides within FBOP between 1983 and 1987. The findings were subsequently summarized in Schimmel, Sullivan, and Mrad (1989), hereafter referred to as the "Schimmel study."

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The term "psychological autopsy" refers to the process of reconstructing an individual's life during the time immediately before his or her death. Through the use of face-to-face interviews with other inmates, correctional staff, mental health staff, and others having contact with the victim, an interviewer attempts to understand the feelings, thoughts, motives, and behaviors leading to the death. While psychological autopsies have been used for many years in the community (see, e.g., Robins, Gassner, Kayes, Wilkinson, and Murphy, 1959; Shneidman, 1969), the technique has been used to a limited extent in jail settings (Salive et al., 1989; Spellman and Heyne, 1989) and rarely in prisons. In fact, a review of the literature reveals that, while suicides in jails have attracted increasing attention from researchers, very little research has been directed at virtually any aspect of prison suicide, regardless of the technique used. The surprisingly small number of studies has produced a rather narrow range of data regarding the most basic information concerning suicides in prison, and the findings that have been reported consequently cannot be generalized for various types of prisons.

The Schimmel study, with its use of psychological autopsies, has been cited as the most comprehensive analysis of prison suicides reported to date (Bonner, 1992a); it has yielded a wealth of new information about suicide in prison. The findings demonstrate a clear difference in the type of inmates at risk in jails and prisons.

The current study was able to build on that earlier Schimmel study by reviewing data from FBOP psychological autopsies for the 5-year period from 1988 through 1992. By analyzing data for both 5-year periods, the present review was able to compare trends, and, by combining the data, substantiate a comprehensive, 10-year analysis of FBOP's program.

Program Description

As of January 1995, 86,378 inmates were incarcerated in over 110 federal institutions throughout the country. Each institution is required to have a suicide prevention program conforming to the requirements set forth in policy. Each institution's program and policy compliance are reviewed periodically, noting and correcting deviations from policy. Psychology Services administers FBOP's suicide prevention program, with the chief psychologist of each facility acting as program coordinator for that facility. The chief psychologist is thus responsible for implementing all policy requirements, including initial screening, treatment, and housing, standardized record keeping, follow-up, and systematic data collection, staff training, and periodic reviews and audits.

Initial Screening

FBOP's suicide prevention program begins with an initial processing of inmates as they arrive at a facility, performed by physician assistants as part of the basic medical assessment. Any inmate showing the potential for suicide at that time is immediately referred to a psychologist for a more in-depth evaluation. New inmates not referred by the physician assistant or other staff (who could also detect suicide potential) are interviewed by a psychologist within 14 days of their arrival at an institution. (Inmates transferred from other federal institutions are seen within 30 days of their arrival.) This interview not only assesses suicide potential, but also provides a general psychological screening to evaluate the inmate's stability, program needs, and potential adjustment to the institution. For example, as a result of this assessment,

the inmate might be identified as needing treatment for drug abuse, individual counseling, or referral for psychotropic medication.

Treatment and Housing

At any point during incarceration, an inmate can be referred to Psychology Services for assessment of suicide risk. If the inmate is determined not to be imminently suicidal, appropriate interventions, such as individual counseling sessions or referral for psychiatric medication, are initiated, along with supervised follow-up as needed. On the other hand, if the program coordinator deems the inmate to be imminently suicidal, he or she is immediately removed from the general population and placed on suicide watch. The conditions of this watch are specific, clearly delineated in policy, and exceed the frequently used technique of 15-minute visual checks. Generally, the inmate is housed in a designated "suicide-proof" hospital room and constantly observed by trained inmate companions or staff. Although any staff member may initiate a suicide watch in an emergency, the program coordinator is the only person with authority to terminate the watch. The coordinator is also responsible for determining the necessary follow-up interventions for an inmate after a suicide watch ends and for ensuring that those interventions are implemented expeditiously.

The overall structure of the program clearly places most decisions about the suicidal inmate's management directly with the program coordinator. Focusing responsibility for the treatment of the inmate on this one qualified individual eliminates the diffusion of responsibility that can occur when several people have equal or overlapping authority. In those cases, the lack of a singular and specific authority can also be a source of confusing or contradictory treatment. Identifying the coordinator as the central decisionmaker provides consistent program implementation and allows staff a specific source of expertise and referral.

Standardized Record Keeping, Follow-Up, and Systematic Data Collection

Comprehensive documentation is critical to any effective suicide prevention program. Psychology Services staff are required to use a series of standardized forms when initiating and terminating suicide watches, documenting and maintaining treatment procedures and referral decisions in a computerized data system, and compiling yearly statistics on all suicide evaluations and watches. The statistics compiled are then incorporated into a yearly report detailing the national outcome of the suicide prevention program. During 1992, for example, FBOP documented 2,200 formal evaluations of suicide risk. Those evaluations resulted in 912 suicide watches, with the average watch lasting approximately 86 hours. Of the 75,363 hours of suicide watch, 28 percent were performed by staff and 72 percent by inmate companions. The standardized record-keeping system forms the basis for effective clinical treatment and follow-up, and the availability of such statistical data is a valuable source of information to be used in training and policy development.

Staff Training

A cornerstone of any effective suicide prevention program is well-trained staff, and the program coordinator is responsible for providing training in a number of areas. The coordinator

must ensure, first, that **all** staff are trained in recognizing suicidal behavior, the proper procedures to follow in referring an inmate for treatment, and their responsibilities if asked to perform a formal suicide watch. Because it is often line staff who are in a position to see the signs of potential suicide, this training is given a high priority and presented to every new employee, as well as to all staff during required annual training. A second broad area of training is supplemental training for staff who have frequent contact with inmates. Specifically, FBOP policy states that additional training should be provided semiannually to physician assistants and correctional counselors, who often deal with inmates in crisis situations (e.g., initial screenings, sick call, or special housing units). Accurate and timely training of line staff is the most practical, cost-effective way to ensure that inmates exhibiting suicide potential are identified and referred for evaluation and treatment.

One of the most innovative and perhaps most controversial aspects of FBOP's program is the use of inmate companions. At the warden's discretion, inmate companions rather than staff may be assigned to perform formal suicide watches. Coordinators select inmates for the program based on a wide range of factors, and companions are not placed in a clinical or therapeutic role. Sixty-five percent of federal institutions use this option, and, as previously noted, 72 percent of all watch hours during 1992 were performed by inmate companions.

The facility's program coordinator is responsible for developing a formal selection procedure and training schedule for each inmate companion. Training typically focuses on ensuring that inmates understand the procedures necessary to summon staff assistance should the inmate at risk attempt suicide. Given their interaction with the suicidal inmate, however, inmate companions are also given basic training in understanding suicidal behavior, empathic listening, and other techniques for building communication. The companion thus has a basic understanding of the skills necessary to communicate more effectively and provide the suicidal inmate with a ready source of peer support.

Periodic Reviews and Audits

All suicide prevention programs are evaluated periodically. Those departments with deficient programs are required to correct any deviations and bring their program into full compliance. For example, if the necessary staff training was not provided, the suicide watch room was inadequate, or inmates were not screened initially, the program coordinator would be required to correct deficiencies and forward documentation of those actions to the appropriate reviewing authority for approval.

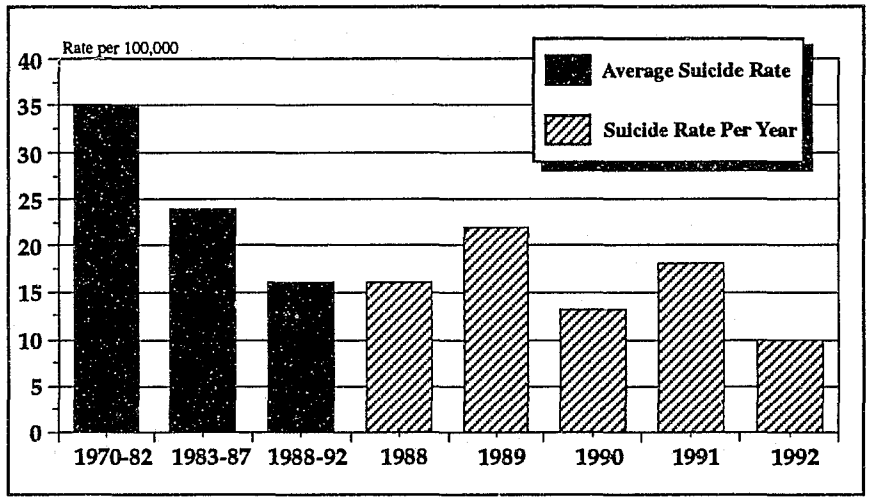
In addition to a formal program review, institutions where a suicide occurs are required to be reviewed by an outside official, typically a Psychology Services regional administrator or chief psychologist from another FBOP facility. The review consists of a structured psychological autopsy examining a number of historical, environmental, demographic, and psychological variables related to the death. Through an analysis of the program review and psychological autopsy, the overall effectiveness of the suicide prevention program is evaluated and changed if necessary. In fact, data collected from these sources was invaluable in developing FBOP's most recent Program Statement on Suicide Prevention (effective April 1990). Such reviews have provided extremely relevant information for presentation in staff training that can also be used in future policy development.

Annual Suicide Rates

Because the express purpose of a suicide prevention program is to reduce suicides, the following analysis begins with an examination of FBOP's annual suicide rate. Unfortunately, as the Schimmel study demonstrated, the calculation of suicide rates is not always standardized, and the inconsistency can lead to considerable variation between studies examining the same data. To avoid problems of this nature in comparing FBOP suicide rates, the present investigation used the same methods employed by the Schimmel study to ensure a standard basis for comparison. Specifically, the annual suicide rate was determined by dividing the number of suicides by FBOP's estimated average daily inmate population for the year. Coincidentally, 43 suicides occurred in each of the 5-year periods being reviewed. Because the population of federal prisons has increased substantially, the average daily population was higher during 1988 to 1992 than during 1983 to 1987. Consequently, with the absolute number of suicides remaining the same and the base population increasing, the suicide rate logically decreased.

The Schimmel study found that when suicide rates for the first 5 years of FBOP's program were compared with pre-program data reported by Schmidt (1978) and Gaes (1981), the average suicide rate decreased from approximately 35 suicides per 100,000 inmates for 1970 through 1982 to 24 per 100,000 for 1983 through 1987. The present review found that, for the period from 1988 to 1992, the average annual suicide rate was slightly less than 16 per 100,000, with the most recent year reporting a rate of only 10 per 100,000 (see Table 5-1). Given that FBOP's overall population is 93 percent male and that the suicide rate for males in the community is approximately 18 per 100,000, FBOP's overall rate is clearly promising. In fact, given the higher suicide rates found in other prison studies (Dooley, 1990; Salive et al., 1989), a rate comparable to that of the general population is encouraging.

TABLE 5-1
YEARLY FBOP SUICIDE RATE



Combining data from the present study (1988 to 1992) with that of the Schimmel study (1983 to 1987) shows FBOP's suicide rate during the first 10 years of its formal suicide prevention program was approximately 20 per 100,000, a 43 percent decrease when compared to the pre-program suicide rate. Because the data is correlational rather than experimental,

interpretation inferring causal links is inappropriate. However, the reduction in suicide rates over the last 10 years does suggest that FBOP's suicide prevention program has had a positive effect in reducing suicides.

Demographic Data

Prison suicide rates have been associated with a number of common demographic variables (Bonner, 1992a). The present review examined the variables of gender, age, race, and psychiatric and suicidal history. In addition, it presents data on several non-personal variables associated with the suicides, such as method used, housing, length of sentence and type of institution, and time of day and time of year the suicides occurred. Finally, it examines precipitating factors and establishes a profile of the typical inmate who committed suicide in federal custody.

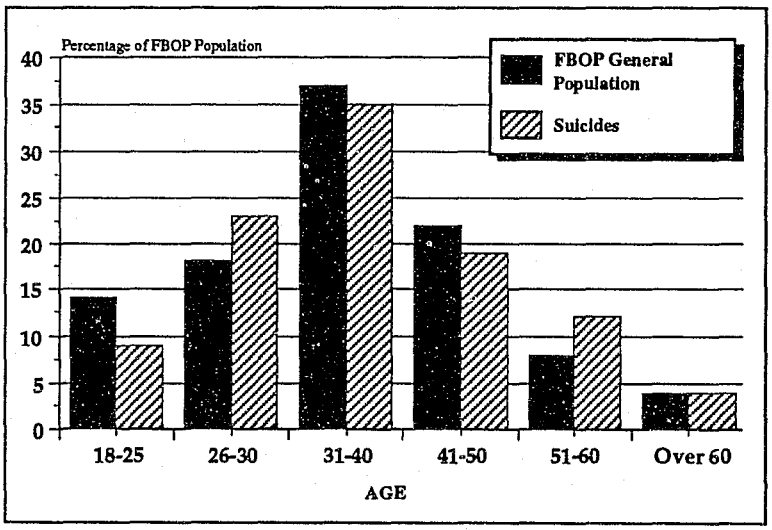
Gender

Of the 43 federal inmates who committed suicide between 1988 and 1992, all were male. The Schimmel study also found that all of the suicide victims in its research were male. In fact, although the number of female inmates has increased to over 7 percent of the total federal prison population, no female has committed suicide in FBOP since 1970.

Age

Data related to age is shown in Table 5-2 and indicates that suicide appears to be more frequent (35%) among inmates between 31 and 40 years of age. These frequencies generally reflect the overall age distribution of offenders in the system, however, and the largest number of suicides would therefore be expected to come from that age group. In fact, these findings are similar to the distributions reported in the Schimmel study and show little in the way of obvious age-related factors that might predict suicide.

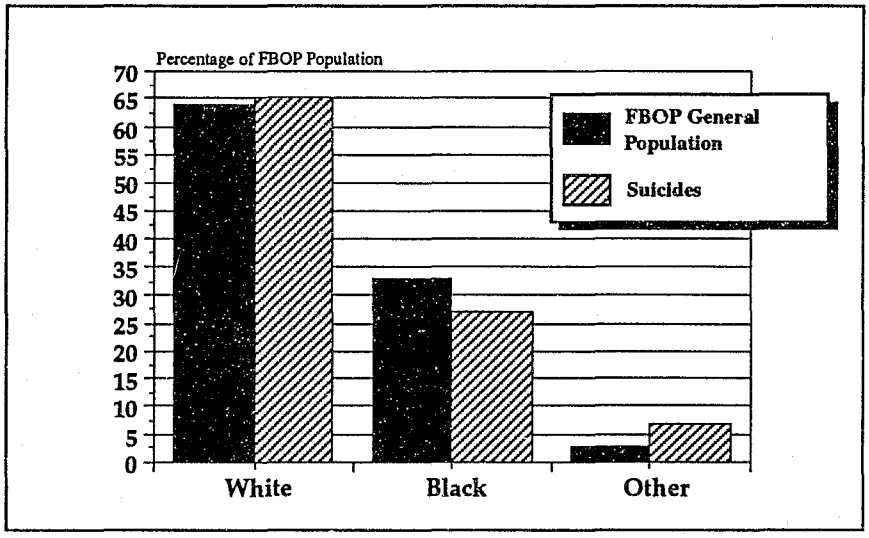
TABLE 5-2
FBOP SUICIDE RATE BY AGE



Race

The prevalence of suicide by race is presented in Table 5-3. It shows that approximately 65 percent of the inmates who committed suicide were white, 28 percent were black, and 7 percent were of other racial groups. A comparison of these figures with the racial distribution of federal inmates indicates that the only group showing any appreciable deviation from what might be expected is the latter group, represented by one American Indian and two Asian victims. Given the small numbers in this group, these figures do not appear significant. Overall, the victims' racial background does not appear to be a predominant factor in predicting those at risk for suicide. Although the Schimmel study did not report racial distributions for the general population, the analysis found that 72 percent of suicide victims were white and 28 percent were black, with other racial groups not represented — reflecting a relatively similar racial breakdown between the two studies.

TABLE 5-3
FBOP SUICIDES BY RACE



Psychiatric/Suicidal History

Of the 43 suicides between 1988 and 1992, 23 victims (53%) had a documented mental health problem. Of these 23 cases, 11 inmates were diagnosed with severe psychotic disturbances, while 6 were diagnosed as having some type of mood or affective disorder, such as depression. The other victims' diagnoses included paranoid ideation (4), organic syndrome (1), and post-traumatic stress disorder (1). In addition to the presence of a psychiatric diagnosis, 17 victims (40%) had made at least one previously documented suicide attempt or gesture.

The Schimmel study found that 37 percent of the victims had received a psychiatric diagnosis reflecting a psychotic condition and 9 percent had been treated for depression — a total of 46 percent with a documented history of mental health disorder. Forty-nine percent of these victims also had a history of previous attempts or gestures. Therefore, approximately 50 percent of the 86 suicides between 1983 and 1992 had a documented history of mental health

diagnosis or treatment, and approximately 44 percent of those inmates who committed suicide had made attempts or gestures in the past.

Method Used

Consistent with past studies of suicides in custody, the most frequently used method of death was strangulation. Of the 43 inmates who committed suicide between 1988 and 1992, 34 (79%) did so by hanging. Of the other victims, three jumped from tiers or buildings, two took an overdose of medication, two shot themselves in an unsuccessful escape attempt, and two cut their arms and wrists. Coincidentally, the Schimmel study also found that 79 percent of the victims committed suicide by hanging. Thus, 79 percent of all inmates who committed suicide over a 10-year period did so by hanging or similar method of strangulation.

Housing

The most common location for suicide was in a special locked unit. Twenty-seven (63%) of the suicides between 1988 and 1992 occurred in segregation, administrative detention, or a psychiatric seclusion unit. Of the 16 suicides in the general population, 9 inmates (21%) committed suicide in their cell, and 7 (16%) in common areas such as showers or stairwells. This current data is similar to that reported in the Schimmel study. For example, the Schimmel study found that 63 percent of the victims committed suicide in locked units, 29 percent in their housing unit, and the remaining 8 percent in other areas. Therefore, during the 10-year period from 1983 through 1992, approximately two-thirds of all inmates who committed suicide did so while confined in some type of locked special housing; with one exception, all victims were in single cells at the time of their deaths. This finding is consistent with the data reported by Bonner (1992a) in his review of jail and prison suicides and supports recommendations that inmates identified as suicidal **not** be placed in isolation without sufficient monitoring.

Length of Sentence/Type of Institution

Similar to the findings reported in the Schimmel study, the current review identified three groups of federal inmates who appear to be at risk for suicide. Two of the high-risk groups — pretrial inmates and Mariel Cuban detainees — were unsentenced prisoners. Although they represented only 6 and 4 percent of the total FBOP population, respectively, these two groups combined accounted for 42 percent of the suicides. The third high-risk group was sentenced inmates serving over 20 years. This group accounted for 28 percent of the suicides but only 12 percent of the total number of sentenced inmates.

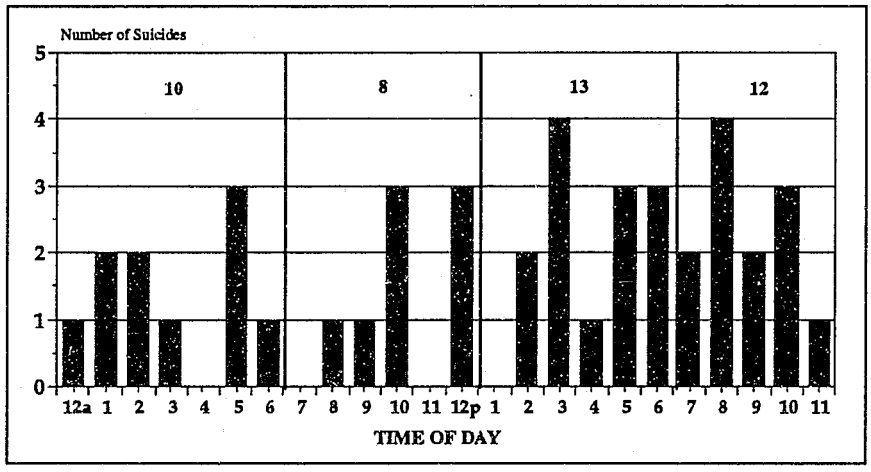
When suicides are viewed in relation to the type and security level of institutions where they occur, it appears that administrative and high-security facilities have higher suicide rates than other institutions. Merging the data on length of sentence with type of institution provides insight into this finding. For example, metropolitan correctional centers, which house the majority of pretrial inmates, had 11 suicides between 1988 and 1992, representing 26 percent of the total. Twelve suicides (28%) occurred in penitentiaries that house a disproportionately high number of inmates with longer sentences and Mariel Cubans; 14 suicides (32%) occurred in medium-security federal correctional institutions. Of the remaining suicides, 5 (12%)

occurred at federal medical centers and only 1 (2%) at a minimum-security camp. Thus, data from the current review shows that institutions housing a greater number of high-security-risk inmates have, as might be expected, higher rates of suicide.

Time of Day

Unlike the findings reported in the Schimmel study, in which nearly 50 percent of suicides occurred between 12:00 midnight and 6:00 a.m., the current review found no readily apparent pattern associated with the time of day the suicides occurred. As indicated in Table 5-4, if the day is divided into four quarters beginning at 12:00 midnight to 6:00 a.m., the suicides were relatively evenly distributed throughout the day, with a small decrease between 6:00 a.m. and 12:00 noon and a slight increase between 12:00 noon and 6:00 p.m. While it is possible to rearrange the time frames (e.g., immediately before and after count, early evening to early morning) to create some variation between different times of day, doing so could yield more artificial than meaningful information.

TABLE 5-4
NUMBER OF FBOP SUICIDES BY TIME OF DAY



Time of Year

Like time of day, time of year counted little in determining when suicides occurred. The highest number occurred in January and October (seven suicides each), with the remainder relatively evenly distributed throughout the year, ranging between two and five suicides for most months.

Precipitating Factors

Although speculative, psychological autopsy data was reviewed to determine the precipitating factors that might have led to the suicides. The present findings were very consistent with data reported in the Schimmel study in that the most frequently cited factors were related to new legal problems (28%), marital or relationship difficulties (23%), and inmate-related conflicts (23%).

Legal problems were most important for pretrial inmates. These problems covered a wide range of concerns primarily related to receiving new charges or additional sentences, being overwhelmed with the prospect of conviction, or facing a lengthy sentence. Marital or relationship difficulties were also common in the pretrial group but could also be found in victims at various stages of their incarceration. These cases most frequently focused on issues pertaining to loss of family ties, marital problems (including separation and divorce), and the death of a family member. In almost all cases, inmate-related conflicts most affected inmates with sentences of 20 years or more. These conflicts, which often emerged after years of incarceration, focused on the inmate's perceived need for protection and subsequent inability to enter the general population (e.g., they might have been labeled, or thought they were labeled, a "snitch"). In some cases, reports suggested that these inmates appeared to develop what might be considered paranoid preoccupation with their safety before their suicide. The cases were often difficult to manage, commonly seen in medium- and high-security institutions. Because of their situations, either real or imagined, these inmates were unable to be released from special housing, but their continued placement in special housing exacerbated emotional fears. Their preoccupation, although often noted, did not represent the degree of psychological instability that would warrant transfer to an in-patient psychiatric facility.

Ten suicides appeared to be related to a variety of issues, such as poor health, parole violations, and psychological difficulties. Mariel Cuban detainees evidenced little in the way of a consistently identified precipitant, but observers often inferred general hopelessness regarding the future. Six of the 43 victims left a suicide note. Typically, the notes did not point directly to precipitating factors but more generally expressed a desire to remove themselves from the long-term confinement they were facing. (Five victims had nothing in their immediate past that provided any information regarding the reasons for their suicides.) In virtually all of the 43 cases, the victims had not demonstrated any significant change in mood or behavior to signal the need for referral to Psychology Services or to warn of their intentions. Even in retrospect, the actions of most individuals before their suicide were not remarkable and did not indicate their intentions.

Inmate Profile

In addition to this demographic information, researchers reviewed several other characteristics relating to personality, education, and social factors. Although none of these additional factors was directly related to attempted suicide, it was possible to combine several pieces of information to produce a profile of the typical inmate who committed suicide in the FBOP system between 1988 and 1992. When this profile was compared with data from previous years, it was remarkably similar.

> The victim was a relatively young (35 years old) male, Caucasian (or possibly Cuban), with few friends or family ties in the community. He was a quiet, aloof individual who stayed to himself, was poorly educated, and had little religious affiliation. He frequently had a history of mental health problems and referrals, including past suicide attempts, but was not viewed as suicidal or actively psychotic immediately before his death. The victim was

probably housed in an administrative facility and facing new legal complications or was in a high-security institution and experiencing significant marital or family problems. Regardless of the institution's level of security, the victim was almost certain to be in a single cell, often in a special housing unit, and confined for protective custody. He was serving either less than a 10-year sentence or more than 20 years (except in the case of Mariel Cuban detainees). As an inmate in protective custody, the victim frequently voiced exaggerated fears for and preoccupation with his safety but other than those concerns did not demonstrate any unusual behavior or give any overt warning of his intention before the suicide. The incident would occur in the early afternoon or evening, and the victim would hang himself with a sheet attached to a light fixture or grate over an air vent. He would leave no suicide note.

Survey of Chief Psychologists — Overview

Because a significant aspect of FBOP's suicide prevention program involves inmate companions and staff training, both the Schimmel study and the current review solicited information about these two issues from chief psychologists at each facility. Approximately 65 percent of respondents in the current study used inmate companions and believed it was a worthwhile and highly beneficial program. This figure was down slightly from the 70 percent reported in the Schimmel study. Despite the slight decrease, most respondents in both surveys reported that inmate companions were conscientious and did an excellent job, and they believed that the program should be continued. In both surveys, most chief psychologists in FBOP institutions that chose not to use inmate companions cited philosophical or ethical problems, liability concerns, or security considerations.

Over 97 percent of respondents in the current survey and 100 percent in the Schimmel study said they provided annual training in suicide prevention to correctional officers. Most chief psychologists recognized the value and importance of this training and found it highly beneficial. In the current study, 68 percent of respondents said they provided supplemental training to selected staff, such as counselors and physician assistants. Finally, respondents in both studies agreed that the suicide prevention program was working well. Only 15 percent of the chief psychologists surveyed in the current study believed the existing policy should be revised. Of those who suggested revisions, almost all recommended more definitive guidelines or training standards for inmate companions. Overall, most chief psychologists believed that the existing policy was an adequate and workable document as it was although it could perhaps benefit from some fine-tuning.

Summary

The results of the present study, while requiring cautious interpretation, support the long-term effectiveness of FBOP's suicide prevention program. Although the correlational nature of the data could not provide a direct causal link between the program's implementation

and a reduction in suicides, the overall decline of 43 percent in suicide rates between 1983 and 1992 appears to be more than coincidental. In addition, FBOP's average suicide rate of 16 per 100,000 between 1988 and 1992 is not only below the rate reported in the Schimmel study, but also slightly lower than the 18 per 100,000 reported for males in the community. Despite the positive findings, however, these results are only a beginning and highlight the need for additional studies using a controlled experimental methodology to better define the cause and effect of the reported relationships. Nevertheless, by any measure, the findings are very promising and suggest that implementation of a comprehensive, well managed suicide prevention program can have a positive impact on reducing the rate of prison suicides.

The data presented in this study came from a review of psychological autopsies performed on each suicide. This methodological approach, while common in the community, has seen only limited application in the long-term assessment of prison suicides, but it could be an invaluable research and management tool. The data thus acquired could serve as the basis for additional training and focused intervention with specific inmate populations.

The data obtained during this study has important implications for future program management, policy review, and training efforts in FBOP. The information can also be applied to other correctional facilities and systems particularly in developing institution-based suicide prevention programs. The existence of written policy providing unambiguous procedures and clear guidelines has made it possible to implement the suicide prevention program uniformly across a wide range of federal institutions. Perhaps the most important aspect of the program relates to the development of an ongoing administrative structure that obtains yearly data on the use of the program and permits program managers to review long-term trends and needed procedural adjustments. Included in this process is a comprehensive audit and the use of psychological autopsies. While all aspects of FBOP's program might not be applicable in a particular setting, its basic structure provides the essential components of a responsive, professionally managed suicide prevention program that merits consideration by other correctional facilities and systems.

Chapter 6

THE COURTS' ROLE IN SHAPING PRISON SUICIDE POLICY

by

*William C. Collins, Esq.**

A prison official has a duty to protect an inmate from any harm the prisoner might inflict upon himself when such harm is reasonably foreseeable. This duty includes preventing the inmate from committing suicide.† Breach of this fundamental principle of American common law will subject the negligent party to liability for damages in a tort lawsuit, absent some state law against such liability. A prison official who is deliberately indifferent to the mental health and protection of an inmate whom the official knows to be suicidal violates the constitutional rights of that inmate. Breach of this constitutional duty could expose the official to damages under 42 USC Section 1983, as well as to remedial court injunctions issued under the same statute.

Both of these principles are well established. Recent reported cases, especially Section 1983 cases, however, indicate that it is becoming increasingly difficult to successfully sue an institution or individual officials as a result of an inmate's suicide.

Jail and Prison Suicide Lawsuits

In a review of the case law regarding prison suicide, one is immediately struck by the comparative lack of suicide litigation from prisons when compared to that from jails. One obvious reason for the difference is the dramatic contrast in the numbers of jail and prison suicides. Hayes and Rowan (1988) reported 401 jail suicides in 1986, whereas NCIA reported 158 prison suicides in 1993 (see Chapter 3).

Another reason for the comparatively small number of reported lawsuits involving prison suicides could be that the decedents had fewer supportive family members in the community who might be interested in pursuing litigation than did jail victims. The "typical" jail suicide victim is "an unmarried, intoxicated Caucasian male about 22 years of age who lacks a significant history of incarceration" (Robertson, 1993, p. 808) and is newly admitted to the jail. In other words, the jail suicide victim might be less than 48 hours removed from the community. Prison suicide victims, on the other hand, have substantially different characteristics and are far more removed from the community and family.

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†72 Corpus Juris Secundum Section 78 (1978).

Two Roads to the Courthouse

The fundamental legal vehicles and theories used in either jail or prison suicide litigation are similar. Two different legal vehicles support liability claims against correctional officials following an inmate suicide — **civil rights actions** and **tort suits.**

Civil Rights Actions

Such claims, brought pursuant to 42 USC Section 1983, allege that a person, acting under state law, violated or acted in such a way as to cause a violation of the decedent's constitutional rights. A civil rights action can seek injunctive relief as well as compensatory and punitive damages. A successful plaintiff in a Section 1983 action is entitled to an award of attorneys' fees, plus any award for damage or other relief a court might give (42 USC Section 1997e). A "lodestar" award, which could be adjusted somewhat depending on the facts of the case, is computed by multiplying the hours the lawyer spent on the successful portions of the case times the prevailing hourly rate in the community for lawyers of similar skill and experience. With hourly rates for attorneys now often exceeding $100 per hour in all but the smallest communities, such an award can be substantial.

Competing against the possibility of a sizable award for attorneys' fees is the "qualified immunity" defense in civil rights cases. Unless the plaintiff can establish that the defendants violated a "clearly established" constitutional right, no damages can be awarded (*Harlow* v. *Fitzgerald*, 1982). It is not enough that a general principle be clearly established; the facts of prior cases must be at least somewhat similar to facts of the current case to clearly establish a right (*Hansen* v. *Soldenwagner*, 1994). Given the comparatively small number of prison suicide cases and hence the lack of factually similar precedents, it is very possible that the qualified immunity defense will provide substantial liability protection from damages for prison officials named in civil rights actions.

Tort Suits

Tort suits allege only that the defendant was negligent in a way that caused, or failed to prevent, the suicide. A tort suit seeks only damages. While either action may be brought in state or federal court, a civil rights action is more likely to be brought in federal court, although state courts enjoy the jurisdiction to consider a Section 1983 action. A tort action may not be brought independently in federal court, but a federal court has the discretion to consider such a claim as a companion to a civil rights claim arising out of the same incident — known as "pendent jurisdiction" (*Roberts* v. *City of Troy*, 1985). In practice, a plaintiff may allege that the same facts demonstrate both negligence (tort) and a civil rights violation so as to maximize the chances of winning a lawsuit. Thus, the same lawsuit may use the same facts to reflect both a tort and a violation of the decedent's civil rights. In other cases, a plaintiff may pursue a civil rights claim in federal court and a tort claim in state court.

Courts as Agents of Reform

Over the last 25 years, reform litigation under Section 1983 has been the greatest force for positive change in U.S. corrections. Recent Supreme Court decisions dealing with a variety of correctional subjects, however, have robbed Section 1983 and the federal courts of much of

their clout. Moreover, while major class action suits are still possible, they are becoming more and more costly and difficult to bring (Dolby, 1994). The threat of damages through tort litigation can produce reform, but tort claims are rarely brought as class actions and a court in a tort case cannot enter an injunction requiring officials to implement improvements. Therefore, the pressure for reform in tort claims differs somewhat from Section 1983 suits, where a court's order can force officials to directly address and correct problems.

Suicide Claims and Section 1983 Actions

The most common claim under a civil rights action is that the acts or omissions of the prison staff resulted in a violation of the decedent's rights under the Eighth Amendment to be free from cruel and unusual punishment. Constitutional claims might also be based on a failure to provide a reasonably safe environment or on a failure to train staff properly (Cohen, 1992). Under any of these theories, the defendants' mental state is equally important in establishing liability as to what actually happened to the decedent. Defendants must be shown to have been "deliberately indifferent" to the needs of the decedent, although, as will be discussed later, the definition of deliberate indifference varies. Proving deliberate indifference is not easy.

The Eighth Amendment and Deliberate Indifference

Probably the most common type of civil rights claim following a prison suicide is an Eighth Amendment claim asserting inadequate medical care. "Medical care" in this context clearly includes mental health care, and this discussion uses the two phrases interchangeably. To win such a claim, the plaintiff must establish that prison officials were deliberately indifferent to the decedent's serious mental health needs. Both medical and non-medical staff can be liable.

The "serious medical care need" part of the equation virtually speaks for itself, as the successful suicide demonstrates a serious mental health problem. Proving the suicide alone, however, will not show a violation of the constitution, nor will showing that failures on the part of the staff contributed to the suicide. Only if the failures are so grievous as to reach the level of deliberate indifference will an Eighth Amendment violation be found.

The phrase "deliberate indifference" made its Supreme Court debut in a 1976 case involving medical care in prison (*Estelle* v. *Gamble*, 1976). Based on *Estelle* and other decisions, such as *Hudson* v. *McMillian* (1992), deliberate indifference was generally defined as conduct that fell somewhere between negligence and willful or purposeful conduct. Most lower federal courts defined the phrase in terms of recklessness but differed on their definitions of that term. Some courts used the definition in civil law, which permits consideration of not only what a defendant knew, but also what the defendant **should have known.** Thus, under this theory, one could argue that if a prison official should reasonably have known an inmate was suicidal and took no action to prevent the attempted suicide, the official was deliberately indifferent. Other lower courts applied the more rigid approach of criminal law to recklessness, where actual knowledge alone would suffice to show recklessness.

In June 1994, the U.S. Supreme Court further defined deliberate indifference (*Farmer* v. *Brennan*, 1994). The Court agreed that the term should be defined in terms of recklessness and adopted the criminal law approach using actual knowledge. Thus, to be deliberately

indifferent, an official must now have actual, not implied or constructive, knowledge of a serious medical need (such as an inmate's mental status) and then fail to make a reasonable preventive response to that known need. Even knowledge of an inmate's mental status or other indicators of potentially suicidal behavior, however, might not be enough under *Farmer*. Writing for an eight-member majority (Justice Thomas concurred in the result but did not join the majority's reasoning), Justice Souter said an official "must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference" (*Farmer* v. *Brennan*, 1994, p. 1979). This reasoning could create an ironic dilemma in a prison environment. For example, a correctional officer trained in the recognition of symptoms of potential suicide who fails to act in the face of certain facts could be liable under *Farmer*. By contrast, a poorly trained officer who sees the same facts but has no training in their interpretation would escape liability.

Failure to Train

Although failure to train commonly appears as an issue in prison suicide cases, establishing liability on the basis of inadequate training is very difficult. The U.S. Supreme Court ruled several years ago that a plaintiff must show that officials were deliberately indifferent to the inmates' constitutionally protected rights (*Canton* v. *Harris*, 1989). Deliberate indifference in a failure-to-train claim, however, does not require a showing of a defendant's actual knowledge of a problem. Instead, according to the *Farmer* ruling, knowledge can be attributed to officials when the need to train is "so obvious, and the inadequacy so likely to result in the violation of constitutional rights, that the policy makers of the city can reasonably be said to have been deliberately indifferent to the need" (*Farmer* v. *Brennan*, 1994, p. 1981).

Applying the failure-to-train teachings from *Canton* to a case involving custodial suicide, one court has said that to succeed, a plaintiff must "1) identify specific training not provided that could reasonably be expected to prevent the suicide that occurred and 2) ...demonstrate that the risk reduction associated with the proposed training is so great and so obvious that the failure of those responsible for the content of the training program to provide it can reasonably be attributed to a deliberate indifference to whether [the inmates] succeed in taking their lives" (*Colburn* v. *Upper Darby Township*, 1991, at 1030).

Current Trends in Section 1983 Suicide Litigation

Almost all recent custodial suicide civil rights decisions have come from jails and typically involve the suicide of an inmate very new to the facility. The clear trend in these cases, however, makes recovery for the plaintiffs very difficult. If one adds the decision in *Farmer* plus the defense of qualified immunity, recovery of damages for plaintiffs in prison suicide cases will be even more difficult than it has been in the past. Federal courts have consistently held that only in the event of a "strong likelihood of suicide" are inmates constitutionally entitled to protection (Robertson, 1993, p. 816). Case law indicates that this threshold is not met unless the following elements are present: 1) the inmate in question had threatened or attempted suicide, 2) the threat or attempt was known to jailers, and 3) the episode was somewhat recent. *Farmer* re-emphasizes only the second of these elements.

In summary, a civil rights complaint, to succeed, must establish that the defendants had actual knowledge that there was a strong likelihood an inmate was suicidal and that officials took no reasonable action to prevent the suicide from occurring.

While federal courts over the years have pushed correctional systems to improve in many different ways, decisions regarding custodial suicide have not often been part of this trend. For example:

> Federal courts have held that two elementary precautions — cursory searches and limited monitoring — discharge jailers from Section 1983 liability. These measures pale in comparison to recommended protections, which include 1) architectural design that precludes opportunity for suicide; 2) constant observation and supervision of suicide-prone persons; 3) multiple-occupancy housing; 4) diversion of inebriated offenders to detoxification centers or other alternate services; 5) crisis intervention; and 6) psychiatric evaluation of high-risk inmates and hospitalization for those diagnosed an "actual suicide risk." The considerable discrepancy between what is recommended by commentators and what is actually required by federal courts speaks poorly of Section 1983 as a vehicle of jail reform (Robertson, 1993, p. 825).

If federal courts are unwilling to impose duties no more basic than screening arrestees for suicide risk as they enter the jail (Hayes, 1989), it is safe to say that, at the present time, decisions from the federal courts will not be a strong motivating factor for improved suicide prevention practices in prisons.

Tort Suits

If case law under Section 1983 offers little assistance to the plaintiff, tort law could offer a somewhat greater chance of recovery. Under a tort theory, the question is not whether officials were deliberately indifferent to a serious risk of which they had actual knowledge, but that they had a duty to protect a prisoner from harming himself when such harm was reasonably foreseeable (*Scott* v. *State*, 1993). Courts generally hold that the official's duty arises when he/she knows or has reason to believe that the inmate might harm himself.

Liability based on a civil rights claim and liability based on a tort theory thus have two major differences. First, constructive knowledge of a potential problem (**should have known**) can trigger the duty to take precautionary measures in a tort action, compared to the requirement of actual knowledge imposed by *Farmer* in a civil rights claim. Second, establishing foreseeability of a suicide is generally easier in a tort claim than in a civil rights action. In the former, foreseeability is established when something, such as a suicide, is shown to be "probable in the light of ordinary prudence" (Robertson, 1993, p. 827) — in contrast to the "strong likelihood of suicide" test in civil rights cases.

As an example of the difference between the two types of actions, consider *Hutchinson* v. *Miller* (1989). Jail staff, in violation of the facility's policy, failed to check a detainee every 15 minutes. The detainee had made repeated requests to be moved to a new cell because of

threats from other inmates. With one hour between checks, the inmate was found dead. The court found that the actions of jail staff did **not** amount to deliberate indifference, thus preventing a civil rights claim from succeeding. The court did find, however, that the facts supported a claim for negligence under common law tort theory.

While a tort approach in general seems to be potentially more fruitful for the plaintiff, some states impose immunity barriers against suits for the government that could limit or bar such actions altogether. Sometimes the product of legislation or judicial intervention, these barriers could allow government agencies or officials to be immune from damages for some or all of their actions (*Tittle* v. *Mahan*, 1991; *Agee* v. *Butler County*, 1991).

It is beyond the scope of this discussion to analyze the varying immunity protections of all 50 states. Suffice it to say that the proposition in general tort law that a prison official has a duty to protect a prisoner from harming himself when such harm is reasonably foreseeable cannot be applied in at least some states because of those limitations. Therefore, plaintiffs in these states will have no choice but to seek recovery through a civil rights action.

So Much for Theory — What About the Facts?

The discussion about legal tests is perhaps of limited interest to the practitioner working in a prison. To that person, the ultimate question is, "Where is the risk of liability?"

System Issues

Most recently reported cases about custodial suicide have involved a single suicide victim and examined only what happened to that decedent. Some cases have addressed a facility's overall ability to prevent suicides, stating that identification, treatment, and supervision of a suicidal inmate are the necessary components of a constitutionally acceptable basic mental health program (*Ruiz* v. *Estelle*, 1983; *Lightfoot* v. *Walker*, 1980).

These cases sweep the prison's ability to deal with inmate-suicide-related issues up into a broad attack on the institution's overall mental health system (see *Casey* v. *Lewis*, 1993, for example). In finding that the Arizona Department of Corrections mental health system violated the Eighth Amendment, the court noted deficiencies in intake screening at the women's prison, failure to review records of inmates transferred within the system, shortages of mental health staff, inadequate programming for mentally ill inmates at one institution, delays in assessment and treatment, inappropriate use of lockdown, and inadequate monitoring of medication.

Individual Cases

Because no substantial body of case law deals with prison suicides and because the basic facts can vary from case to case, it is difficult to make general statements of principle that provide much more guidance than "do not be negligent!" Civil rights case law from jail suicides provides little guidance. Several common themes are repeated in custodial suicide cases, however, that at least help define where risks exist. While the same facts can be litigated as a tort suit or civil rights action, the difference between the two is how intensely the facts are scrutinized. Cases are subject to three basic areas of focus.

Recognizing Suicide Threats

Should prison staff have recognized that an inmate was potentially suicidal? Because of the requirement of actual knowledge of a strong likelihood of suicide, proving the threat has been difficult in jail cases. For instance, courts have held that no general constitutional duty exists to screen inmates for potential suicide (*Belcher* v. *Oliver*, 1990). In prison, however, the practical burden of showing a threat of suicide could be somewhat easier to prove, as the inmate would have been more familiar to prison staff and perhaps have had a record of prior suicide attempts or mental health problems about which staff were aware.

Greater knowledge of a victim's mental health history could be the greatest difference between jail and prison suicide litigation, as so much jail litigation focuses on what staff knew or should have discovered about an arrestee within the first hours or days of his or her entry into the facility. In contrast, prison officials would probably know a great deal more about inmates who commit suicide, and the litigation can focus on the question of what the officials did with the knowledge they had.

Supervision and Response

Having identified the inmate as suicidal, were proper precautionary measures ordered, and were they carried out? Was the inmate placed on a suicide watch, was the intensity of that watch consistent with the urgency of the inmate's case, and was the watch carried out as ordered? Was proper medical care given?

Typically, jail suicide cases do not delve into questions regarding the adequacy of mental health care given the decedent. Instead, they focus on the responses of non-medical staff to such issues as failing to closely monitor the suicidal inmate (*Buffington* v. *Baltimore County*, 1990) or failing to conduct searches to adequately reveal instruments of suicide (*Matje* v. *Leis*, 1983).* In contrast, the adequacy of the professional treatment the decedent received appears to arise more commonly in the scant body of prison suicide cases (*Waldrop* v. *Evans*, 1989; *Torraco* v. *Maloney*, 1991).

Emergency Response

Once the attempted suicide was discovered, was the response proper? The courts will not receive well a response that treats a hanging inmate as a crime scene and leaves the victim dangling while staff wait for investigators or the medical examiner to arrive, yet this situation has arisen more than once (*Hake* v. *Manchester Township*, 1985; *Heflin* v. *Stewart County*, 1992).† Custodial staff not trained to determine medically whether someone is dead should normally treat the scene as a medical emergency, not as a sterile crime scene.

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*Detainee hid drugs she used to commit suicide in her diaphragm, which they did not search, although jail staff had reason to know where drugs were hidden.

†But see also *Reed* v. *Woodruff County* (1993), in which the court found no deliberate indifference, as the police officer, who was also a trained medical technician, decided a hanging inmate was dead and did not begin life-saving measures. Plaintiffs provided no evidence to suggest life-saving measures would have done any good.

Other Factors

Within these three general areas of concern are several other areas of potential focus in prison suicide litigation. First, the question of **foreseeability** is a critical part of both a civil rights and a tort claim. Courts in tort suits (generally involving jail suicides) have recognized several indicators of foreseeability (Kappeler, Vaughn, and del Carmen, 1991). Several, if not all, of them are relevant in the prison setting as well:

- Actual suicide attempts while the detainee is in custody;
- Detainee's statement of intent to commit suicide;
- Detainee's history of mental illness;
- Health care professional's determinations of detainee's suicidal tendencies;
- Detainee's emotional state and behavior;
- Circumstances surrounding the detainee's arrest; and
- Detainee's level of intoxication or drug dependence (Kappeler et al., 1991, pp. 381, 384).

Second, **basic organization and staffing** of the mental health system is a factor. Without a functional mental health system, an institution cannot be expected to meet the needs of the suicidal inmate.

Third, **failure of the medical staff** to properly diagnose or treat suicidal inmates is a factor. In *Greason* v. *Kemp* (1990), for example, spending only a few minutes with a patient who entered the prison on antidepressant medication, not taking the time to read the patient's clinical file (which would have revealed a lengthy history of mental problems, hospitalization, and warnings about the risks of taking the patient off his medications), and failure to examine the inmate's mental status were facts that allowed a jury to find deliberate indifference. Inadequate numbers of medical staff could contribute to their failures, as many are overwhelmed by the sheer volume of demand for their services.

Fourth, the *Greason* decision points up one value of **examining prior records** — obtaining relevant information for diagnosis and treatment. Prior records might also show a history of attempted suicide, which in turn could suggest the need for special precautions.

Fifth, for want of a better word, is **carelessness**. In *Lewis* v. *Parish of Terrebonne* (1990), an inmate had been taken by jail staff to a local hospital to have his stomach pumped following the claim that he had taken a large number of pills. From the emergency room, the inmate was taken to a mental hospital for examination. The psychiatrist wrote a letter to the jail, indicating the inmate was suicidal and recommended that special precautions be taken. The doctor gave the letter to the transport deputy to give to the warden. The deputy left the envelope from the psychiatrist on the jail booking desk. Shortly thereafter, the inmate hit the

officer and was immediately placed in solitary confinement. The warden did not open and read the letter although he knew of the inmate's earlier suicide threat and attempt. Only after the inmate committed suicide in solitary confinement did the warden look at the letter.

Sixth, **facility design** — protrusions such as hooks or pipes that could be used in a suicide attempt — are a recognized architectural concern (Atlas, 1989, p. 161). While facility design has been an issue in a handful of cases, it has not fared well as the basis for liability. Two opinions in *Tittle* v. *Jefferson County Commission* (1994) provide an example. The suit sought damages in part because cells contained an exposed pipe near the ceiling, from which the victim hanged himself. In the first *Tittle* opinion, a panel of the 11th Circuit opined that the majority of 57 suicide attempts during a 2-year period (including 4 successful suicides within 12 months) were the result of hanging from the pipes, and the sheriff's concern about the pipes' presence, provided enough evidence to raise the issue at trial as to whether the defendants were deliberately indifferent to a dangerous design flaw in the jail. In the second opinion, after an *en banc* review of the first decision, the court overturned it, saying that the prior history of suicides did not show that "all prisoners of the Jefferson County Jail are substantially likely to attempt suicide" (*Tittle* v. *Jefferson County Commission*, 1994, p. 1540).

The same plaintiffs brought a tort action against the jail's architects, only to lose that case as well (*Tittle* v. *Giattina, Fisher & Co., Architects*, 1992). The court there said that, while an architect has a duty to design a building that is safe for its intended use, the duty did not extend to preventing suicides, citing a decision of an Illinois appeals court (*La Bombarde* v. *Phillips Swager Associates, Inc.*, 1985). The court also noted the large number of variables affecting a potential suicide that are clearly beyond the architect's control. In the midst of this prolonged litigation, however, the defendants covered up the pipes in the facility and updated intake screening and staff training policies.

Despite the fate of the design issue in the *Tittle* cases, claims of negligence or deliberate indifference based on design flaws retain at least theoretical viability, especially in the case that combines an inmate known to be suicidal with a cell with exposed lighting fixtures, air vents, or other design features that all but say "place noose here."

Seventh, good **record keeping** is one of the most important parts of risk management. One author, writing about potential liability for psychiatrists and psychologists following patients' suicides, recommended that paranoia be a guide for record keeping: "As a general rule...clinicians should write their notes as if a lawyer were sitting on their shoulders, reviewing every word" (Bongar, 1991, p. 169). While it might be something of an exaggeration, the basic points are sound. Convincing a judge or jury that something happened that is not noted in the written records, when normally it should be noted, is very difficult.

Good documentation will help the prison avoid liability by providing a method by which staff become aware of potential problems and demonstrate their response to those problems. Poor documentation can work against the facility, and missing documentation can imply actions that should have occurred but did not. For instance, if an inmate was on a 10-minute suicide watch and a log showed gaps of an hour or more between checks, it would be virtually impossible for defendants to convince a judge or jury that the necessary checks were in fact made.

Documentation can also reflect some of the lack of cooperation problems that often exist between custody and mental health staff. Line staff who do not have confidence in the judgment of mental health staff might carefully document inmate referrals to cover themselves

in the event of a problem. Similarly, mental health records might show failures of the custody staff to cooperate with treatment plans.

Eighth, **sharing information**, especially between custody and medical/mental health staff, is closely related to sound record keeping. Custody staff can be the source of valuable information regarding an inmate's behavior in the cellblock and can serve as the eyes of the mental health staff. Distrust between these two departments is common, and the greater it becomes, the more likely it will be played up in litigation, even to the point of the plaintiff's lawyers trying to use the concerns of one department to demonstrate the failings of the other.

Ninth, **failure to follow policy** will not necessarily show negligence and is even less likely to indicate deliberate indifference. It can be relevant to either determination, however. The most enlightened policies and procedures concerning suicide prevention can become a noose around the neck of prison officials if those policies and procedures are not followed. This is particularly true when those failures to follow policy are known to supervisory officials, are seen as playing a critical role in allowing the inmate to commit suicide, or are related to prompt discovery of the attempt.

Finally, as noted earlier, **failure-to-train** claims might commonly be made in custodial suicide cases, but they seldom succeed — which is not to suggest that training and liability are unrelated. Realistically, the risk of liability from inadequate training is simply that poorly trained staff will make mistakes, which become the focal point of the lawsuit. State indemnification laws suggest that, in the great majority of cases, the government will in fact bear the cost of litigation, including any damages, regardless of who the court finally holds to be liable. Thus, the agency — and the taxpayers — pay the costs of inadequate training, even if the lawsuit does not succeed on a failure-to-train claim.

Summary

The advice and recommendations of the correctional profession to itself about preventing suicide are more relevant and important in meeting the goal of reducing prison suicides than anything the federal courts say the constitution demands. While courts recently have not been as active in the area of custodial suicide as in years past, agencies still must recognize that they have legal duties to protect prison inmates, including those who are suicidal. Failures in the general areas of recognizing suicide threats, protection and treatment, and emergency response can produce liability. The lawsuit that seeks to recover damages from an inmate's suicide will probably fare better if it is brought as a tort claim alleging negligence than if brought as a civil rights action, except in those states where state law bars such a damages claim. When a tort claim can be maintained, it will be easier for the plaintiff to introduce current, contemporary correctional practices as benchmarks against which to measure the defendant's acts or omissions.

Chapter 7

SUMMARY AND CONCLUSIONS

Observers historically have assumed that, while the risk of suicide looms large in jail among inmates facing the initial stages of confinement, such risk dissipates over time in prisons as individuals become more comfortable or tolerant of their predicament and develop skills to cope with life behind bars. This assumption has not been empirically studied; it is far too simplistic and ignores both the process and individual stressors of prison life. Prison suicide must be viewed in the context of a process by which an inmate is (or becomes) ill-equipped to handle certain stressful factors of confinement (Bonner, 1992a). Over time, these factors can include loss of outside relationships, conflicts within the facility, victimization, further legal problems, physical and emotional breakdown, and a wide variety of other problems. When the inmate cannot effectively cope with these stressors, the result can be varying degrees of suicidal behavior — from ideation to contemplation, attempt, or completion.

Although the rate of suicide in prisons is far lower than in jails, it remains disproportionately higher than the general population and a significant public health problem. During the past 10 years, the rate of suicide in prisons throughout the country was 20.6 deaths per 100,000 inmates. In addition, states with small prison populations appear to have exceedingly high rates of suicide — often more than two and one-half times the national average. Yet while the prison suicide rate has gradually decreased since 1984, punctuated by a dramatic decline after 1989, the rate increased noticeably during 1993. In fact, 15 states experienced higher rates of prison suicide during 1993 compared to their 9-year (1984 to 1992) averages.

The majority of DOCs throughout the country have not comprehensively adopted the suicide prevention standards advocated by either the National Commission on Correctional Health Care or the American Correctional Association. Such standards include the six critical components of a suicide prevention program: staff training, intake screening/assessment, housing, levels of supervision, intervention, and administrative review. Although NCIA found that 79 percent of the DOCs had a suicide prevention policy, 15 percent did not have a policy but had varying numbers of protocols in other DOC directives. Six percent of the departments did not address the issue of suicide prevention in any written policy or directive. More than a quarter (27%) of all DOCs had either no policy or a policy that contained only one or two of the six critical components of suicide prevention. Only 15 percent of all DOCs had policies that contained all or all but one of the components. Two of those prison systems were Louisiana and Pennsylvania, which have experienced gradual reductions in their suicide rates that parallel the national trend. The Elayn Hunt Correctional Center in Louisiana and State Correctional Institution-Retreat in Pennsylvania exemplify highly effective suicide prevention programs.

As a result of litigation, many states have improved their general conditions of confinement and implemented specific programs designed to improve prison health care, including suicide prevention. Recent Supreme Court decisions, however, have robbed civil rights laws and the federal courts of much of their reform clout. And while major civil class-action suits are still possible, they are becoming more and more costly and difficult to prove. With regard to liability for prison suicide, federal courts have consistently held that only when a strong likelihood of suicide exists are inmates constitutionally entitled to legal protection.

The "strong likelihood" threshold includes a threatened or attempted suicide known to personnel in the recent past. It is safe to conclude that future decisions from the federal courts will not be a strong motivating factor for improved practices to prevent prison suicides.

The higher rate of prison suicides experienced in 1993 could indicate an upward trend or be merely an aberration. Observers have noted that several recent developing trends suggest higher suicide rates in the future. These recent trends (e.g., mandatory sentencing laws, dramatic increases in life sentences, AIDS, and the graying of inmate populations) have instilled despair and hopelessness in inmates. Future efforts to prevent prison suicides will be predicated on several factors: further research, resources, and progressive prison management.

Large-scale, prospective studies of prison suicide and empirical studies on the **process** of custodial suicide are needed. As the awareness of inmate suicide as a serious health problem within prisons continues to grow, resources must follow. Some encouraging signs are apparent. For example, the National Institute of Corrections is currently providing technical assistance to departments of correction and jails in various specialized areas of correctional health care, including developing comprehensive plans for suicide prevention."* Other resources are available, including a recently released comprehensive training manual on preventing prison suicides produced jointly by the New York State Office of Mental Health, Department of Correctional Services, and Commission of Correction. *Suicide Prevention and Intervention in State Correctional Facilities* is geared toward an 8-hour staff training seminar and includes 10 modules of instruction: overview of the problem, a model for understanding suicide, myths and misconceptions about suicide, substance abuse and suicide, mental illness and suicide, screening inmates for suicide risk, communication skills, suicidal inmates in the housing unit, accessing crisis and other mental health services, and the impact of suicide on the staff.†

Finally, future success in reducing prison suicides throughout the country will rely not only on progressive prison administrators' developing comprehensive and operational suicide prevention policies, but also on the **attitude** enunciated earlier by EHCC Warden C.M. Lensing: "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 each day, and schedule suicide prevention training every Friday, you symbolize to all staff the commitment we have to suicide prevention."‡ The prevention of future prison suicides might very well depend on the attitude displayed toward whether to treat the increase in prison suicides during 1993 as an aberration or as a signal of an upward trend.

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*See National Institute of Corrections, *Annual Program Plan for Fiscal Year 1995*, (Washington, D.C: U.S. Department of Justice, 1994), p. 24.

†For more information on *Suicide Prevention and Intervention in State Correctional Facilities — Trainer's Manual*, contact Judith F. Cox, Acting Director, Bureau of Forensic Services, New York State Office of Mental Health, 44 Holland Avenue, Albany, New York 12203, telephone 518/474-7275; or James F. Newton, Director, Correctional Mental Health, New York State Department of Correctional Services, 875 Central Avenue, Albany, New York 12203, telephone 518/457-5067.

‡Interview with author, June 2, 1994.

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Matje v. *Leis,* 571 F. Supp. 918 (S.D. Ohio 1983).

Newman v. *Alabama,* 503 F. 2d 1320 (5th Cir. 1974).

Reed v. *Woodruff County,* 7 F. 3d 8089 (8th Cir. 1993).

Rhodes v. *Chapman,* 452 U.S. 337 (1981).

Roberts v. *City of Troy,* 773 F. 2d 720 (6th Cir. 1985).

Ruiz v. *Estelle,* 503 F. Supp. 1265, 1339 (S.D. Texas 1980), aff'd in part, 679 F. 2d 1115 (5th Cir. 1982), cert. Denied, 40 U.S. 1042 (1983).

Scott v. *State,* 618 So. 2d 1053 (La App. 1 Cir. 1993).

Tittle v. *Giattina, Fisher & Co., Architects,* 597 So. 2d 679 (Ala. 1992).

Tittle v. *Jefferson County Commission,* 10 F. 3d 1535 (11th Cir. 1994), *en banc,* vacating a contrary opinion appearing at 966 F. 2d 606 (11th Cir. 1992).

Tittle v. *Mahan,* 566 N.E. 2d 1064 (Ind. App. 3 Dist. 1991).

Torraco v. *Maloney,* 923 F. 2d 231 (1st Cir. 1991).

Waldrop v. *Evans,* 871 F. 2d 1030 (11th Cir. 1989).

Williams v. *McKeithen,* 939 F. 2d 1100 (5th Cir. 1991).

Appendix A
SAMPLE SUICIDE PRECAUTION PROTOCOLS*

If any staff suspects that an inmate is depressed and/or suicidal, the medical department should be notified. The physician and/or on-call psychiatrist should then be consulted. Any of the following levels of precaution may be recommended:

LEVEL 1

In most circumstances, this level will pertain to persons who have actually recently attempted suicide. The on-call psychiatrist will have been notified. Efforts will be in progress to have the inmate committed to a mental health facility.

The inmate should be in a "safe room" or in the health clinic. Health staff should provide one-to-one constant attention while the person is awake, with visual checks every five to ten minutes while the inmate is asleep in a safe environment (described in Level 2). Toileting and bathing may or may not be visually supervised, depending on the inmate's mood at the time; if visually unsupervised, staff should be standing close by with the door slightly ajar.

LEVEL 2

This level will pertain to inmates who are considered at high risk for suicide. The on-call psychiatrist will have been consulted. Efforts will probably be made to have the inmate committed to a mental health facility.

The person should be either in a "safe room" or in the health clinic. Safety precautions should be observed. These should include searches of room and clothes for removal of all potentially harmful objects such as glass, pins, pencils, pens, and matches. Plastic bags should be removed. The room should be near the staff office, with no access to breakable glass and no electrical outlets (or outlets that can and should be turned off.) There should be no bed in the room if possible, and no pipes from which sheets could be hung. There may be a mattress and pillow on the floor. The person may have clothes (no belts), linen, and blankets. If the inmate verbalizes or demonstrates immediate intent to harm himself/herself, bedding should be removed and the health staff notified. The person should be checked at least every five minutes while awake and every

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ten minutes while asleep. He/she should have one-to-one attention when out of room, if potentially harmful objects (pencils, TV, etc.) are brought into room, or if he/she seems unusually distraught. Toileting and bathing: same as for Level 1.

LEVEL 3

This level will pertain to persons whom the physician or on-call psychiatrist feels are at moderate risk for suicide. They may be inmates who have previously been on Level 1 or 2 and whose mental status is improving.

Safety precautions should be taken. These should include searches of room and clothes for removal of obviously potentially harmful objects, such as broken glass, pins and matches. Plastic bags should not be permitted. Bed and linen may be allowed in room. The person may have writing materials (and TV in the health clinic) at staff discretion, but they should be removed when not in use. Toileting and bathing may be done as in the normal routine. The person should be checked visually at least every ten minutes while awake, every one-half hour while asleep.

LEVEL 4

This level will most often pertain to inmates who are at risk for becoming severely depressed/suicidal. This assumption may be based on past history.

The person may be dealt with as in the normal unit routine; however staff should observe the inmate for symptoms of depression and signs of suicidal ideation, and should notify health staff if new signs or symptoms occur. The person should be checked visually at least every half hour while awake and asleep.

The mental status of any given inmate may vary greatly from day-to-day and sometimes from hour-to-hour; therefore, it is imperative that staff have good observational skills and knowledge of signs and symptoms to look for. If any staff member has reason to feel that a person who is already on a precaution level should be moved to a higher level of precaution, the medical department should be notified, and the physician and/or psychiatrist again consulted.

Appendix B

TOTAL PRISON SUICIDES AND RATES BY STATE: 1984-1992

STATE	1984			1985			1986		
	Suicides	Total Population	Rate	Suicides	Total Population	Rate	Suicides	Total Population	Rate
AL	4	8,866	45.1	0	9,541	—	0	10,190	—
AK*	1	1,855	53.9	4	1,934	206.8	2	1,999	100.1
AZ	1	7,845	12.7	4	8,587	46.6	5	9,296	53.8
AR	1	4,346	23.0	1	4,504	22.2	0	4,578	—
CA	18	41,785	43.1	17	50,111	33.9	13	59,111	22.0
CO	1	3,230	31.0	0	3,369	—	2	3,677	54.4
CT*	2	5,375	37.2	4	5,771	69.3	2	6,382	31.3
DE*	0	1,890	—	0	2,189	—	1	2,551	39.2
DC*	0	5,973	—	0	6,496	—	1	6,226	16.1
FL	7	26,914	26.0	5	28,759	17.4	3	31,629	9.5
GA	3	15,668	19.1	5	16,047	31.2	5	17,343	28.8
HI*	0	1,734	—	0	1,881	—	1	1,975	50.6
ID	1	1,186	84.3	1	1,303	76.7	0	1,418	—
IL	4	16,854	23.7	6	18,279	32.8	4	19,456	20.6
IN	1	9,392	10.6	4	9,964	40.1	1	10,209	9.8
IA	1	2,839	35.2	1	2,832	35.3	1	2,942	34.0
KS	1	4,033	24.8	1	4,538	22.0	2	5,261	38.0
KY	1	4,845	20.6	2	4,956	40.4	2	5,221	38.3
LA	1	10,575	9.5	2	10,637	18.8	5	10,684	46.8
ME	0	419	—	1	1,100	90.9	0	1,205	—
MD	9	12,164	74.0	1	12,671	7.9	6	13,030	46.0
MA	1	4,974	20.1	4	5,473	73.1	3	5,538	54.2
MI	3	13,084	22.9	6	16,003	37.5	4	18,836	21.2
MN	4	2,323	172.2	3	2,485	120.7	3	2,515	119.3
MS	1	6,115	16.4	1	6,392	15.6	1	6,866	14.6
MO	2	8,800	22.7	3	9,926	30.2	3	10,182	29.5
MT	2	882	226.8	3	1,075	279.1	2	980	204.1
NE	1	1,733	57.7	2	1,830	109.3	0	1,885	—
NV	1	3,468	28.8	2	3,817	52.4	2	4,445	45.0
NH	1	547	182.8	1	642	155.8	0	797	—
NJ	1	10,261	9.7	2	10,912	18.3	3	12,102	24.8
NM	0	2,043	—	1	2,225	44.9	0	2,367	—
NY	5	33,249	15.0	7	35,322	19.8	3	38,647	7.8
NC	2	16,459	12.2	2	17,498	11.4	1	17,902	5.6
ND	1	434	230.4	1	434	230.4	0	441	—
OH	1	18,351	5.4	1	20,539	4.9	8	22,179	36.1
OK	2	6,960	28.7	3	7,127	42.1	1	7,598	13.2
OR	0	3,439	—	0	3,688	—	2	4,001	50.0
PA	5	13,126	38.1	2	14,260	14.0	7	14,824	47.2
RI*	1	1,236	80.9	1	1,327	75.4	0	1,370	—
SC	3	8,371	35.8	2	9,242	21.6	0	10,348	—
SD	1	913	109.5	1	1,042	96.0	1	1,040	96.2
TN	2	7,227	27.7	2	7,000	28.6	2	7,182	27.8
TX	9	36,682	24.5	8	37,532	21.3	9	38,534	23.4
UT	1	1,302	76.8	3	1,523	197.0	1	1,821	54.9
VT*	0	558	—	0	657	—	0	603	—
VA	1	9,786	10.2	3	10,767	27.9	4	11,119	36.0
WA	2	6,281	31.8	3	6,418	46.7	4	5,979	66.9
WV	1	1,524	65.6	0	1,796	—	0	1,200	—
WI	0	4,902	—	0	5,429	—	0	5,367	—
WY	0	774	—	0	811	—	0	865	—
FBOP*	10	32,121	31.1	6	36,640	16.4	6	40,864	14.7
TOTAL	121	446,212	27.1	132	485,301	27.2	126	522,780	24.1

*Dual system of both pretrial and sentenced inmates.

STATE	1987			1988			1989		
	Suicides	Total Population	Rate	Suicides	Total Population	Rate	Suicides	Total Population	Rate
AL	0	11,020	—	3	11,251	26.7	1	11,815	8.5
AK*	2	2,109	94.8	1	2,307	43.3	2	2,556	78.2
AZ	4	10,780	37.1	5	12,012	41.6	3	13,148	22.8
AR	2	5,324	37.6	2	5,457	36.7	0	5,777	—
CA	16	65,041	24.6	17	73,909	23.0	19	83,893	22.6
CO	1	4,377	22.8	3	5,016	59.8	2	5,525	36.2
CT*	3	6,923	43.3	5	7,516	66.5	3	8,777	34.2
DE*	0	2,733	—	1	3,045	32.8	0	3,382	—
DC*	1	7,368	13.6	2	8,509	23.5	2	9,315	21.5
FL	6	31,924	18.8	2	34,276	5.8	4	39,566	10.1
GA	6	18,522	32.4	4	18,659	21.4	2	20,840	9.6
HI*	1	2,100	47.6	1	2,155	46.4	2	2,291	87.3
ID	0	1,340	—	2	1,477	135.4	1	1,641	60.9
IL	3	19,850	15.1	4	21,081	19.0	4	24,712	16.2
IN	7	10,871	64.4	1	11,444	8.7	1	12,353	8.1
IA	0	3,109	—	0	3,311	—	1	3,907	25.6
KS	3	5,710	52.5	0	5,595	—	2	5,464	36.6
KY	1	5,536	18.1	1	6,227	16.1	2	6,406	31.2
LA	0	11,206	—	4	11,895	33.6	5	12,896	38.8
ME	2	1,238	161.6	2	1,249	160.1	1	1,439	69.5
MD	1	12,751	7.8	0	13,539	—	4	15,730	25.4
MA	1	7,395	13.5	1	7,930	12.6	3	8,646	34.7
MI	1	21,900	4.6	4	24,980	16.0	7	29,006	24.1
MN	4	2,694	148.5	3	2,930	102.4	2	3,114	4.2
MS	1	6,020	16.6	2	6,316	31.7	1	6,623	15.1
MO	4	11,343	35.3	2	12,207	16.4	3	14,819	20.2
MT	0	1,165	—	0	1,159	—	1	1,206	82.9
NE	1	2,029	49.3	0	2,178	—	1	2,391	41.8
NV	3	4,371	68.6	5	4,898	102.1	0	5,367	—
NH	0	845	—	1	983	101.7	0	1,197	—
NJ	4	13,428	29.8	4	14,629	27.3	5	15,674	31.9
NM	0	2,614	—	0	2,751	—	0	3,004	—
NY	2	40,842	4.9	4	44,560	9.0	10	51,227	19.5
NC	3	17,421	17.2	1	17,294	5.8	3	17,663	17.0
ND	2	481	415.8	1	520	192.3	0	509	—
OH	4	23,943	16.7	12	25,861	46.4	5	30,300	16.5
OK	5	8,430	59.3	2	8,850	22.6	4	9,818	40.7
OR	1	4,309	23.2	2	4,703	42.5	1	5,841	17.1
PA	3	15,877	18.9	7	17,494	40.0	8	19,236	41.6
RI*	3	1,440	208.3	2	1,918	104.3	1	2,476	40.4
SC	5	11,004	45.4	1	12,262	8.2	2	14,207	14.1
SD	1	1,128	88.7	0	1,030	—	0	1,277	—
TN	4	7,253	55.1	1	7,354	13.6	1	7,897	12.7
TX	8	38,125	21.0	10	39,525	25.3	7	43,191	16.2
UT	2	1,818	110.0	0	2,091	—	1	2,433	41.1
VT*	0	751	—	0	710	—	1	746	134.0
VA	1	11,410	8.8	1	12,702	7.9	5	14,351	34.8
WA	2	5,870	34.1	4	6,519	61.4	1	6,434	15.5
WV	1	1,089	91.8	1	1,399	71.5	0	1,478	—
WI	3	5,823	51.5	0	6,014	—	1	6,446	15.5
WY	1	852	117.4	1	892	112.1	0	905	—
FBOP*	10	43,152	23.2	7	45,650	15.3	11	53,278	20.6
TOTAL	139	554,654	25.1	139	598,239	23.2	146	672,193	21.7

*Dual system of both pretrial and sentenced inmates.

STATE	1990			1991			1992		
	Suicides	Total Population	Rate	Suicides	Total Population	Rate	Suicides	Total Population	Rate
AL	4	13,142	30.4	3	13,894	21.6	1	16,035	6.2
AK*	2	2,427	82.4	1	2,432	41.1	3	2,599	115.4
AZ	2	14,115	14.2	1	15,286	6.5	7	16,316	42.9
AR	2	6,533	30.6	2	7,385	27.1	2	7,627	26.2
CA	17	94,050	18.1	15	95,642	15.7	15	103,812	14.4
CO	0	6,057	—	4	7,342	54.5	2	7,535	26.5
CT*	2	10,101	19.8	9	10,573	85.1	1	11,055	9.0
DE*	1	3,474	28.8	1	3,717	26.9	1	3,975	25.2
DC*	1	9,121	11.0	1	9,716	10.3	1	9,798	10.2
FL	2	43,920	4.6	3	46,533	6.4	6	48,466	12.4
GA	3	22,302	13.5	2	23,644	8.5	1	25,081	4.0
HI*	1	2,370	42.2	0	2,444	—	1	2,674	37.4
ID	1	1,857	53.9	1	2,056	48.6	0	2,219	—
IL	4	27,516	14.5	2	29,115	6.9	3	31,640	9.5
IN	2	12,736	15.7	0	13,008	—	1	13,166	7.6
IA	2	4,307	46.4	0	4,527	—	0	4,995	—
KS	0	5,635	—	3	5,774	52.0	0	5,930	—
KY	0	7,705	—	2	8,110	24.7	2	8,729	22.9
LA	3	13,849	21.7	2	14,508	13.8	4	16,350	24.5
ME	1	1,548	64.6	0	1,564	—	2	1,519	131.7
MD	3	16,899	17.8	2	18,390	10.9	1	18,990	5.3
MA	1	9,183	10.9	3	9,991	30.0	8	10,395	77.0
MI	5	31,240	16.0	3	31,517	9.5	3	35,433	8.5
MN	3	3,179	94.4	2	3,453	57.9	3	3,832	78.3
MS	3	6,724	44.6	1	8,915	11.2	4	7,898	50.6
MO	4	14,946	26.8	1	15,467	6.5	2	16,198	12.3
MT	1	1,393	71.8	1	1,441	69.4	0	1,521	—
NE	2	2,382	84.0	2	2,539	78.8	0	2,604	—
NV	2	5,640	35.5	2	5,848	34.2	3	5,982	50.2
NH	0	1,407	—	0	1,590	—	0	1,758	—
NJ	2	16,743	11.9	1	18,032	5.5	1	18,110	5.5
NM	0	3,195	—	0	3,137	—	1	3,288	30.4
NY	1	54,895	1.8	6	57,862	10.4	7	61,736	11.3
NC	3	18,605	16.1	2	19,115	10.5	5	20,642	24.2
ND	0	527	—	0	534	—	0	536	—
OH	4	31,501	12.7	4	35,446	11.3	2	37,991	5.3
OK	5	10,502	47.6	3	10,694	28.1	4	12,211	32.8
OR	0	6,102	—	2	6,494	30.8	2	6,375	31.4
PA	7	21,399	32.7	3	22,794	13.2	4	24,227	16.5
RI*	1	2,377	42.1	1	2,783	35.9	0	2,783	—
SC	1	15,529	6.4	3	15,962	18.8	3	16,327	18.4
SD	0	1,360	—	1	1,391	71.9	0	1,390	—
TN	3	8,360	35.8	4	9,288	43.1	2	10,569	18.9
TX	1	49,316	2.0	11	50,516	21.8	9	51,592	17.4
UT	3	2,459	122.0	0	2,798	—	1	2,968	33.7
VT*	0	787	—	1	908	110.1	0	873	—
VA	4	14,507	27.6	3	16,929	17.7	2	16,996	11.8
WA	1	7,995	12.5	2	8,343	24.0	3	9,027	33.2
WV	0	1,504	—	0	1,534	—	0	1,687	—
WI	0	7,247	—	0	7,686	—	3	8,812	34.0
WY	0	796	—	0	920	—	1	958	104.4
FBOP*	8	59,002	13.6	11	64,611	17.0	6	72,092	8.3
TOTAL	118	730,486	16.2	127	774,198	16.4	133	825,322	16.1

*Dual system of both pretrial and sentenced inmates.

Appendix C

SUICIDE PREVENTION PROTOCOLS OF THE ELAYN HUNT CORRECTIONAL CENTER

ARDC PRELIMINARY HEALTH SCREENING*

Name: _____ DOB #: _____ Age: _____

DOC#: _____ Race: _____ PPD: _____ (date applied)

Parish: _____ Allergies: _____

Vision (Snelling Chart): Left 20/_____ Right 20/_____

Highest grade completed: _____ Any Special Education Classes? _____

Language: ❑ English ❑ Spanish ❑ French ❑ Other (Specify): _____

Medical Insurance: ❑ Yes ❑ No Religion: _____

1. Currently taking any prescribed medications? ❑ Yes ❑ No
   If yes, specify name of medication and date/time of last dose:

Medication/Dosage	Last Dose	Verified By:

   (If additional space is needed, use back of this page and note.)

2. Any current health problems? ❑ Yes ❑ No (If yes, specify)

   _____

   _____

3. To your knowledge, have you been exposed to any infectious diseases? ❑ Yes ❑ No
   (If yes, specify): _____

   To your knowledge, did you receive your childhood immunizations? ❑ Yes ❑ No

4. Have you ever been treated or hospitalized for any medical or mental problems? ❑ Yes ❑ No
   (If yes, specify):

Date	Reason	Hospital or Physician	Length of Stay

   To your knowledge, do you have any scheduled clinical appointments? ❑ Yes ❑ No
   (If yes, specify): _____

5. Are you presently on any prescribed diet? ❑ Yes (specify): _____ ❑ No

   Are you eating and sleeping without difficulty? ❑ Yes ❑ No
   Describe any difficulty noted: _____

   _____

   Do you engage in any type of exercise on a regular basis? ❑ Yes ❑ No _____
   ❑ Sports ❑ Weight-Lifting ❑ Calisthenics Comments:

   _____

   Do you smoke? ❑ Yes ❑ No Amount/Day: _____ How Long? _____ Years

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6. Are there any illnesses that run in your family? ❑ Yes ❑ No (If yes, specify).
❑ HBP ❑ ASHD ❑ DM ❑ Cancer ❑ Asthma ❑ Other_____

7. Do you have any dental problems? ❑ Yes ❑ No
If yes, specify: _____
If URGENT, note disposition: _____

8. Do you use alcohol? ❑ Yes ❑ No What kind?_____
How often? ❑ Daily ❑ Weekends ❑ Occasionally How Much? _____
Last time used? ❑ Less than week ❑ Less than 6 months ❑ Less than year
❑ More than _____ year(s)

Do you use drugs? ❑ Yes ❑ No What kind? _____
How much?_____ How often? _____
Mode of use? ❑ IV ❑ Other
Last time used? ❑ Less than week ❑ Less than 6 months ❑ Less than year
❑ More than _____ year(s) ❑ Other:_____

Have you ever had a problem following withdrawal from alcohol or drug use? ❑ Yes ❑ No
What kind of problem? ❑ Seizures ❑ Depression ❑ Suicide Attempt
❑ Other (describe):_____

---

9. General Appearance (check):

9.1) Psychological
❑ Alert ❑ Oriented ❑ Anxious/Nervous
❑ Calm ❑ Depressed ❑ Attentive

9.2) Musculoskeletal System
❑ Ambulates without difficulty ❑ Ambulates with difficulty
❑ Visible deformity ❑ Prosthesis (describe):_____

9.3) Integumentary System
❑ Bruises ❑ Needle Marks ❑ Lesions
❑ Jaundice ❑ Rashes ❑ Clear

States can read	❑ Yes	❑ Limited	❑ No
States can write	❑ Yes	❑ Limited	❑ No
Appears to understand	❑ Yes	❑ Limited	❑ No
Appears able to follow instructions	❑ Yes		❑ No
Appears able to provide accurate information	❑ Yes		❑ No

DISPOSITION

❑ General population/chart review by RN and MD
❑ General population, needs chart reviews of medications by MD
❑ General population with prompt referral for the following reasons:
  ❑ 45 and above
  ❑ Acute health problems
  ❑ Scheduled appointment at outside facility
  ❑ Other (i.e., need for special duty status, issue of "particular concern," etc.)
❑ Refer to MD for emergency treatment today

Preliminary Health Screening Performed By:_____
Date/Time:_____

NAME: _____ DOC #: _____ AGE: _____ R/S: _____ DATE/TIME: _____

❑ PT ❑ PV ❑ Impact Other _____

SUICIDE HX

Current Id: _____

Past Id: _____

Gestures: _____

MENTAL HEALTH HX

Hospital: _____

Outpatient: _____

Meds Current: _____

Past: _____

SUBSTANCE ABUSE

Alcohol: _____

Drugs: _____

IV ____ TX _____

Last Use of Alcohol: _____

Last Use of Drugs: _____

How are you doing now? _____

SUMMARY

❑ No major MH problems
❑ Sit. Distress _____
❑ Psychosis active/remit
❑ Substance abuse

Other (specify) _____

SORT

0-#5	1. Sp. Ed.	0 1 2	6. Repair
O-R	2. DL	0 2	7. Day
O-R	3. 12G	0 1	8. Cork
O-R	4. GED	0 1	9. Colder
O-R	5. N/E	0 1	10. Flag
X = Scale		0 1	11. Oranges
C = O/R		0 1	12. Newsman

Special A B C Regular

Comments: _____

Immediate Recommendations:

___ 1. None
___ 2. Psychiatric Consultation
___ 3. Records Requested
___ 4. A&I Observation
___ 5. Suicide Watch Extreme / Standard
___ 6. Other Recommendations: _____

Signature: _____

ADULT RECEPTION AND DIAGNOSTIC CENTER
HUNT CORRECTIONAL CENTER
ASSESSMENT AND INTERVENTION SCREENING

CLINICAL REPORT

DATE: _____

NAME: _____ DOC #: _____ DOB: _____

EDUCATION CLAIMED: _____ IQ EST: _____ RACE/SEX: _____

MMPI CODE: _____ SERVICE CODE: _____

LEVEL OF CARE: _____

INTERVIEW:

Reportedly there was:

1. no mental health history.
2. mental health evaluation.
3. treatment in jail only.
4. psychiatric hospitalization.
5. outpatient mental health treatment.
6. treatment for behavior problems only.
7. substance abuse treatment.
8. self-report of prior problems only.

_____

_____

IF TREATED, ANSWER THE FOLLOWING TWO:

Psychotropic medication:

1. was not prescribed.
2. included anti-psychotic.
3. included anti-depressant.
4. included anti-manic.
5. included anti-anxiety.
6. included anti-seizure.
7. prescription unknown.
8. _____

Previous diagnosis:

1. is unknown.
2. _____

Substances abused (by history):

1. none known.
2. alcohol.
3. marijuana.
4. cocaine.
5. a wide range of drugs.
6. _____

Suicidal tendencies:

1. none known.
2. current suicidal ideation.
3. recent suicidal gesture.
4. prior suicidal ideation.
5. prior suicidal gesture.
6. multiple suicidal gestures.
7. _____

CURRENT FUNCTIONING:

Psychomotor activity:

1. within normal limits.
2. slow or lethargic.
3. rapid and hyperactive.
4. resting tremor.
5. intentional tremor.
6. bradykinesia.
7. muscular rigidity.
8. decreased eyeblink rate.
9. abnormal posture maintained.
10. akathisia.
11. _____

Orientation for:

1. all spheres is demonstrated.
2. person is deficient.
3. place is deficient.
4. time is deficient.
5. situation is deficient.
6. _____

Thought processes:

1. logical, coherent & relevant.
2. flight of ideas.
3. illogical and psychotoform.
4. _____

NAME: _____ DOC #: _____

Delusions:

1. were not elicited.
2. with paranoid content.
3. with grandiose content.
4. _____

Associations:

1. tight, within normal limits.
2. markedly loosened.
3. somewhat loosened.
4. _____

Sensorium:

1. clear with no hallucinations.
2. some hypnogogic phenomena.
3. auditory hallucinations.
4. visual hallucinations.
5. olfactory hallucinations.
6. above claims are suspect.
7. _____

Mood:

1. level, calm, WNL.
2. mildly depressed.
3. moderately depressed.
4. severely depressed.
5. elevated (hypomanic).
6. very elevated (manic).
7. mildly anxious.
8. moderately anxious.
9. severely anxious.
10. _____

Affect is:

1. appropriate w/adequate range.
2. flat.
3. labile.
4. inappropriate.
5. silly.
6. sad.
7. pleasant.
8. angry.
9. fearful.
10. _____

Speech:

1. within normal limits.
2. discontinuity (stuttering).
3. excessively low in volume.
4. excessively high in volume.
5. mute.
6. contains some neologisms.
7. shows some deficits in syntax.
8. syntax impaired (word salad).
9. _____

Attitude:

1. cooperative with interview.
2. hostile.
3. friendly.
4. guarded & withholding.
5. manipulative.
6. indifferent.
7. marginally cooperative.
8. _____

Impression:

1. no serious, treatable syndrome.
2. antisocial personality.
3. malingering.
4. substance abuse (by history).
5. _____

ADDITIONAL CLINICAL COMMENTS (IF ANY)

ADULT RECEPTION AND DIAGNOSTIC CENTER
HUNT CORRECTIONAL CENTER
ASSESSMENT AND INTERVENTION SCREENING

INSTITUTIONAL REPORT

DATE: _____

NAME: _____ DOC #: _____ RACE/SEX: _____

OFFENSE: _____ SENTENCE: _____

SERVICE CODE: _____ LEVEL OF CARE: _____

Criminal history summary:

1. no prior arrests.
2. property offenses.
3. drug offenses.
4. sex offenses.
5. violent offenses.
6. not available.
7. _____

Estimated probability of institutional violence is:

0. extremely low.
1. considerably below average.
2. somewhat below average.
3. average.
4. somewhat above average.
5. considerably above average.
6. extremely high.

Recommendations:

A No current need for mental health intervention.
B1 Psychological consultation.
B2 Psychiatric consultation.
B3 Neurological consultation.
C Self-referral (prn) instructions.
D Substance abuse treatment referral.
E Professional follow-up within two weeks.
F Immediate professional attention.
G Inpatient mental health treatment.
S Suicide watch.

_____

_____

_____ _____

Examiner Clinical Psychologist (Director)

_____

Title of Examiner

NOTE: Additional clinical information may be found in the subject's medical file. That information is privileged under LA R.S. 37:2363, and is inappropriate for inclusion in the institutional record under provisions of the Louisiana Administrative Code 46:1309 and Standard 3-4377 of the American Correctional Association.

FORM A

MENTAL HEALTH BEHAVIORAL CHECKLIST

(THIS FORM IS TO BE COMPLETED ONLY WHEN A SUICIDE WATCH IS INITIATED)

NAME:_____ DOC#: _____ DATE:_____ TIME:_____

LOCATION:_____

		Yes	Comment
* 1.	Self-Destructive Act		
* 2.	Suicide Ideation		
3.	Critical Changes in Situation		
4.	Depressed		
5.	Mood Changes		
6.	Agitated		
7.	Hostile		
8.	Insomnia/Hypersomnia		
* 9.	Gives Away Property		
*10.	Bizarre Behavior		
11.	Homicidal Ideation		
12.	Other		

*If any of these items with the asterisk are checked, suicide precautions should be initiated.

Mental Health Notified: _____ _____
(Name) (Time)

Action Taken: _____

Supervisor's Signature: _____ Date: _____

Reporting Officer: _____ Date: _____

Definitions:

1. **Self-destructive acts** — cuts self, hangs, makes noose, bashes head against wall.
2. **Suicide Ideation** — talks of suicide, indirectly talks of suicide (the world would be a better place without me).
3. **Critical Changes** — death of loved one, major change in health status, change in loved one's health, change in marital or significant relationship, additional sentence, appeal denied, dropped from IMPACT or other special program.
4. **Depression** — cries, emotionally flat, apathetic, withdrawn, uncommunicative, verbalize hopelessness/worthlessness, moves/speaks slowly, difficulty carrying out routine tasks.
5. **Mood Changes** — severe changes in mood from sad to happy or happy to sad.
6. **Agitation** — offender begins pacing, has excessive body movements or excessive speech.
7. **Hostility** — out of character hostility; offender normally cooperative becomes hostile.
8. **Insomnia/Hypersomnia** — sleeps too little or too much (not *one* sleepless night or one period of sleeping too much).
9. **Gives Away Personal Possessions** — pays debts, says goodbye to friends.
10. **Bizarre Behavior** — speaks in nonsensical manner, expresses bizarre ideas, inattentive to surroundings (appears to be attending only to his own thoughts, appears "lost"), rapid speaking with overflow of ideas, talks to self, appears to be hallucinating.
11. **Homicidal Ideation** — talks of homicide; indirectly talks of homicide; threatens to hurt or kill someone.
12. **Other** — any observation that reporter feels significant; describe briefly.

HUNT CORRECTIONAL CENTER

FOR YOUR INFORMATION

TO: Assessment and Intervention
Hunt Correctional Center

FROM: _____
(Department, Section, Etc.)

DATE: _____

INMATE NAME: _____ **DOC#:** _____ **LOCATION:** _____

(CHECK ANY APPROPRIATE BOX)

- ☐ Inmate has refused to take medication and has not signed refusal form.
- ☐ Inmate has refused to take medication and has signed refusal form.
- ☐ Problems sleeping.
- ☐ Problems in dorm.
- ☐ Inmate request to see A & I.
- ☐ Other _____

_____

- ☐ Inmate has been informed how to contact A & I.
- ☐ Response necessary.
- ☐ No response necessary.

Remarks (if any): _____

_____

_____
Signature

_____
Title

FORM B

MENTAL HEALTH MANAGEMENT ORDER

NAME:_____ DOC#:_____ LOCATION:_____

BEGIN:_____ STANDARD WATCH:_____

DISCONTINUE:_____ EXTREME WATCH:_____

CONTINUE:_____

CHANGE TO:_____

MANAGEMENT INSTRUCTIONS:_____

HOUSING:_____

PROPERTY:_____

OBSERVATION FREQUENCY:_____

OTHER:_____

_____

DATE AND TIME EXAMINED:_____

DATE AND TIME OF ORDER:_____

ORDERED BY:_____ TITLE:_____

CONCURRENCE BY:_____ TITLE:_____

Any change requires a new Mental Health Management Order.

Copies: Medical Records, Security, Mental Health

FORM C

SUICIDE WATCH LOG SHEET

(To be completed at least every 15 minutes)

OFFENDER'S NAME: _____ DOC #: _____ DATE: _____

Circle One — 6:00 a.m. to 6:00 p.m. / 6:00 p.m. to 6:00 a.m. Circle One — Extreme / Standard

Please record the time of the observation, check ( ) the behavior you observe, or write in the appropriate space the behavior you observe, and sign.

NAME OF THERAPIST: _____

Time	acting out (racking down, yelling, throwing things, flooding cell, etc.)	sitting quietly or standing at bars	sleeping	using bathroom	talking to others	laughing or crying to self	self-stimulating (rocking, masturbating, talking to self, singing	Officer's Signature

Please check if the inmate ate his/her meals and record the time of each meal. Also record the time of his/her shower.
Breakfast time: _____ Lunch time: _____ Dinner time: _____ Time of Shower: _____

HUNT MENTAL HEALTH
CLINICAL SOCIAL WORK NOTE

Patient: _____ DOC #: _____ HUNT/ARDC

Date: _____ Time: _____ a.m./p.m.

THEME OF SESSION/CHIEF COMPLAINT:

MENTAL STATUS EXAM:

MOOD/AFFECT: ❑ Appropriate ❑ Euphoric ❑ Depressed
❑ Flat ❑ Labile ❑ Other

PSYCHOMOTOR ACTIVITY: ❑ WNL ❑ Increased ❑ Decreased

FACIAL EXPRESSION: ❑ WNL ❑ Sad ❑ Serious
❑ Expressionless ❑ Avoids Gaze ❑ Other

SPEECH: ❑ WNL ❑ Slowed ❑ Pressured ❑ Mute

ORIENTATION: ❑ WNL Not oriented to _____

JUDGMENT: ❑ WNL ❑ Flawed
INSIGHT: ❑ WNL ❑ Poor

INTERVIEW BEHAVIOR: ❑ WNL ❑ Aggressive ❑ Bizarre
❑ Dramatic ❑ Manipulation ❑ Withdrawn
❑ Uncooperative ❑ Guarded ❑ Restless

THOUGHT CONTENT: ❑ WNL ❑ Grandiose ❑ Suicidal ❑ Homicidal
❑ Delusional ❑ Paranoid ❑ Phobic
❑ Blame-avoidant ❑ Excessive religiosity ❑ Hypochondriasis
❑ A/___V hallucinations ❑ Claimed ❑ Observed

FLOW OF THOUGHT: ❑ WNL ❑ Loose associations ❑ Blocking
❑ Tangential ❑ Circumstantial ❑ Unable to assess

ASSESSMENT:

❑ No distress noted at this time
❑ Manipulation observed
❑ Situational depression/anxiety
❑ Possible threat to self/others
❑ Possible malingering
❑ Psychotic symptoms
❑ Stress reaction

PLAN:

❑ Psychiatric referral
❑ Self referral instructions given
❑ Referred to case manager for follow-up
❑ Warned against making invalid MH emergencies
❑ Threat to security
❑ Suicide Watch ❑ Begin ❑ DB action, malingering ❑ Continue ❑ Discontinue
❑ MH Observation ❑ Begin ❑ Continue ❑ Discontinue
❑ Medical referral
❑ See PRN

_____ _____
MSW BCSW

Appendix D
SELECTED PROCEDURES OF THE
PENNSYLVANIA DEPARTMENT OF CORRECTIONS

CHAPTER IX:
"PROCEDURES FOR DEALING WITH POTENTIALLY SUICIDAL INMATES AND INMATES WHO ATTEMPT SUICIDE"
OF THE
*MENTAL HEALTH PROCEDURES MANUAL**

COMMONWEALTH OF PENNSYLVANIA
Department of Corrections
October 27, 1993

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IX-00 GENERAL CONSIDERATION

Suicide and self-injurious acts are a serious danger in any correctional setting. Aspects of the correctional environment such as the authorization structure, perceived callous treatment by some staff, and social isolation may foster self-injurious acts. Moreover, areas of the prisons such as the Restricted Housing Units (RHUs) appear to be the sites of a large proportion of self-destructive acts. Therefore, early identification, appropriate housing and monitoring, and proper treatment of potentially self-destructive inmates is critically important, both for the individuals in need of service and for the institutions charged with their care.

IX-01 PURPOSE

Each institution shall establish procedures for suicide prevention and intervention. The purpose of this chapter is twofold: (1) to provide guidelines for the development of institutional procedures and (2) to aid staff in identifying the individual inmate needs in relation to suicide risk potential.

IX-02 ASSESSMENT OF SUICIDE RISK

Suicidal potential can be evaluated by using the criteria which are listed below. They are intended to help staff formulate a plan of prevention and treatment.

A) **Suicidal Plan:** The potential for suicide is greater when there is a well organized and detailed plan developed by the inmate. The potential also increases when the means of the suicide identified in the plan is readily available to the inmate and can be lethal.

B) **Prior Suicidal Behavior:** The potential for suicide is greater if the individual has experienced one or more prior attempts of a lethal nature or has a history of repeated threats and depression.

C) **Stress:** The potential for suicide is greater if the individual is subject to stress from increased pressures such as but not limited to the following:

1. Difficulties in coping with legal problems.

2. The loss of a loved one through death or divorce.

3. The loss of valued employment (e.g., high paying position in Correctional Industries).

4. Anniversary of incarceration date or offense.

5. Serious illnesses or diagnosis of terminal illness.

6. Threats or perceived threats from peers.

7. Sexual victimization, particularly after the first submission.

8. Placement in RHU.

9. Unexpected punishment (e.g., misconduct or additional sentence or parole denial).

10. Cell restriction.

11. Recent transfer from another institution or county facility.

12. Any movement to and from RHU (watch closely for several hours).

13. Somatic complaints of a vague nature which do not respond to treatment.

D) **Prior Suicidal Behavior of Significant Other:** The potential for suicide is greater if a parent, spouse or other close relative has attempted or committed suicide.

E) **Symptoms:** The potential for suicide is greater if the individual manifests such symptoms such as:

1. Auditory and visual hallucinations, particularly command hallucinations.

2. Delusions.

3. Any change from the individual's sleep pattern. This may be manifested by either a decrease or increase in sleep.

4. Any change from the individual's ordinary eating pattern. This may be manifested by either a decrease or an increase in the individual's appetite with an accompanied decrease or increase in weight.

5. Social withdrawal.

6. Apathy.

7. Despondency.

8. Severe feelings of hopelessness and helplessness.

9. General attitude of physical and emotional exhaustion.

10. Agitation through such symptoms as tension, guilt, shame, poor impulse control or feelings of rage, anger, hostility or revenge.

11. Giving away personal property.

12. Removal of all visitors from visiting list.

13. Sudden elevated mood ("everything's OK attitude")

F) **Personal Resources:** The potential for suicide is greater if the person has no family or friends, or his family and friends are unwilling to help. Potentiality is greater if a significant other evidences a defensive, rejecting, punishing attitude, or denies that the individual needs help.

G) **Acute vs. Chronic Aspects:** The potential for suicide is greater when there is a sudden onset of specific symptoms, a recurrent outbreak of similar symptoms, or a recent increase in long-standing maladapted traits.

H) **Medical Status:** The potential for suicide is greater when there is a chronic, debilitating illness, especially when it involves an alteration of body image or life style.

A person considering suicide does not demonstrate all of these signals. Generally, the more characteristics the individual has, the greater the potential for self-destruction. All suicidal attempts, including gestures, must be taken seriously.

Each institution will write local policy to indicate whether they plan to use this instrument or an alternate (e.g., Beck Inventory) to assess the potential for self-harm.

IX-03 SCREENING/ASSESSMENT

A) All staff who have contact with inmates shall be trained annually on the signs and symptoms of suicidal behavior (e.g., threats, depression, self-mutilation). If a staff member observes this behavior, the unit manager shall be notified, and a referral shall be made to the chief psychologist or his/her designee. In the absence of the unit manager, the staff person shall contact the shift commander. The unit manager or shift commander shall immediately contact the chief psychologist or designee and brief him/her on the situation.

B) The chief psychologist or designee shall assess the inmate's suicidal potential in the most appropriate area depending on the inmate's level of agitation and security needs (e.g., inmate's cell, psychologist's office or observation area").

C) Based on the screening, a referral to the psychiatrist may be necessary for further evaluation and treatment. If the psychiatrist determines the inmate is a danger to self and/or others, he/she shall order a watch with a recommendation for a specific level of observation. The watch may only be reduced or terminated by the ordering physician.

D) In the absence of the psychiatrist, the chief psychologist or designee with authorization of the senior ranking official can also order specific levels of observation. Without a mental health professional available, the senior ranking official (in consultation with the institutional nursing supervisor or charge nurse) can authorize similar levels. However, a psychiatrist shall be contacted immediately after the watch is instituted. The inmate shall be evaluated by a physician on the next daily round and by the psychiatrist or psychologist the next working day.

IX-04 LEVELS OF OBSERVATION AND HOUSING

A) Each institution shall provide an observation area to monitor suicidal inmates. Such an area requires well lit, adequately ventilated and heated cells which allow for quiet and for necessary communication with appropriate treatment and custody staff. The area should be as nearly suicide-proof as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself.) Insofar as possible, observations shall be conducted in infirmary areas, Mental Health Unit settings (if a MHU is available in the facility), or other areas outside of the Restrictive Housing Unit.

B) Staff safety shall be a critical consideration in deciding where to conduct the observation. Custody and supervisory staff shall not enter a cell until sufficient staff is available to handle the patient.

C) Individuals placed in these settings shall be provided with basic items needed for personal hygiene as well as items such as eyeglasses and writing materials. If mental health staff judge there is imminent danger that an inmate will destroy an item or use it to induce self-injury, the inmate may be deprived of the item; however, every effort will be made to provide a substitute for the item or allow the inmate to use the item under the supervision of an officer.

D) A suicidal inmate shall not be housed or left alone unless constant supervision can be maintained.

E) The different levels of observation require different types of restrictions. In all cases, the least restrictive measures shall be determined by the psychiatrist, chief psychologist or designee, and the senior ranking official (in consultation with the institutional nursing supervisor or charge nurse) based on the inmate's security needs. If the inmate is behind a locked door, the observing staff shall be able to open the cell door immediately.

The levels of observation are described below. Post orders for the observation shall specify the officer's duties in providing for custody and control and the treatment staff responsibility in providing clinical services.

1. **Constant Watch:** This is the most restrictive watch and requires constant visual contact with recording of observation every 15 minutes. If the mental health staff determine that it is necessary to remove the inmate's clothing to prevent self-harm, then a paper gown will be provided. If this level of observation is deemed necessary, then a mental health commitment shall be initiated as soon as possible, if appropriate.

2. **Close Watch:** This is less restrictive than constant; however, there is still potential danger for self-injurious behavior (e.g., an inmate cannot give a firm commitment not to harm him/herself). Visual checks are made on an irregular schedule that does not develop a pattern but at least one within every 15-minute period. The type of clothing and cell items permitted are based upon the inmate's security needs and

current behavior. A log is kept of the visual checks, and a record is maintained for the approved clothing and related items.

3. **Regular Watch:** This is the least restrictive level of observation and is usually the last step prior to release from observation. Visual checks shall be made in such a fashion that the inmate is not aware of a pattern developing, but at least within a 30-minute period and are recorded in a log.

4. A **Treatment Plan** shall be designed by the Psychiatric Review Team (PRT) with goals to reduce the level of restriction as soon as possible and eventually discharge the inmate from the observation area to a follow-up plan. If appropriate, double celling shall be considered, particularly for patients under regular or close watch. Entries shall be made on the DC-14.

IX-05 GOVERNING AUTHORITY OVER THE WATCHES

A) Operation of the watches in the infirmary areas is governed by the standards of the National Commission on Correctional Health Care (NCCHC). Admissions or discharges can only be ordered by a physician. A qualified health care professional (e.g., licensed psychologist, registered nurse and physician) can place an inmate in observation in the infirmary for up to 24 hours; however, after this period a formal admission or release is required.

B) Operation of the watches in the Mental Health Units shall be governed by the administration and clinical staff of the MHU, and service delivery is governed by Chapter 5320, Draft Regulations for Inpatient Forensic Psychiatric Programs of the Department of Public Welfare (DPW).

C) Confinement outside of the infirmary areas is governed by the 801 and 802 Administrative Directives. Insofar as possible, each inmate shall be allowed privileges and personal property, encouraged to exercise, and provided reading and legal materials consistent with his/her level of custody within the guidelines established by directives.

1. In cases where an inmate is placed in observation outside the infirmary, he/she shall be given written notice of the reasons for Administrative Segregation utilizing a DC 141

Other Report Form. A hearing is scheduled shortly after placement in observation status according to the provision of DC-ADM 802.

2. Inmates placed in observation status outside the infirmary must be given a right to due process whereby they are presented with the reasons for Administrative Segregation and are given the opportunity to discuss the situation with an administrative review authority [e.g., the Deputy who sits on the Program Review Committee (PRC)].

3. The PRC controls the level of observation outside of the infirmary areas and segregation based on the recommendations made by members of the Psychiatric Review Team (PRT). Privileges are recommended by the mental health staff and authorized by the PRC.

D) Each institution will write local policy to ensure close collaboration between the health care, treatment, and custody departments and compliance with the NCCHC standards, DPW regulations, and the 801 and 802 directives. Although PRC technically controls confinement outside of the infirmary, it is critical that levels of observation are based upon physician's/ psychiatrist's "order" to minimize liability placed upon non-medical staff.

IX-06 USE OF MECHANICAL AND CHEMICAL RESTRAINTS

A) Restraints shall be used for medical purposes to protect mentally disordered inmates from harming themselves or others. (Refer to Department of Corrections Administrative Directive 201, "Use of Force"). They are only applied after the consideration and/or use of any available less restrictive measures, such as counseling. Restraints are employed for the minimal amount of time that is necessary and not as punitive measures.

B) The order to use restraints shall be under the direction of a physician, and nursing personnel shall supervise the administration of the restraints. Facility manager or senior ranking official or designee may authorize the use of restraints. In this instance, the manager or designee shall immediately consult a licensed physician to obtain permission and consultation. A licensed physician or nurse must examine the inmate within eight (8) hours or earlier. Staff shall complete an Extraordinary Occurrence Report every time restraints are used.

C) Local policies and procedures shall be developed to cover the authorization, application, monitoring and documentation of their use.

IX-07 MENTAL HEALTH COMMITMENT

If the individual remains a high suicidal risk, the institutional mental health staff shall initiate a mental health commitment to a licensed inpatient facility using established local procedures for processing the necessary commitment.

A) Emergency Involuntary (302) Commitments may be initiated to a Department of Welfare Forensic State Hospital or one of the Mental Health Units in the DOC system.

B) Long Term Involuntary (304) Commitments may be initiated to a Department of Welfare Forensic State Hospital.

C) Voluntary (201) Commitments may be pursued if a Mental Health Unit is housed in the SCI.

IX-08 TREATMENT PLANNING AND RESPONSIBILITIES

A) **Psychiatric Review Team (PRT):** The PRT members (the inmate's unit manager, health care administrator, unit counselor/DATS, psychiatrist, unit psychologist, and any other staff deemed appropriate by the Superintendent are included) shall meet within three working days of the inmate's placement in observation to discuss present and future interventions. The PRT shall develop an aftercare plan based on the inmate's therapeutic needs. The Psychiatric Review Team shall monitor the inmate's progress for at least 30 days after his/her release from observation, and longer if determined by team members based on the inmate's risk level.

B) **Continuity of Care:** An Aftercare Plan is developed by the PRT based on the inmate's therapeutic and custodial needs. Recommendations for Special Needs Unit placement, if one is available in the facility, monitoring via the regular institutional tracking system, and/or weekly counselor or psychologist contacts are possible components of a plan. The PRT monitors the inmate's progress for at least 30 days after his/her release from observation, and longer if determined by team members based on the inmate's risk level.

C) **Unit Psychologist and Counselor/DATS:** Based upon the recommendation of the PRT, both the unit psychologist and counselor/DATS, as part of the PRT shall visit the inmate daily while the individual is on a continuous or close watch. Afterward, follow-up is determined by the PRT.

D) **Psychiatrist:** The psychiatric visits are determined by the psychiatrist's availability during a one week period. If the inmate is on continuous or close watch, the treating psychiatrist visits the inmate every day of his/her service and no less than once a week on any watch.

E) **Physician:** The institutional physician shall visit the inmate daily.

F) **Chief Psychologist:** The chief psychologist or designee shall arrange for timely mental status examinations and monitor the daily adjustment of all inmates in the observation area. The chief psychologist shall chair the treatment planning meetings and insure that recommendations are provided to the Program Review Committee.

G) **Unit Manager:** The unit manager shall provide input into the inmate's current situation, and assists in the implementation of the follow-up plan after the inmate's release from observation.

H) **Nursing Staff:** The nursing staff shall open a psychiatric inpatient record upon inmate admission. The registered nurse shall be the contact person for the psychiatrist and shall assure that the original Risk Assessment Form is placed into the psychiatric inpatient record. Nursing documentation, to include psychiatric behavior and physical assessment (e.g., hands-on restraint check if applicable), shall be completed at no more than two hour intervals unless otherwise specified by the psychiatrist order.

I) **Training Officer:** The training officer shall insure that all contact staff receive one hour of training per year in suicide prevention and one hour in signs of mental disturbance. The training sessions shall be team taught by a member of the treatment staff and a management or supervisory level custody staff.

POLICY STATEMENT
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject: CLINICAL REVIEW OF SUICIDE		Policy Number: 7.3.5.
Date of Issue: February 26, 1993	Authority: *Joseph D. Lehman*	Effective Date: March 26, 1993

I. AUTHORITY

The Authority of the Commissioner of Corrections to direct the operation of the Department of Corrections is established by Section 201, 206, 506, and 901-B of the Administrative Code of 1929, Act of April 9, 1929, P.L. 177, No. 175, as amended.

II. PURPOSE

The purpose of this policy is to establish a systematic method for conducting clinical reviews of suicides committed by inmates under the Department of Corrections supervision.

III. APPLICABILITY

The policy, guidelines and procedures contained herein are applicable to all Department of Corrections facilities and staff members.

IV. DEFINITIONS

"Clinical Review": A clinical review is a process of reviewing a suicide or attempted suicide from a clinical perspective. The process includes reviewing all known factors in the case in an effort to determine what brought about the suicide or attempted suicide, detect signs and symptoms, develop a plan to correct or deter similar incidents in the future, if possible, and collect pertinent data to be used in training of all staff in order that they may become more proficient in detecting potential suicidal incidents before they occur.

"Clinical Review Team": A Clinical Review Team shall consist of an interdisciplinary team of correctional professionals including administration, counseling, psychological, psychiatric, medical and custodial services.

"Suicide": As applied in this policy suicide shall mean the act or instance of taking one's own life voluntarily and intentionally by a person of sound mind or during acute depressive episodes, acute mental illness episodes or periods of acute exacerbation of a chronic mental illness, or while under the influence of an agent either injected, ingested, inhaled or absorbed which caused the person to act irrationally and irresponsibly.

V. POLICY

It is the policy of the Department of Corrections that the superintendent of a department facility shall cause a clinical review, of all successful inmate suicides, to be conducted by appropriate staff. In cases of attempted suicide, it will be up to the discretion of the superintendent as to whether or not a clinical review shall be conducted.

The clinical review shall be a learning experience and, as such, shall be conducted in an open and honest manner with contributions encouraged from all staff in order to sharpen staff detection skills and help prevent unnecessary loss of life due to suicide. All information gathered as a result of the clinical review shall be confidential.

VI. PROCEDURES

A) Each superintendent shall establish within his/her facility a clinical review team whose function will be to conduct an in-depth clinical analysis of all successful suicide cases and any other cases designated by the superintendent.

B) The exact composition of the clinical review team will be determined by the superintendent and will to some extent depend on the nature of the incident to be reviewed. However, at a ***minimum***, the Review Team shall contain the following staff: consulting ***psychiatrist***, a ***psychologist*** (or PSAS if psychologist is unavailable), inmate's ***counselor, director of treatment*** (in lieu of DOT, the Deputy Superintendent for Treatment or Counselor Supervisor or Unit Manager may be substituted) and a supervisor level ***corrections officer***. Such other staff members as the superintendent feels are necessary may be added to the team as needed.

C) It will be the function of the clinical review team to conduct an in-depth review of all successful suicide cases and of any other cases referred to the team by the superintendent. The focus of the review should be two-fold: What happened in the case under review and what can be learned to help prevent future incidents. The team should carefully review what was done in the particular case, what precautions were taken and what procedures were followed. The clinical review team can interview other appropriate staff members or inmates (should interview victim of attempted suicide if available) or request or review written reports

prepared by other staff relative to the incident. Any additional information relative to a particular case should be explored fully.

D) Meetings of the clinical review team will be scheduled within five working days after the incident has occurred. A designated team member will take the responsibility for making sure that the central file, treatment file, medical file, incident reports etc., are available to the team at the time of the review. The team will be advised in advance of the date, time, and place of the review meeting.

E) In determining whether or not to request a clinical review of an attempted suicide, the superintendent may request a joint evaluation by the inmate's counselor and the institutional psychologist as to the seriousness of the attempt. Based on this report and the incident report, the superintendent can decide if he/she wants a review of the attempted suicide.

F) At the conclusion of the review, the chairperson of the clinical review team will make a written confidential report to the superintendent of their findings and any recommendations the team may have concerning changes in procedures. The team will also gather information that can help to sensitize all staff members to the cues and situations that are present before such incidents occur. The aim is to help all staff become more proficient at detecting potential suicidal incidents before their occurrence. Appropriate information, not the confidential report, will be shared with the institutional training coordinator, who in turn will present an annual in-service training seminar for all staff on recognition and prevention of suicide based on information gathered by the clinical review team.

G) The superintendent will forward a copy of the confidential staff report with his/her comments to the appropriate regional deputy. The report should have appended a copy of the *Critical Incident Report, Classification Summary* entries on the *DC-14 Cumulative Adjustment Record* for the 30 day period prior to the suicide or attempted suicide and any other reports considered pertinent to the incident.

VII. SUSPENSION DURING EMERGENCY

In an emergency situation or extended disruption of normal institutional operation, any provision or section of this policy may be suspended by the commissioner or his/her designee for a specific period of time.

VIII. RIGHTS UNDER THIS POLICY

This policy does not create rights in any person nor should it be interpreted or applied in such a manner as to abridge the rights of any individual. This policy should be interpreted to have sufficient flexibility so as to be consistent with law and to permit the accomplishment of the purpose of the policies of the Department of Corrections.

IX. SUPERSEDED POLICY AND CROSS-REFERENCE

This policy supersedes all previous policy on this subject (OM-107.05, memorandum dated April 18, 1990).

Policy Manual Cross-Reference: 7.3.1. SCAN Policy

ACA Cross-Reference: 3-4364

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