National Commission on Correctional Health Care

Suicide Prevention Resource Guide

National Response Plan for Suicide Prevention in Corrections

In Collaboration With

American Foundation for Suicide Prevention

National Commission on Correctional Health Care

The National Commission on Correctional Health Care is a nonprofit 501(c)(3) organization working to improve the quality of care in the nation's jails, prisons, and juvenile detention and confinement facilities. NCCHC establishes standards for health services in correctional facilities, operates a voluntary accreditation program for institutions that meet those standards, produces and disseminates resource publications, offers a quality review program, conducts educational trainings and conferences, and offers a certification program for correctional health professionals. NCCHC is supported by the major national organizations representing the fields of health, mental health, law and corrections. Each of these organizations has named a liaison to the NCCHC board of directors. For more information, go to *ncchc.org*.

American Foundation for Suicide Prevention

The American Foundation for Suicide Prevention is dedicated to saving lives and bringing hope to those affected by suicide. AFSP creates a culture that's smart about mental health through education and community programs, develops suicide prevention through research and advocacy, and provides support for those affected by suicide. Led by CEO Robert Gebbia and headquartered in New York, and with a public policy office in Washington, DC, AFSP has local chapters in all 50 states with programs and events nationwide. Learn more about AFSP at *afsp.org*.

PROJECT 2025

AFSP.ORG/PROJECT2025

Project 2025 is a high-impact, collaborative initiative developed by the American Foundation for Suicide Prevention, aimed at achieving the organization's bold goal of reducing the annual suicide rate in the U.S. 20 percent by 2025.

This publication represents the work of several national experts in suicide, mental health, corrections and correctional health care. The advice and suggestions offered here are in no way guaranteed to prevent all suicides. Some ideas may not be applicable or feasible at all facilities.

Table of Contents

2 Forewords

4 Introduction

6 Assessment of Suicide Risk in Correctional Settings

16 Suicide Prevention and Treatment of Suicidal Behavior

22 Suicide Identification and Prevention Training Curriculum Guide

30 References and Resources

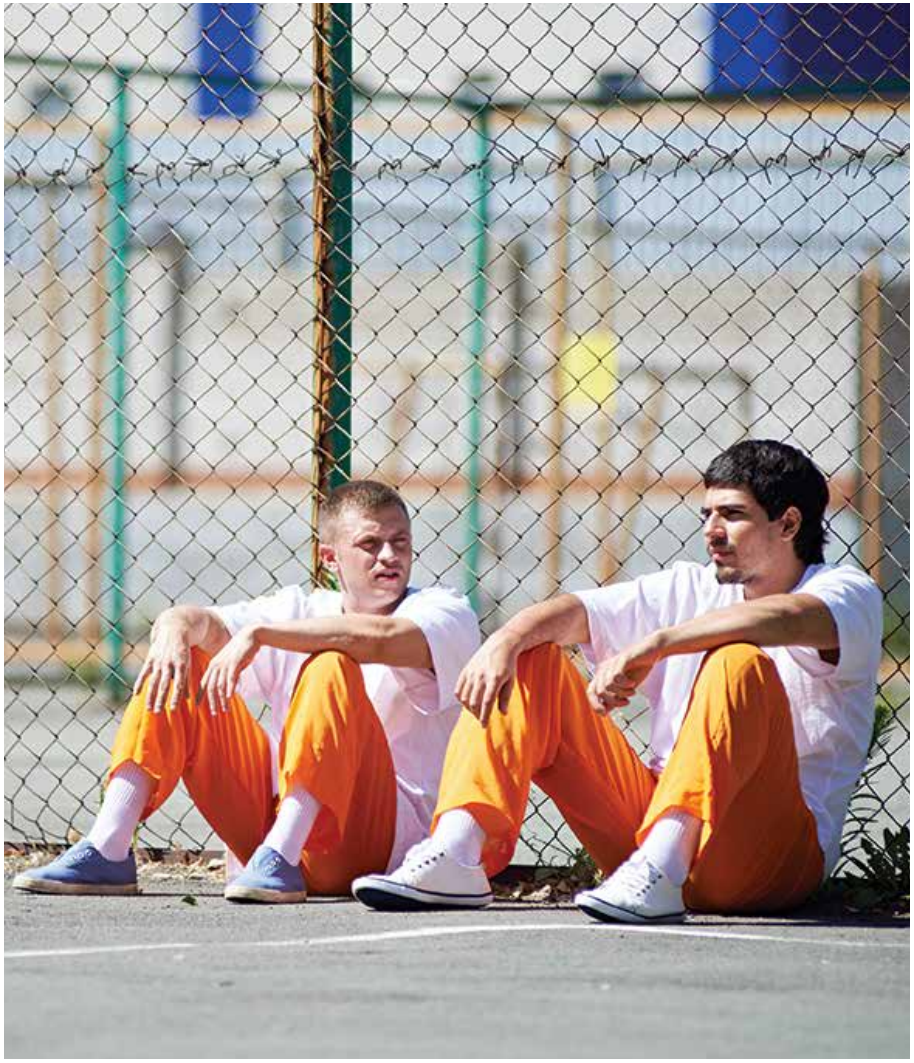
32 Facility Design: Creating a Physical Environment That Supports Well-Being

34 Case Study: Hudson County Correctional Center, New Jersey

36 Case Study: Middlesex Jail and House of Correction, Massachusetts

38 NCCHC Standard B-05 Suicide Prevention and Intervention

40 Acknowledgments and Thanks



To find this resource online, visit *ncchc.org/suicide-prevention-plan*.

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FOREWORD

National Commission on Correctional Health Care

The idea for the Suicide Prevention Resource Guide was conceived in August 2017 in a conference room in Chicago, where a group of mental health experts convened with National Commission on Correctional Health Care leadership for the inaugural Suicide Prevention Summit. The gathered participants were remarkable not only because of their collective expertise, but also because they were, in many ways, competitors, representing five major providers of correctional health care services. They came together determined to find solutions to a problem common to all correctional facilities. They discussed the complexities of suicide in corrections, shared their challenges and insights, considered possible process improvements, and discussed other ideas for keeping suicidal inmates safe. Most importantly, they agreed to keep meeting, collaborating and problem-solving.

In 2015, the American Foundation for Suicide Prevention launched its Project 2025, an ambitious initiative with the goal of reducing the annual suicide rate 20% by 2025. The project's focus on corrections as one of four key areas with potential to save the most lives created a natural synergy with NCCHC's ongoing suicide prevention efforts. The next Suicide Prevention Summit, cosponsored by AFSP, brought back the original participants, plus thought leaders from jails, universities, departments of corrections and the federal government to brainstorm next steps and start drafting an action plan.

The result is this Suicide Prevention Resource Guide, representing the collective knowledge of countless experts. The guide includes insight into assessing suicide risk, promising practices and guidelines for treating at-risk individuals, and guidance on developing a training curriculum – all through the lens of working with justice-involved patients within a correctional setting.

AFSP graciously supported this project financially, as well as provided perspective and subject-matter expertise. NCCHC provided our deep experience in correctional health care and nationally recognized standards to guide practice, as well as editing and production services.

The work of the AFSP–NCCHC partnership is not over. Together we will continue to work to reduce the incidence of suicide behind bars.

Deborah Ross, CCHP
Chief Executive Officer (interim)

Brent Gibson, MD, MPH, CAE, CCHP-P
Chief Health Officer

FOREWORD

American Foundation for Suicide Prevention

The American Foundation for Suicide Prevention is the nation's leading suicide prevention organization, and Project 2025 is our bold initiative aimed at reducing the national suicide rate 20% by the year 2025. As part of this initiative, we have identified the corrections system as one of four critical areas through which we can save the most lives in the shortest amount of time.

According to the U.S. Department of Justice, suicide is the leading cause of death in jails, and the suicide rate in prisons continues to increase. Incarcerated people are particularly vulnerable to suicide for a variety of complex reasons. As such, we are partnering with the National Commission on Correctional Health Care to create a comprehensive guide to preventing inmate suicide in jails and prisons.

This guide provides a road map for navigating the complexities of suicide prevention in correctional settings. Research tells us that people in times of transition are at especially high-risk for suicide, and that there are particularly critical windows during which we can provide effective, life-saving suicide prevention interventions. Working together with NCCHC, we can educate both correctional staff and health care professionals who work in the correctional system about suicide risk and how to identify and care for the suicidal inmate-patient.

This Resource Guide is the result of the combined knowledge of our two organizations, and was developed with input from mental health experts from the nation's largest jail and prison health care providers. Three areas have been identified as crucial for suicide prevention in a correctional setting – assessment, intervention, and training. In these pages, you will learn how to better identify and help inmates at risk for suicide, safely manage those identified as suicidal, and provide consistent, comprehensive training to all involved personnel.

Suicide can be prevented. By working together, we will save lives.

Robert Gebbia
Chief Executive Officer

Christine Moutier, MD
Chief Medical Officer

Introduction

Suicide is a profoundly solitary act. The response to it, however, must not be. Suicide prevention requires a coordinated, multifaceted team effort. Nowhere is that more true than in jails and prisons.

Incarcerated men and women are a socially excluded population characterized by a multitude of personal and social problems and, often, mental health or substance abuse issues. Those risk factors for suicide are compounded by confinement, leaving some people feeling overwhelmed and hopeless. Tragically, too many of them die by suicide as a means of ending what feels like inescapable pain.

The goal of suicide prevention is to reduce risk before it becomes a crisis and, when necessary, defuse a crisis before it becomes fatal. The correctional mental health professional's role is to help at-risk individuals find better mental health, hope, and reasons for living, and thus avert tragic and preventable suicides. That life-saving effort requires the cooperation, knowledge, observations and insights of the entire facility staff. Furthermore, suicide prevention is not a one-time event. It begins at intake and does not end until the individual returns to the community.

Fortunately, understanding of suicide risks and warning signs specific to incarcerated populations is expanding. Effective prevention strategies and interventions are being used today in correctional settings, and progress will continue to be made as knowledge continues to grow.

Through the Suicide Prevention Resource Guide, the National Commission on Correctional Health Care and the American Foundation for Suicide Prevention have joined forces to work toward reducing the incidence of suicide in jails and prisons. The guide focuses on three areas key to suicide prevention in corrections: assessment, intervention and treatment, and training. The aim is to educate the field on how to better identify and help inmates at risk for suicide, safely manage those identified as at high risk, and provide consistent, comprehensive training to all involved personnel.

Combining NCCHC's knowledge of correctional mental health care with AFSP's expertise in suicide prevention represents a unique opportunity to develop solutions that can effect real change – and save lives. In its Project 2025, AFSP identified corrections as one of four critical areas with the highest potential for preventing suicide, with the goal of reducing the suicide rate 20% by the year 2025.

Joining in the NCCHC–AFSP partnership are mental health experts serving some of the nation's largest jail and prison systems, private health care providers, and leaders from within the corrections field – individuals who operate on the front lines of the suicide crisis and offer real-world perspective.

The result of this partnership to date is this Suicide Prevention Resource Guide. NCCHC and AFSP are deeply indebted to the cadre of experts who contributed writing, research, scholarship, review, critique, input, and wisdom to the resulting product.

We hope this guide proves useful in your facility's quest to prevent inmate suicide.

(See page 40 for a complete list of acknowledgments.)

While suicide is a profoundly solitary act, suicide prevention requires a coordinated, multifaceted effort.

Assessment of Suicide Risk in Correctional Settings

Preventing suicide requires ongoing assessment to identify patients who are at heightened risk and need intervention. Only by identifying those individuals can resources be appropriately directed to target interventions and save lives.

In correctional settings, however, valid and reliable suicide risk assessment has remained elusive for a number of reasons, many of which will be discussed here. There is no magic formula or definitive approach to suicide risk assessment, as understanding of this complex behavior among a complex patient population continues to evolve. What follows are state-of-the-art recommendations based on advancements in the science and consensus among experts.

Understanding Suicide Risk

Many people have thoughts of suicide without acting on those thoughts. Fewer people make attempts, and deaths by suicide are less frequent.

The goal of suicide prevention is to reduce risk for individuals before it becomes a crisis. There are many biological, psychological, social, and environmental factors that can lead to suicidal behavior. Some contributors that may combine to increase the possibility for suicidal behavior over the course of one's life include, but are not limited to: a mental health condition, including alcohol and substance use disorders; a physical health condition or chronic pain; family history of mental health conditions or suicide; head trauma, and early life trauma or abuse (physical or sexual).

On top of lifetime risk factors, current factors may include life stressors; current alcohol and substance use; current mental and physical health, and access to care. Access to lethal means is the key factor leading to death.

When an individual is in a suicidal crisis, their thinking becomes limited and less flexible, and they feel tremendous pain and desperation. In these moments, they don't have access to their usual coping abilities, and protective factors such as family, friends, religion, and hope may be stretched.

Fortunately, tools and interventions exist that can help to prevent suicide. They involve: treating mental health conditions; developing a plan for managing suicidal thoughts and behaviors; and limiting access to lethal means. Suicidal crises come and go, and research shows that the intensely painful moment of possible action is temporary, so buying someone time to get through it by limiting access to means, and helping them get through the immediate crisis can save their life.

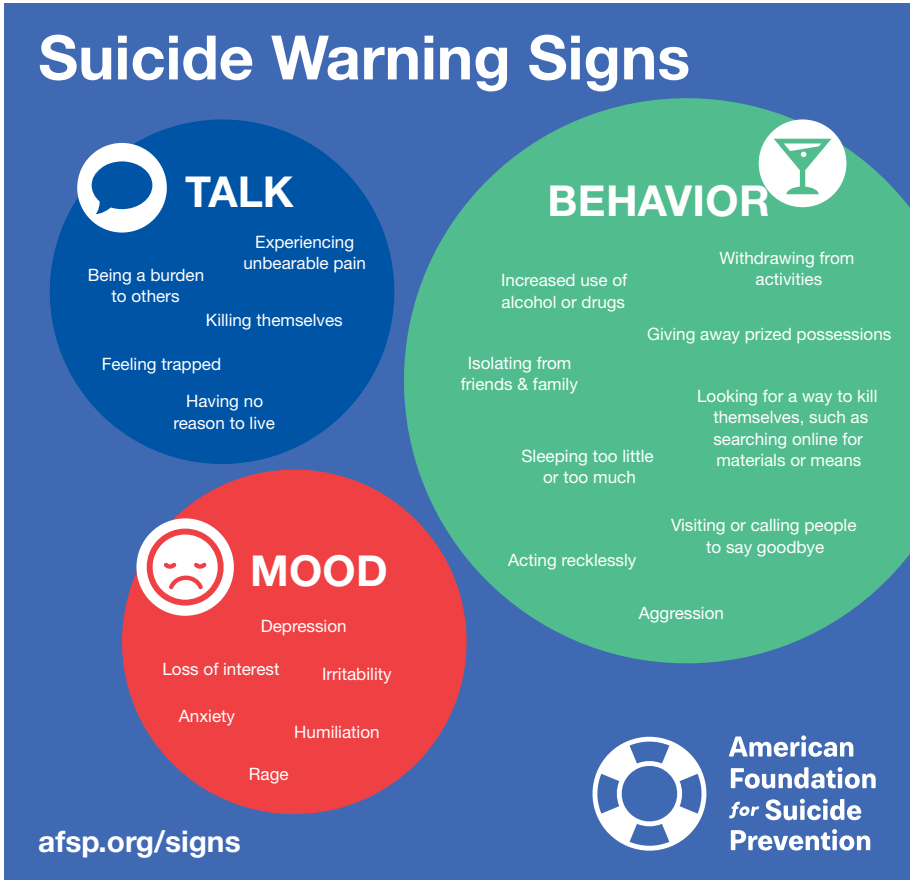
Assessment: More Thorough Than Screening

Screening and assessment, while both important to identifying individuals at risk for suicide, are

not the same thing. That is an important distinction, as the terms are often mistakenly interchanged.

Screening is generally a one-time event used at intake for the early identification of individuals at potentially high risk for suicide. Screenings are usually brief, use simple "yes/no" questions, and can be administered by health care professionals or trained custody staff. Screening results do not definitively diagnose a specific condition or disorder, but can indicate a need for further evaluation or preliminary intervention.

Screening tools for suicide risk that have been validated in the community are available that can be used in correctional settings with modification. *(See box on page 11 for list of validated screening tools.)* They can be used during the admission process to help identify immediate needs and in special situations, such as placement in restrictive housing/ segregation, following a court hearing, proximate to a transfer or a change in security status.



Assessment, on the other hand, is an in-depth process involving a comprehensive examination conducted by a qualified mental health professional (QMHP).

Assessment is not a one-time event, but a process that should be ongoing throughout the at-risk patient's incarceration.

An assessment includes a thorough evaluation of the individual's history and functioning across multiple domains, providing a more complete clinical picture. Assessments assist in identifying key risk factors, including mental health conditions or psychological problems and their severity, and aid in treatment planning. Assessments typically integrate results from multiple sources, including psychological tests, clinical interviews, behavioral observations, clinical records, and collateral information.

A comprehensive assessment of suicide risk includes sufficient description of the current behavior and justification for the interventions being provided to mitigate risk and move the individual away from suicidal thoughts and behaviors.

This section of the Suicide Prevention Resource Guide focuses on assessment, as it is assessments that inform health staff about the targeted interventions required for the individual patient.

Understanding Incarcerated Populations

Justice-involved individuals, as a whole, present certain characteristics that make suicide risk assessment and intervention particularly complicated. To understand those challenges, it is important to understand the incarcerated population.

Common risk factors are all too common. Research has identified certain risk factors that heighten the risk for suicide. Those risk factors are common and chronic among incarcerated individuals, underscoring the need to provide prevention strategies for the entire incarcerated population.

Justice-involved patients often have histories of trauma. Trauma is a risk factor for suicide. According to the National Center for Posttraumatic Stress Disorder, about 4% of men and 10% of women in the United States will develop PTSD sometime in their lives, while approximately 6% of male inmates and 21% of female inmates meet criteria for PSTD. An even larger number of incarcerated individuals have been exposed to traumatic events, including domestic violence, neglect, emotional abuse, physical abuse, assault, sexual abuse, and sexual assault. Among female inmates, staff have estimated trauma exposure as high as 90%.

About "Suicide Watch" or Precautions

Patients assessed as at current risk for suicide must be placed on a level of suicide precautions consistent with their level of risk. All cells housing suicidal inmates must be suicide-resistant. Decisions regarding the removal of a patient's clothing, bedding, possessions (e.g., books, slippers/sandals, eyeglasses) and privileges should be commensurate with the level of suicide risk as determined on a case-by-case basis by the assessing qualified health care professional.

If the health care professional determines that a patient's clothing needs to be removed for reasons of safety, the patient should always be issued a safety smock and safety blanket. All patients on suicide precautions should be allowed access to a shower consistent with schedules in other special housing units. A safety mattress should be issued to any patient on suicide precautions unless he/she utilizes the mattress in ways in which it was not intended (e.g., attempting to tamper with/destroy, utilize to obstruct visibility into the cell).

Patients on suicide precautions should not automatically be locked down; they should be allowed all routine privileges (e.g., family visits, telephone calls, out-of-cell exercise) commensurate with their security status. Finally, all patients on suicide precautions should be allowed to attend court/parole hearings unless exigent circumstances exist in which a patient is out of control and at immediate risk to self and others.

A complicating factor is that individuals with histories of trauma may not easily engage in open and honest discussions about their thoughts and feelings, especially with people they do not know.

Justice-involved patients can be impulsive. Many incarcerated individuals have antisocial traits, as expressed by their willingness to violate the law, and many also struggle with substance use disorders. Common characteristics of people with those challenges include impulsivity and recklessness. Impulsivity is marked by engaging in behavior without forethought. Recklessness is marked by engaging in behavior without consideration of the danger or consequences of one's actions. Both result in unpredictable and often sudden dangerous behaviors, including suicidal actions.

It is difficult to assess risk in a population for whom impulses play a large part. As an example, a suicide risk screening completed during the reception process may not identify the risk factors that characterize an impulsive response to interpersonal conflict days later.

Suicide Risk Assessment: A Process, Not an Event

At present, there are no known validated suicide risk assessment instruments designed specifically for use in correctional settings. The principles and approaches described below are based on a general population in the community. As such, they are a useful starting point for risk assessment of incarcerated individuals, while not addressing the unique challenges discussed.

While each method provides a foundation for conducting suicide risk assessment, additional information is needed to develop an assessment process appropriate for incarcerated populations and correctional settings. Until a validated corrections-specific assessment instrument is developed, these principles are to be used as guidelines.

Each of these methods highlights that suicide risk assessment is a process, not an event; is multifaceted;

and requires information from multiple sources. These methods also rely heavily on patient self-report, which can present challenges with correctional populations.

Zero Suicide: The Zero Suicide initiative describes three components of a full assessment and provides a foundation for treatment planning:

1. Gather complete information about past, recent, and present suicidal ideation and behavior
2. Gather information about the patient's context and history (e.g., mental and physical health, family mental health history, early trauma and abuse history, head injury)
3. Synthesize that information into a prevention-oriented suicide risk formulation anchored in the patient's life context

Collaborative Assessment and Management of Suicidality (CAMS): CAMS is an evidence-based, flexible assessment and intervention model based on a process of collaboration between the clinician and the patient. The goal is to identify drivers of suicidal ideation and behavior along with reasons for living and reasons for dying to discuss ambivalence about suicide. This establishes a basis for collaborative solutions. It functions as a tool for both assessment and intervention.

Chronological Assessment of Suicide Events (CASE): The CASE approach involves exploring the chronology of suicidal ideation and behavior with the patient and provides recommendations for interviewing techniques to help elicit disclosure of suicidal ideation. The CASE approach involves three tasks:

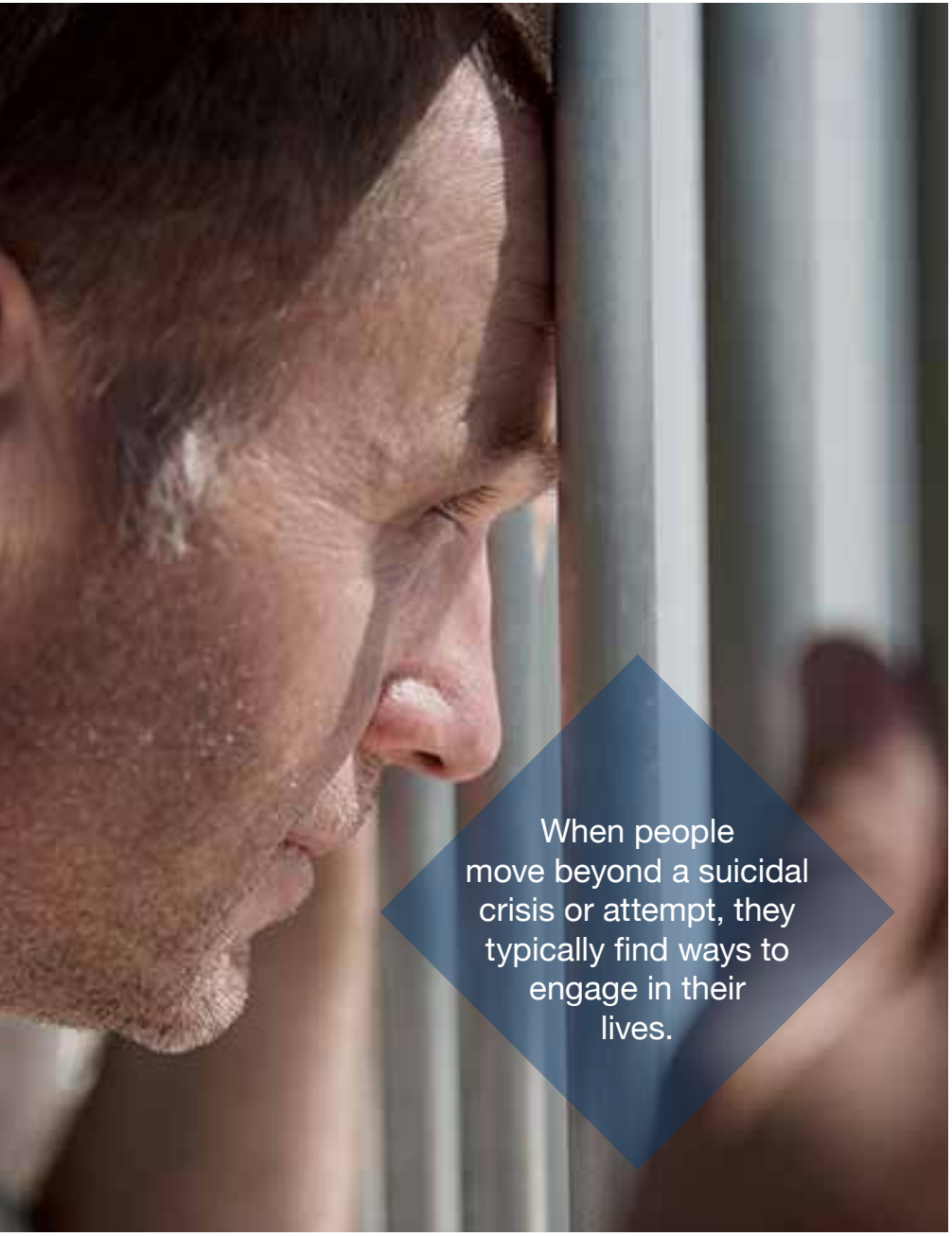
1. Gathering information related to the risk factors for suicide
2. Gathering information related to the patient's suicidal ideation and planning
3. Making clinical decisions based on those data

H.E.L.P.E.R: The H.E.L.P.E.R system has three phases: 1) collection of data (information about the patient), 2) analysis of that data, and 3) documentation. The H.E.L.P.E.R system includes the following:

- Historical factors
- Environmental factors
- Lethality of the suicide thinking and behaviors
- Psychological factors
- Evaluation of suicide risk potential
- Reporting of findings

National Suicide Prevention Lifeline: Under a grant from the Substance Abuse and Mental Health Services Administration, the National Suicide Prevention Lifeline developed a set of core principles and subcomponents for suicide risk assessment that includes four main areas to be probed during an assessment: suicidal desire, suicidal capability, suicidal intent, and mitigating buffers/connectedness.

- Suicidal desire
  - Suicidal ideation
  - Psychological pain
  - Hopelessness
  - Helplessness
  - Perceived burden on others
  - Feeling trapped
  - Feeling intolerably alone
- Suicidal capability
  - History of suicide attempts
  - Exposure to someone else's death by suicide
  - History of/current violence to others
  - Extreme agitation/rage
  - Available means of killing oneself
  - Currently intoxicated
  - Substance abuse
  - Acute symptoms of mental illness
- Suicidal intent
  - Attempt in progress
  - Plan to kill self, method known
  - Preparatory behaviors
  - Expressed intent to die
- Buffers/connectedness
  - Immediate supports
  - Social supports
  - Planning for the future
  - Engagement with helper
  - Ambivalence for living/dying
  - Core values/beliefs
  - Sense of purpose



Approaches to Assessing Suicide Risk

Clearly, the process of assessing suicide risk involves more than completing a simple questionnaire with the patient.

Be collaborative, confident and compassionate. The Zero Suicide initiative emphasizes that screening and assessment of suicide risk must attend to more than just the instrument being used or the questions being asked. The qualified health care professional conducting a clinical interview is encouraged to:

- Adopt a collaborative stance, reflecting empathy and genuineness.
- Convey confidence that pain can be alleviated by alternative means and that the patient can be empowered to use care and services to do so.
- Treat the interview as an exploration of what has happened to the patient, not as a task to complete or an examination of what is wrong with the patient.
- Indicate that when people move beyond a suicidal crisis or attempt, they typically find ways to engage in their lives. More than 90% of people who make a suicide attempt do not die by suicide even upon long-term follow-up.
- Express an understanding of the ambivalence in the patient's desire to die to relieve pain.

Ensure reasonable privacy and confidentiality during the screening and assessment processes. Experience has demonstrated that it is not unusual for an otherwise suicidal inmate to deny suicidal ideation when questioned in a physical environment that lacks privacy and confidentiality. The intake or reception area of any jail or prison is traditionally chaotic and noisy, an environment where staff feel pressure to process a high number of inmates in a short period of time. Two key ingredients for identifying suicidal behavior – time and privacy – are at a minimum. The ability to carefully assess the potential for suicide by asking the inmate a series of questions, interpreting their response (including gauging the truthfulness of their denial of suicide risk), and observing their behavior is grossly compromised by an impersonal environment that lends itself to something quite the opposite. Efforts should be made to ensure privacy and confidentiality (from other inmates and non-health care personnel) when conducting suicide risk screening and assessments.

Maximize rapport and self-disclosure. In *The Practical Art of Suicide Prevention*, C.S. Shea identified the following approaches to help establish rapport and encourage self-disclosure on the part of the patient:

- Ask for specific descriptions of behavioral incidents, not the patient's opinions.
- Avoid judgmental or shame-inducing questions by framing questions in a manner that is consistent with the patient's experience.
- Assume the existence of suicidal impulses and ask about them directly, in a matter-of-fact tone.
- Frame questions regarding frequency of behavior and ideation in a manner that may overestimate their true frequency, so that the patient will respond with a more accurate estimation of their frequency, rather than minimizing them.
- Avoid blanket questions. Instead, ask about specific types of suicidal behavior and ideation separately.

But don't rely solely on self-report. It is extremely important for a qualified health care professional (QHCP) to balance patient self-report with the collection of objective data related to the patient's suicide risk using all information available to them.

Screening and Assessment Instruments

The following list includes some of the screening tools that have been validated on community populations (not corrections):

- **Columbia Suicide Severity Rating Scale (C-SSRS):** Three versions are available for use. The "Lifetime/Recent" version supports inquiry into a patient's lifetime history of suicidal ideation and behavior as well as any recent suicidal ideation and/or behavior. The "Since Last Visit" version of the C-SSRS screens for suicidal ideation and behavior since the patient's last visit. The "Screener" version is a shortened form of the full version. Available at: *cssrs.columbia.edu*
- **Suicide Behaviors Questionnaire – Revised (SBQ-R):** This 4-item questionnaire includes questions about suicidality over the lifespan as well as future risk. It includes a scoring guide with validated cut-scores. Available at: *integration.samhsa.gov/images/res/SBQ.pdf*
- **Patient Health Questionnaire – 9 (PHQ-9):** Used most often in primary care settings, this nine-item questionnaire has been validated in the identification of high-risk patients. Download from: *uspreventiveservicestaskforce.org/Home/GetFileByID/218*

The following assessment instruments have been validated on community populations (not corrections) and are entirely self-report based:

- **Beck Scale for Suicide Ideation:** Available for purchase at *pearsonassessments.com/store*
- **Beck Hopelessness Scale:** Available for purchase at *pearsonassessments.com/store*

Whenever possible, previous treatment information should be reviewed, along with objective data from staff observations and incident reports, and direct observation of the patient during the clinical interview. Include family members, if possible, as people may convey their distress more directly to family.

Include discussion of coping strategies and other protective factors during the assessment interview. A critical ingredient to the suicide risk assessment process (as well as clinical rationale for discharging the patient from suicide precautions) is the development of a safety plan.

A safety plan includes warning signs, ways the person can distract themselves, who they can be with to distract themselves, people they can discuss their distress with, professionals and how to contact them, how to limit access to lethal means, and reasons for living. While this is an intervention, the development of the plan provides a wealth of information to support the assessment. A suicidal crisis is not a good time to develop a plan.

One helpful instrument is the Reasons for Living Inventory, which assesses life-maintaining beliefs. Areas of potential inquiry include the patient's:

- In-cell activities
- Distress tolerance skills
- Emotion regulation skills
- Long-term goal orientation
- Relationships with cellmates or others on the tier
- Relationships with supports in the community
- Ability to ward off suicidal/self-injurious impulses
- Ability to ask for help
- How the patient has handled similar situations in the past

Conduct comprehensive training for health and custody staff. All staff members who work with inmates should receive both initial and recurring suicide prevention training that includes, but is not limited to, the following topics: avoiding negative attitudes to suicide prevention, why correctional environments are conducive to suicidal behavior, risk factors to suicide, high-risk suicide periods, warning signs and symptoms (verbal and behavioral cues) and identifying suicidal inmates despite the denial of risk.

Use the *Suicide Identification and Prevention Training Curriculum Guide* on page 22 as the foundation for study and staff training.

Provide adequate staffing. Many correctional facilities function with staff vacancies. Shortages in mental health staffing do not support thoughtful, attentive, and comprehensive suicide risk assessments. Instead, cursory screenings may be conducted just to ensure that at least some evaluation of risk is completed. Vacancies in custody staff can result in systemic and dangerous barriers to patients' access to care.

Without sufficient staff, the risk for inmate suicide will remain high in correctional settings, exacerbated by inmate isolation, lack of access to mental health staff, and decreased monitoring by custody staff.

Take time to establish rapport and trust. Conversations about suicidal thoughts, despair, and hopelessness are difficult even in the best therapeutic contexts. Correctional settings are far from therapeutic and are challenging with respect to privacy and confidentiality. Effective suicide risk assessment requires that the assessment be conducted in a private and confidential setting, not cell-front.

Health staff can feel pressure to be efficient and may feel rushed to complete an assessment rather than to connect with a patient experiencing distress. Despite good intentions, health staff may "signal" to the patient that there is insufficient time to dive in to his or her experience. Suicidal individuals can be sensitive to these dynamics and shut down in the midst of an assessment.

Communicate with family members and supports, especially when they convey concern. It is important for any incarcerated individual at risk for suicide to be able to access social supports. Early on in the evaluation of these patients, it is important to work with them to identify individuals who can be relied upon for support. Whenever possible, health care staff should obtain releases of information to be able to contact family and friends to discuss patient needs.

Open communication allows for the patient to experience support from multiple relationships. It also allows for health care staff to alert family and friends to high-risk times, warning signs and other factors that may be identified by those social supports but may not be shared with clinical staff. Family and friends should be encouraged to contact facility staff whenever they have concerns.

Balance safety and autonomy. Most models of health care and wellness share the foundational assumption that patient health is maximized when patients are autonomous, engaged, and able to make informed decisions about their care. In correctional settings, health staff must balance support for patient autonomy with support for patient (and often institutional) safety. Often there are two choices for patients experiencing suicidal thoughts: return to general population with a plan for follow-up, or be placed in a single cell under observation on suicide watch. Both options are far from ideal.

Typically, suicide watch is highly restrictive and very uncomfortable. Patients are placed alone in a cell, clothed in a tear-proof smock, with a tear-proof mat, and observed continuously by another individual. Finger food is provided without utensils.

While that approach can often support safety, it removes the patient's ability to develop or practice the skills necessary to cope with distress. For many patients, it intensifies feelings of shame, triggers traumatic memories, increases feelings of hopelessness, and erodes therapeutic connections with health staff. The underlying message is that the patient is incapable of keeping safe. Understandably, patients may be hesitant to reveal suicidal thoughts when they know the result of doing so.

Decisions about whether or not to place a patient on "suicide watch" need to be made based on a thorough evaluation of risks, protective factors, contexts, and patient characteristics. There is no one formula that will work for every patient. Qualified health care professionals need to weigh all factors to determine how best to support patient safety while also providing care in the least restrictive environment possible to maintain that safety.

Conduct suicide reviews/ psychological autopsies under protection from litigation. In some facilities, clinical mortality reviews and psychological autopsies – critical quality improvement processes – can be hindered or diluted by litigation fears.

It is important for any incarcerated individual at risk for suicide to be able to access social supports.

In NCCHC's 2018 *Standards for Health Services* for jails and prisons, standard A-09 Procedure in the Event of an Inmate Death requires the following:

- A clinical mortality review is conducted within 30 days
- An administrative review is conducted in conjunction with custody staff
- A psychological autopsy is performed on all deaths by suicide within 30 days

The purpose of these reviews is "to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study." The intent is to improve care and prevent future deaths.

However, the litigiousness surrounding inmate deaths and the media attention those lawsuits attract can create a degree of hesitancy about fully discussing and documenting the specifics of an inmate suicide. Fear of litigation might make full transparency seem like a liability and legal risk rather than a quality improvement opportunity. To fully examine the event and understand where improvements are needed, staff must be able to study events in an open and transparent way.

Guidance may be needed on how to conduct thoughtful, relevant, and transparent reviews that inform quality improvement and procedural changes without putting the correctional system at undue risk for liability and litigation.

Collect and share data on suicide. Sharing suicide data among facilities is essential to the field's increased understanding of this complex behavior and the unique risks and protective factors specific to incarcerated and justice-involved populations.

See *The Need for a Corrections-Specific Suicide Risk Assessment Process* on page 15 for more information.

The Need for a Corrections-Specific Suicide Risk Assessment Process

In order to create a clinically comprehensive, effective, efficient, corrections-specific suicide risk assessment process, a structured risk assessment guide needs to be developed. Ideally, this guide would be informed by relevant risk and protective factors specific to justice-involved and incarcerated populations, along with prompts for exploring relevant issues during an interview.

Development of such a guide will require research, data collection, and shared findings, as well as training and statistical analysis. It will also require determination of whether one guide can provide support for valid risk assessment in both jails and prisons, or if two separate sets of factors or risk assessment processes are needed for those distinct populations.

Currently, little research is available on the risk and protective factors that may be unique to incarcerated individuals. At a minimum, the following need to be identified:

- Historical (static) risk factors
- Clinical (dynamic) risk factors
- Institutional/situational risk factors
- Protective factors and coping skills

Unfortunately, collection of the data required for a clearer understanding of risk factors and suicidal behavior are not usually shared among correctional systems for reasons that include legal liability risks, negative press, and fear of blame. Each system is limited to analyzing its own suicide data, and the ability to aggregate information is lost. No individual correctional system is capable of generating the amount of data needed.

Development of a corrections-specific list of risk factors that can be analyzed with sufficient statistical power will require collaboration across multiple correctional agencies. It will likely be necessary to develop a national database of information that can be used to better determine which factors impact the likelihood of completed suicide.

The following data points are likely to assist in better understanding of suicide among the inmate-patient population:

- Date of incarceration
- Date and time of suicide
- Demographics: age, ethnicity, gender, marital status, education, diagnoses
- Crime and custody information: type of crime (violent, nonviolent property, drug, etc.); type of pending charges; incarceration status; security level, housing location, and type of cell; length of time in segregation or length of time pending in segregation (if applicable); length of time remaining on sentence; recent change in any of those factors
- Suicide characteristics: method; objects used; precautions against discovery (no, little/passive, or yes); active substance use (if yes, type of substance); toxicology conducted with results
- Lifetime historical risk factors: substance abuse, impulsivity, suicidal or self-injurious behaviors, trauma/abuse, psychiatric treatment, family/close friend suicide
- Clinical risk factors: recent presentation of agitation/severe anxiety, hopelessness, psychological turmoil, alienation, depressive symptoms, psychotic symptoms, suicide plan, sudden change in mental status, sudden onset stressor, one or more mental health conditions

- Other risk factors: recent self-injury, recent change in physical health, recent conflicts with peers or officers, recent bad news, recent suicide in facility, recent transition
- Protective factors: family support, frequent visits, role in caring for a loved one, positive peer relationship(s), actively involved in programming, strong religious/spiritual beliefs, recent future orientation, recent goal orientation, treatment compliance, recent use of positive coping skills, safety plan
- Management/treatment at the time of suicide: on mental health caseload, when added to caseload, on psychotropic medications, recent change in medications, date of last mental health contact, date last released from suicide precautions

Those data can be collected from information in patient records as well as findings from mortality reviews and psychological autopsies.

Suicide Prevention and Treatment of Suicidal Behavior

The correctional mental health professional's role is to help patients manage their mental health, identify hope, and recognize reasons for living, and thus avert tragic and preventable suicides.

At its core, intervention and treatment for suicidal ideation, suicidal behavior and nonsuicidal self-injury should be: private and confidential, evidence-based, collaborative, and patient-centered.

While much of the information in this guide is specifically geared toward qualified mental health professionals, it is important that administrative and custody staff also understand the factors that affect intervention and treatment, so that all disciplines can work collaboratively.

Before delving in to the specifics of suggested intervention methods, it is important to review some basic principles and realities to keep in mind when working with correctional populations.

Understanding Self-Injury's Connection to Suicide

Nonsuicidal self-injury (NSSI) is a significant problem in jails and prisons. Despite the word "nonsuicidal" in the term, there tends to be a significant overlap between NSSI and suicidal ideation and behavior. It is important to regard self-injury and threats of self-harm as a legitimate target of ongoing suicide prevention, management, and treatment efforts.

Some patients who initially engage in NSSI may miscalculate the lethality of the behavior, while others who chronically self-injure can become suicidal over time. Research indicates that many suicide victims had previously engaged in self-injurious behavior, displayed problems with impulse control, or expressed hopelessness or suicidal thoughts.

Episodes of self-injury are emotionally charged events not only for those who engage in this behavior but also for the health and custody staff members involved in managing such episodes. The time and effort expended in managing these cases is considerable and fraught with frustration and indecision. There can be a tendency to consider self-injurious behavior as driven by manipulative intent, thereby suggesting that the individual is not suicidal. Collaborative, interdisciplinary strategies for the management and treatment of inmates who self-injure or threaten to harm must be developed and implemented, regardless of the perceived motivation of such behavior.

One way to reframe the misguided interpretation of behavior as simply manipulative rather than reflecting suicide risk is to understand that at a moment of crisis, many people at risk for suicide lose their usual, more effective coping strategies, and therefore engage in behaviors that may appear manipulative but come from a place of desperation and thinking that is inflexible and constricted.

For the purposes of these guidelines, therefore, ***the term NSSI will be used in conjunction with the term suicidal to describe at-risk patients.***

The Need for Privacy and Confidentiality

The physical and social environment in which treatment is provided plays a prominent role in the success of therapeutic interventions. For suicidal patients, those interventions have traditionally been delivered within the context of suicide risk assessment prior to, during, and immediately after the individual's placement on suicide watch. In the correctional setting, such intervention typically occurs at cell front, lacking privacy or confidentiality. Moreover, suicide watch is often conducted in areas that do not constitute a therapeutic environment.

Qualified mental health professionals (QMHPs) should, to the degree possible, deliver assessments and treatment to suicidal inmates in a location that offers privacy and confidentiality and is physically separate from the suicide watch cell/room. Therapeutic interventions are to be considered separate and distinct from routine daily risk assessments.

Administrative officials and custody staff can help ensure that therapeutic services to suicidal and NSSI patients can be provided in an area that is conducive to treatment. At a minimum, the location should have adequate lighting and ventilation, essential furniture, and privacy.

The Importance of Self-Care and Support

Mental health professionals are at high risk for professional burnout due to their exposure to anger and despair in an environment that is not always conducive to treatment. In addition, a significant portion of the clientele suffers from serious mental illness and is often resistant to therapeutic intervention. That potent combination can cause unhelpful or even dangerous emotions within the professional, who needs to guard against, acknowledge, and respond appropriately. Please keep the following in mind as you work with suicidal and NSSI patients.

Photo: Tampa Bay Times

Remain vigilant for cynicism, hypervigilance, apathy, and other warning signs of stress, and actively seek supervision, consultation, and peer support to prevent burnout and its adverse consequences. Working with suicidal patients and those who engage in persistent self-injury exposes mental health professionals to trauma. Proactive self-care is essential for optimal patient care, and for maintaining empathy, work satisfaction, and efficacy.

Pay close attention to negative feelings toward a patient and immediately seek consultation or supervision if negative feelings persist. It is not uncommon to become frustrated with, or even resentful toward, certain patients. Such feelings can undermine the delivery of effective treatment to the very patients most in need of help. Research also has demonstrated that negative feelings on the part of health care professionals can be detected by patients and contribute to increased suicide risk. If negative feelings are strong or persistent, the mental health professional is obligated to refer the patient to a colleague.

Make sure that personal attitudes about suicide and suicidal patients do not undermine the therapeutic alliance. One of the most consistent findings in psychotherapy research is that a strong therapeutic alliance or bond between the patient and mental health professional is positively correlated with treatment outcome. QMHPs must be aware of their own beliefs and how they could hinder the ability to structure treatment in a collaborative fashion.

Do not acquiesce to patients' demands for fear that they may attempt or die from suicide. Under pressure from a patient, it is possible to lose perspective and feel compelled to abandon the treatment plan, resulting in reactive and chaotic treatment. **Remember, as a qualified mental health professional, you exercise due diligence and proper care when you:**

- Transparently work in the patient's best interest
- Remain clear about the necessary elements of suicide-specific treatment
- Refer patients to other professionals when appropriate
- Seek professional consultation
- Carefully document clinical decisions and actions

Become a "behavioral consultant" to educate team members from other disciplines. Custody and health staff may not fully understand the unique clinical factors in self-injurious and suicidal behavior. Furthermore, while correctional policies and procedures regarding the management of suicidal patients that are promulgated without input from QMHPs tend to be concrete, specific, and rigid, mental health professionals necessarily adhere to more general, flexible, and case-specific clinical guidelines. Flexibility in the application of both correctional directives and therapeutic interventions is required for effective management and treatment of self-harm and suicidal behavior. Of course, development of any policy, procedure, and/or directive regarding the management of suicidal patients should exemplify collaboration between custody and mental health staff.

Seek input and consultation from supervisors and colleagues. The assessment, management, and treatment of suicidal patients is a stressful, high-stakes challenge for most QMHPs. They are often under pressure from administrative officials to make quick decisions (e.g., whether the patient is at true risk or "just manipulating"), and pressured by custody personnel to restrict both the frequency and the duration of suicide watches. Therefore, peer consultation or clinical supervision is always helpful in clinical decision making and treatment planning related to suicidal patients. Moreover, consultation with a colleague has proven most helpful to those mental health professionals who have been the subject of civil litigation as the result of patient suicide.

When possible, meet as multidisciplinary treatment teams, so that qualified mental health professionals and other appropriate staff members can review all patients receiving suicide-specific treatment. Such meetings are rich sources of ideas and suggestions regarding therapeutic interventions and management strategies, and can be an excellent forum in which to consider barriers to treatment and brainstorm strategies to address them.

Find peer support, consultation, and/or supervision in the immediate aftermath of a death by suicide. Sadly, research indicates that more than one in five mental health professionals will lose a patient to suicide in the course of their career. The experience can be shocking, disheartening, and surreal, and must be addressed with compassion, respect, and a reparative approach.

Therapeutic Intervention Principles

Although NCCHC does not endorse any specific therapeutic approach for suicidal patients, it is imperative that all therapeutic interventions are founded on an evidence-based and clinically useful treatment model.

The model should directly target suicidal ideation and behavior, emphasize patient adherence to the treatment protocol, and focus on cognitive and behavioral skill deficits with the opportunity to rehearse new skills. While each patient and each situation is unique and complex, the following are agreed-upon principles for working with suicidal and NSSI patients.

The first therapeutic encounter with the patient should be highly structured and involve creation of a safety plan. A safety plan, sometimes called a crisis response plan, is a prioritized, written list of coping strategies and sources of support developed by the QMHP in collaboration with the patient. As discussed in the *Assessment* section of this guide, the safety plan should be guided by the mental health staff in conjunction with the patient to address relapse prevention and initiate a risk management plan. The risk management plan should describe signs, symptoms, and the circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur.

Based on the person's condition, capacity, and assessment, safety planning can include conceptualization of reasons for living, crisis management skills, relaxation techniques, mindfulness exercises, and problem-solving skills. Evaluation for and treatment with medication is an important component for some patients.

Note: A safety plan is not a "no-suicide contract." As they are generally used, no-suicide contracts ask patients to promise to stay alive without providing guidance on how to do that. They are, therefore, not recommended by experts in the field.

The first encounter might also include a narrative, the patient's perspective on the suicidal crisis, in which he or she is asked to tell a story associated with the most recent episode of suicidal thoughts or behavior. That narrative serves as a foundation for treatment planning and a model for understanding how best to deactivate the patient's wish to die.

Subsequent sessions, if available, can be less structured but should focus on developing a dynamic treatment plan into which the patient has substantial input. Later sessions should concentrate on restructuring attitudes and beliefs that are supportive of suicidal or NSSI behaviors. The final session should be devoted to the consolidation of skills and further refinement of the treatment plan, including safety planning and relapse prevention.

Help the patient review his or her reasons for living and reasons for dying, and then capitalize on the therapeutic alliance to inspire the patient's motivation to live. Virtually all suicidal patients engage in an internal debate over the decision to take their own life. In every therapeutic relationship, the patient's sense of caring and support by the provider can help move the patient toward their own innate reasons to fight the suicidal urge and to remain alive. Gaining the patient's own engagement against ambivalence will help him or her more fully embrace life and the use of other coping strategies.

Explore the patient's perception of his or her identity and otherwise remain culturally competent. Ethical and clinical standards require qualified mental health professionals to remain culturally aware in the treatment of all patients. This is especially important with regard to suicidal individuals, with recognition of both within-group and individual differences. If unfamiliar with the patient's culture, seek relevant training or education. However, don't assume that an individual identifies with a specific cultural group based on observed characteristics.

Treatment Plans

Address safety planning as the first and foremost clinical issue to address. A treatment plan targeting the reduction of suicidal ideation and behavior, as well as NSSI, should flow directly from a collaborative suicide risk assessment performed in collaboration with the patient. This approach is far superior to "no suicide contracts" or "contracting for safety," neither of which is clinically efficacious nor legally defensible.

Review treatment plans during every therapeutic encounter. Local or agency policy may prescribe the timeframes for updating suicide-specific treatment plans. However, it is recommended that those reviews occur during each therapeutic encounter and that treatment plans are updated as needed.

Develop a stabilization plan that promotes constructive activities, reframes negative thoughts, and enlists the support of others. Stabilization planning is a critical step in the development of a larger suicide treatment plan. Stabilization plans typically focus on direct management of suicidal thoughts, means restriction, self-soothing coping strategies, distraction techniques, physical activities, and methods for seeking support. Such plans are designed to increase the patient's ability to cope with current and future crises.

Consider a behavioral management plan for inmates who frequently engage in NSSI behavior. Such plans use positive "reinforcers" along with certain restrictions to increase the frequency of behaviors incompatible with NSSI and replace the self-destructive behavior with new, more effective behaviors and cognitive approaches. A behavioral management plan should begin with very short-term expectations. Then, as the absence of NSSI is witnessed over time, timeframes are expanded for the administration of reinforcers. For behavioral management plans to succeed, the multidisciplinary treatment team must ensure that goals and objectives are attainable, reinforcers are delivered in accordance with timelines, and all staff are fully committed to the plan's consistent execution.

Provide a schedule of follow-up for patients released from suicide precautions. Due to the strong correlation between suicide and prior suicidal behavior, in order to safeguard the continuity of care for suicidal individuals, all patients discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health personnel until their release from custody. Although there is not a nationally acceptable schedule for follow-up, unless otherwise specified in an individual treatment plan, at a minimum, patients discharged from suicide precautions should be seen within 24 to 72 hours and periodically thereafter based upon clinical judgment and caseload requirements.

Longer-Term Treatment

Help the patient identify valuable coping skills to respond differently when confronted by a situation or crisis that would normally promote suicidal ideations or behavior. Evidence-based treatment literature clearly indicates that effective strategies for preventing or coping with future crisis situations (i.e., relapse prevention) are essential to achieving successful outcomes. That can involve the use of guided imagery coupled with rehearsal of suicide-specific coping strategies.

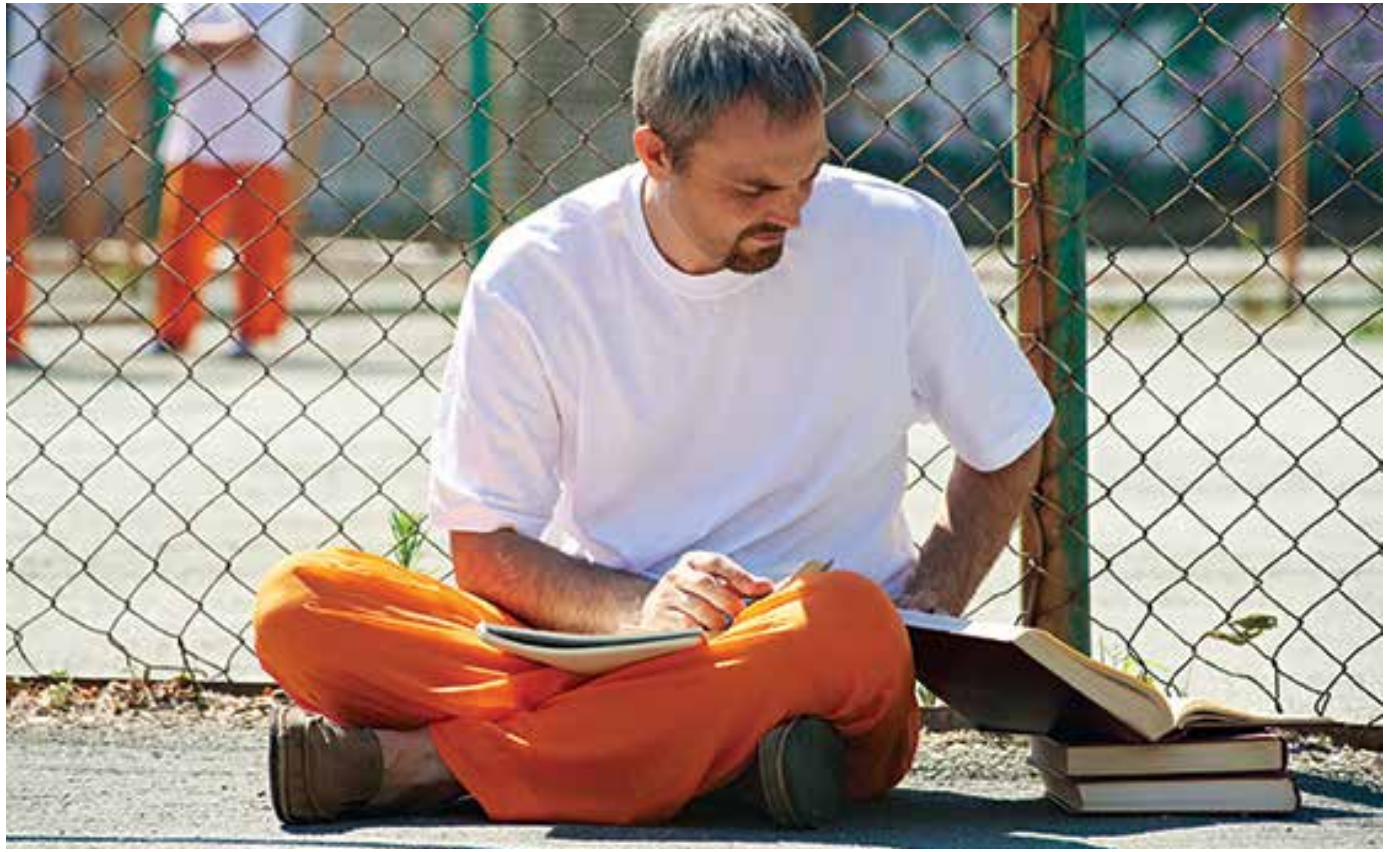
Consider CBT interventions in the treatment of suicidal and NSSI patients. The most significant advancements in the treatment of suicidal individuals have come from the cognitive-behavioral therapy (CBT) tradition. Indeed, brief CBT interventions have produced consistent evidence of their superiority to other suicide-specific treatment approaches. The following CBT-based interventions have been demonstrated to be effective:

- Dialectical behavior therapy (DBT)
- Cognitive therapy for suicide prevention (CT-SP)
- Brief cognitive behavioral therapy for suicide prevention (BCBT-SP)

Provide psychoeducation. Regardless of the therapeutic model used, the following psychoeducation is essential:

- Help patients better understand suicide risk factors as well as protective factors that can insulate them from suicidal urges
- Educate them about their mental health diagnosis, if warranted
- Teach them to recognize warning signs and precipitating factors leading to suicidal behavior
- Use bibliotherapy – a therapeutic approach that uses storytelling or the reading of specific books as therapy – combined with journaling as an adjunct to treatment
- Indicate resources available when they are in crisis

Maintain up-to-date, thorough, and suicide-specific documentation in the health record. Complete documentation is perhaps the single most important means to decrease the risk of malpractice litigation following a suicide. It is strongly recommended that, at a minimum, clinical notes include the patient's diagnosis, mental status, and current suicide risk, as well as information concerning



therapeutic interventions employed and the patient's treatment progress to date. If the QMHP determines that there is no foreseeable suicide risk at the time of the clinical visit, he or she must be sure to document the factors that led to that decision. For purposes of litigation, the clinician will always be judged by their last clinical entry into the health record. As such, the clinical decision to discharge a patient from suicide precautions should be documented as a suicide risk assessment template rather simply as a progress note. Communication with facility staff, family, and supports should also be documented.

Consider the use of peer support. The Federal Bureau of Prisons and some state correctional systems (e.g., Indiana) make extensive use of inmate peers in the care and treatment of suicidal and NSSI patients. Those inmates must be carefully screened, well trained, and closely supervised. Note that the NCCHC standards do not endorse the use of other inmates in any way (e.g., suicide watch companions, suicide-prevention aides) to provide exclusive supervision of acutely and nonacutely suicidal inmates. The presence of another inmate companion/aide does not take the place of required observations by facility staff.

When Psychiatric Medication Is Indicated

Qualified mental health professionals may not have received formal training nor otherwise have expertise in psychopharmacology. However, psychiatric medication may be included in the care of many patients. Two main principles need to be kept in mind regarding psychotropic medications:

Suicidal patients who show significant symptoms of mental illness should be referred for psychiatric medication consultation. The position of most forensic experts is that failure to do so would reflect nonadherence to the professional standard of care in such situations.

QHMPs must be aware of any psychotropic medication the suicidal patient has been prescribed by a psychiatric provider so they can remain vigilant for adverse side effects associated with specific medications, as well as for evidence that the patient is noncompliant with the medication regimen.

Suicide Identification and Prevention Training Curriculum Guide

Suicide is a leading cause of death in correctional facilities, and a rising cause of death in the community. An effective suicide prevention program can save lives. In addition, a suicide prevention program can promote a healthy environment for justice-involved people and the staff who work with them, and can lessen certain legal risks to systems and individuals.

Suicide Prevention Training Saves Lives

The NCCHC Standards for Health Services for jails and prisons standard on Suicide Prevention and Intervention (B-05) identifies the key components of a correctional suicide prevention program. The first component is training: "All staff members who work with inmates are trained to recognize verbal and behavioral cues that indicate potential suicide and how to respond appropriately. Initial and at least annual training is provided."

When staff understand that training can enable them to save lives, they are more likely to master the content and necessary skills.

Avoid Web-Based Learning

Suicide prevention is all about attitude and collaboration, principles that are lost sitting alone in a chair at a computer terminal or laptop. Therefore it is strongly recommended that any suicide prevention training be provided jointly to custody staff and health care personnel in a classroom environment, and not as a web-based (e-learning) training module.

How To Use This Guide

This guide provides a basic structure to assist any system or facility in developing a training strategy that aligns with its needs and priorities, and is consistent with key components of standard B-05 Suicide Prevention and Intervention. It is a curriculum development guide, intended as an outline to help facilities develop a full training curriculum in-house.

Please refer to the *Assessment* and *Treatment* sections for important information to include in training.

Who Needs Training? Everyone

As indicated in the NCCHC standards, all staff members who work with inmates must be trained in suicide prevention. Everyone should be provided at least a basic knowledge

about risk factors, warning signs, what to do if they think someone may be at risk, and the overall suicide prevention plan. One never knows who a suicidal person may talk with and who may be in a position to identify someone at risk.

Since a correctional environment encompasses a broad range of professionals, the goals and content of training must match the roles and baseline knowledge of a variety of trainees. These can be divided into four broad groups: custody staff (line security and custody administrators), qualified health care professionals, qualified mental health professionals, and executive leadership – those who set administrative regulations, policies, and procedures that apply across a facility or system.

While some training needs overlap, each group has its own priorities and roles in suicide prevention.

1. **Custody staff** are the eyes, ears, and leaders of every correctional and detention facility, the first to see and first to respond. Every member of the custody staff must possess the necessary

knowledge and skills to recognize the warning signs that signal an opportunity to prevent a suicide. Training should focus on increasing each staff member's ability to do three crucial things:

- Recognize and respond effectively to warning signs of impending suicide or self-harm
- Intervene to interrupt a suicidal act in progress
- Recognize when an individual needs to be referred for mental health care and ensure the referral is made in a timely and effective manner

2. **Qualified health care professionals (QHCPs)** are on the front line of health care; inmates who die by suicide have often recently been treated for primary medical problems, including chronic disorders, substance use disorders, or pain conditions. Training should provide health staff with the knowledge and skills to:
   - Screen for suicide risk in the course of providing primary care
   - Recognize the warning signs of a mental health crisis, including risk of suicide or self-injury
   - Recognize signs and symptoms of common mental health conditions
   - Refer patients in need of mental health services in a timely and effective manner

3. **Qualified mental health professionals (QMHPs)** need to possess up-to-date knowledge and skills necessary to assess and treat potentially suicidal or self-harming individuals in a manner that ensures that appropriate safety precautions are in place. Research is continually expanding our understanding of suicide; mental health professionals must regularly update their knowledge and skills accordingly. Training should enable them to skillfully:
   - Interview and build a therapeutic alliance with vulnerable inmates while eliciting the information necessary to determine if the individual is acutely or nonacutely suicidal
   - Perform and document a thorough suicide risk assessment
   - Formulate and implement a treatment plan that addresses safety and treatment needs using the least restrictive means consistent with clinical guidelines and institutional policies

4. **Executive leadership**, those individuals responsible for creating regulations, policies, and procedures, need training focused on the public health dimensions of suicide prevention, including primary preventive measures that have the potential to reduce risk throughout an entire system. Executive leadership is in a position to promote suicide prevention across a system when making decisions about environmental design, programming, staffing, and operations. *(See Strategies for Primary Prevention of Suicide on page 25.)*

Training: A Shared Responsibility

Leadership at the system, facility, and clinical program levels must share responsibility for overseeing an effective training program, as well as assessing its impact.

Training should enable them to:

- Develop and implement a system-wide suicide prevention plan
- Enumerate risk factors and warning signs of suicide risk
- Facilitate the treatment of individuals deemed to be at risk

At the system level, the responsible mental health authority and/or the responsible mental health clinician is responsible for ensuring that the clinical elements of a training program are consistent with appropriate practice guidelines and NCCHC standards.

At the facility level, the responsible health authority (RHA) and/or responsible mental health authority, in conjunction with the correctional administrator, ensures that training is available to both health and custody staff, and that training is completed.

At both the system and facility levels, correctional leadership is responsible for ensuring that custody staff complete required suicide prevention training.

Systems that contract with a vendor for health services must ensure that the lines of responsibility for training are always clear.

Training = Knowledge, Skills, and Attitudes

Training increases knowledge and skills, while at the same time shaping attitudes; therefore, the format must be structured to address each of those three areas. Preservice and annual training are essential in order to establish a baseline, measure progress, provide feedback, and enhance retention.

- The **knowledge** component of training relies on a combination of oral and visual content presentation, supplemented with written materials, matched to the baseline understanding and needs of the learners.

- The **skills** component requires practice and constructive feedback, using methods such as role-play for officers and mentored evaluations for health professionals.
- Joint training exercises in which correctional and health staff participate together can promote a confident **attitude** toward suicide prevention among all staff and underscores that suicide prevention involves a holistic, multidisciplinary approach. Requiring custody and health care personnel to sit together in a classroom environment is not only symbolically appropriate, but instills the philosophy that all professionals, regardless of credentials or agency affiliation, have an equal responsibility for inmate suicide prevention and can learn from one another's backgrounds, insights, and experiences.

Effective training answers three questions: What (knowledge), how (skills), and why (attitude). Every training activity should start by ensuring that each trainee understands why the content is relevant to their professional role. The curriculum should be designed so that every fact taught assists trainees in mastering at least one new skill. Practice, feedback, and mentoring will impart the confidence needed to put newly learned skills into action.

Strategies for Primary Prevention of Suicide in Correctional Facilities

Primary prevention strategies reduce suicide risk factors and promote protective factors across an entire incarcerated population. This impact occurs directly (such as increasing opportunities for offenders to connect with others) and indirectly (such as promoting hope). Given that the majority of deaths by suicide in the United States occur in persons not known to have a mental illness, the need to emphasize primary prevention is great.

Options to consider include:

1. Create a healthy correctional community
   - Each facility is like a "village behind walls."
     - Provide safe housing
     - Reduce emotional/physical trauma
     - Promote gender and cultural awareness
     - Support healthy activities and daily routine

2. Promote connectedness
   - Ensure that each incarcerated person, especially those housed alone, can maintain regular contact with family and other sources of support, regardless of administrative status or financial resources.
   - Reduce isolation of offenders

3. Lower barriers to seeking mental health care
   - Reduce stigma
   - Ensure confidentiality
   - Maintain an effective referral system

4. Reduce access to the means of suicide
   - Focus on locations where offenders are isolated

5. Reduce the harmful use of alcohol and drugs
   - Provide addictions treatment that include a full spectrum of treatment options and follow NCCHC guidelines

6. Promote resilience
   - Educate and reach out to inmates about coping with stress and asking for help
     - Inmate education and outreach can include classroom, written and other means of teaching incarcerated persons about suicide prevention, with an emphasis on the opportunity for each incarcerated person to experience himself or herself as part of a community whose members can make a difference to others.
     - Promote peer-to-peer outreach such as the DVD presentation, "Suicide is Forever: Recognizing & Preventing Suicide," produced by offenders for offenders in the Missouri Correctional system.
   - Educate inmates about life skills and coping skills
   - Provide work skills development and opportunities
   - Educate inmates about basic money management (to reduce financial crises)

7. Promote general health and physical functioning
   - Encourage healthy physical activities
   - Ensure restorative sleep
   - Ensure healthy nutrition
   - Control noise levels
   - Lower barriers to primary care
     - Ensure that offenders have access to effective management of
       - Chronic pain
       - Chronic illness

Facts: Choose Wisely

One note of caution: While certain facts are essential, irrelevant information can distract from overall learning. Choose facts and information that support enhancing the skills relevant to the trainee's role and "need to know."

Line security staff, for instance, need to know how to spot the risk factors and warning signs of suicide and how to refer and intervene as first responders. An emphasis on demographic correlates of suicide is of little relevance to those tasks, while training that emphasizes awareness and monitoring for unusual behavior changes is essential. Executive leadership, on the other hand, would likely find information about the rates of suicide in various demographic groups to be extremely helpful in making system-level programmatic decisions.

As another example, QMHPs need to be up-to-date about recent research findings that can aid them in differentiating acute from nonacute suicide risk, while QMHPs need to hone their skills at identifying and referring patients who may be at any level of risk.

An Effective Curriculum

The most important measure of an effective training curriculum is the results it produces in a specific group of trainees. For example, a curriculum that results in custody or health care staff referring more individuals for emergency mental health care before self-harm occurs is an effective curriculum. So is one that results in mental health professionals more

Suicide Risk Despite Denial

A critical ingredient to suicide prevention training for all personnel is the basic understanding that we should not rely exclusively on the direct statements of inmates who deny that they are suicidal and/or have a prior history of suicidal behavior, particularly when their behavior, actions and/or history suggest otherwise. For example, consider an inmate who is on suicide precautions for attempting suicide the previous day. He is now naked except for a suicide smock, given finger foods, and on lockdown status. The mental health professional approaches the cell and asks the inmate through the food slot (within hearing distance of others on the unit): "How are you feeling today? Still feeling suicidal?"

Why would a suicidal inmate deny being suicidal? Possible answers include:

- Perceived punitive aspects of suicide precautions
- Desire to end their life and not be stopped
- Inability or unwillingness to articulate their thoughts
- Fear of being ridiculed and/or ostracized by other inmates
- Lack of privacy when the questions are asked
- Manner in which the questions are asked

Recent research has found that a sizable percentage of inmates (between 30 and 40%) reported that it would be "unlikely" for them to report any current suicidal ideation to a mental health clinician. The principal reason why suicidal inmates do not report their ideation is because of the conditions of suicide precautions, namely, the sterile housing and loss of privileges and possessions. This same research suggests that suicide risk assessments should not rely on a patient's self-report of suicidal ideation, and "patients with strong and acute and chronic risk factors, even in the absence of reported suicidal ideation, should be taken seriously and appropriate interventions to prevent suicide should be taken."

If an inmate's simple denial of being suicidal was the only criteria utilized to assess suicide risk, then it would be unnecessary to ask any other questions during the intake screening or assessment process, nor would we need a mental health professional to make an assessment because any staff member could listen to an inmate deny they were suicidal and assume they were not.

thoroughly completing suicide risk assessments. Training that results in leadership making systemwide operational decisions that reduce and address risk factors (such as access to means of suicide) or elevate protective factors (such as ways to stay in touch with family) is effective.

Content Outline for Suicide Prevention Training

Below are suggested learning objectives for each group of training participants. These objectives follow the key components of a suicide prevention program listed in NCCHC Standard B-05 Suicide Prevention and Intervention. By creating learning modules around these objectives, trainers can be confident that they are covering the most important points for each group of trainees.

This outline emphasizes the components that most closely match the needs of specific groups of staff, although some shared training experience is highly desirable to promote effective collaboration, and can serve as a guide when allocating training time and resources. Training needs to balance role-specific components with a multidisciplinary component. The items highlighted specifically for custody, qualified health care professionals, qualified mental health, and executive leadership should be seen as areas to emphasize, while not undermining the need to work across disciplines. Effective training balances the two.

Training may need to be adapted to meet the needs of specific subgroups under each heading. For example, under the mental health professionals heading, training for psychiatric providers will emphasize different topics and skills than training for nurses or administrative program managers, though certain content and skills, such as interviewing techniques for eliciting disclosure of suicidal thinking, are common to all clinical training. Use these learning objectives as a guide, and customize as needed.

Learning Objectives for Custody Staff

Upon completion of suicide prevention training, custody staff should be able to:

Identification

- Describe common warning signs of suicide and nonsuicidal self-injury
- Identify common signs and symptoms of mental health conditions
- Recognize behavioral signs of medical conditions that require immediate medical care
- Explain how to collaborate with mental health staff in monitoring individuals with lifetime risk and during high-risk periods such as transition points

Referral

- Cite policies and procedures for obtaining emergency evaluations

Housing

- Verify that housing used for suicide watch is suicide resistant and clear of items that could raise the risk of self-harm
- Emphasize that isolation undermines suicide prevention, and restrictive housing should be avoided to the extent possible in persons known to be at elevated risk

Monitoring

- Describe the procedures and circumstances for providing constant observation for persons determined to be acutely suicidal
- Describe the procedures and circumstances for providing intermittent (staggered) watch for those determined to be nonacutely suicidal

Communication

- Demonstrate interpersonal skills that can de-escalate crises and lower barriers to mental health care for patients

A Word About Language

When talking about suicide, avoid using terms like “commit suicide” or “successful attempt.” Those phrases perpetuate suicide’s stigma and moral judgment. Preferred terms are “ended one’s life” or “died by suicide,” according to the American Foundation for Suicide Prevention.

- Explain procedures for documentation and communication at shift change
- Describe how to obtain emergency clinical services for an inmate when indicated
- Explain policies and procedures for verbal/written communications with mental health staff, transferring authorities, and outside facilities
- Review the institutional suicide prevention plan

Intervention

- Apply relevant policies and procedures in the event of a suicide attempt in progress
- Locate and use safety equipment (such as cut-down tool)
- Demonstrate ability to perform CPR and use an AED when medically necessary

Learning Objectives for Qualified Health Care Professionals

Upon completion of suicide prevention training, QHCPs should be able to:

Identification
- Describe warning signs of suicide and nonsuicidal self-injury
- Identify signs and symptoms of mental health conditions
- Recognize behavioral signs of medical conditions that can mimic mental disorders

Referral
- Review procedures for making a mental health referral in a manner that ensures safety and continuity of care

Treatment
- Collaborate with mental health professionals to ensure continuity of care for individuals who receive crisis care

Communication
- Demonstrate interviewing and interpersonal skills that lower barriers to mental health care, such as stigma
- Communicate medical information and behavioral observations to mental health professionals when making a referral
- Review policies and procedures for communicating with custody staff when referring individuals for routine or emergency mental health care
- Provide systematic follow-up with patient after the referral or visit

Intervention
- Provide medical intervention, including CPR and use of an AED when indicated, in the event of a suicide attempt

Review
- Review institutional suicide prevention plan
- Explain institutional policy on postsuicide review

Learning Objectives for Qualified Mental Health Professionals

Upon completion of suicide prevention training, QMHPs should be able to:

Identification *(See Assessment of Suicide Risk in Correctional Settings, page 6)*
- Describe the risk factors and warning signs for suicide and nonsuicidal self-injury
- Explain how screening, assessment, evaluation, and ongoing monitoring are used to identify individuals at elevated risk of suicide

Evaluation
- Demonstrate use of suicide risk assessment tools to augment the clinical assessment of individuals who are have been referred for mental health evaluation
- Explain how suicide risk assessment is used to determine an individual's risk level

Treatment Planning *(See Suicide Prevention and Treatment of Suicidal Behavior, page 16)*
- Discuss effective interventions consistent with licensure, qualifications, and relevant clinical guidelines
- Describe how treatment of mental health conditions impacts suicide risk
- Demonstrate development of a safety plan as part of a comprehensive treatment plan

Monitoring
- Clarify the purpose for placing acutely suicidal individuals on constant watch, and nonacutely suicidal persons on staggered watch

Communication
- Examine the importance of meeting safety and treatment needs of individuals at elevated risk of suicide
- Review institutional policies relevant to communicating with custody and health staff

- Explain the need for both oral and written communication with inmate and custody staff

Intervention
- Demonstrate ability to perform or assist with CPR and AED use when medically necessary

Reporting
- Explain institutional policies on reporting of crisis care, suicide watch, or postevent summaries

Review
- Review the institutional suicide prevention plan
- Discuss the importance of postevent review or psychological autopsy
- Conduct a psychological autopsy

Debriefing
- Explain the role of the mental health professional in a postevent debriefing

Be Aware of High-Risk Times and Situations

It is important to understand that suicide can occur at any time, so focusing too narrowly on the "typical" risks and times can be dangerous. However, certain times and situations are particularly high-risk for inmates who may be suicidal. According to NCCHC standard B-05 Suicide Prevention and Intervention, those high-risk situations are:

- Upon admission (e.g., 2 to 14 days following incarceration)
- Following new legal problems (e.g., within 48 hours of a court appearance, new charges, additional sentences, institutional proceedings, denial of parole)
- After admittance to segregation or single-cell housing
- After the receipt of bad news regarding self or family (e.g., serious illness, the loss of a loved one)
- After suffering humiliation (e.g., sexual assault) or rejection
- Pending release after a long period of incarceration

Other high-risk situations include:

- Anniversary dates
- Decreased staff supervision
- Pending release from custody, especially if the inmate lacks a viable discharge plan due to lack of family, employment, housing, and other stabilizing resources.

- Describe ways to mitigate the impact of a suicide event on the organization

Learning Objectives for Executive Leadership

Executive leadership plays a key role in promoting suicide prevention across systems when making high-level decisions.

Upon completion of suicide prevention training, executive leadership should understand the importance of:

Identification
- Explain the importance of providing a physical environment that allows for privacy and confidentiality during the intake screening process
- Identify opportunities for primary suicide prevention across the institution
- Explain the importance of internal and external statistical data in making decisions about operational, programmatic, and resource allocation issues that may impact suicide prevention
- Review risk factors and warning signs for suicide and institutional procedures for identification and intervention for individuals at risk

Housing
- Demonstrate that adequate suicide-resistant housing is available to meet the needs for emergency care of acutely and nonacutely suicidal inmates
- Ensure that individuals have easy access to mental health care (including crisis/emergency care) to meet their needs in a safe manner
- Provide appropriate ongoing monitoring whenever inmates are housed in relatively isolated settings

Notification
- Confirm that policies and personnel are in place to provide timely notification of appropriate authorities and family members in the event of a death by suicide or serious suicide attempt

Reporting
- Ensure adequate data collection and reporting in the event of a death by suicide

Review
- Utilize review results to inform operational and correctional decision-making

Debriefing
- Describe debriefing procedures for custody staff and inmates

References and Resources

Assessment

American Foundation for Suicide Prevention. *https://afsp.org*

American Psychiatric Association. (2003). Practice guideline for the assessment and treatment of patients with suicidal behaviors. American Journal of Psychiatry, 160(11 Suppl.), 1-60.

Baranyi, G., Cassidy, M., Fazel, S., Priebe, S., & Mundt, A. (2018). Prevalence of posttraumatic stress disorder in prisoners. Epidemiological Review, 40(1), 134-145.

Bostwick, M. J., Pabbati, C., Geske, J. F., & McKean, A. J. (2016). Suicide attempt as a risk factor for completed suicide: Even more lethal than we knew. American Journal of Psychiatry, 173, 1094–1100. doi: 10.1176/appi.ajp.2016.15070854

Commonwealth of Massachusetts. Executive Office of Public Safety, Department of Corrections. Governor's Commission on Corrections Reform. (2005). Dedicated external female offender review. Boston, MA. *http://www.mass.gov/eopss/docs/doc/research-reports/gccr-13-review-final.pdf*

Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): An evolving evidence-based clinical approach to suicide risk. Suicide and Life-Threatening Behavior, 42(6), 640-653.

Hayes, L. M. (2013). Suicide prevention in correctional facilities: Reflections and next steps. International Journal of Law and Psychiatry, 36, 188-194.

Hayes, L. M. (2016). Training curriculum and program guide on suicide detection and prevention in jail and prison facilities: Instructor's manual. Mansfield, MA: National Center on Institutions and Alternatives.

Ivanoff, A., Jang, S. J., Smyth, N. J., & Linehan, M. M. (1994). Fewer reasons for staying alive when you are thinking of killing yourself: The brief reasons for living inventory. Journal of Psychopathology and Behavioral Assessment, 16, 1-13. doi: 10.1007/BF02229062

Miller, N. A., & Najavits, L. M. (2012). Creating trauma-informed correctional care: A balance of goals and environment. European Journal of Psychotraumatology, 3. doi: 10.3402/ejpt.v3i0.17246

National Center for PTSD. *https://www.ptsd.va.gov*

National Commission on Correctional Health Care. (2018a). Standards for health services in jails. Chicago, IL: Author.

National Commission on Correctional Health Care. (2018b). Standards for health services in prisons. Chicago, IL: Author.

National Suicide Prevention Lifeline. (2007). Suicide risk assessment standards. *https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Suicide-Risk-Assessment-Standards-1.pdf*

Noonan, M. (2016a). Mortality in local jails, 2001-2014 – statistical tables (NCJ 250169). Washington, DC: Bureau of Justice Statistics. *https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5868*

Noonan, M. (2016b). Mortality in state prisons, 2001-2014 – statistical tables (NCJ 250150). Washington, DC: Bureau of Justice Statistics. *https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5867*

Shea, S. C. (2002). The practical art of suicide assessment: A guide for mental health professionals and substance abuse counselors. Lexington, KY: Mental Health Presses.

White, T. W. (1999). How to identify suicidal people: A systematic approach to risk assessment. Philadelphia, PA: Charles Press.

ZeroSuicide. *https://zerosuicide.sprc.org/toolkit/identify/screening-and-assessing-suicide-risk#footnote2_qcsd5s8*

Treatment

Brown, C. K., Have, T. T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts. Journal of the American Medical Association, 294, 563-570.

Bryan, C. J., & Rudd, D. M. (2018). Brief cognitive behavioral therapy for suicide prevention. New York, NY: Guilford.

Fagan, T. J., Cox, J., Helfand, S. J., & Aufderheide, D. (2010). Self-injurious behavior in correctional settings. Journal of Correctional Health Care, 16, 48-66.

Galynker, I. (2017). The suicidal crisis. New York, NY: Oxford Press

Jobes, J. A. (2016). Managing suicidal risk: A collaborative approach (2nd ed.). New York, NY: Guilford.

Junker, G., Beeler, A., & Gates, J. (2005). Using trained observers for suicide watch in a federal correctional setting: A win-win solution. Psychological Services, 2, 20-27.

Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Langu, A., & Neasciu, A. D. (2015). Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder. JAMA Psychiatry, 72, 475-482.

National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). Recommended standard care for people with suicide risk: Making health care suicide safe. Washington, DC: Education Development Center. *https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf*

National Commission on Correctional Health Care. (2018a). Standards for health services in jails. Chicago, IL: Author.

National Commission on Correctional Health Care. (2018b). Standards for health services in prisons. Chicago, IL: Author.

Stanley, B., Brown, G. K., Brenner, L. A., Galfalvy, H. C., Currier, G. W., Knox, K. L., . . . Green, K. L. (2018). Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. JAMA Psychiatry, 75, 894-900.

Yaseen, Z. S., Galynker, I. I., Cohen, L. J., & Briggs, J. (2017). Clinicians' conflicting emotional responses to high suicide-risk patients—Association with short-term suicide behaviors: A prospective pilot study. Comprehensive Psychiatry, 76, 69-78.

Training

Barry, L. C., Wakefield, D. B., Trestman, R. L., & Conwell, Y. (2016). Active and passive suicidal ideation in older prisoners. Crisis, 37(2), 88-94. DOI: 10.1027/0227-5910/a000350

Centers for Disease Control and Prevention. (n.d.) Strategic direction for the prevention of suicidal behavior: Promoting individual, family, and community connectedness to prevent suicidal behavior. *https://www.cdc.gov/violenceprevention/pdf/Suicide_Strategic_Direction_Full_Version-a.pdf*

Cheatle, M. D. (2011). Depression, chronic pain, and suicide by overdose: On the edge. Pain Medicine, 12(Suppl. 2), S43-S48. doi: 10.1111/j.1526-4637.2011.01131.x

Hirsch, J. K., Duberstein, P. R., & Unützer, J. (2009). Chronic medical problems and distressful thoughts of suicide in primary care patients: Mitigating role of happiness. International Journal of Geriatric Psychiatry, 24, 671-679. doi: 10.1002/gps.2174

Insomnia and suicide attempts. (2016, October). Suicide Prevention Resource Center. *https://www.sprc.org/news/insomnia-suicide-attempts*

National Commission on Correctional Health Care. (2016). Substance use disorder treatment for adults and adolescents (position statement). *https://www.ncchc.org/substance-use-disorder-treatment-for-adults-and-adolescents*

National Commission on Correctional Health Care. (2018a). Standards for health services in jails. Chicago, IL: Author.

National Commission on Correctional Health Care. (2018b). Standards for health services in prisons. Chicago, IL: Author.

Townsend, M., & Morgan, K. (2017). Essentials of psychiatric mental health nursing concepts of care in evidence-based practice (7th ed.). Philadelphia, PA: F. A. Davis.

Way, B., Kaufman, A., Knoll, J., & Chlebowski, S. (2013). Suicidal ideation among inmate-patients in state prison: Prevalence, reluctance to report, and treatment preferences. Behavioral Sciences & the Law, 31, 230-238.

FACILITY DESIGN

Creating a Physical Environment That Supports Well-Being

A comprehensive physical plant assessment is an essential component of a carefully thought-out suicide prevention plan. While it is not possible to design a "suicide-proof" cell, best practices for planning and design can mitigate the risk. These practices relate to operations, appropriate fixtures and furnishings, and the environmental quality of cells and living units. These practices must be considered as working in concert, not individually.

Planning Considerations

It is essential for staff to be able to perform their duties in a safe and efficient manner. Thoughtful consideration must be given to how staff will perform their rounds, respond to emergencies, and maintain visual and audial control of their surroundings. Obstacles that impede efficient movement and visibility should be avoided, which will affect the location of staff and nurse workstations in relation to observed cells, corridor locations and connections, and glazed window openings. Technology should be used to support the physical observation of inmates by staff.

Physical Characteristics

Careful review of all of the physical attributes of the environment is required to identify unsuspected or mundane objects that inmates could utilize as ligature devices. Visibility is critical when monitoring suicidal inmates. Inmate cells should be glazed to the greatest extent possible, allowing staff to view the interior of a cell in its entirety. Floor drains and air vents, plumbing and lighting fixtures, and furniture must be carefully selected to prevent any opportunity for an inmate to affix a ligature. Where small gaps or voids may be present, they should be filled with tamper-resistant security-grade caulking or grout. Many manufacturers today provide products that are designed to be suicide resistant.

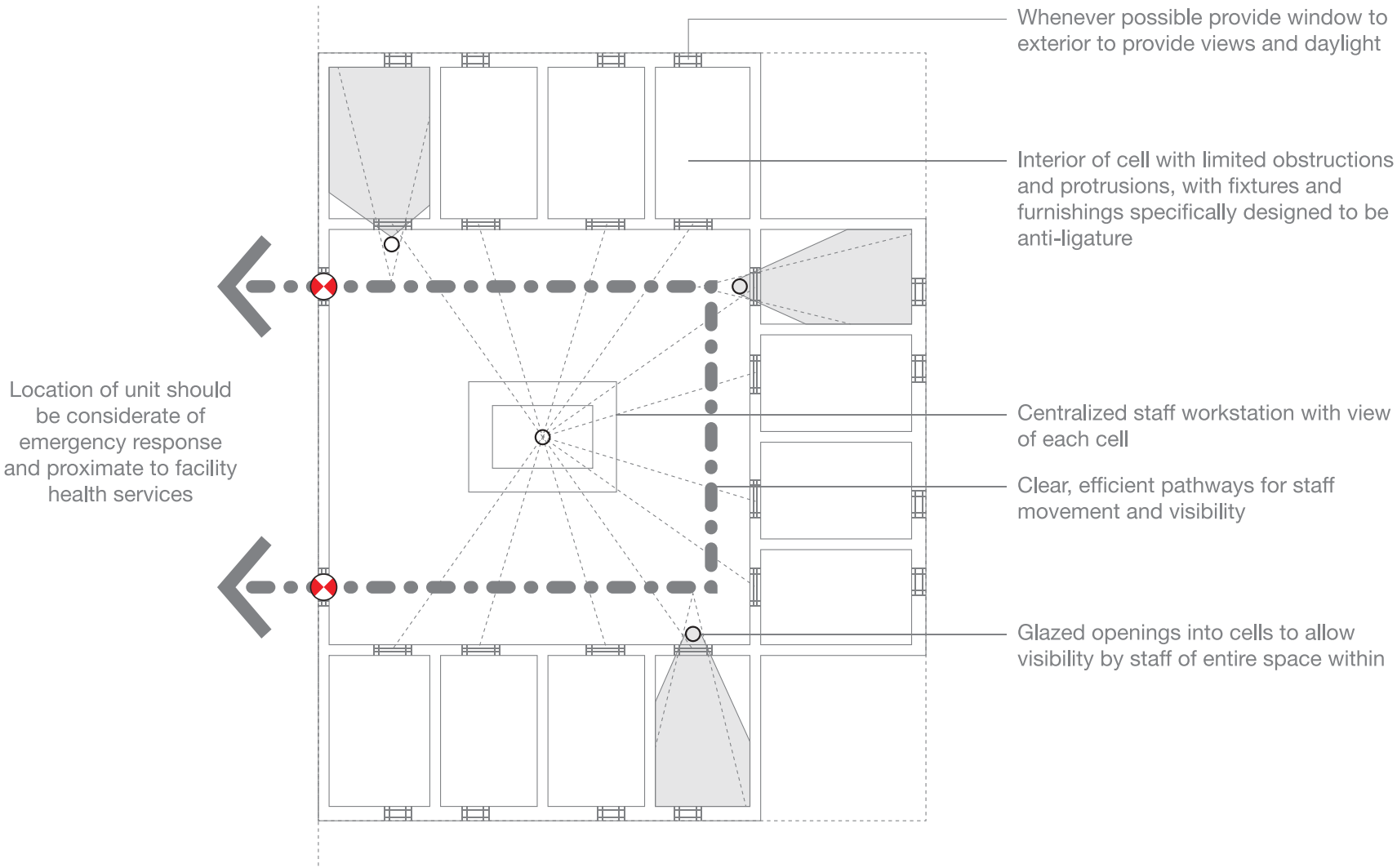
Environmental Aspects

The environmental quality of a space has a profound impact on health and wellness. Although this is important to consider for all inmates and staff in a correctional facility, priority should be given to those inmates who have limited access to movement, programs, and other amenities, including those under suicide precaution.

Photo: Hudson County Correctional Center

Excessive noise, which is prevalent in correctional institutions, can lead to sleep loss and fragmentation. Such noise should be mitigated through the strategic use of acoustical materials. Observation cells should have natural light and exterior views, as there is evidence that greater exposure to daylight can reduce stress and depression, and the absence of windows has been linked to higher rates of anxiety. Windows also provide the feeling of connection to the outside world, which can be beneficial to mental health restoration and recovery.

The buildings in which we work and reside must support the mission and activities that take place within them. By eliminating features and characteristics of a space that might be considered vulnerabilities with regard to safety, and including features that have been shown to improve wellness, we can be assured that the design of a facility meets the mission of health and safety.


Whenever possible provide window to exterior to provide views and daylight
Interior of cell with limited obstructions and protrusions, with fixtures and furnishings specifically designed to be anti-ligature
Location of unit should be considerate of emergency response and proximate to facility health services
Centralized staff workstation with view of each cell
Clear, efficient pathways for staff movement and visibility
Glazed openings into cells to allow visibility by staff of entire space within

CASE STUDY

Hudson County Correctional Center, New Jersey

Six deaths in nine months – four of them suicides –at Hudson County Correctional Center in Kearney, NJ, rocked the facility staff, county officials, fellow inmates, and the community and made headlines in the region.

Hudson County wasn't the only jail to experience a rise in suicides. Fueled by drug addiction, mental illness, and, often, a combination of the two, suicide had been on the rise in jails across New Jersey for several years.

Director of Corrections Ronald Edwards, MAS, was determined to turn this trend around. Director since August 2017, and deputy director for a year before that, Edwards had not been in charge very long, but after 25 years with the jail he had a good sense of what did – and didn't – work. He knew that tweaking the policies and procedures was not enough, nor was refresher training for correctional officers. Radical change was needed.

The first step was to examine the circumstances surrounding the cases, as well as the jail's assessment procedures and staff training. Edwards found that 90% of the people entering the facility had a mental health and/or substance abuse issue, and all of the individuals to recently die by suicide had had such problems. Most suicides were happening soon after arrival, sometimes by "frequent fliers" and by those arrested on nuisance charges. He also found that the nurses performing intake screening needed additional training to assess for suicide risk, and that staff in general needed to improve their skills at crisis assessment and intervention.

A crucial step was to convene an informal task force with medical, mental health, and corrections personnel, as well as advisors from the community: people who worked at the local psychiatric hospital, crisis centers, and suicide helplines. They met monthly to brainstorm on solutions and develop plans.

Transforming Health Care Also Prevents Suicides

Ultimately, Edwards and his team identified numerous changes aimed at transforming the culture around inmate health care as a whole, not only suicide prevention. The 30-year-old facility was ill-equipped to handle the needs of a population with complex health, mental health, and substance abuse needs. So, during this same period, the jail built a modern medical housing unit with a variety of cells/beds for infirmary care and other special needs. Suicide prevention was integral to the design of the 54-bed unit.

Improved design features are straightforward and commonsense. All cells in the unit now have ligature-resistant components: bunk, stool, wall-mounted desk, toilet, light fixture, vents. Lighting has been improved. The cells doors have larger windows for greater two-way visibility. The three suicide observation cells have a camera with monitors at the nurses station and custody control room for additional "eyes-on" capability.

An innovative move was to place the nurses station inside the medical housing unit. Stepdown housing is in the same unit, on the other side of the nurses station. This close contact ensures better patient care and strengthens teamwork among health staff and correctional officers. The cells also have a nurse call button for more proactive care.

"Jails usually design the infirmary like an isolation unit," says Edwards. "Now, with all of these pieces in the same housing unit, people get to know each other. There are more eyes watching and more ears listening." The nurses were given whistles to help keep them safe should a patient act out.

Edwards brought in Dennis Sandrock, PhD, CCHP, regional mental health director of the jail's health services vendor at the time, to help with the effort. Sandrock reviewed and strengthened policies, procedures, and training on suicide prevention, and developed separate training modules geared to mental health staff and to nursing staff. Over a three-week period, each of the 43 nurses took part in a four-hour,

off-site training session. “We wanted the nurses to feel that they were helping to solve the issues and save people’s lives,” says Edwards.

To sharpen the patient-centered focus, staff are instructed to greet patients in a personal manner, introducing themselves by name. Edwards also identified a high level of burnout among the mental health professionals and worked to improve the environment for them.

“This approach changed the atmosphere immediately,” says Edwards. Health care grievances have dropped by about 67% in two years. He also credits a new ombudsman program with addressing all problems cited by inmates even if they don’t rise to the level of a grievance.

While all of this was happening, the jail switched to a new health services vendor, and Edwards says the buy-in to the suicide-prevention culture was immediate. He points to several cases where suicide was averted due to efforts by staff. “Everybody understands: we are a team,” he says. “We work together to heal these people and save lives.”

Change – Cultural, Structural, and Procedural – Essential to Suicide Prevention

At Hudson County Correctional Center, these improvements have been implemented:

- Updated suicide prevention policies and procedures
- Granted the desk sergeant authority to place individuals at risk (based on a brief questionnaire) on close observation until they can see a mental health counselor
- Expanded the mental health staff with additional counselors
- Hired counselors who are bilingual (primarily Spanish)
- Greatly expanded availability of interpreter services in the medical unit
- Added a second emergency response code: 911 is called immediately for nonresponsive inmates
- Strengthened medical grievance and ombudsman programs

Many initiatives are ongoing:

- Provide thorough four-hour suicide assessment training for every nurse
- Conduct 24/7 receiving screening by an RN, with a health assessment by an RN within 4 hours
- Check the electronic health record of every new arrival for medical, mental health, and substance use history, including past prescription medications
- Provide a suicide blanket to all new intakes until cleared
- Provide evidence-based medical care for detoxing patients
- When possible, pair up patients on suicide watch and/or leave the cell door open
- Reduce suicide watch shifts to two hours (vs. eight), and require officers to remain on their feet during those shifts
- Certify all correctional officers in cardiopulmonary resuscitation
- Address staff burnout and improve interpersonal communication between caregivers and patients

CASE STUDY

Middlesex Jail and House of Correction, Massachusetts

After an inmate at the Middlesex Jail and House of Correction died by suicide, his phone records revealed that in the days leading up to his death, he had placed an alarmingly high number of calls to his family – calls that went unanswered.

Now, the jail has set up a system to monitor records for unusual activity, such as high numbers of unconnected calls or hang-ups, that might provide a clue to an inmate's state of mind, indicate a crisis and, potentially, save a life.

That is one way that the Billerica, Mass., facility has boosted its suicide prevention efforts, after a comprehensive audit of its processes, policies and procedures conducted by a leading expert in suicide prevention in corrections whom Middlesex Sheriff Peter Koutoujian brought in as a proactive measure. Not willing to accept the cold comfort that some suicides are not preventable, Koutoujian called for a deeper dive. "Even one suicide is one too many," he says.

A number of proactive measures were recommended and put in place. Many of them were relatively easy to institute, but are proving to have big impact on the culture and practices within the facility.

One of those things is the placement of posters in visiting areas and other public spots, urging family members and friends to contact jail officials if they are worried about a loved one's mental health. The posters provide a phone number that is manned 24/7 by jail staff trained to respond immediately and appropriately to such concerns.

Calls go to an in-house dispatcher who fills out a form so that all pertinent information is gathered. He or she then contacts mental health or medical staff, who immediately see the inmate and determine if further mental health evaluation or assessment is needed.

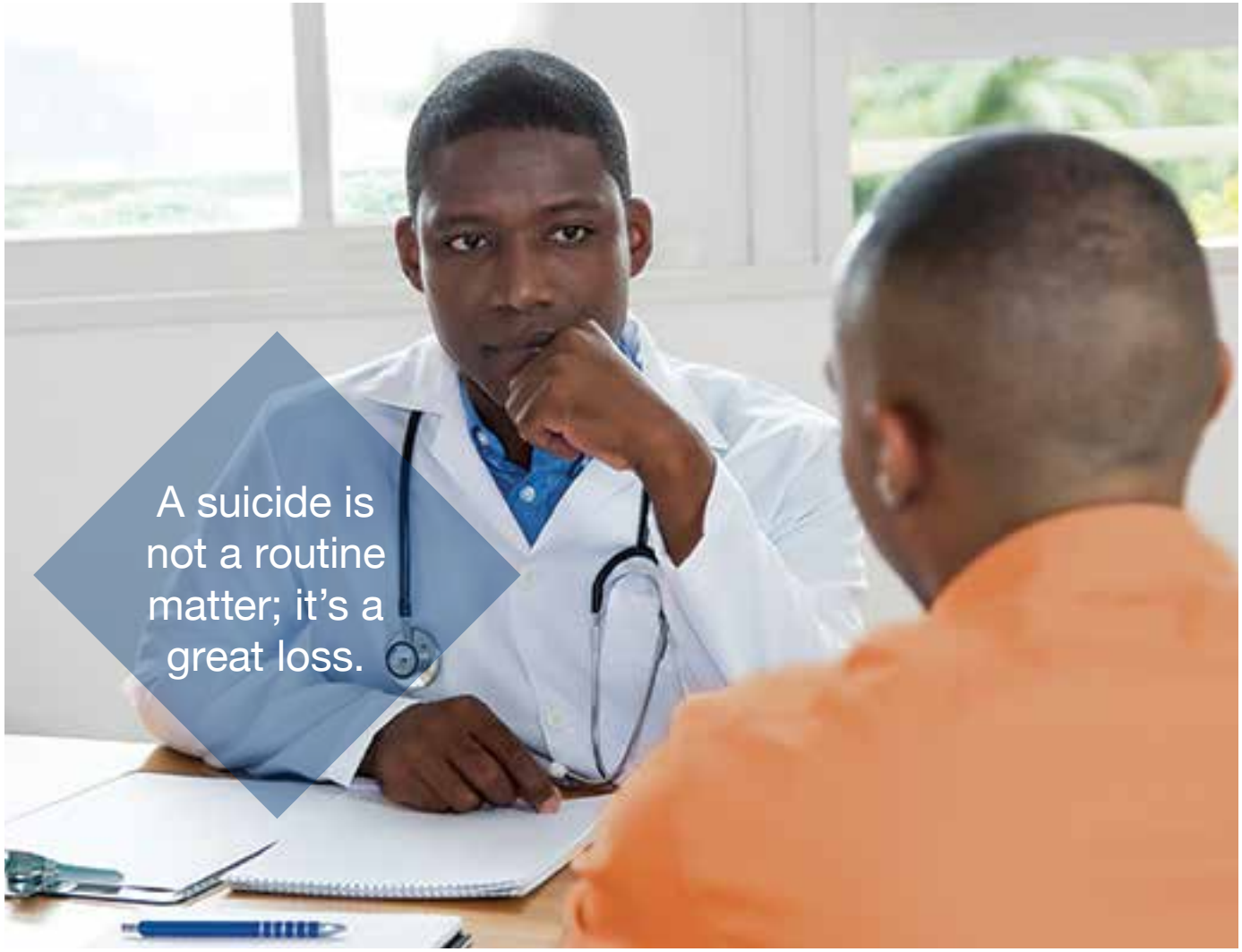
An automated recording with a similar message is now included at the beginning and end of every phone call so that both incarcerated individuals and their loved ones know that help is available and how to access it.

"Families can play a key role in suicide prevention," says Special Sheriff Shawn Jenkins. "We have been surprised by the numbers of phone calls we receive. Many family members have told us how much they appreciate having a place to call, and it helps us immeasurably."

The required number of hours of suicide prevention training has doubled, both for new hires and for all staff. And additionally, the Middlesex Sheriff's Office has worked with the National Institute of Corrections (NIC) to host crisis intervention team (CIT) training open to offices across the Commonwealth.

"Mental health has become so much more important in our training," says Superintendent Osvaldo Vidal. "The entire staff is very aware of mental health issues and the risks for suicide. Everyone is much more apt now to report it or call for mental health follow-up if they see something concerning."

Another cultural change is the awareness of times and situations that can put people at particular risk for suicidal behavior, such as after receiving an update about their case, sentence or denial of parole. Jail staff are now more cognizant that a visit or phone call from an attorney, law enforcement officer or other outside agent can mean bad news for the inmate, signaling the need for closer observation.



The department improved suicide prevention screening by adding a much more thorough assessment of mental health to the intake process and increased the level of privacy for the interviews, allowing individuals to speak more openly.

Simple structural improvements also have been implemented. To create suicide-resistant cells, hooks were removed, holes in metal bedframes were filled, sharp-edged sprinklers were replaced with flushed sprinkler heads, and suicide-resistant beds are now placed in the middle of the cells to improve visibility.

"The measures seem to be working," Jenkins reports. "We have had a lot of phone calls, but we have not had any completed suicides or significant attempts since this all went into effect."

Sheriff Koutoujian told the New England Center for Investigative Reporting, "A suicide is not a routine matter; it's a great loss."

NCCHC STANDARD B-05

Suicide Prevention and Intervention

Suicides are prevented when possible by implementing prevention efforts and intervention.

Compliance Indicators

1. The responsible health authority and facility administrator approve the facility's suicide prevention program.
2. A suicide prevention program includes the following:
   a. Facility staff identify suicidal inmates and immediately initiate precautions.
   b. Suicidal inmates are evaluated promptly by the designated health professional, who directs the intervention and ensures follow-up as needed.
   c. *Acutely suicidal* inmates are monitored by facility staff via constant observation.
   d. *Nonacutely suicidal* inmates are monitored by facility staff at unpredictable intervals with no more than 15 minutes between checks.
3. The use of other inmates in any way (e.g., companions, suicide-prevention aides) is not a substitute for staff supervision.
4. Treatment plans addressing suicidal ideation and its reoccurrence are developed.
5. Patient follow-up occurs as clinically indicated.
6. All aspects of the standard are addressed by written policy and defined procedures.

Definitions

Acutely suicidal (active) inmates are those who are actively engaging in self-injurious behavior and/or threaten suicide with a specific plan.

Nonacutely suicidal (potential or inactive) inmates are those who express current suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or have a recent history of self-destructive behavior.

Discussion

Although many suicides are unpredictable, a suicide prevention program can help reduce risks. Inmates may become suicidal at any point during their stay, but high-risk periods include the following:

a. Upon admission (e.g., 2 to 14 days following incarceration)
b. Following new legal problems (e.g., within 48 hours of a court appearance, new charges, additional sentences, institutional proceedings, denial of parole)
c. After admittance to segregation or single-cell housing
d. After the receipt of bad news regarding self or family (e.g., serious illness, the loss of a loved one)
e. After suffering humiliation (e.g., sexual assault) or rejection
f. Pending release after a long period of incarceration

In addition, juveniles in an adult correctional setting and inmates in the early stages of recovery from severe depression may be at risk.

A treatment plan should be developed or revised for any inmate expressing suicidal ideation. This treatment plan should be developed by the mental health staff in conjunction with the patient to address relapse prevention and initiate a risk management plan. The risk management plan should describe signs, symptoms, and the circumstances in which the risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided; and actions the patient or staff can take if suicidal thoughts do occur.

Key components of a suicide prevention program include the following:

a. Training. All staff members who work with inmates are trained to recognize verbal and behavioral cues that indicate potential suicide and how to respond appropriately. Initial and at least annual training is provided.
b. Identification. The receiving screening form contains observation and interview items related to potential suicide risk. If a staff member identifies someone who is potentially suicidal, the inmate is placed on suicide precautions and is referred immediately to mental health staff (see E-02 Receiving Screening).

c. Referral. There are procedures for referring potentially suicidal inmates and those who have attempted suicide to qualified mental health professionals or facilities. The procedures specify a time frame for response to the referral.
d. Evaluation. An evaluation, conducted by a qualified mental health professional, determines the level of suicide risk, level of supervision needed, and need for transfer to an inpatient mental health facility or program. Patients are reassessed regularly to identify any change in condition indicating a need for a change in supervision level or required transfer or commitment. The evaluation includes procedures for periodic follow-up assessment after the individual's discharge from suicide precautions.
e. Treatment. Strategies and services to address the underlying reasons (e.g., depression, auditory commands) for the inmate's suicidal ideation are to be considered. The strategies include treatment needs when the patient is at heightened risk for suicide as well as follow-up treatment interventions and monitoring strategies to reduce the likelihood of relapse.
f. Housing. Unless constant supervision is maintained, a suicidal inmate is not isolated but is housed in the general population, mental health unit, or medical infirmary and located in close proximity to staff. All cells or rooms housing suicidal inmates are as suicide-resistant as possible (e.g., without protrusions that would enable hanging).
g. Monitoring. There are procedures for monitoring an inmate identified as nonacutely suicidal. Unpredictable, documented supervision is maintained, with irregular intervals no more than 15 minutes apart. Although several protocols exist for monitoring suicidal inmates, when an acutely suicidal inmate is housed alone in a room, continuous monitoring by staff should be maintained. Other supervision aids (e.g., closed circuit television, inmate companions or watchers) can supplement, but never substitute for, direct staff monitoring.
h. Communication. Procedures for communication between mental health, medical, and correctional personnel regarding inmate status are in place to provide clear and current information. These procedures include communication between transferring authorities (e.g., county facility, medical/psychiatric facility) and facility correctional personnel.
i. Intervention. There are procedures addressing how to handle a suicide attempt in progress, including appropriate first-aid measures.
j. Notification. Procedures state when correctional administrators, outside authorities, and family members are notified of attempted or completed suicides.
k. Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides are detailed, as are procedures for reporting a completed suicide.
l. Review. There are procedures for mental health, medical, and administrative review, including a psychological autopsy, for completed suicides. For details, see A-09 Procedure in the Event of an Inmate Death.
m. Debriefing. There are procedures for offering timely debriefing to all affected personnel and inmates. Debriefing is a process whereby individuals are given an opportunity to express their thoughts and feelings about an incident (e.g., suicide or attempt), develop an understanding of stress symptoms resulting from the incident, and develop ways to deal with those symptoms. Debriefing can be done by an in-house response team or outside consultants prepared to handle these highly stressful situations.

An active approach to the management of suicidal inmates is recommended. In facilities where 24-hour mental health staff coverage is not present, designated health and/or custody staff should be able to initiate suicide precautions until the qualified mental health professional on call can be contacted for further orders. Only designated qualified mental health professionals should be authorized to remove an inmate from suicide precautionary measures.

A suicide or suicide attempt can be a stressful event for staff and other inmates. Where feasible, persons trained in debriefing procedures should be used. Practical guidelines on the debriefing process are available from organizations such as the International Critical Incident Stress Foundation.

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