REPORT ON SUICIDE PREVENTION PRACTICES WITHIN THE DISTRICT OF COLUMBIA, DEPARTMENT OF CORRECTIONS' CENTRAL DETENTION FACILITY

Washington, DC

(NIC T.A. No. 13J1092)

by

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A. INTRODUCTION

The following is a summary of the observations, findings, and recommendations of Lindsay M. Hayes, Project Director of the National Center on Institutions and Alternatives, following the provision of short-term technical assistance to the District of Columbia, Department of Corrections' (DOC) Central Detention Facility (CDF). As of August 2013, the CDF has experienced a much higher number (three) of inmate suicides than in previous years. Because of the higher incidence of suicide, the DOC and its health care provider (Unity Health Care) began to examine the deaths, as well as review various policy and procedural directives relating to suicide prevention. In order to independently assess current practices, as well as offer any appropriate recommendations to suicide prevention policies and procedures within the CDF, DOC Director Thomas Faust decided to seek the assistance of an outside consultant. Through the technical and financial assistance of the National Institute of Corrections - Jails Division, this writer's consulting services were offered to, and selected by, Director Faust.

It should be noted that the determination for the need of this writer's assessment was not prompted by litigation or critical investigation of any of the recent inmate suicides. Rather, these actions were taken through the pro-active initiative of Director Faust who was committed to determining what steps, if any, were necessary to improve suicide prevention practices within the Central Detention Facility.

In conducting the assessment, this writer met with and/or interviewed numerous correctional, medical, and mental health officials and staff from the DC Department of Corrections, Central Detention Facility, and Unity Health Care; reviewed numerous policies and procedures related to suicide prevention, and screening/assessment protocols; reviewed various health care charts and investigative reviews of three (3) inmate suicides between November 2012 and June 2013;[1] and toured the Central Detention Facility. The on-site assessment was conducted on August 27 thru August 29, 2013.

It should also be noted that, as a result of the recent inmate suicides, DOC Director Faust assembled a Suicide Prevention Task Force comprised of representatives from the DC Department of Corrections, Unity Health Care, DC Department of Mental Health, and Corrections Corporation of America (which administers the Correctional Treatment Facility under contract with the Department of Corrections). The Task Force initially met on July 22, 2013 to review current policies and procedures governing the custodial, medical, and mental health care of inmates as it related to suicide prevention. This writer had an opportunity to review a draft of the Task Force report, as well as converse by telephone with Elspeth Ritchie, MD, Chief Clinical Officer for the DC Department of Mental Health and Task Force member.

As of August 2013, the Central Detention Facility had an average daily population of 1,739 inmates, with more than 14,000 new intakes processed through the facility each year. As shown by Table 1, the CDF has experienced 5 inmate suicides during the 5-year period of 2009 through 2013, including three (3) deaths this year. Based upon the average daily population

[1]The investigative reviews of an inmate suicide occurring in August 2013 had not yet been completed at the time of this writer's assessment and, therefore, not available for review prior to development of this report.

during this same time period, the suicide rate in the CDF was 50.8 deaths per 100,000 inmates -- a rate that is slightly higher than that of county jails of varying size throughout the country.[2] However, the suicide rate at the facility during 2013 (i.e., 172.5 deaths per 100,000 inmates) was substantially higher than that of county jails of varying size throughout the country.

[2] According to Heron, M. (2012), "Deaths: Leading Cause for 2009," *National Vital Statistics Report*, 61 (7), Hyattsville, MD: National Center for Health Statistics, the suicide rate in the general population is approximately 12 deaths per 100,000 citizens. According to the most recent data on jail suicide, the suicide rate in county jails throughout the country is approximately 43 per 100,000 inmates, Noonan, M. and Ginder, S. (2013), *Mortality in Local Jails and State Prisons, 2000-2011 - Statistical Tables*, Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice, Office of Justice Programs.

TABLE 1
AVERAGE DAILY POPULATION, SUICIDES, AND SUICIDE RATE
WITHIN THE CENTRAL DETENTION FACIITY
JANUARY 2009 THRU AUGUST 2013*

Year	ADP	Suicides	Suicide Rate
2009	1,962	1	50.9
2010	2,092	0	0
2011	2,095	0	0
2012	1,945	1	51.4
2013	1,739	3	172.5
2009-2013	9,833	5	50.8

*Source: DC Department of Corrections

B. FINDINGS AND RECOMMENDATIONS

Detailed below is this writer's assessment of jail suicide prevention practices within the DC Department of Corrections' Central Detention Facility. It is formatted according to this writer's eight (8) critical components of a suicide prevention policy: staff training, identification/screening, communication, housing, levels of supervision/management, intervention, reporting, and follow-up/morbidity-mortality review. This protocol was previously developed by this writer and is consistent with national correctional standards, including those of the American Correctional Association's *Performance-Based Standards for Adult Local Detention Facilities* (2004); Standard J-G-05 of the National Commission on Correctional Health Care's *Standards for Health Services in Jails* (2008); and the "Suicide Prevention and Intervention Standard" of the U.S. Department of Homeland Security's *Operations Manual ICE Performance-Based National Detention Standards* (2011).[3] Where indicated, recommendations are also provided.

At the outset, it should be noted that both the DC Department of Corrections and Unity Health Care have very comprehensive suicide prevention policies. Both the DC Department of Corrections' Suicide Prevention and Intervention Policy (No. 6080.2F) and Unity Health Care's Suicide Prevention Policy (No. CF705) more than adequately cover the required components to a suicide prevention program. However, as detailed in the following report, this writer found suicide prevention ***practices*** *for many of these required components to be lacking in varying degrees and in need of immediate corrective action.*

[3]American Correctional Association (2004), *Performance-Based Standards for Adult Local Detention Facilities*, 4th Edition, Lanham, MD: Author; National Commission on Correctional Health Care (2008), *Standards for Health Services in Jails*, 8th Edition, Chicago, IL: Author; and U.S. Department of Homeland Security (2011), Immigration and Customs Enforcement, *Operations Manual ICE Performance-Based National Detention Standards*, Washington, DC: Author.

1) Staff Training

> ***All* correctional, medical, and mental health staff should receive eight (8) hours of initial suicide prevention training, followed by two (2) hours of annual training. At a minimum, training should include avoiding negative attitudes to suicide prevention, inmate suicide research, why correctional environments are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, components of the agency's suicide prevention policy, and liability issues associated with inmate suicide.**

The key to any suicide prevention program is properly trained correctional staff, who form the backbone of any correctional system. Very few suicides are actually prevented by mental health, medical or other professional staff. Because inmates attempt suicide in their housing units, often during late afternoon or evening, as well as on weekends, they are generally outside the purview of program staff. Therefore, these incidents must be thwarted by correctional staff who have been trained in suicide prevention and are able to demonstrate an intuitive sense regarding the inmates under their care. Simply stated, correctional officers are often the only staff available 24 hours a day; thus they form the front line of defense in suicide prevention.

Both the American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC) standards stress the importance of training as a critical component to any suicide prevention program. ACA Standard 4-ALDF-7B-10 requires that all correctional staff receive both initial and annual training in the "signs of suicide risk" and "suicide precautions;" while Standard 4-ALDF-4C-32 requires that staff be trained in the implementation of the suicide prevention program. As stressed in NCCHC Standard J-G-05 --

"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 biennial training are provided, although annual training is highly recommended." Finally, the U.S. Department of Homeland Security's *Operations Manual ICE Performance-Based National Detention Standards* require that all staff receive both pre-service and annual training in the following areas: recognizing verbal and behavioral cues that indicate potential suicide; demographic, cultural, and precipitating factors of suicidal behavior; responding to suicidal and depressed detainees; effective communication between correctional and health care personnel; necessary referral procedures; constant observation and suicide-watch procedures; follow-up monitoring of detainees who have already attempted suicide; and reporting and written documentation procedures."

FINDINGS: According to the DC Department of Corrections' Suicide Prevention and Intervention Policy (No. 6080.2F), all employees who work within the Central Detention Facility are required to receive 40 hours of pre-service training upon employment, including a module on suicide prevention. Annual, in-service suicide prevention training is also required for these employees. In addition, "prior to assignment to a mental health unit or to the female housing unit (noting females with mental illness may also be housed there), each correctional officer shall receive forty (40) hours training in correctional management of inmates who have mental illness. Eight (8) hours of the training shall be dedicated to the suicide prevention program. Each correctional officer assigned to the mental health unit and/or female mental health tear/cells shall be provided an annual forty (40) hours training session which includes eight (8) hours dedicated to the suicide prevention program."

The Unity Health Care's *Suicide Prevention Policy (No. CF705)* has similar mental health and suicide prevention training requirements, and states that the eight (8) hour annual mental health training required of correctional staff that work in the mental health units "shall include instruction on suicide warning signs and symptoms, potential suicide risk pre-disposing factors, high-risk suicide periods, why jails and prisons are conducive to suicides, liability issues, and a discussion of the jail's suicide prevention policy and procedures."

Despite the policy requirements from the DC Department of Corrections and Unity Health Care, current practices reflect a different training schedule and focus. For example, this writer was informed that correctional officers that are assigned to the mental health unit (South 3) in the Central Detention Facility do *not* receive any specialized mental health and/or suicide prevention training (either on a pre-service or annual basis). In practice, the totality of suicide prevention training to *all* employees (including CDF correctional and Unity Health Care staff) is a 39-slide PowerPoint presentation entitled "Suicide Prevention (Module 16)." This workshop, encompassing only one (1) hour of instruction, is offered by Unity Health Care clinicians on a pre-service basis to new civilian employees and then repeated annually to all employees.[4] The slides present accurate information regarding signs and symptoms of suicidal behavior, research on suicide in community (not in the jail environment), liability issues, and the CDF policy on suicide prevention. According to training records, 70% of all correctional officers have received this suicide prevention training workshop within the past 12 months.[5]

[4]Although Unity Health Care clinicians provide the training, the "Suicide Prevention (Module 16)" lesson plan was previously developed by the DC Department of Corrections.

[5]This writer was informed that, although the DOC's Training Department has an annual target of 95% completion for training, completion of suicide prevention training has been lower this year because of budget considerations.

In addition to the "Suicide Prevention (Module 16)" training, the CDF Mental Health Director (for Unity Health Care) provides a 44-slide PowerPoint presentation entitled "Suicide Prevention and Corrections" to all Unity Health Care providers and qualified mental health professionals on both a pre-service and annual basis.[6] This one (1) hour PowerPoint slide presentation contains much of the same information found in the DOC's "Suicide Prevention (Module 16)" training, but, given its intended audience, is not clinically-focused and does not provide guidance on the clinical assessment of suicide risk. According to training records, 88% of Unity Health Care clinicians have received this suicide prevention training workshop within the past 12 months.

In sum, it would be this writer's opinion that the number of hours devoted to both pre-service and annual suicide prevention training for correctional, medical, and mental health staff is inadequate, and the content of the training curricula is in need of improvement. In addition, although only reflected in policy and not practice, a commitment to additional hours of suicide prevention training for correctional officers that are assigned to the lone Mental Health Unit (South 3) is misplaced because most of the identification of potentially suicidal behavior normally takes place outside of South 3 and in other units of the facility. Therefore, such additional hours of training is necessary for *all* correctional staff that work in the CDF.

RECOMMENDATIONS: Several recommendations are offered to strengthen both the length and content of jail suicide prevention training offered to both correctional and healthcare personnel who work within the Central Detention Facility. *First*, it is strongly recommended that either the DC Department of Corrections or Unity Health Care develop a pre-service suicide

[6]It was unclear to this writer if such training was also required of the Unity Health Care *nursing* staff.

prevention curriculum (of between 4 to 8 hours in length) and that all new correctional and health care staff be required to complete this initial program. It is strongly recommended that the curriculum include the following topics:

- avoiding obstacles (negative attitudes) to prevention
- inmate suicide research
- why facility environments are conducive to suicidal behavior
- identifying suicide risk despite the denial of risk
- potential predisposing factors to suicide
- high-risk suicide periods
- warning signs and symptoms
- components of the CDF's suicide prevention program
- liability issues

There are several nationally-recognized suicide prevention training curricula that can be utilized as guides to development of a recommended suicide prevention training curriculum.[7] Much of this information is available through the US Justice Department's National Institute of Corrections at the following website: http://nicic.gov/?q=suicide+prevention+training. In addition, the new curriculum should include more recent national data on inmate suicides. Data from this writer's *National Study of Jail Suicide: 20 Years Later* can be included in the revised curriculum.[8]

Second, it is strongly recommended that either the DC Department of Corrections or Unity Health Care develop an annual suicide prevention curriculum (of 2 hours in length) and

[7]See, for example, Hayes, L.M. and Rowan, J.R. (1995), *Training Curriculum on Suicide Detection and Prevention in Jails and Lock-ups*, Mansfield, MA: National Center on Institutions and Alternatives; New York State, Office of Mental Health, Commission of Correction (2003), *Suicide Prevention and Crisis Intervention in County Jails and Police Lockups – Basic Program Trainer's Manual*, Albany, NY: Authors.

[8]Hayes, L.M (2010), *National Study of Jail Suicides: 20 Years Later*, Washington, DC: National Institute of Corrections, U.S. Department of Justice, http://www.ncianet.org/services/suicide-prevention-in-custody/publications/; Hayes, L. (2012), "National Study of Jail Suicides: 20 Years Later," *Journal of Correctional Health Care*, 18 (3).

that *all* correctional and health care staff be required to complete the workshop each year. The annual training curriculum should be a consolidation of the pre-service curriculum, offer case studies of any suicides during the previous year, and any changes in the CDF suicide prevention policy during the previous year.

2) Intake Screening/Assessment

> **Intake screening for suicide risk must take place immediately upon confinement and prior to housing assignment. This process may be contained within the medical screening form or as a separate form, and must include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/ close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; transporting officer(s) believes inmate is currently at risk. The intake screening process should include procedures for referral to mental health and/or medical personnel. Any inmate assigned to a special housing unit should receive a written assessment for suicide risk by mental health staff upon admission.**

Intake screening/assessment is also critical to a correctional system's suicide prevention efforts. An inmate can attempt suicide at any point during incarceration -- beginning immediately following reception and continuing through a stressful aspect of confinement. Although there is disagreement within the psychiatric and medical communities as to which factors are most predictive of suicide in general, research in the area of jail and prison suicides has identified a number of characteristics that are strongly related to suicide, including: intoxication, emotional state, family history of suicide, recent significant loss, limited prior incarceration, lack of social support system, psychiatric history, and various "stressors of confinement."[9] Most importantly, prior research has consistently reported that at least two thirds of all suicide victims communicate their intent some time prior to death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those

[9]Bonner, R. (1992), "Isolation, Seclusion, and Psychological Vulnerability as Risk Factors for Suicide Behind Bars," in R. Maris et. al. (Editors) *Assessment and Prediction of Suicide*, New York, NY: Guilford Press, 398-419.

who have never made an attempt.[10] In addition, according to the most recent research on inmate suicide, at least one-third of all inmate suicide victims had prior histories of both mental illness and suicidal behavior.[11] The key to identifying potentially suicidal behavior in inmates is through inquiry during both the intake screening/assessment phase, as well as other high-risk periods of incarceration. Finally, given the strong association between inmate suicide and special management (i.e., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit should receive a written assessment for suicide risk by mental health staff upon admission to such placement.

Both the ACA and NCCHC standards address the issue of assessing inmates assigned to segregation. According to ACA Standard 4-ALDF-2A-45: "When an inmate is transferred to segregation, health care personnel are informed immediately and provide assessment and review as indicated by the protocol as established by the health authority." NCCHC Standard J-E-09 states that "Upon notification that an inmate is placed in segregation, a qualified health care professional reviews the inmate's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation."

FINDINGS: Both the DC Department of Corrections and Unity Health Care policies adequately address requirements for intake screening to identify potentially suicidal behavior. Upon admission, all new inmates are processed through the Reception and Discharge (R &D)

[10]Clark, D. and S.L. Horton-Deutsch (1992), "Assessment in Absentia: The Value of the Psychological Autopsy Method for Studying Antecedents of Suicide and Predicting Future Suicides," in R. Maris et. al. (Editors) *Assessment and Prediction of Suicide*, New York, NY: Guilford Press, 144-182.

[11]Hayes, L.M. (2010), *National Study of Jail Suicide: 20 Years Later*, Washington, DC: U.S. Department of Justice, National Institute of Corrections; "National Study of Jail Suicides: 20 Years Later," *Journal of Correctional Health Care*, 18 (3).

Unit. The DOC recently initiated a new protocol by which the R & D Shift Lieutenant administers a "Booking Questionnaire" to each inmate. This 17-item intake screening form is very good and was adapted from the "Suicide Prevention Screening Guidelines" form that was originally developed by the New York State Office of Mental Health and Commission of Correction during the 1980s. In addition, the Shift Lieutenant reviews the "alert screen" in the Jail and Community Corrections System (JACCS), the agency's jail management system, to determine if the inmate has been flagged as a potential risk for suicide based upon current or prior behavior known to the agency.[12] Following the screening process, each inmate is escorted to the Medical Unit or additional intake screening.

Each inmate admitted into the Central Detention Facility receives intake screening administered by a health care provider from Unity Health Care, either a physician, physician's assistant, or nurse practitioner.[13] Mental health/suicide risk inquiry during the intake screening process is found on the "Psych Screen" section of the electronic medical record (EMR), entitled "Centricity." Following questions are on the screen:

- Currently receiving MH services in community?
- Received MH services in the past?
- Experienced a significant loss within six months?
- Very worried about 'major' problems other than legal?
- Family or significant other attempted suicide?
- Holds position of respect in community and/or charged with crime of notoriety?
- Thinking about killing him/her self?
- History of suicide(s), self injury, or suicidal ideation?
- Lacks close family or friends in the community?
- First DC incarceration?
- Referred for court-ordered forensic evaluation?

[12]This process was initiated a few months ago following the recent inmate suicides.
[13]This practice far exceeds the standard of care in similar sized jail facilities throughout the country in which intake screening is completed by nursing staff (preferably a registered nurse).

- Have you ever been a victim of a physical or sexual assault?
- History of special education placement?
- History of sex offenses?
- Apparently under influence of alcohol or drugs?
- Is inmate a juvenile?
- Referred to comprehensive assessment because of a positive response to screening questions?

These are all good questions for an adequate suicide risk inquiry. In addition, and perhaps most importantly, the screening process is conducted within the privacy of the medical provider's office. This better ensures the likelihood of an inmate feeling comfortable in self-reporting sensitive medical and mental health information. This writer had the opportunity to observe the intake screening process within the Medical Unit. Unfortunately, due to scheduling problems, only one new intake could be observed. However, this writer's observation of that one case was not very favorable. Despite a "Psych. Screen" that listed over 15 lines of inquiry, this writer observed the provider only making the following inquiries to the inmate:

- Ever seen a psychiatrist?
- Are you thinking of hurting yourself?
- Suffered any significant loss?

Although the observed inmate answered "no" to each of these three questions, because it was his first CDF incarceration, pursuant to policy, the inmate was referred to a mental health clinician for further assessment. This writer followed the inmate and subsequently observed this mental health assessment (in another private office). The mental health clinician asked the following questions to the inmate:

- Any MH treatment in community?
- Ever tried to harm yourself?
- Any drug use?
- Do you have any significant relationships?
- Schooling?
- Employment?

- Need any mental health services? (Informed how to access mental health services through sick call slips.)

Ironically, there was no inquiry from this clinician regarding *current* suicide risk. Although disappointing to observe, based upon a sample of only one case, this writer will not offer any conclusions as to the quality of intake screening administered by either Unity Health Care providers or mental health clinicians.

Further, one of the indicators of current suicide risk during confinement is suicide risk during prior confinement. Although the "alert screen" in the JACCS has the ability to capture information about an inmate's placement on suicide precautions during a prior CDF confinement, such critically important information is not currently contained within JACCS (despite CDF staff assurances that it was).[14] In addition, this writer was informed that the Centricity EMR will be upgraded in the next several weeks, with one new feature being the ability to flag and inmate's placement on suicide precautions during a prior confinement through an alert screen.

Finally, as previously offered, there is a strong association between inmate suicide and special management (i.e., disciplinary and/or administrative segregation) housing unit placement. Therefore, any inmate assigned to a segregation unit should receive a written assessment for suicide risk by mental health staff upon admission to such placement. This writer was informed by Unity Health Care officials that each inmate assigned to segregation must be seen face-to-face by a medical provider and given "pre-segregation clearance." In addition, an inmate assigned to

[14]For example, this writer reviewed the JACCS and found that none of the inmates on suicide precautions for August 27 were listed on the alert screen.

segregation with a history of mental illness must be seen by, and cleared for, such housing by a mental health clinician. However, documentation of such assessment appears only as a "cleared for segregation" entry in the chart." Finally, this writer was informed that nursing staff are required to make daily rounds of segregation, whereas a mental health clinician conducts rounds once or twice a week in segregation. These are good practices.

In sum, the intake screening process for identifying potentially suicidal behavior is more than adequate, with medical providers responsible for administering the screening form in the privacy of their offices. However, the suicide risk inquiry is not as robust as it could be, and an alert system should be activated within both the JACCS and Centricity EMR to flag an inmate's placement on suicide precautions during a prior CDF confinement.

RECOMMENDATIONS: A few recommendations are offered to improve the intake screening/assessment process within the Central Detention Facility. *First*, it is strongly recommended that the current suicide risk inquiry contained on the current "Psych. Screen" in the centricity EMR be replaced by the "Mental Health/Suicide Risk Intake Screening Form" contained in Appendix A. This form was previously forwarded to both DC Department of Corrections and Unity Health Care officials for consideration.

Second, it is strongly recommended that the DC Department of Corrections initiate a continuous quality assurance audit of the intake screening process to ensure that all suicide risk questions are asked to new inmates and responses appropriately documented within the EMR.

Third, regardless of the inmate's behavior or answers given during intake screening, an immediate referral to mental health staff should always be initiated based on documentation reflecting possible mental illness and/or suicidal behavior during an inmate's prior confinement within the Central Detention Facility. As such, the "alert screen" should be activated within both the JACCS and Centricity EMR according to the following procedures:

- Any inmate placed on suicide precautions in the CDF should be tagged on the "alert screen" of both the JACCS and Centricity EMR by Unity Health Care staff;

- Medical providers conducting intake screening should always review the inmate's alert screen to verify whether they were previously confined in the CDF and had any history of suicidal behavior/placement on suicide precautions during a prior confinement; and

- Regardless of the inmate's behavior or answers given during intake screening, an immediate referral to mental health staff should always be initiated based on documentation reflecting possible mental illness and/or suicidal behavior during an inmate's prior confinement within the CDF.

Fourth, it would also be strongly recommended that, rather than simply entering "cleared for segregation" in the EMR, a better practice to document a "pre-clearance for segregation" assessment by mental health staff would be to enter a progress note into the chart that details the inmate's current mental health status.

3) Communication

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

Certain signs exhibited by the inmate can often foretell a possible suicide and, if detected and communicated to others, can prevent such an incident. There are essentially three levels of communication in preventing inmate suicides: 1) between the sending institution/arresting-transporting officer and correctional staff; 2) between and among staff (including mental health and medical personnel); and 3) between staff and the suicidal inmate. Further, because inmates can become suicidal at any point in their incarceration, correctional staff must maintain awareness, share information and make appropriate referrals to mental health and medical staff.

FINDINGS: Effective communication between correctional, medical, and mental health staff is not an issue that can be easily written as a policy directive, and is often dealt with more effectively through examples of multidisciplinary problem-solving. Although on-site for only a few several days, this writer sensed that correctional, medical, and mental health personnel had a good working relationship, although there appeared to be some tension between DOC and Unity Health Care officials regarding the recent inmate suicides, as well as appropriate management of suicidal inmates. In addition, the Centricity EMR is integrated and contains both medical and mental health records that better ensures the continuity of care and enhancing communication. Further, there are regularly scheduled management meetings between DOC and Unity Health Care supervisory personnel. These are all good practices.

RECOMMENDATION: As previously stated, a multi-agency Suicide Prevention Task Force was initiated by DOC Director Faust in July 2013 following two recent inmate suicides. One of the Task Force recommendations was to develop better tools for outside agencies (including the DC court system, DC Pre-Trial Services, etc.) to communicate with CDF and Unity Health Care staff regarding potentially suicidal inmates. This writer was informed that the JACCS was available to these outside agencies, but rarely utilized by them. It would be this writer's opinion that the JACCS would be an ideal tool to communicate such information and would strongly encourage its expanded use by both internal and external agencies.

4) <u>Housing</u>

> **Isolation should be avoided. Whenever possible, house in general population, mental health unit, or medical infirmary, located in close proximity to staff. Inmates should be housed in suicide-resistant, protrusion-free cells. Removal of an inmate's clothing (excluding belts and shoelaces), as well as use of physical restraints (e.g. restraint chairs/boards, straitjackets, leather straps, etc.) and cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is physically engaging in self-destructive behavior.**

In determining the most appropriate location to house a suicidal inmate, there is often the tendency for correctional officials in general to physically isolate the individual. This response may be more convenient for staff, but it is detrimental to the inmate. The use of isolation not only escalates the inmate's sense of alienation, but also further serves to remove the individual from proper staff supervision. National correctional standards stress that, to every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located in close proximity to staff.

Of course, housing a suicidal inmate in a general population unit when their security level prohibits such assignment raises a difficult issue. The result, of course, will be the assignment of the suicidal inmate to a housing unit commensurate with their security level. Within a correctional system, this assignment might be a "special housing" unit, e.g., restrictive housing, disciplinary confinement, administrative segregation, etc., However, to every extent possible, such inmates should be housed in suicide-resistant, protrusion-free cells. Further, cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), removal of clothing (excluding belts and shoelaces), as well as the use of physical restraints (e.g., restraint

chairs/boards, straitjackets, leather straps, etc.) should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is physically engaging in self-destructive behavior. Housing assignments should not be based on decisions that heighten depersonalizing aspects of incarceration, but on the ability to maximize staff interaction with inmates.

FINDINGS: Pursuant to policy, inmates identified as suicidal are permitted to be housed in three locations within the Central Detention Facility: three (3) cells in the Medical Unit, three (3) cells in the Special Management Unit (South 1), and three (3) cells within the Mental Health Unit (South 3). This writer examined each of these cell locations and found that, for the most part, they were "suicide-resistant" and did not contain any obvious protrusions that could act as an anchoring device from which an inmate could attach a ligature in a suicide attempt by hanging. However, with only nine (9) designated safe cells in the CDF, this writer observed that there were more than nine (9) inmates on observation status each day during this on-site assessment that resulted in several inmates being housed in non-suicide resistant cells on the mental health unit. Several of these South 3 cells contained several dangerous anchoring devices, including a towel rack on the desk, a towel rack on the sink, ventilation holes in bunks, large holes in ventilation grates, and clothing hooks.[15]

There were several other concerns regarding the management of inmates on suicide precautions or "Behavioral observation" (a practice that will be discussed in detail in the next section) in the Central Detention Facility. First, *all* inmates are stripped of all clothing and possessions, and given only a paper gown without undergarments. Contrary to DOC policy, no

[15]These anchoring devices were utilized in several of the recent inmate suicides. In fact, during this writer's on-site assessment, an inmate was found hanging (without subsequent serious injury) from a ventilation grate in his South 3 cell on August 29.

other possessions, including safety blanket, mattress, or footwear, are provided. In addition, these inmates are only allowed out of their cells for a shower (at the officer's discretion and/availability) and legal visits. Access to the telephone and family visitation is prohibited. Clinical judgment to determine possessions/privileges offered and removed based upon suicide risk level and lethality are *not* practiced at the CDF.

It would be this writer's opinion that current management of placed on suicide precautions and Behavioral Observation within the Central Detention Facility is overly restrictive and seemingly punitive. Confining a suicidal inmate to their cell for 24 hours a day only enhances isolation and is anti-therapeutic. Under these conditions, it is also difficult, if not impossible, to accurately gauge the source of an inmate's suicidal ideation. Take, for example, the daily scenario of a clinician interviewing an inmate on suicide precautions or Behavioral Observation. The inmate has been in the cell for a few days, clothed only in a paper gown. The inmate has not been out of the cell and has an incredibly foul odor because he has not showered (even if it had been offered). The clinician then asks the inmate: "Are you suicidal?" Given the circumstances he finds himself in, the likelihood of an inmate answering affirmatively to that question, the result of which will be his continued placement under these conditions, is highly questionable.

Therefore, it would be this writer's opinion that the overly restrictive and seemingly punitive environment of suicide precautions and Behavioral Observation within the Central Detention Facility influences an inmate's suicide risk assessment by mental health staff, as well as the suicidal inmate's willingness to self-report suicidal ideation. Several Unity Health Care

staff informed this writer that the conditions of suicide precautions and Behavioral Observation are not intentionally punitive, but driven by concern for the safety of the inmate and staff assigned to the housing units.[16] The commitment to safety is not being challenged here. Safety of the inmate is, of course, of utmost concern when developing a suicide prevention policy. But the number and types of restrictions imposed in the name of safety must be reasonable and commensurate with the inmate's level of suicide risk.

Officials might also argue (although they did not to this writer) that the rationale for these restrictions is that suicidal inmates are unpredictable and bad news received during a family visit or telephone call might trigger suicidal ideation and result in an increased risk for suicide. This rationale, however, ignores the obvious -- what better opportunity is there to observe an inmate's reaction to potentially negative news then when they are on suicide precautions, as well as the fact that interaction with the outside world can be therapeutic and reduce isolation -- a leading cause for suicidal behavior. Staff might also argue that most inmates who are mentally ill and on suicide precautions are so debilitated by their illness that "they do not care" how they are treated (i.e., the withholding of basic privileges). Of course, this assumption is not only unsupported but ignores the real possibility that these measures are contributing to an inmate's debilitating mental illness.

Finally, mental health clinicians from Unity Health Care told this writer that these highly restrictive measures are effective in managing those inmates suspected as being manipulative or malingering. As should be discussed during suicide prevention training workshops, although

[16]As will be explained in the next section, it was somewhat ironic that clinicians stressed to this writer that they were concerned about an inmate's safety while at the same time ordering observation at 30-minute or 60-minute intervals, a frequency of observation that was obviously contrary to a concern for self-harm.

distinguishable, manipulative behavior and suicidal behavior are not mutually exclusive. Both types of behavior can occur (or overlap) in the same individual and cause serious injury and death. Several studies of self-harm and suicide in the correctional environment have found "substantial co-existence of manipulative motive with both suicidal intent and potentially high lethality of self-harming behavior."[17] As one observer has stated, "There are no reliable bases upon which we can differentiate 'manipulative' suicide attempts posing no threat to the inmate's life from those 'true, non-manipulative' attempts which may end in death. The term 'manipulative' is simply useless in understanding, and destructive in attempting to manage, the suicidal behavior of inmates (or of anybody else).[18] Self-harm is often a complex, multifaceted behavior, rather than simply manipulative behavior motivated by secondary gain. At a minimum, any inmate who would go to the extreme of threatening suicide or engaging in self-harming behavior is suffering from at least an emotional imbalance that requires special attention. They may also be mentally ill. Simply stated, inmates labeled as manipulative still commit suicide.

RECOMMENDATIONS: The following recommendations are offered to improve the housing of inmates on suicide precautions within the Central Detention Facility. *First*, it is strongly recommended that DOC officials embark upon an inspection program to ensure that inmates on suicide precautions are housed in "suicide-resistant" cells, i.e., without any obvious protrusions that would easily enable an inmate to hang themselves. For example, bunk holes should be covered and/or bunk replaced, dangerous ventilation grates be replaced with grates that

[17]Dear G, Thomson D, Hills A. (2000), "Self-Harm in Prison: Manipulators Can Also Be Suicide Attempters," *Criminal Justice and Behavior*, 27: 160-175.
[18]Haycock J. (1992), "Listening to 'Attention Seekers:' The Clinical Management of People Threatening Suicide," *Jail Suicide Update* 4 (4): 8-11.

have holes that are ideally 1/8 inches in diameter and no more than 3/16 inches diameter (or 16-mesh per square inch), and clothing hooks and towel racks removed from all cells designated to house suicidal inmates. Specific recommendations regarding the removal of obvious protrusions in cells can be found in the "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities," which is contained in Appendix B of this report.

Second, it is strongly recommended that the overly restrictive and seemingly punitive environment of suicide precautions be reduced by revision of both DOC and Unity Health Care suicide prevention policies that would include the following requirements:

- All decisions regarding the removal of an inmate's clothing, bedding, possessions (books, slippers/sandals, eyeglasses, etc.) and privileges shall be commensurate with the level of suicide risk *as determined on a case-by-case basis by mental health staff*;

- If mental health staff determine that an inmate's clothing needs to be removed for reasons of safety, the inmate shall always be issued a safety smock *and safety blanket*;[19]

- A mattress shall be issued to all inmates on suicide precautions unless the inmate utilizes the mattress in ways in which it was not intended, i.e., attempting to tamper with/destroy, utilizes to obstruct visibility into the cell, etc.);

- All inmates on suicide precautions shall be allowed all routine privileges (e.g., family visits, telephone calls, recreation, etc.), unless the inmate has lost those privileges as a result of a disciplinary sanction; and

- Inmates on suicide precautions shall not automatically be locked down. They should be allowed dayroom access commensurate with their security level and clinical judgment of mental health staff.

[19]Paper gowns should not be utilized in the Central Detention Facility. Their use is antiquated and the explanation given to this writer that safety smocks were previously utilized but "disappeared from the facility by staff" is more of an issue of security and inventory and not the appropriate response for properly clothing a suicidal inmate.

Third, this writer would strongly support a Suicide Prevention Task Force recommendation relating to better utilization of the existing Mental Health Unit (South 3) and re-introduction of a step-down mental health unit. Although this writer did not have sufficient time to conduct a thorough analysis of the existing Mental Health Unit, it would appear that it is currently being utilized simply as a regular housing unit to house inmates with serious mental illness, rather than a fully functioning mental health unit. This writer observed very few mental health staff assigned to the unit, no group therapy or other program activities, and very few inmates permitted out of their cells in the dayroom area. As offered in the next section, the standard of care (as well as reflected in Unity Health Care's suicide prevention policy) requires treatment planning for inmates on suicide precautions. Given the lack of mental health staffing and programmatic resources currently available in the existing Mental Health Unit, few treatment planning options beyond medication management are available.

5) Levels of Supervision/Management

> **Two levels of supervision are generally recommended for suicidal inmates -- *close observation* and *constant observation. Close Observation* is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 10 minutes. *Constant Observation* is reserved for the inmate who is actively suicidal, either by threatening or engaging in self-injury. This inmate should be observed by a staff member on a continuous, uninterrupted basis. Other supervision aids (e.g., closed circuit television, inmate companions/watchers, etc.) can be utilized as a supplement to, but never as a substitute for, these observation levels. Inmates on suicide precautions should be reassessed on a daily basis.**

Experience has shown that prompt, effective emergency medical service can save lives. Research indicates that the overwhelming majority of suicide attempts in custody is by hanging.[20] Medical experts warn that brain damage from asphyxiation can occur within four minutes, with death often resulting within five to six minutes. In inmate suicide attempts, the promptness of the response is often driven by the level of supervision afforded the inmate. Both the ACA and NCCHC standards address *levels of supervision*, although the degree of specificity varies. ACA Standard 4-ALDF-2A-52 vaguely requires that "suicidal inmates are under continuous observation," while NCCHC Standard J-G-05 requires physical observation ranging from "constant supervision" to "every 15 minutes or more frequently if necessary." According to the Suicide Prevention and Intervention Standard from the U.S. Department of Homeland

[20]Hayes, L.M. (2010), *National Study of Jail Suicide: 20 Years Later*, Washington, DC: U.S. Department of Justice, National Institute of Corrections; "National Study of Jail Suicides: 20 Years Later," *Journal of Correctional Health Care*, 18 (3).

Security's *Operations Manual ICE Performance-Based National Detention Standards*, "Suicidal detainees will be monitored by the assigned security officers who maintain constant one-on-one visual observation, 24 hours a day, until the detainee is released from suicide watch. The assigned security officer makes notations every 15 minutes on the behavioral observation checklist."

In addition, the component of "Levels of Supervision" encompasses the overall management of the inmate on suicide precautions and includes the appropriate level of observation, timely and comprehensive suicide risk assessments, downgrading the level of observation following a period of stability, and providing periodic follow-up assessments following discharge from suicide precautions.

FINDINGS: Both the DC Department of Corrections and Unity Health Care policies adequately address the two authorized levels of observation required for suicidal inmates:

> **Suicide Precaution**: A measure utilized for the inmate who, though suicidal, is not thought to require continuous observation. Inmates on close observation may be housed in an observation bed/cell and are observed at staggered intervals that do not exceed 15 minutes;
>
> **Suicide Watch**: A measure utilized for the inmate who is actively suicidal. Inmates on constant observation are housed in an observation bed/cell that allows continuous observation without interruption with documentation every 15 minutes.

Behavioral Observation

Despite the above policy language, current practices of Unity Health Care clinicians within the Central Detention Facility are to place inmates identified as either suicidal and/or those threatening/engaging in self-injurious behavior on a status commonly referred to as

"B**ehavioral Observation**."[21] In fact, *Suicide Watch and Suicide Precautions are rarely utilized in the facility, and incredibly there were not any inmates on either Suicide Watch or Suicide Precaution status during this writer's three-day on-site assessment. Instead, there were numerous inmates on Behavior Observation status.* This writer conversed with several Unity Health Care clinicians and they offered varying interpretations as to the types of inmates and behavior warranting Behavioral Observation. For example, one clinician offered that Behavioral Observation was utilized for inmates who were threatening suicide, but thought to be manipulative and/or malingering, as well as for inmates being aggressive/assaultive toward other inmates or staff. Another clinician was more specific and offered that Behavioral Observation was utilized for inmates who *expressed* suicidal ideation or *threatened* suicide, as well as inmates who engaged in *non-lethal* self-injurious behavior; whereas Suicide Watch and Suicide Precaution was utilized for inmates who actually engaged in serious suicidal behavior (i.e., a lethal suicide attempt).

This writer was also informed by Unity Health Care clinicians that whereas a psychiatrist is the only clinician permitted to remove an inmate from Suicide Watch and Suicide Precaution, any mental health clinician can discharge an inmate from Behavioral Observation. According to Unity Health Care clinicians, inmates on Behavioral Observation status are housed in the Mental Health (South 3) and Special Management (South 1) units, whereas inmates on Suicide Watch and Suicide Precautions are housed in the Medical Unit. (During this on-site assessment, however, this writer observed two inmates on Behavioral Observation status in the Medical Unit.)

[21]It should be noted that Unity Health Care officials informed this writer that the practice of utilizing Behavioral Observation in the Central Detention Facility pre-dated their agency's initiation of health care services in 2006.

Of particular interest, this writer was informed by Unity Health Care officials that inmates on Behavioral Observation status are observed at varying intervals contingent upon their housing location. For example, inmates on Behavioral Observation status in the Medical Unit are observed at 60-minute intervals by nursing staff;[22] inmates on Behavioral Observation status in the Mental Health Unit (South 3) are observed at 30-minute intervals by nursing staff (although staff on that unit offered contradictory information and claimed the observations occurred at 60-minute intervals); and inmates on Behavioral Observation status in the Special Management Unit (South 1) are observed at 15-minute intervals by correctional officers (based upon a recent directive from the DOC Director mandating 15-minute observation of all inmates in Special Management and Intake [South 2] units). *Of course, none of the above described practices are in writing because the use of Behavioral Observation is not even addressed in either the DC Department of Corrections' Suicide Prevention and Intervention Policy (No. 6080.2F) or Unity Health Care's Suicide Prevention Policy (No. CF705). Such unauthorized practices should be very concerning to legal counsel for each agency.*

In conclusion, there are numerous problems associated with the use of Behavioral Observation status within the Central Detention Facility. *First*, beyond the fact that it is not even authorized in any DOC or Unity Health Care policy or directive, it appears to be predicated upon the belief that clinical staff can easily distinguish "genuinely suicidal behavior" from "manipulative behavior." As offered earlier in this report, manipulative behavior and suicidal

[22]In addition, although informed that inmates housed in the Medical Unit on Behavioral Observation were also continuously observed via closed-circuit television (CCTV) monitoring, this writer spent considerable time in the Medical Unit and *never* observed any nursing and or correctional staff monitoring the CCTV.

behavior are not mutually exclusive; both types of behavior can occur (or overlap) in the same individual and cause serious injury and death. In fact, as aptly stated on a PowerPoint slide utilized in suicide prevention training by mental health clinicians from Unity Health Care: "Most researchers suggest the better and safer approach may be to manage a non-suicidal (manipulative behavior) prisoner as if he was suicidal."

Second, inmates on Behavior Observation status are stripped of their uniform and all other possessions, and issued only a paper gown. They are confined to their cell 24 hours a day with no privileges. These highly restrictive measures are said to be taken for the inmate's safety and concern for the potential of self-injurious behavior. However, in demonstration of complete unconcern for inmate safety, clinicians then order the inmate to be observed at 60-minute intervals. In addition, these inmates are sometimes housed in cells that are not suicide-resistant.

It was obvious to this writer that the use of Behavioral Observation in the Central Detention Facility is predicated upon two factors: 1) a misguided belief that most inmates who threaten suicide and/or engage in self-injurious behavior are simply manipulative and the overtly restrictive and punitive aspects of Behavioral Observation is meant to deter such behavior; and 2) a mechanism to by-pass requirements of either continuous or 15-minute observation on Suicide Watch/Suicide Observation by utilizing an observation status that only requires nursing staff to monitor an inmate at 30 or 60-minute intervals.

An additional concern involves the quality of documentation found in progress notes as they relate to the assessment and treatment of suicide risk. Pursuant the DOC and Unity Health

Care suicide prevention policies, inmates on suicide precautions are required to be seen daily by either a psychiatrist or nurse practitioner to determine continuation of, or discharge from, suicide precautions. This writer reviewed several charts of inmates on Behavioral Observation status. The following case exemplifies concerns regarding the quality of documentation. The inmate had multiple diagnoses, including Bi-Polar Disorder. He had been placed on, and discharged from, Behavioral Observation status on several occasions since his confinement in the Central Detention Facility beginning in February 2013. The rationale for initiation of Behavioral Observation varied from having physical altercations with other inmates in the Mental Health Unit, throwing urine on staff, and threatening suicide and/or engaging in self-injurious behavior. In July 2013, the inmate tied a paper gown around his neck and attempted to flush it down the toilet, as well as later attaching his paper gown to a ventilation grate in his cell. The paper gown was subsequently removed and he was housed completely naked in his cell for over a week. The inmates was discharged from Behavior Observation status on July 23, and continued on and off this observation status on several more occasions, most recently on August 13 when he was observed with a sheet tied around his neck and threatening suicide. He had also thrown feces at another inmate, as well as accused correctional staff of sexual abuse. The following are examples of the "assessments" by psychiatric staff in this case, provided in their *entirety*:

> August 20: "The patient continues to be loud and asking to be removed from the safe cell. He claims he wants to see the sister, he has no visitors, safe cell order continues."
>
> August 22: "The patient has reached maximum benefit in the safe cell. He was counseled about his behavior, he will be released from the safe cell and seen within 24 hours."
>
> August 23: "The patient was removed from the safe cell yesterday. He is stable and not in any distress."

Several days later on August 29 (while this writer was on-site), the following nursing note was found in the chart:

> At about 8:15am, Cpl. _____ entered the nurses' station and reported that _____ had something tied around his neck and attached to the ceiling. His feet barely touch the floor, his eyes were bulging, saliva was coming from his mouth, and he urinated on himself. Writer immediately proceeded to untie the knots and asked the officer to call MERT and get the wonder knife. Mr. _____ raised his hand to assist writer to untie the second knot. With assistance from the officer, the sheet was untied and he was lowered to the floor. When the MERT arrived he was lying on the floor and was assisted to sit on his bunk. He ambulated to the stretcher and was transported to urgent care."

Despite the seriousness of the incident, the inmate was later placed on Behavioral Observation status, *not* Suicide Watch or Suicide Observation.

Further, the "Comprehensive Mental Health Assessment" template form currently in the Centricity EMR does *not* provide an adequate documentation of an adequate suicide risk assessment. The template is limited to the following fields: "Suicide History (attempts and methods) and Potential for Harm (self injurious and suicidal ideation)." The standard of care requires that documentation of a comprehensive assessment of suicide risk include sufficient description of the current behavior and justification for either, placement on, or discharge from, suicide precautions. For example, the assessment should include a brief mental status examination, listing of chronic and acute risk factors, listing of any protective factors, level of suicide risk (e.g., low, medium, or high), and a treatment plan.[23]

[23]See American Psychiatric Association (2003), "Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors," *American Journal of Psychiatry*, (160) 11: 1-60 (Supplement).

Finally, there were additional concerns regarding the continuity of care for inmates identified as suicidal and/or engaging in self-injurious behavior. For example, there is no step-down or transitioning process from suicide precautions. An inmate is simply placed on observation status, stripped of all clothing and possessions and issued a paper gown, prohibited from most privileges, and then discharged from the status and returned to their housing unit. In addition, there is very limited treatment planning for inmates identified as suicidal and/or engaging in self-injurious behavior.[24] NCCHC standards (J-G-02), as well as other national correctional standards, require that a treatment plan "should describe signs, symptoms, and the circumstances in which risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided, and the actions the patient or staff can take if suicidal thoughts do occur." As found in the Centricity EMR, a typical treatment plan for an inmate released from observation status would be: "1) Continue taking medication, 2) Place sick call slip as needed, 3) MH to follow-up within 24 hours." Similar to treatment planning, follow-up assessments of inmates recently discharged from observation status is limited to one 24-hour "check-in."

RECOMMENDATIONS: This writer would offer several recommendations to strengthen the observation and management of inmates identified as suicidal and/or exhibiting self-injurious behavior within the Central Detention Facility. *First*, and perhaps most importantly, the DC Department of Corrections should immediately prohibit the practice of utilizing Behavioral Observation status for inmates expressing suicidal ideation, threatening suicide, engaging in suicidal and/or other forms of self-injurious behavior, *but* perceived to be

[24]This writer reviewed several monthly Treatment Plan Reviews that were developed for the inmate described above. Even though the inmate was on Behavior Observation status on numerous occasions from February 2013 through August 2013, these treatment plans failed to address any problem areas relevant to suicidal behavior, self-injurious behavior, or even perceived manipulative and/or malingering behavior.

manipulative and/or malingering.[25] Regardless of any perceived intent, any inmate expressing suicidal ideation, threatening suicide, engaging in suicidal and/or other forms of self-injurious behavior should immediately be placed on suicide precautions until assessed by a qualified mental health professional.

Second, both the DOC and Unity Health Care suicide prevention policies should be revised to include specific reference to the observation of inmates threatening/displaying self-injurious behavior. A proposed revision is offered as follows:

> ***Close Observation*** (or ***Suicide Precaution***) is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of self-destructive behavior and would be considered a low risk for suicide. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 10 minutes, and should be documented as it occurs.
>
> ***Constant Observation*** (or ***Suicide Watch***) is reserved for the inmate who is actively suicidal, either by threatening or engaging in self-injury and would be considered a high risk for suicide. This inmate should be observed by an assigned staff member on a continuous, uninterrupted basis. The observation should be documented at 10-minute intervals.

Third, the recommended prohibition of utilizing Behavior Observation status for inmates who threaten suicide and/or engage in self-injurious behavior will result in a dramatic increase of inmates placed on suicide precautions and requiring observation of at least 15-minute intervals.

[25]Although the terms "mental health observation" or "medical observation" are often utilized in correctional facilities around the country to provide increased supervision of inmates based upon a medical and/or mental health issue, e.g., detoxification, monitoring food/fluid intake, stabilization on psychotropic medication, etc., these levels of observation are *never* associated with suicidal and/or self-injurious behaviors.

Given the fact that current practices within the Central Detention Facility require nursing staff to conduct observation of these inmates in both the Medical and Mental Health units, unless the DOC assumes responsibility for this observation with the assignment of the appropriate number of correctional staff, it would appear that Unity Health Care will need to receive additional funding to provide the appropriate number of nursing staff.

Fourth, it is strongly recommended that the current "Comprehensive Mental Health Assessment" template form in Centricity EMR be replaced with a form that allows for adequate documentation of a suicide risk assessment. As previously offered, such documentation should include a sufficient description of the current behavior and justification for either, placement on, or discharge from, suicide precautions, as well as a brief mental status examination, listing of chronic and acute risk factors, listing of any protective factors, level of suicide risk (e.g., low, medium, or high), and a treatment plan. A sample "Suicide Risk Assessment" form is contained in Appendix C and was previously forwarded to both DC Department of Corrections and Unity Health Care officials for consideration.

Fifth, in addition to completion of a Suicide Risk Assessment form *only* when an inmate is placed on, or discharge from, suicide precautions, when an inmate is continued on suicide precautions following a daily assessment, mental health clinicians should be required to document justification for continued suicide precautions as a progress note that provides sufficient description of the current behavior and justification for a particular level of observation.

Sixth, it is strongly recommended that, consistent with national correctional standards,[26] mental health clinician(s) develop treatment plans for inmates on suicide precautions that "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" (see NCCHC, 2008).

Seventh, it is strongly recommended that, in order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health staff until their release from custody. As such, unless an inmate's individual circumstances directs otherwise (e.g., an inmate inappropriately placed on suicide precautions by non-mental health staff and released less than 24 hours later following an assessment), it is recommended that the reassessment schedule following discharge from suicide precautions be as follows: within 24 hours, again within 72 hours, again within 1 week, and then periodically until release from custody.

[26]For example, the U.S. Department of Homeland Security's *Operations Manual ICE Performance-Based National Detention Standards* state that "Based on the evaluation, the appropriately trained qualified medical personnel will develop a treatment plan placed and documented in the patient's medical record. This treatment plan will address the environmental, historical, and psychological factors that contribute to the detainee's suicidal ideation. The plan should include: strategies and interventions to be followed by the staff and detainee if suicidal ideation reoccurs, strategies for improving for improved functioning, and regular follow-up appointments based on level of acuity."

6) Intervention

> **A facility's policy regarding intervention should be threefold: 1) all staff who come into contact with inmates should be trained in standard first aid and cardiopulmonary resuscitation (CPR); 2) any staff member who discovers an inmate attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin standard first aid and/or CPR; and 3) staff should never presume that the inmate is dead, but rather initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, all housing units should contain a first aid kit, pocket mask or mouth shield, Ambu bag, and rescue tool (to quickly cut through fibrous material). All staff should be trained in the use of the emergency equipment. Finally, in an effort to ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training for all staff.**

Following a suicide attempt, the degree and promptness of intervention provided by staff often foretells whether the victim will survive. Although both ACA and NCCHC standards address the issue of intervention, neither are elaborative in offering specific protocols. For example, ACA Standard 4-ALDF-4D-08 requires that -- "Correctional and health care personnel are trained to respond to health-related situations within a four-minute response time. The training program...includes the following: recognition of signs and symptoms, and knowledge of action required in potential emergency situations; administration of basic first aid and certification in cardiopulmonary resuscitation (CPR)..." NCCHC Standard J-G-05 states -- "Intervention: There are procedures addressing how to handle a suicide attempt in progress, including appropriate first-aid measures."

FINDINGS: Both the DOC and Unity Health Care suicide prevention policies provide very good descriptions of the proper emergency response to a suicide attempt. In addition, first

aid kits were located in each housing unit that was toured by this writer. Each kit contained a microshield or CPR mask. In addition, emergency rescue tools (utilized to quickly cut through fibrous material), were also found in each toured unit. Further, Automated External Defibrillators (AEDs) were located in most toured housing units. With regard to training, this writer was informed that 100% of Unity Health Care's medical staff are currently up-to-date with their training and/or certification in CPR/AED; whereas only 73% of correctional staff are up-to-date with their training and/or certification in CPR/AED.[27] In addition, the DOC suicide prevention policy requires that "mock drill" exercises to simulate an emergency response to a suicide attempt be conducted twice each year. This writer was informed that such drills have been conducted as scheduled. This is an excellent practice.

This writer reviewed the investigative reports and mortality reviews of several of the recent inmate suicide cases and would support the recent Suicide Prevention Task Force recommendations for improving emergency medical responses, including updating AED equipment, reinforcing correctional staff's ability to contact Emergency Medical Services via Central Control without first waiting for medical staff to arrive at the scene of the emergency, and creating better ways to expedite the MERT response.

RECOMMENDATIONS: Apart from a recommendation to increase the compliance rate of CPR/AED training for correctional staff, this writer would support the recommendations previously offered by the Suicide Prevention Task Force.

[27]As previously stated, this writer was informed that, although the DOC's Training Department has an annual target of 95% completion for training, completion of CPR/AED training has been lower this year because of budget considerations.

7) Reporting

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

FINDINGS: With the exception of one reviewed case that involved falsification of observation logs by a correctional officer, this writer's review of the investigative reports concerning the recent inmate suicides found that all reporting requirements appeared to have been appropriately followed.

RECOMMENDATION: None

8) Follow-up/Morbidity-Mortality Review

Every completed suicide, as well as serious suicide attempt (i.e., requiring hospitalization), should be examined by a morbidity-mortality review. (If resources permit, clinical review through a psychological autopsy is also recommended.) The review, separate and apart from other formal investigations that may be required to determine the cause of death, should include: 1) review of the circumstances surrounding the incident; 2) review of procedures relevant to the incident; 3) review of all relevant training received by involved staff; 4) review of pertinent medical and mental health services/reports involving the victim; 5) review of any possible precipitating factors that may have caused the victim to commit suicide or suffer a serious suicide attempt; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. Further, all staff involved in the incident should be offered critical incident stress debriefing.

Experience has demonstrated that many correctional systems have reduced the likelihood of future suicides by critically reviewing the circumstances surrounding incidents as they occur. While all deaths are investigated either internally or by outside agencies to ensure impartiality, these investigations are normally limited to determining the cause of death and whether there was any criminal wrongdoing. *The primary focus of a morbidity-mortality review should be two-fold: What happened in the case under review and what can be learned to help prevent future incidents?* To be successful, the morbidity-mortality review team must be multidisciplinary and include representatives of both line and management level staff from the corrections, medical and mental health divisions.

FINDINGS: Both the DOC and Unity Health Care suicide prevention policies provide very good descriptions of the morbidity and mortality review process following an inmate suicide or serious suicide attempt. Each suicide (and any other death in the jail system) results in

an investigation by the DC Department of Corrections' Office of Investigative Services. This writer reviewed most of the investigative reports for each of the recent inmate suicides and found them to be quite thorough.

In addition, each suicide results in a "psychological autopsy" conducted by Unity Health Care clinicians. Review of several of these documents found them also to be quite thorough, and included possible precipitating factors to each incident. Finally, multidisciplinary mortality reviews were conducted following each of the recent suicides. The initial review was conducted by Unity Health Care clinicians, with a secondary review conducted with the DOC's Health Systems Administrator, DOC Medical Director, and Unity Health Care administrative and clinician personnel comprising a Morbidity and Mortality Review Committee. Review of several of these documents found them also to be quite thorough. The only noted concern was that documentation of recommendations offered by the Committee did not contain any indication as to whether such recommendations were accepted or rejected, as well as a corrective action plan with responsible parties and timetables for completion noted for those recommendations accepted by the Committee and/or DOC and Unity Health Care officials.

RECOMMENDATIONS: Only one recommendation is offered. It is strongly recommended that documentation of a mortality review that includes recommendations should contain an indication as to whether or not each recommendation was accepted or rejected, as well as a corrective action plan with responsible parties and timetables for completion noted for any recommendation accepted by the Committee and/or DOC and Unity Health Care officials.

C. SUMMARY OF RECOMMENDATIONS

Staff Training

1) It is strongly recommended that either the DC Department of Corrections or Unity Health Care develop a pre-service suicide prevention curriculum (of between 4 to 8 hours in length) and that all new correctional and health care staff be required to complete this initial program. It is strongly recommended that the curriculum include the following topics:

- avoiding obstacles (negative attitudes) to prevention
- inmate suicide research
- why facility environments are conducive to suicidal behavior
- identifying suicide risk despite the denial of risk
- potential predisposing factors to suicide
- high-risk suicide periods
- warning signs and symptoms
- components of the CDF's suicide prevention program
- liability issues

There are several nationally-recognized suicide prevention training curricula that can be utilized as guides to development of a recommended suicide prevention training curriculum. Much of this information is available through the US Justice Department's National Institute of Corrections at the following website: http://nicic.gov/?q=suicide+prevention+training. In addition, the new curriculum should include more recent national data on inmate suicides. Data from this writer's *National Study of Jail Suicide: 20 Years Later* can be included in the revised curriculum.

2) It is strongly recommended that either the DC Department of Corrections or Unity Health Care develop an annual suicide prevention curriculum (of 2 hours in length) and that *all* correctional and health care staff be required to complete the workshop each year. The annual training curriculum should be a consolidation of the pre-service curriculum, offer case studies of any suicides during the previous year, and any changes in the CDF suicide prevention policy during the previous year.

Intake Screening/Assessment

3) It is strongly recommended that the current suicide risk inquiry contained on the current "Psych. Screen" in the centricity EMR be replaced by the "Mental Health/Suicide Risk Intake Screening Form" contained in Appendix A. This form was previously forwarded to both DC Department of Corrections and Unity Health Care officials for consideration.

4) It is strongly recommended that the DC Department of Corrections initiate a continuous quality assurance audit of the intake screening process to ensure that all suicide risk questions are asked to new inmates and responses appropriately documented within the EMR.

5) Regardless of the inmate's behavior or answers given during intake screening, an immediate referral to mental health staff should always be initiated based on documentation reflecting possible mental illness and/or suicidal behavior during an inmate's prior confinement within the Central Detention Facility. As such, the "alert screen" should be activated within both the JACCS and Centricity EMR according to the following procedures:

- Any inmate placed on suicide precautions in the CDF should be tagged on the "alert screen" of both the JACCS and Centricity EMR by Unity Health Care staff;

- Medical providers conducting intake screening should always review the inmate's alert screen to verify whether they were previously confined in the CDF and had any history of suicidal behavior/placement on suicide precautions during a prior confinement; and

- Regardless of the inmate's behavior or answers given during intake screening, an immediate referral to mental health staff should always be initiated based on documentation reflecting possible mental illness and/or suicidal behavior during an inmate's prior confinement within the CDF.

6) It would also be strongly recommended that, rather than simply entering "cleared for segregation" in the EMR, a better practice to document a "pre-clearance for segregation" assessment by mental health staff would be to enter a progress note into the chart that details the inmate's current mental health status.

Communication

7) One of the Task Force recommendations was to develop better tools for outside agencies (including the DC court system, DC Pre-Trial Services, etc.) to communicate with CDF and Unity Health Care staff regarding potentially suicidal inmates. This writer was informed that the JACCS was available to these outside agencies, but rarely utilized by them. It would be this writer's opinion that the JACCS would be an ideal tool to communicate such information and would strongly encourage its expanded use by both internal and external agencies.

Housing

8) It is strongly recommended that DOC officials embark upon an inspection program to ensure that inmates on suicide precautions are housed in "suicide-resistant" cells, i.e., without any obvious protrusions that would easily enable an inmate to hang themselves. For example, bunk holes should be covered and/or bunk replaced, dangerous ventilation grates be replaced with grates that have holes that are ideally 1/8 inches in diameter and no more than 3/16 inches diameter (or 16-mesh per square inch), and clothing hooks and towel racks removed from all cells designated to house suicidal inmates. Specific recommendations regarding the removal of obvious protrusions in cells can be found in the "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities," which is contained in Appendix B of this report.

9) It is strongly recommended that the overly restrictive and seemingly punitive environment of suicide precautions be reduced by revision of both DOC and Unity Health Care suicide prevention policies that would include the following requirements:

- All decisions regarding the removal of an inmate's clothing, bedding, possessions (books, slippers/sandals, eyeglasses, etc.) and privileges shall be commensurate with the level of suicide risk *as determined on a case-by-case basis by mental health staff*;

- If mental health staff determine that an inmate's clothing needs to be removed for reasons of safety, the inmate shall always be issued a safety smock *and safety blanket*;

- A mattress shall be issued to all inmates on suicide precautions unless the inmate utilizes the mattress in ways in which it was not intended, i.e., attempting to tamper with/destroy, utilizes to obstruct visibility into the cell, etc.);

- All inmates on suicide precautions shall be allowed all routine privileges (e.g., family visits, telephone calls, recreation, etc.), unless the inmate has lost those privileges as a result of a disciplinary sanction; and

- Inmates on suicide precautions shall not automatically be locked down. They should be allowed dayroom access commensurate with their security level and clinical judgment of mental health staff.

10) This writer would strongly support a Suicide Prevention Task Force recommendation relating to better utilization of the existing Mental Health Unit (South 3) and re-introduction of a step-down mental health unit.

Levels of Supervision/Management

11) The DC Department of Corrections should immediately prohibit the practice of utilizing Behavioral Observation status for inmates expressing suicidal ideation, threatening suicide, engaging in suicidal and/or other forms of self-injurious behavior, *but* perceived to be manipulative and/or malingering. Regardless of any perceived intent, any inmate expressing suicidal ideation, threatening suicide, engaging in suicidal and/or other forms of self-injurious behavior should immediately be placed on suicide precautions until assessed by a qualified mental health professional.

12) Both the DOC and Unity Health Care suicide prevention policies should be revised to include specific reference to the observation of inmates threatening/displaying self-injurious behavior. A proposed revision is offered as follows:

> ***Close Observation*** (or ***Suicide Precaution***) is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of self-destructive behavior and would be considered a low risk for suicide. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 10 minutes, and should be documented as it occurs.
>
> ***Constant Observation*** (or ***Suicide Watch***) is reserved for the inmate who is actively suicidal, either by threatening or engaging in self-injury and would be considered a high risk for suicide. This inmate should be observed by an assigned staff member on a continuous, uninterrupted basis. The observation should be documented at 10-minute intervals.

13) The recommended prohibition of utilizing Behavior Observation status for inmates who threaten suicide and/or engage in self-injurious behavior will result in a dramatic increase of inmates placed on suicide precautions and requiring observation of at least 15-minute intervals. Given the fact that current practices within the Central Detention Facility require nursing staff to conduct observation of these inmates in both the Medical and Mental Health units, unless the DOC assumes responsibility for this observation with the assignment of the appropriate

number of correctional staff, it would appear that Unity Health Care will need to receive additional funding to provide the appropriate number of nursing staff.

14) It is strongly recommended that the current "Comprehensive Mental Health Assessment" template form in Centricity EMR be replaced with a form that allows for adequate documentation of a suicide risk assessment. As previously offered, such documentation should include a sufficient description of the current behavior and justification for either, placement on, or discharge from, suicide precautions, as well as a brief mental status examination, listing of chronic and acute risk factors, listing of any protective factors, level of suicide risk (e.g., low, medium, or high), and a treatment plan. A sample "Suicide Risk Assessment" form is contained in Appendix C and was previously forwarded to both DC Department of Corrections and Unity Health Care officials for consideration.

15) In addition to completion of a Suicide Risk Assessment form *only* when an inmate is placed on, or discharge from, suicide precautions, when an inmate is continued on suicide precautions following a daily assessment, mental health clinicians should be required to document justification for continued suicide precautions as a progress note that provides sufficient description of the current behavior and justification for a particular level of observation.

16) It is strongly recommended that, consistent with national correctional standards, mental health clinician(s) develop treatment plans for inmates on suicide precautions that "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" (see NCCHC, 2008).

17) It is strongly recommended that, in order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health staff until their release from custody. As such, unless an inmate's individual circumstances directs otherwise (e.g., an inmate inappropriately placed on suicide precautions by non-mental health staff and released less than 24 hours later following an assessment), it is recommended that the reassessment schedule following discharge from suicide precautions be as follows: within 24 hours, again within 72 hours, again within 1 week, and then periodically until release from custody.

Intervention

18) Apart from a recommendation to increase the compliance rate of CPR/AED training for correctional staff, this writer would support the recommendations previously offered by the Suicide Prevention Task Force.

Reporting

None

Follow-Up/Morbidity-Mortality Review

19) It is strongly recommended that documentation of a mortality review that includes recommendations should contain an indication as to whether or not each recommendation was accepted or rejected, as well as a corrective action plan with responsible parties and timetables for completion noted for any recommendation accepted by the Committee and/or DOC and Unity Health Care officials.

D. CONCLUSION

It is hoped that the suicide prevention assessment provided by this writer, as well as the recommendations contained within this report, will be of assistance to both the DC Department of Corrections and Unity Health Care. As stated in the preface of this report, both agencies have very comprehensive suicide prevention policies. It is the current suicide prevention *practices* that are of concern. However, this writer met numerous DOC and Unity Health Care officials and supervisors, as well as officers and mental health clinicians, who appeared genuinely concerned about inmate suicide and committed to taking whatever actions were necessary to reduce the opportunity for such tragedy in the future. And based upon a pro-active approach and high caliber management and line staff, this writer is confident that full implementation of the numerous recommendations contained within this report will result in successful efforts to reduce the likelihood of future inmate suicides within the Central Detention Facility.

In conclusion, this writer would be remiss by not extending sincere appreciation to DOC Director Thomas Faust, Diana Lapp, MD, Medical Director for Unity Health Care, and Bruce Reid, CDF Mental Health Director for Unity Health Care. Special thanks is extended to Forrest Daniels, DOC Health Systems Administrator, Beth Mynett, MD, DOC Medical Director, and CDF Major Walter Coley. Without the total candor, cooperation and assistance these individuals, as well as from all correctional, medical, and mental health personnel that were interviewed, this writer would not have been able to complete this technical assistance assignment.

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APPENDIX A

MENTAL HEALTH/SUICIDE RISK INTAKE SCREENING FORM

1) Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency/facility, family member/guardian, etc.) that indicates detainee is a medical, mental health or suicide risk now (requires verification from arresting and/or transporting officer)?

2) Was detainee a medical, mental health or suicide risk during any prior contact and/or confinement within this facility (requires verification on ALERT screen of EMR)?

3) Are you now or have you received counseling for mental health or emotional issues?

4) Have you ever been hospitalized for a mental health issue?

5) Have you ever received medication for a mental health issue?

6) Are you currently taking any medication for a mental health issue?

7) Have you ever received treatment for abuse of alcohol and/or legal or illegal substances?

8) Have you ever heard or seen things that other people could not hear or see?

9) Do you have any mental health issues that you would like to talk to mental health staff about?

10) Are you now or have you ever been accused of committing a violent and/or sexual act?

11) Have you ever been a victim of a violent and/or sexual act?

12) Is this your first incarceration?

13) Do you feel you will have difficulty adjusting to jail?

14) Have you ever attempted suicide?

15) Have you ever considered suicide?

16) Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?

17) Has a family member/close friend ever attempted or committed suicide?

18) Do you feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?

19) Are you thinking of hurting and/or killing yourself?

Observation of Mental Status

Appearance: __ Appropriate __Sweating __Tremors __Disheveled __Bizarre __Intoxicated

Mood: __Appropriate __Depressed __Euphoric __Anxious __Angry __Irritable __ Fearful

Affect: __Appropriate __Tearful __Blunted __Flat __Labile __Hostile

Speech: __Appropriate __Expressive __Loud __Slowed __Pressured __ Slurred__ Disorganized

Thought Content/Process: __Appropriate __ Delusional/Paranoid Thoughts __ Remorseful __Shameful __Hopelessness __Other

Orientation: __Person __Place __Time __Situation

Insight: __Good __Fair __Poor

Perceptions: __Auditory/Visual Hallucinations

APPENDIX B
CHECKLIST FOR THE "SUICIDE-RESISTANT" DESIGN OF CORRECTIONAL FACILITIES

The safe housing of suicidal inmates is an important component to a correctional facility's comprehensive suicide prevention policy. Although impossible to create a "suicide-proof" cell environment within any correctional facility, given the fact that almost all inmate suicides occur by hanging, it is certainly reasonable to ensure that all cells utilized to house potentially suicidal inmates are free of all obvious protrusions. And while it is more common for ligatures to be affixed to air vents and window bars (or grates), *all* cell fixtures should be scrutinized, since bed frames/holes, shelves with clothing hooks, sprinkler heads, door hinge/knobs, towel racks, water faucet lips, and light fixtures have been used as anchoring devices in hanging attempts. As such, to ensure that inmates placed on suicide precautions are housed in "suicide-resistant" cells, facility officials are strongly encouraged to address the following architectural and environmental issues:

1) Cell doors should have large-vision panels of Lexan (or low-abrasion polycarbonate) to allow for unobstructed view of the entire cell interior at all times. These windows should ***never*** be covered (even for reasons of privacy, discipline, etc.) If door sliders are not used, door interiors should not have handles/knobs; rather they should have recessed door pulls. Any door containing a food pass should be closed and locked.

Interior door hinges should bevel down so as not to permit being used as an anchoring device. Door frames should be rounded and smooth on the top edges. The frame should be grouted into the wall with as little edge exposed as possible.

In older, antiquated facilities with cell fronts, walls and/or cell doors made of steel bars, Lexan paneling (or low-abrasion polycarbonate) or security screening (that has holes that are ideally 1/8 inches wide and no more than 3/16 inches wide or 16-mesh per square inch) should be installed from the ***interior*** of the cell.

Solid cell fronts must be modified to include large-vision Lexan panels or security screens with small mesh;

2) Vents, ducts, grilles, and light fixtures should be protrusion-free and covered with screening that has holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

3) Wall-mounted corded telephones should ***not*** be placed inside cells. Telephone cords of varying length have been utilized in hanging attempts;

4) Cells should ***not*** contain any clothing hooks. The traditional, pull-down or collapsible hook can be easily jammed and/or its side supports utilized as an anchor;

5) A stainless steel combo toilet-sink (with concealed plumbing and outside control valve) should be used. The fixture should *not* contain an anti-squirt slit, toothbrush holder, toilet paper rod, and/or towel bar;

6) Beds should ideally be either heavy molded plastic or solid concrete slab with rounded edges, totally enclosed underneath.

If metal bunks are utilized, they should be bolted flush to the wall with the frame constructed to prevent its use as an anchoring device. Bunk holes should be covered; ladders should be removed. (Traditional metal beds with holes in the bottom, not built flush to the wall and open underneath, have often been used to attach suicide nooses. Lying flat on the floor, the inmate attaches the noose from above, runs it under his neck, turns over on his stomach and asphyxiates himself within minutes.);

7) Electricity should be turned off from wall outlets outside of the cell;

8) Light fixtures should be recessed into the ceiling and tamper-proof. Some fixtures can be securely anchored into ceiling or wall corners when remodeling prohibits recessed lighting. All fixtures should be caulked or grouted with tamper-resistant security grade caulking or grout.

Ample light for reading (at least 20 foot-candles at desk level) should be provided. Low-wattage night light bulbs should be used (except in special, high-risk housing units where sufficient lighting 24 hours per day should be provided to allow closed-circuit television (CCTV) cameras to identify movements and forms).

An alternative is to install an infrared filter over the ceiling light to produce total darkness, allowing inmates to sleep at night. Various cameras are then able to have total observation as if it were daylight. This filter should be used only at night because sensitivity can otherwise develop and produce aftereffects;

9) CCTV monitoring does *not* prevent a suicide, it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should *only* supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around the housing should be caulked or grouted.

Cells containing CCTV monitoring should be painted in pastel colors to allow for better visibility. To reduce camera glare and provide a contrast in monitoring, the headers above cell doors should be painted black or some other dark color.

CCTV cameras should provide a clear and unobstructed view of the entire cell interior, including *all* four corners of the room. Camera lens should have the capacity for both night or low light level vision;

10) Cells should have a smoke detector mounted flush in the ceiling, with an audible alarm at the control desk. Some cells have a security screening mesh to protect the smoke detector from

vandalism. The protective coverings should be high enough to be outside the reach of an inmate and far enough away from the toilet so that the fixture could not be used as a ladder to access the smoke detector and screen. Ceiling height for new construction should be 10 feet to make such a reasonable accommodation. Existing facilities with lower ceilings should carefully select the protective device to make sure it cannot be tampered with, or have mesh openings large enough to thread a noose through.

Water sprinkler heads should not be exposed. Some have protective cones; others are flush with the ceiling and drop down when set off; some are the breakaway type;

11) Cells should have an audio monitoring intercom for listening to calls of distress (*only* as a supplement to physical observation by staff). While the inmate is on suicide precautions, intercoms should be turned up high (as hanging victims can often be heard to be gurgling, gasping for air, their body hitting the wall/floor, etc.);

12) Cells utilized for suicide precautions should be located as close as possible to a control desk to allow for additional audio and visual monitoring;

13) If modesty walls or shields are utilized, they should have triangular, rounded or sloping tops to prevent anchoring. The walls should allow visibility of both the head and feet;

14) Some inmates hang themselves under desks, benches, tables or stools/pull-out seats. Potential suicide-resistant remedies are: (a) Extending the bed slab for use as a seat; (b) Cylinder-shaped concrete seat anchored to floor, with rounded edges; (c) Triangular corner desk top anchored to the two walls; and (d) Rectangular desk top, with triangular end plates, anchored to the wall. Towel racks should also be removed from any desk area;

15) All shelf tops and exposed hinges should have solid, triangular end-plates which preclude a ligature being applied;

16) Cells should have security windows with an outside view. The ability to identify time of day via sunlight helps re-establish perception and natural thinking, while minimizing disorientation.

If cell windows contain security bars that are not completely flush with window panel (thus allowing a gap between the glass and bar for use as an anchoring device), they should be covered with Lexan (or low-abrasion polycarbonate) paneling to prevent access to the bars, or the gap, should be closed with caulking, glazing tape, etc.

If window screening or grating is used, covering should have holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

17) The mattress should be fire retardant and not produce toxic smoke. The seam should be tear-resistant so that it cannot be used as a ligature;

18) Given the fact that the risk of self-harm utilizing a laundry bag string outweighs its usefulness for holding dirty clothes off the floor, laundry bag strings should be removed from the cell;

19) Mirrors should be of brushed, polished metal, attached with tamper-proof screws;

20) Padding of cell walls is prohibited in many states. Check with your fire marshal. If permitted, padded walls must be of fire-retardant materials that are not combustible and do not produce toxic gasses; and

21) Ceiling and wall joints should be sealed with neoprene rubber gasket or sealed with tamper-resistant security grade caulking or grout for preventing the attachment of an anchoring device through the joints.

NOTE: A portion of this checklist was originally derived from R. Atlas (1989), "Reducing the Opportunity for Inmate Suicide: A Design Guide," *Psychiatric Quarterly*, 60 (2): 161-171. Additions and modifications were made by Lindsay M. Hayes, and updated by Randall Atlas, Ph.D., a registered architect. See also Hayes, L.M. (2003), "Suicide Prevention and "Protrusion-Free Design of Correctional Facilities," *Jail Suicide/Mental Health Update*, 12 (3): 1-5. Last revised in January 2004.

APPENDIX C
SUICIDE RISK ASSESSMENT

INMATE'S NAME:_____**I.D. NUMBER:**_____
(Last) (First) (M.I.)

DOB:_____ **AGE:**___ **SEX:**___ **INITIAL ASSESSMENT:**___ **REASSESSMENT:**_____ **DATE:**_____

SUICIDE PRECAUTIONS DURING PRIOR CONFINEMENT: YES___ (When:_____) NO_____

REASON FOR REFERRAL:_____
_____
_____
_____
_____
_____
_____

SUICIDE RISK INDICATORS (Check all that apply):

Suicide Attempt____	Suicide Ideation/Gesture____	Self-Mutilation____
Depressed_____	Agitated_____	Mood Change_____
Hostile/Aggressive____	Sleep Problems_____	Recent Loss_____
Lethargy_____	Excessive Weight Gain/Loss____	Isolation/Withdrawal_____
Giving Away Possessions_____	Intoxicated____	Hopeless/Helpless_____
Afraid/Fearful____	Bizarre Behavior (Explain Above)___	Other (Explain Above)___

TYPE OF THREAT/ATTEMPT: Hanging_____Cutting____Jumping____Ingestion___Overdose___Other____

PROTECTIVE FACTORS (Check all that apply):

Identifies reason to live/not commit suicide_____	Future orientation/plans for future_____
Family Support_____	Children at home_____
Religious/spiritual/cultural beliefs_____	Spousal support_____
Interpersonal social support_____	Insight into problems_____
Exercises regularly_____	Job or school assignment_____
Positive coping skills/conflict resolution skills_____	Active and motivated in mental health treatment_____

PREVIOUS PSYCHIATRIC/SUICIDE HISTORY:_____
_____
_____
_____
_____
_____
_____
_____

CURRENT MEDICATIONS:_____
_____
_____

ASSESSMENT OF LETHALITY: Low (1)_____ Medium (2)_____ High (3)_____

DIAGNOSIS:
_____
_____
_____
_____
_____

FINDINGS/RECOMMENDATIONS:_____

TREATMENT PLAN (Describe circumstances in which risk for suicide is likely to recur; specific strategies/actions patient and clinician will take if suicidal thoughts do occur; include frequency of continued contact, referrals, etc.)

ACTIONS: **Suicide Precautions Authorized:** Yes_____ No_____

Level: CLOSE (Physical checks at staggered intervals not to exceed every 10 minutes)___
CONSTANT (1:1 Continuous, uninterrupted observation)_____
OTHER (Specify)_____

Medical Restraints: Yes_____ No_____
Safety Smock: Yes_____ No_____
Items Allowed (Check): Clothing___Undergarments___Blankets___Mattress___Pillow____
Reading Materials____Toiletries___Other_____
Shower: Yes_____ No_____
Visits: Yes_____ No_____
Telephone Cells: Yes_____ No_____
Housing Assignment:_____
Transfer Recommendation:_____
Other Referrals/Recommendations:_____

SIGNATURE/TITLE: _____TIME:_____
(Qualified Mental Health Professional)