Scope of a National Public Health Problem and Guiding Principles to Prevention

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Scope of the Problem. There are between 400 and 600 jail suicides (excluding state/federal prisons) each year, and suicide is the leading cause of death in most jails throughout the country. During the 1980s, a national study on jail suicides that was conducted by our agency for the U.S. Justice Department estimated that the rate of suicide in county jails was 107 deaths per 100,000 inmates, or a rate that was approximately 9 times greater than in the community. In 2001, however, the U.S. Justice Department's Bureau of Justice Statistics estimated that the rate of suicide in county jails has dropped dramatically: in 1999, it was 54 deaths per 100,000 inmates, or a rate that was approximately 4.5 times greater than in the community.

Based upon our agency's research:

- *75% of jail suicide victims are detained on non-violent charges,*
- *60% of victims are intoxicated at time of confinement,*
- *51% of suicides occur within the first 24 hours of confinement (with 29% occuring within the first three hours),*
- *Two out of three victims are in isolation at the time of their suicide, and*
- *94% of suicides are by hanging.*

There are close to 200 prison suicides each year, and suicide is the third leading cause of death in prisons, behind natural causes and AIDS. From 1984 through 1993, a national study on prison suicides conducted by our agency for the U.S. Justice Department estimated that the rate of suicide in state and federal prisons was 21 deaths per 100,000 inmates, or a rate that was approximately 50% greater than in the community. During 1999, however, the rate of suicide in state and federal prisons dropped to approximately 15 deaths per 100,000 inmates or a rate that is slightly greater than in the community. The majority of prison suicide victims have documented histories of mental illness and suicidal behavior. In one recent study, 64% of victims had a suicide attempt during confinement, with 56% having more than three attempts prior to their deaths. Most victims are serving terms of ten years or more prior to their suicides; yet most suicides occur between six months and two years of confinement. The majority of prison suicides occur in "special housing unit" cells (including disciplinary confinement, administrative segregation, and protective custody).

Guiding Principles to Suicide Prevention: More times than not, we do an admirable job of safely managing inmates identified as suicidal and placed on precautions. After all, very few inmates successfully complete suicide while on suicide watch. What we continue to struggle with is the ability to prevent the suicide of an inmate who is not easily identifiable as being at risk for self-harm. Kay Redfield Jamison, a prominent psychologist and author of Night Falls Fast - Understanding Suicide (1999), has better articulated the point by stating in her book that "If suicidal individuals were either willing or able to articulate the severity of their suicidal thoughts and plans, little risk would exist."

With this in mind, I offer the following guiding principles to suicide prevention:

1. The assessment of suicide risk should not be viewed as a single event, but as an ongoing process. Because an inmate may become suicidal at any point during confinement, suicide prevention should begin at the point of arrest and continue until the inmate is released from the facility.
2. Intake screening should be viewed as something similar to taking someone's temperature; it can identify a current fever, but not a future cold. Therefore, the shelf life of behavior that is observed and/or self-reported during intake screening is time-limited.
3. Prior risk of suicide is strongly related to future risk. If an inmate had been placed on suicide precautions during a previous confinement in the facility, that information should be accessible when determining whether the inmate might be at risk during their current confinement.
4. We should not rely exclusively on the direct statements of an inmate who denies that they are suicidal and/or have a prior history of suicidal behavior, particularly when their behavior, actions and/or history suggest otherwise. Often, despite an inmate's denial of suicidal ideation, their behavior, actions and/or history speak louder than their words. For example:
   - *In Washington State, an inmate was booked into a county jail and informed the intake officer that she had a history of mental illness, had attempted suicide two weeks earlier, but stated she "would not hurt herself in jail." Jail records indicated that the inmate threatened suicide during a recent prior confinement in the facility. The inmate attended court two days later and the escort officer noticed that she appeared despondent, was crying, and appeared worried about her children. She was not referred to mental health staff, nor placed on suicide precautions. The inmate committed suicide the following day.*
   - *In Michigan, police were called to the home of a man who accidentally shot and killed a friend during a domestic dispute with his estranged wife. Upon arrival, the suspect placed a handgun to his head and clicked the trigger several times. He also encouraged the officers to shoot him. Following five hours of negotiations, the suspect surrendered without incident. He was transported to the county jail and denied being suicidal during the intake screening process. The inmate was not referred to mental health staff, nor placed on suicide precautions. He committed suicide the following day.*

These are a few of the preventable deaths that too often escape our detection.

5. Many preventable suicides result from poor communication among correctional, medical, and mental health staff. Communication problems are often caused by lack of respect, personality conflicts, and other boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides.
6. We need to avoid creating barriers that discourage inmates from accessing mental health services. Often, certain management conditions of a facility's policy on suicide precautions appear punitive to an inmate (such as automatic clothing removal/issuance of safety garment, lockdown, or limited visiting, telephone, and shower access). To an inmate, these may also be seen as as excessive and unrelated to their level of suicide risk. As a result, inmates who become suicidal and/or despondent during confinement may be reluctant to seek out mental health services if they know that loss of these and other basic amenities are an automatic outcome. Decisions regarding the management of suicidal inmates should be based on the individual's level of risk, and these barriers to services should be avoided whenever possible.
7. Once an inmate has been successfully managed with and discharged from suicide precautions, they should remain on a mental health caseload and assessed periodically until released from the facility.
8. As previously noted, few (if any) suicides take place under suicide precautions. Rather, most inmate suicides take place in "special housing units" (intake/booking, classification, disciplinary/administrative segregation, mental health, etc.) of the facility. One effective prevention strategy is to create more interaction between inmates and correctional, medical and mental health staff in these housing areas by: increasing rounds of medical and/or mental health staff, requiring regular follow-up with all inmates released from suicide precautions, increasing rounds of correctional staff, and avoiding lockdown due to staff shortages (and the resulting limited access of medical and mental health staff to the units).
9. All correctional facilities, regardless of size, should have a detailed written suicide prevention policy that addresses each of the following critical components: staff training, intake screening/assessment, communication, housing, levels of observation, intervention, reporting, follow-up/mortality review. These eight components are explained in detail as follows:

Training: All correctional, medical, and mental health staff should receive eight (8) hours of initial suicide prevention training, followed by two (2) hours of annual training. Training should include predisposing factors, high-risk suicide periods, warning signs and symptoms, and components of the facility's suicide prevention policy.

Identification/Screening: Intake screening for suicide risk must take place immediately upon confinement and prior to housing assignment, and must include inquiry regarding: current and past suicidal behavior; prior mental health treatment, recent significant loss, suicidal behavior by family member/close friend, suicide risk during prior contact/confinement with agency, and arresting/transporting officer(s) believes inmate is currently at risk. Process must include procedures for referral to mental health and/or medical personnel.

Communication: Procedures that enhance communication at three levels: 1) between the arresting/transporting officer(s) and jail staff; 2) between and among jail staff (including medical and mental health personnel); and 3) between jail staff and the suicidal inmate.

Housing: Isolation should be avoided; whenever possible, house in general population, mental health unit, or infirmary, in close proximity to staff. Inmates should be housed in suicide-resistant, protrusion-free cells. Removal of clothing (excluding belts and shoelaces), as well as use of physical restraints should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is engaging in self-destructive behavior.

Levels of Supervision Two levels are recommended for suicidal inmates: Close observation, reserved for the inmate who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of suicidal behavior, requires supervision at staggered intervals not to exceed every fifteen minutes. Constant Observation, reserved for the inmate who is actively suicidal (threatening/engaging in the act) requires supervision on a continuous, uninterrupted basis. CCTV or inmate companions/watchers can be utilized as a supplement to (but never as a substitute for) these observation levels.

Intervention: A facility's policy regarding intervention should be threefold: 1) all staff should be trained in standard first aid and CPR; 2) any staff member who discovers an inmate attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin life-saving measures; and 3) staff should never presume that the inmate is dead, but rather initiate and continue appropriate life-saving measures until relieved by

medical personnel. All housing units should contain a first - aid kit, pocket mask or mouth shield, Ambu bag, and rescue tool (to quickly cut through fibrous material).

Reporting: In the event of a suicide attempt or suicide, all appropriate jail officials should be notified through the chain of command. All staff who came into contact with the victim prior to the incident should be required to submit a statement as to their full knowledge of the inmate and incident.

Follow up/Mortality Review: Every completed suicide, as well as serious suicide attempt (i.e. requiring hospitalization), should be examined by a mortality review. (If resources permit, clinical review through a psychological autopsy is also recommended.) All staff involved in the incident should participate in each process, as well as offered critical incident stress debriefing. A mortality review, separate and apart from other formal investigations that may be required to determine the cause of death, should include: 1) review of the circumstances surrounding the incident; 2) review of jail procedures relevant to the incident; 3) review of all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; and 5) recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures.

10. We need to avoid the "obstacles to prevention." Experience has shown that negative attitudes often impede meaningful suicide prevention efforts within correctional facilities. Such attitudes form obstacles to prevention and are no more than empty excuses that "inmate suicides cannot be prevented." For example, an "obstacle to prevention" might sound something like this - "We did everything we could to prevent this death, but he showed no signs of suicidal behavior;" "There's no way you can prevent suicides unless you have someone sitting watching the prisoner all the time, and no one can afford to be a baby sitter;" "We didn't consider him suicidal - he was simply being manipulative and it just went too far;" or "If someone really wants to kill themselves, there's generally nothing you can do about it."

There are various ways to defuse these obstacles, the most appropriate of which is to demonstrate successful interventions. For example, with more than 5,000 inmates, the Orange County Jail System in Santa Ana, CA, is the twelfth largest jail system in the country, and third largest in California. During the past ten years, more than 831,040 prisoners have been processed through the system and only five inmates have completed suicide. The suicide rate in the Orange County Jail System is only 9.4 deaths per 100,000 inmates. Why? Because of the attitude exemplified by both jails and staff. As the jail commander once told me: "When you begin to use excuses to justify a bad outcome, whether it be low staffing levels, inadequate funding, physical plant concerns - issues we struggle with each day - you lack the philosophy...that even one death is not acceptable. If you are going to tolerate a few deaths in your correctional system, then you've already lost the battle."

Emerging Issues: There are several recent emerging issues that might provide optimism for continuing the trend toward lower inmate suicide rates throughout the country. For example:

• **Death in Custody Act of 2000:** Effective October 2000, each state receiving prison construction funding under the federal truth-in-sentencing grant program is required to report on a quarterly basis the death of any individual who is in the process of arrest, is en route to be incarcerated, or is incarcerated at a municipal or county jail, state prison or other correctional facility (including any juvenile facility). Entitled the Death in Custody Act of 2000, the law requires the reporting of the following: a) name, gender, race, ethnicity, and age of the deceased; b) date, time, and location of death; and c) a brief description of the circumstances surrounding the death.

Unfortunately, reporting of deaths in custody is sporadic and not enforced, and we still do not have accurate and current data on those inmates that commit suicide in jails throughout the country.

• **National Strategy for Suicide Prevention:** In May 2001, the U.S. Surgeon General's Office released the National Strategy for Suicide Prevention: Goal and Objectives for Action, which establishes 11 goals and 68 measurable objectives for public and private sector involvement to prevent suicides in the community, as well as reduce the harmful after-effects they have on families and communities.

As inmate suicide has been identified as a serious public health problem within correctional facilities, the National Strategy includes three objectives that specifically address suicide prevention within both adult and juvenile correctional facilities:

* *Increasing the proportion of correctional institutions with evidence-based suicide prevention programs;*
* *Increasing the proportion of correctional staff who have received training on identifying and responding to persons at risk for suicide; and*
* *Defining and implementing national guidelines for mental health screening, assessment and treatment of suicidal adult and juvenile incarcerated populations.*

Although very little money has yet to be appropriated for this initiative, the inclusion of suicide prevention within correctional facilities into the National Strategy clearly puts a face on the problem and is very encouraging.

• **Litigation:** Litigation has been, and will continue to be, an important factor in suicide prevention in correctional facilities. Most inmate suicides result in lawsuits and although families of suicide victims are not always successful in court, the initiation of litigation often forces correctional systems to examine themselves and institute corrective measures to reduce the opportunity for future suicides. Court awards or settlements in inmate suicide cases vary dramatically, from as low as $10,000 to as high as $2 million.

Most lawsuits target three major areas: 1) identification of potentially suicidal behavior (was behavior verbalized by the inmate and/or other sources; or was non-verbal behavior demonstrated?); 2) management of the suicidal inmate (once behavior was identified, was the inmate properly and safely monitored?); and 3) response to the suicide attempt (following a suicide attempt, how quickly and effectively did jail and medical staff respond to the emergency?). Other possible liability issues are failure to communicate, provide a safe environment, train, and provide appropriate treatment/assessment.

• **Family Survivors of Inmate Suicides:** Following an inmate suicide, family members and friends are often angry and suspicious that a loved one could complete suicide in such a restrictive and seemingly safe environment as a correctional facility. Their anger and suspicion only fester when jail officials treat them poorly, refuse to disclose details of the death, and/or are generally uncooperative. Family survivors can only begin the long and difficult process of closure when all of their questions and concerns have been satisfactorily answered by jail officials. Given that, they should contact the appropriate jail official, make their inquiries in a cordial and professional manner, and request all investigative reports of the incident. Persistence is important and full cooperation by a jail official may only come following the threat of litigation.

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Corrections Learning Network and QPR Provide Suicide Prevention Training

Anne Charles and Paul Quinnett, Ph.D.

To help implement the Surgeon General's National Strategy for Suicide Prevention, and to reduce the risk of suicide and its attendant negative outcomes (death, survivor suffering, staff trauma and stress, litigation, etc.) the Corrections Learning Network and the QPR Institute have developed state-of-the-art, modularized, exportable and online training programs for correctional workers who are in a position to identify, screen, and refer persons who may be at risk for suicidal behavior, including other officers and even their own friends and family members. These state-of-the-art training programs, including train-the-trainer formats available via distance learning, match the level of training with level of duty to inmates.

QPR is currently the most widely taught suicide prevention education program in the United States. **The Corrections Learning Network** is a distance learning initiative, administered by Educational Service District (ESD) 101, and funded through the U.S. Department of Education, providing interactive instructional programming for the nation's correctional facilities. In 1999, ESD 101 was awarded a grant from the U.S. Department of Education to develop and distribute instruction to correctional facilities. CLN programs and services include over 2,000 hours per year of broadcast instruction for incarcerated youth and adults and over 600 hours of professional development for corrections educators, administrators, officers and medical staff. The Network is now available in 800 correctional facilities in 46 states and the District of Columbia.

Working together, CLN and the QPR Institute are also planning a series of programs to broadcast over the CLN network. Experts in the fields of mental health, substance abuse, risk assessment, risk management and monitoring, establishing environmental safeguards and avoiding suicide malpractice will provide expert information and guidance to help correctional facilities reduce the risk of suicide not only among their inmates, but among their staff.

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