REPORT ON SUICIDE PREVENTION PRACTICES WITHIN THE VOLUSIA COUNTY DIVISION OF CORRECTIONS

Daytona Beach, Florida

by

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May 31, 2017

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A. INTRODUCTION

The following is a summary of the observations, findings, and recommendations of Lindsay M. Hayes, Project Director for the National Center on Institutions and Alternatives, following the provision of short-term technical assistance in the area of jail suicide prevention to the Volusia County Division of Corrections (VCDOC) in Daytona Beach, Florida. The VCDOC, administered by the Volusia County Department of Public Protection, contains two jail facilities: Branch Jail and Correctional Facility. The Branch Jail is a pre-trial facility housing approximately 800 male detainees; whereas the Correctional Facility houses approximately 260 sentenced male inmates, and approximately 240 pre-trial and sentenced female inmates.

During the past few years, the VCDOC has experienced a higher number of inmate suicides then in previous years. Because of the higher incidence of suicide, Mark Flowers, VCDOC Acting Director, and his staff began to examine the deaths, as well as review various policy and procedural directives relating to suicide prevention. In order to more independently assess current practices, as well as offer any appropriate recommendations for improving suicide prevention policies and practices, Director Flowers decided to seek the assistance of an outside consultant.

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 Flowers, as well as his

supervisors within the Volusia County Department of Public Protection, who were committed to determining what steps, if any, were necessary to improve suicide prevention practices within the Volusia County Division of Corrections.

In conducting the assessment, this writer met with and/or interviewed numerous correctional, medical, and mental health officials and staff from the VCDOC, Armor Correctional Health Services (the County's medical provider), and Stewart-Marchman Act (the mental health provider); reviewed numerous policies and procedures related to suicide prevention, as well as screening/assessment protocols; reviewed various files of six (6) inmate suicides between 2015 and 2016; and toured the Branch Jail and Correctional Facility. The on-site assessment was conducted during the four-day period of February 28, 2017 through March 3, 2017.

As of December 2016, the Volusia County Division of Corrections had an average daily population of 1,331 inmates. As shown by Table 1, the jail system has experienced eight (8) inmate suicides during the six-year period of 2011 through 2016, including six (6) such deaths during 2015-2016. The jail system averages more than 24,000 admissions per year, resulting in a ratio of one suicide per 18,804 admissions. Based upon the average daily population during this same time period, the suicide rate in the jail system was 93.4 suicides per 100,000 inmates -- a rate that greatly exceeds that of county jails of varying size throughout the country.[1]

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[1]According to Heron, M. (2016), "Deaths: Leading Causes for 2013," *National Vital Statistics Report*, 65 (2), Hyattsville, MD: National Center for Health Statistics, the suicide rate in the general population is approximately 13 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 50 per 100,000 inmates, Noonan, M. (2016), *Mortality in Local Jails, 2000-2014 - Statistical Tables*, Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice, Office of Justice Programs.

TABLE 1
ANNUAL ADMISSIONS, AVERAGE DAILY POPULATION,
INMATE SUICIDES, AND SUICIDE RATE
WITHIN THE VOLUSIA COUNTY DIVISION OF CORRECTIONS
2011 THRU 2016[2]*

Year	Admissions	ADP	Suicides	Suicide Rate
2011	26,175	1,400	0	0
2012	25,809	1,506	0	0
2013	25,037	1,483	2	134.9
2014	24,988	1,452	0	0
2015	24,271	1,390	3[3]	215.8
2016	24,155	1,331	3	225.3
2011-2016	150,435	8,562	8	93.4

Finally, although an analysis was outside the purview of this assessment, it was noteworthy that Volusia County, as well as other Florida counties, has become an epicenter for opiate use such as heroin, as well as synthetic opioids like fentanyl. As such, many drug users find their way into the local criminal justice system, including Volusia County. In fact, four (4) of the six (6) inmates who committed suicide during 2015 and 2016 were placed on the opiate detoxification protocol within the VCDOC at some point prior to their deaths. In addition, this writer observed booking and intake screening process at the Branch Jail on two different on-site days. The vast majority of newly admitted detainees were either under the influence of an opiate and/or in various phases of withdrawal.

[2]Source: Volusia County Division of Corrections
[3]Includes an inmate who attempted suicide in March 2015 and ultimately died of his injuries three months later in June 2015.

B. QUALIFICATIONS

This writer is a Project Director of the National Center on Institutions and Alternatives, with an office in Mansfield, Massachusetts. This writer is nationally recognized as an expert in the field of suicide prevention within jails, prisons and juvenile facilities, and has been appointed as a Federal Court Monitor (and expert to special masters/monitors) in the monitoring of suicide prevention practices in several adult and juvenile correctional systems under court jurisdiction. This writer has also served as a suicide prevention consultant to the U.S. Justice Department's Civil Rights Division (Special Litigation Section) and selectively for the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security (Immigration and Customs Enforcement) in their investigations of conditions of confinement in both adult and juvenile correctional facilities throughout the country. This writer also serves as an expert witness/consultant in inmate suicide litigation cases, as well as serving as a technical assistance consultant/expert by conducting training seminars and assessing inmate and juvenile suicide prevention practices in various state and local jurisdictions throughout the country.

This writer has conducted the only five national studies of jail, prison, and juvenile suicide (*And Darkness Closes In...National Study of Jail Suicides* in 1981, *National Study of Jail Suicides: Seven Years Later* in 1988, *Prison Suicide: An Overview and Guide to Prevention* in 1995, *Juvenile Suicide in Confinement: A National Survey* in 2004, and *National Study of Jail Suicide: 20 Years Later* in 2010). The jail and prison suicide studies were conducted through contracts with the National Institute of Corrections (NIC), U.S. Justice Department; whereas the first national study of juvenile suicide in confinement was conducted through a contract with the Office of Juvenile Justice and Delinquency Prevention, U.S. Justice Department.

This writer served as editor/project director of the *Jail Suicide/Mental Health Update*, a quarterly newsletter devoted to research, training, prevention, and litigation that was funded by NIC from 1986 thru 2008; and was a consulting editor and editorial board member of *Suicide and Life-Threatening Behavior*, the official scientific journal of the American Association of Suicidology, as well as current editorial board member of *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, the official scientific journal of the International Association of Suicide Prevention. This writer has authored over 70 publications in the area of suicide prevention within jail, prison and juvenile facilities, including model training curricula on both adult inmate and juvenile suicide prevention. This writer's *Training Curriculum and Program Guide on Suicide Detection and Prevention in Juvenile Detention/Correctional Facilities and Residential Programs: Instructor's Manual* was released in April 2013; whereas the *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities: Instructor's Manual* was released in March 2016.

As a result of research, technical assistance, and expert witness consultant work in the area of suicide prevention in correctional facilities, this writer has reviewed and/or examined over 3,500 cases of suicide in jail, prison, and juvenile facilities throughout the country during the past 37 years. This writer was a past recipient of the National Commission on Correctional Health Care's Award of Excellence for outstanding contribution in the field of suicide prevention in correctional facilities. This writer's work has been cited in the suicide prevention sections of various state and national correctional health care standards, as well as numerous suicide prevention training curricula.

C. FINDINGS AND RECOMMENDATIONS

Detailed below is this writer's assessment of jail suicide prevention practices within the Volusia County Division of Corrections. 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. The 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* (2014); 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).[4] Of note, although the *Florida Model Jail Standards* were reviewed, they were not utilizing in this assessment because they do not adequately address suicide prevention. Where indicated, recommendations are also provided.

Although the above correctional standards are generally not legally binding (unless correctional facilities are accredited by the ACA or NCCHC and/or have a contract with ICE) and do not set constitutional requirements, the U.S. Supreme Court has stated that such standards have the ability to serve as guidelines or benchmarks in assessing "duty of care" or "reasonable conduct." With that said, numerous jurisdictions throughout the country are required through

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[4]American Correctional Association (2004), *Performance-Based Standards for Adult Local Detention Facilities*, 4th Edition, Lanham, MD: Author; National Commission on Correctional Health Care (2014), *Standards for Health Services in Jails*, 9th 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.

court-orders and/or settlement agreements to develop and maintain comprehensive suicide prevention programs in their correctional systems. These program requirements, consistent with this writer's above listed eight (8) critical components of a suicide prevention policy, are based upon national correctional standards.

Finally, as noted above, medical services for inmates within the Volusia County Division of Corrections is provided under contract from Armor Correctional Health Care Services; whereas mental health services for inmates is provided by Stewart-Marchman-Act (SMA) through a sub-contract with Armor. Although SMA does *not* have a policy on suicide prevention for inmates within the VCDOC, the VCDOC has a policy entitled "Suicidal Inmates" (No. 305.04), and Armor has a policy entitled "Suicide Prevention Program" (No. J-G-05). The VCDOC and Armor policies each reference the ACA and NCCHC standards cited above, respectively.

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: VCDOC's "Suicidal Inmates" policy (No. 305.04) does *not* address the requirements for suicide prevention training; whereas Armor's "Suicide Prevention Program" policy (No. J-G-05) states that "All healthcare personnel and correctional staff will be trained in all aspects of suicide prevention," but does not address the length and frequency of such training.

Following this writer's review of various training material, as well as discussions with several correctional, medical, and mental health personnel, suicide prevention training within the VCDOC can best be described as piecemeal. For example, upon employment with the VCDOC, all correctional staff is required to complete a 420-hour *pre-service* Basic Recruit Training Program from the Florida Department of Law Enforcement (FDLE)'s Criminal Justice Standards and Training Commission. The program is offered at the Daytona State College. In addition,

recognizing that VCDOC and not been provided with adequate *annual* suicide prevention training for several years, Director Flowers authorized several training initiatives during 2016, albeit in a piecemeal and disjointed fashion. For example, in July 2016, approximately 50 correctional officers assigned to VCDOC's "special needs units" received a 40-hour "Crisis Intervention" training based upon curriculum from the FDLE's Criminal Justice Standards and Training Commission. In addition, Armor Correctional Health Care Services' corporate mental health director has recently conducted two 8-hour "Suicide Prevention in the Jail Setting" workshops for VCDOC personnel. Two additional workshops are planned with the Armor mental health director, with a total of approximately 80 staff (or one third of all personnel) scheduled to be trained from the four workshops. The overall goal is to have all VCDOC personnel trained by the end of 2017. This writer reviewed the 54-slide PowerPoint presentation and found it to be adequate. Further, SMA is scheduled to conduct an 8-hour "Mental Health First-Aid" workshop to approximately 50 correctional officers during March-April 2017. According to the course summary, the "Mental Health First Aid" workshop provides "the skills, resources, and knowledge to help an individual in crisis connect with appropriate professional, peer, and self-help care. Participants learn the unique risk factors and warning signs of mental health problems, builds understanding of the importance of early intervention, and, most importantly, teaches individuals how to help someone in crisis or experiencing a mental health challenge." Finally, the SMA mental health supervisor at the VCDOC has provided targeted suicide prevention training for newly hired correctional officers, as well as those assigned to the Behavior Management Unit (segregation). Approximately four sessions have been held, totally 45 minutes each.

In addition, all Armor medical personnel are required to complete a 2-hour "Suicide Prevention in Correctional Setting" workshop each year. The last workshop was completed in October 2016. This writer reviewed the 18-page lesson plan and found it to be adequate.

Finally, SMA clinicians who work in the VCDOC are provided with suicide prevention training each year. This writer was informed that the curriculum is focused upon suicide prevention in the community, and does *not* address inmate suicide prevention.

In sum, through the recent initiatives by Director Flowers (and his lieutenant overseeing the special needs units), there has been an infusion of various suicide prevention and crisis intervention training to VCDOC correctional staff during the past year. Although delivery of the training has been piecemeal and disjointed, the agency should be commended by these recent initiatives efforts. The annual suicide prevention training for Armor medical staff is adequate. Although not reviewed by this writer, it appeared that the SMA suicide prevention training for clinicians working within the VCDOC was not targeted to inmate suicide prevention nor the unique features of a correctional environment.

RECOMMENDATIONS: A few recommendations are offered to better organize both the length and content of suicide prevention training offered to both jail and healthcare personnel working within the VCDOC. *First*, it is strongly recommended that all new correctional, medical, and mental health personnel receive 8 hours of initial instruction on jail suicide prevention. At a minimum, the following topics should be included in the initial training:

- 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 VCDOC's suicide prevention program
- liability issues

The 8-hour workshop should be conducted by a mental health clinician. Armor's 54-slide PowerPoint entitled "Suicide Prevention in the Jail Setting" and developed by its corporate mental health director could be slightly revised to ensure it includes the above topics. As an alternative, this writer's *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities*, which was previously purchased by the VCDOC, could be utilized for this training.

Second, it is strongly recommended that all current jail and healthcare (medical and mental health) personnel receive 2 hours of annual suicide prevention training conducted by a mental health clinician. The following topics should be included in the annual training:

- obstacles to prevention
- warning signs and symptoms/high-risk periods
- identifying suicide risk despite the denial of risk
- review of any recent suicides and/or serious suicide attempts
- review of any changes to the suicide prevention policy

Although Armor's current 2-hour "Suicide Prevention in Correctional Setting" workshop, currently delivered in an 18-page lesson plan to its medical staff is adequate, it is preferable that all correctional, medical, and mental health personnel receive the same training together in a collaborative workshop. The annual training should also include general discussion of any recent suicides and/or serious suicide attempts in the VCDOC. The training should be conducted "live"

by a mental health clinician utilizing a PowerPoint slide format.[5] This writer's *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities* could also be utilized for annual training.

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

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[5]It has been this writer's experience that on-line training, although convenient for administrators and personnel, is generally not as effective as live, classroom instruction that allows for both collaboration and participation of correctional, medical, and mental health staff.

confinement."[6] 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 who have never made an attempt.[7] 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.[8] 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."

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[6]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.
[7]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.
[8]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).

FINDINGS: VCDOC's "Suicidal Inmates" policy (No. 305.04) does *not* address the requirements for intake screening to identify suicidal inmates suicide prevention training; whereas Armor's "Suicide Prevention Program" policy (No. J-G-05) simply states that "the receiving/screening staff will assess each patient's suicide potential at intake." Currently, there are several layers of intake screening within the VCDOC. In practice, all newly admitted inmates are brought to the Identification and Receiving Area of the Branch Jail for initial processing. There are several layers of intake screening. First, the arresting and/or transporting officer is required to complete an "ID and Receiving Intake Sheet" which contains the following inquiry: "Has the inmate reported prior suicide attempts, Baker Acts, and/or mental health issues?" In addition, VCDOC classification staff subsequently complete an "Intake Classification Questionnaire" that contains inquiry regarding "Mental health issues" and "Are you depressed or suicidal?"

The newly admitted detainee is subsequently escorted into the medical area of the Identification and Receiving Area (with sufficient privacy) and screened by Armor staff (either an RN or paramedic) utilizing "Patient Intake Health Screening" and "Mental Health Intake Screening" forms. The Intake Health Screening form includes multiple inquires on various medical issues, as well as mental health and suicide risk questions. The Mental Health Intake Screening, adapted from a nationally-recognized intake screening form, includes inquiry regarding mental illness and suicide risk:

1) Does officer believe inmate may be a suicide risk?
2) Have you received mental health treatment for depression, emotional problems, psychiatric illness, or anything similar?
3) Have you ever been in a mental health hospital?

4) Have you experienced a major loss within the last six months?
5) Has anyone in your family or close friend attempted or committed suicide?
6) Do you have problems with drugs or alcohol?
7) Are you a public official or professional, or charged with a shocking crime, or especially embarrassed about being arrested?
8) Are you currently thinking about killing or hurting yourself?
9) Have you ever tried or seriously considered killing or hurting yourself? (and within last month)
10) Do you feel there is nothing to look forward to in the future?
11) Is this your first time in jail?
12) Shows active symptoms of depression.
13) Presents afraid, overly anxious or angry about current situation.
14) Refuses to make eye contact, withdrawn, low verbal tones.
15) Psychosis (hallucinating, disoriented to time, person, place, paranoid, unable to focus attention due to cognitive disorientation).
16) Shows signs of mental retardation or developmental disability.
17) If presenting as a transgender, transsexual and answered no to No. 11., Referred to MHP notify security in regards to potential safety concerns.

The 17-item Mental Health Intake Screening form includes inquiry into past and current suicidal ideation, as well as behavior and appearance. If the inmate affirmatively answers 8 or more questions, or affirmative answers questions No. 1, 8, 9a, or 15 above, they are placed on suicide precautions and then referred to mental health staff for further assessment.

In addition, all inmates answering in the affirmative to mental health questions on either the Patient Intake Health Screening or Mental Health Intake Screening forms, but *not* identified as suicidal, are referred to an SMA clinician and required to be seen within 72 hours. When seen by a clinician, a "Mental Health Initial Evaluation" is completed. When seen by a psychiatrist, a "Psychiatric Progress Note" can be utilized.[9] Current SMA practice is that the "Mental Health Initial Evaluation" is completed on all new patients and patients who have not received a similar assessment in more than 90 days. In addition, all inmates who are housed in the VCDOC for 14

[9]SMA clinicians utilize assessment forms developed by Armor Correctional Health Care Services and document their encounters within CorEMR, the electronic medical record system utilized by Armor.

days or more are provided with a "Health Assessment" by a registered nurse. The form includes a mental health assessment section. With the exception of limiting completion of the "Mental Health Initial Evaluation" to new patients and/or patients who have not received a similar assessment in more than 90 days, these are all very good practices and consistent with national correctional standards.

This writer observed the intake screening process in the Identification and Receiving Area of the Branch Jail for a few hours on two different occasions during the on-site assessment. The Armor medical staff responsible for the intake screening process appeared competent, displayed patience with a wide array of in-coming arrestees, and thoroughly completed the required forms.

There were, however, two areas of concern regarding the intake screening process. First, a key component of the identification process is the ability to verify whether the newly arrived inmate was a suicide risk during any prior confinement in the VCDOC. The current jail management system (JMS) has the ability to store information regarding prior suicide risk within the VCDOC in two ways:

> 1) A red colored alert flag labeled "suicide risk" is placed in the JMS for all inmates currently on suicide precautions and is deleted from the system when the inmate is discharge from suicide precautions;
>
> 2) A blue colored alert flag labeled "suicide risk" is contained in the JMS for inmates previously placed on suicide precautions, *but is currently not activated or utilized by staff.*

Second, current policy and practice requires that inmates displaying a wide variety of behaviors are automatically placed on suicide precautions and then subsequently referred to

mental health staff for assessment. For example, the VCDOC's "Mental Health Referral Form" is required to be completed by either medical or correctional staff whenever an inmate is referred to mental health staff. The form contains two options for referral: "emergent" (requiring a mental health response within 12 hours) and "routine" (requiring a mental health response within 72 hours). Criteria for an "emergent" referral is as follows:

- confused/disoriented - gets lost on the unit, doesn't know current time/location
- bizarre, odd, unusual behavior
- threatens homicide or suicide
- suicide attempt or possible suicide attempt
- purposefully injured self
- doesn't make any sense when talking
- information about inmate's suicide risk -received from family member, friend, or other
- found to be hoarding pills in cell
- describes "voices" commanding suicide or harm
- feels hopeless/cites preference to be dead

Currently, *all of the above behaviors are required to result in immediate placement on suicide precautions*, and then referral to mental health staff for assessment. In practice, any inmate displaying the above behaviors are stripped of their clothing, issued a safety smock and safety blanket, and placed on suicide precautions regardless of their level of suicide risk and availability of mental health staff. Following such placement, the "Mental Health Referral Form is then completed and forwarded to mental health staff. A clinician is required to subsequently complete an assessment within 12 hours. As such, the practice of automatically placing an inmate on suicide precautions and clothed in a safety smock before they can be assessed by a mental health clinician has not only resulted in the inappropriate and unnecessary placement of inmates on suicide precautions within the VCDOC, but the diversion of staff resources to more emergent cases.

This writer observed several intake screenings during the on-site assessment. In one case, the newly admitted detainee self-reported a history of "psychosis," but denied any current suicidal ideation or prior history of suicidal behavior. A second newly admitted detainee self-reported that he had attempted suicide in the community approximately 4 to 6 weeks ago, but denied any current suicidal ideation. In both cases, these inmates were first placed on suicide precautions and then referred to mental health staff despite the fact that mental health staff were on duty and available by telephone for consultation.

A third case observed by this writer was particularly concerning. The newly admitted detainee, a 52-year-old woman and mother of two adult children and two grandchildren, had been arrested for having a dispute with her daughter regarding the raising of her grandchild. She presented as extremely distraught during the booking process, had never been arrested before, with her only knowledge of jail limited to what she had observed on television. The woman was crying uncontrollably during the intake screening process despite an attempt by the nurse to relieve her fear and anxiety about the jail environment. The detainee was also very overweight and had several medical issues, including high blood pressure, asthma, and diabetes. She did not have any history of mental illness, nor did she express any suicidal ideation or history of suicidal behavior. When her blood pressure continued to register as high, the detainee asked the nurse "Am I going to die in here?" -- in reference to a concern that she might be assaulted by other detainees and/or concerns about her medical issues. The nurse continued to attempt to relieve her anxiety. Following the intake screening, the nurse directed the woman back to a bench in the Identification and Receiving area. When this writer asked the nurse what the disposition of the

case was going to be, and the nurse responded that the woman was going to be placed on suicide precautions based upon her behavior and statement of "Am I going to die in here?" This writer then called the SMA clinical supervisor and asked if a clinician was available to conduct a suicide risk assessment of the detainee. Shortly thereafter, the SMA clinical supervisor arrived and assessed the woman utilizing a "Mental Health Initial Evaluation" form. The clinician was able to de-escalate the detainee's highly agitated and anxious behavior and the subsequent assessment found that she was not suicidal. The suicide precautions were rescinded and a follow-up assessment within seven days was ordered. Subsequent discussions with both the SMA clinical supervisor and intake nurse found that this case was not unique and numerous inmates were often inappropriately placed on suicide precautions before they can be assessed by mental health staff.

In conclusion, although the VCDOC had appropriate tools for the identification of suicidal inmates at intake, with screening provided with appropriate privacy and confidentiality by competent Armor nursing personnel, the process was in need of some corrective action.

2 **RECOMMENDATIONS:** A few recommendations are offered to improve the intake screening/assessment process within the VCDOC. *First*, although it is strongly recommended that all of the behaviors listed within the "emergent issues" box of the current "Mental Health Referral Form," as well as affirmatively responses to 8 or more questions, or affirmative answers questions No. 1, 8, 9a, or 15, on the "Mental Health Intake Screening' form should result in a mental health referral, not all such behaviors require immediate placement on suicide precautions *if mental health staff are on duty*. As such, when mental health clinicians are on duty,

correctional and/or medical staff should first initiate an emergency mental health referral prior to placing the inmate on suicide precautions. Mental health staff, in turn, should prioritize the referral by immediately responding to provide a suicide risk assessment. In addition, when mental health staff is *not* on duty, correctional and/or medical staff should place inmates presenting as suicidal on suicide precautions and then initiate a mental health referral.

Second, it is strongly recommended that VCDOC officials consult with the SMA clinical supervisor and other SMA officials to revise the "Mental Health Referral Form" to ensure that it accurately reflects behaviors that necessitate both "emergent" and "routine" referrals. For example, currently listed "emergent" referrals such as presenting as "confused/disoriented - gets lost on the unit, doesn't know current time/location," "bizarre, odd, unusual behavior," and "doesn't make any sense when talking" are certainly concerning behaviors that require a mental health referral, but not necessarily an emergent referral. Likewise, a behavior listed as "states not suicidal or homicidal" should be deleted as a "routine" referral from the form because it is not an indication of any concerning behavior.

Third, regardless of the detainee's behavior or answers given during intake screening, an immediate referral to mental health staff should always be initiated based on documentation reflecting suicide risk and/or mental health treatment during their prior confinement within the VCDOC. As such, the blue colored alert flag labeled "suicide risk" in the JMS should be activated according to the following procedures:

- Any inmate placed on suicide precautions should be tagged on the "alert" screen of the JMS with a simple notation (e.g., "suicide precautions-April 2017") by booking or classification staff;

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

- 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 suicidal behavior/placement on suicide precautions during an inmate's prior confinement within the VCDOC; and

- Referral to mental health staff for further assessment does *not* automatically require that the inmate be placed on suicide precautions unless their current behavior dictates such.

Fourth, it is strongly recommended that the current practice of only completing a "Mental Health Initial Evaluation" for new patients and/or patients who have not received a similar assessment in more than 90 days be revised to delete the "90-day" criteria. Because an individual's mental health status, diagnosis, history, psychotropic medication, etc. can change in less than 90 days, the "Mental Health Initial Evaluation" should be completed on all newly referred patients.

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.

3 **FINDINGS:** Although VCDOC's "Suicidal Inmates" policy (No. 305.04) does not address the requirements for communication with the suicidal inmate, and Armor's "Suicide Prevention Program" policy (No. J-G-05) simply states that "Daily communication is to be maintained between designated health staff, correctional staff, classification staff and others regarding any patient who is on suicide precautions," 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 days, this writer sensed that custody and healthcare personnel had a good working relationship. There were numerous examples of effective communication within the VCDOC. For example, as previously detailed in this report, arresting/transporting officers are required to complete a section of the "ID and Receiving Intake Sheet" on any newly admitted detainee presenting as potentially suicidal. In addition, the VCDOC Director conducts daily morning meetings with his executive staff that includes medical and mental health representation. Further, "Mental Health Meetings" are held weekly and include multidisciplinary representation from custody, medical, and mental health supervisors and personnel. These meetings, one of which was observed by this writer, provide an excellent opportunity to discuss the management of challenging cases. Finally, Armor utilizes an electronic medical record (CorEMR) that is user-friendly, utilized by both Armor and SMA personnel, and contains both a patient's medical and mental health records to better ensure the continuity of care and enhancing communication between healthcare staff.

RECOMMENDATION: Based upon the fact that recommendations for revision of the current "Mental Health Referral Form" were provided in the previous section, no further recommendations are applicable.

4) **Housing**

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, because the vast majority of jail suicides occur by hanging,[10] inmates identified as suicidal and placed on suicide precautions must 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.

4 **FINDINGS:** VCDOC's "Suicidal Inmates" policy (No. 305.04) briefly addresses the requirements for housing of suicidal inmates by simply stating that "The Mental Health/Medical Staff and shift Supervisor (SC)/Operations Supervisor (OS) shall determine the appropriate cell assignment of an inmate identified as a suicide risk," but does not require that the cell be suicide-resistant. Armor's "Suicide Prevention Program" policy (No. J-G-05) requires that "Patients shall be placed in housing that is rendered suicide-resistant, e.g., free of sharp objects, protrusions such as hooks or clothing items that can be used in hanging."

In practice, all male inmates identified as suicidal were primarily housed in the Branch Jail's A-Block or B-Block housing units. Each unit had 16 single cells in two tiers. Cells on the first tier had closed circuit television (CCTV) monitoring and solid cement bunks. Shelves and

[10]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).

desk tops had been removed, however, the cells were not completely suicide-resistant because they contained eyebolts attached to the bunks for restraint use, as well as two wall ventilation grates that were hazardous because they contained holes in excess 3/16 inch in diameter, which is outside the industry standard. Cells on the second tier of both A-Block and B-Block housing units contained metal bunks that were not suicide-resistant because they contained bunk holes and other anchoring devices, as well as gaps between the bunk and wall that could be utilized in a suicide attempt by hanging. In addition, each cell contained two wall ventilation grates that were hazardous because they had holes in excess 3/16 inch in diameter, which is outside the industry standard. In addition, there were four cells in the six-cell Medical Unit that could be used for overflow when A-Block and B-Block housing units were at capacity. These cells were also hazardous because they contained wall ventilation grates with holes in excess 3/16 inch in diameter, which is outside the industry standard.

Finally, this writer was informed that Unit 10 in the Branch Jail, commonly referred to as the Behavior Management Unit (BMU) was, on occasion, utilized for suicide precautions if the inmate was housed in segregation and threatened and/or engaged in self-injurious, suicidal behavior. In such a scenario, the BMU inmate would automatically be placed in four-point restraints regardless of their level of suicide risk. Although utilized infrequently, this writer was informed that the most recent incident of placing an inmate on suicide precautions in the BMU occurred in February 2017. In that particular case, the inmate had been a general population inmate when he threatened both suicidal and homicidal ideation on February 15, 2017. He was initially placed in A-Block on suicide precautions (without restraints), then moved to Unit 10 (the BMU) to serve a disciplinary sanction. Upon arrival, the inmate was immediately placed in

did inmate commit suicide

four-point restraints for approximately 48 hours (simply based upon the suicidal ideation expressed on February 15). This case, as well as any case involving the indiscriminate use of four-point restraints without justification (or policy authorizing its use), was extremely problematic and should be prohibited.

All female inmates identified as suicidal were primarily housed in the H-Unit of the Correctional Facility. Similar to the A-Block and B-Block of the Branch Jail, the H-Unit had 16 single cells in two tiers. Cells on the first tier had solid cement bunks. Shelves and desk tops had been removed, however, the cells were not completely suicide-resistant because they contained eyebolts attached to the bunks for restraint use, as well as two wall ventilation grates that were hazardous because they contained holes in excess 3/16 inch in diameter, which is outside the industry standard. Cells on the second tier of H-Unit contained metal bunks that were not suicide-resistant because they contained bunk holes and other anchoring devices, as well as gaps between the bunk and wall that could be utilized in a suicide attempt by hanging. In addition, each cell contained two wall ventilation grates that were hazardous because they had holes in excess 3/16 inch in diameter, which is outside the industry standard. (Of note, female inmates identified as suicidal, as well as serving a disciplinary sanction, remained in the H-Unit on suicide precautions.)

The issue of possessions and privileges afforded inmates on suicide precautions was not clearly articulated and/or individualized in either the VCDOC or Armor suicide prevention policies, with the Armor policy stating that inmates on suicide precautions "will continue to receive all privileges unless security and safety requirements dictate otherwise (as determined by

the medical provider or the facility commander) or unless a violation of the facility rules and regulation takes place. Patients at risk of suicide may not be given bedding, utensils, or other items that could be used in self-harm per physician's order. It is recommended that the facility consider smocks/blankets for these patients." However, in practice, all male and female inmates on suicide precautions are stripped of their clothing and issued a safety smock, safety blanket, and mattress. According to staff interviewed by this writer, recreation was offered three times a week, and showers also offered three times a week, but only after the third day of placement on suicide precautions.

RECOMMENDATIONS: A few recommendations are offered to improve the housing of suicidal inmates within the VCDOC. *First*, it is strongly recommended that the currently designated cells for housing inmates on suicide precautions (i.e., A-Block and B-Block in the Branch Jail, H-Unit in the Correctional Facility, and four cells in the Medical Unit) be renovated to ensure that they are suicide-resistant and do not contain any obvious protrusions that could be utilized in a suicide attempt by hanging. To assist VCDOC officials in identifying the requirements of a suicide-resistant cell, this writer's "Checklist for the Suicide-Resistant Design of Correctional Facilities" is attached as Appendix A for consideration.

Second, it is strongly recommended that the current practice of automatically placing BMU inmates in four-point restraints while on suicide precautions be prohibited. The VCDOC policy on the use of restraints for suicidal inmates should be extremely restrictive, and any type of restraint should be utilized as a last resort when the inmate is physically engaging in suicidal and/or other self-injurious behavior and other less restrictive measures have failed to stop the

behavior. In addition, any decision regarding the placement of a suicidal inmate in restraints must be done in collaboration with both mental health and medical personnel.

Third, in conjunction with the above recommendation to retrofit designated cells so that they are suicide-resistant and protrusion-free, thus allowing discretion regarding the issuance of clothing, it is strongly recommended that VCDOC, Armor and SMA officials instruct their respective staff on the appropriate use of safety smocks, i.e., they should *not* be utilized as a default, and not to be used as a tool in a behavior management plan (i.e., to punish and/or attempt to change perceived manipulative behavior). Rather, safety smocks should only be utilized when a clinician believes that the inmate is at high risk for suicide by hanging. Should an inmate be placed in a safety smock, the goal should be to return full clothing to the inmate prior to their discharge from suicide precautions. Finally, custody personnel should never place an inmate in a safety smock unless it had been previously approved by medical and/or mental health personnel.

Fourth, because both the VCDOC and Armor suicide prevention policies do not clearly articulate and/or individualize procedures for deciding which possessions and privileges are provided to inmates on suicide precautions, it is strongly recommended that the policies be revised to 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 and as documented in the medical chart;

- 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 *always* 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 and/or out-of-cell access commensurate with their security level and clinical judgment of mental health staff.

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. As previously indicated, research indicates that the overwhelming majority of suicide attempts in custody is by hanging. 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 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 based upon an individualized treatment plan.

FINDINGS: VCDOC's "Suicidal Inmates" policy (No. 305.04) contains four levels of observation:

> "Constant/Continuous Watch (CWI) - defined as constant, continuous visual observation of an inmate by a Correctional Officer/Medical Staff. Fifteen (15) minute entries shall be maintained....;
>
> Close Supervision - Suicide Precautions (CSP/15/S) - defined as an inmate being within hearing distance of a Correctional Officer/Medical Staff and shall be physically observed every 15 minutes... Inmate will be in a suicide gown with suicide blanket;

> Close Supervision (CSP/15/W) - defined as an inmate being within hearing distance of a Correctional Officer/Medical Staff and shall be physically observed every 15 minutes... Inmate may be issued jail uniform, linens and allowable personal property;
>
> Close Monitoring - defined as an inmate being within hearing distance of a Correctional Officer/Medical Staff and shall be physically observed every 30 minutes.... Inmate will be issued jail uniform, linens and allowable personal property;
>
> Periodic Watch - is defined as an observation of an inmate for a time specified by Medical /Security Staff not to exceed one (1) hour.

In addition, Armor's "Suicide Prevention Program" policy (No. J-G-05) lists three levels of observation for suicidal inmates:

> "Continuous Observation - patient is constantly observed by any trained staff member, correctional, medical or other. This watch is generally used for patients who present as acutely suicidal and who are at imminent risk of engaging in self-injurious behavior. A continuous watch should also be considered when there is a question of imminent risk and the clinical picture is unclear. Recent, serious suicide attempts (e.g., tempted hangings, wrist slashing, etc.) may also want this watch....
>
> Close Observation - patient is checked and observed every 15 minutes or less. This watch requires that the patient remain a full view of a correctional staff member or medical staff when the check is done....
>
> Closely Monitored - required 30 minute interval observations. This watch requires that the patient be in full view of a correctional officer when the check is done."

In practice, despite the various observation levels listed above, almost all inmates placed on suicide precautions are stripped of their clothing, issued a safety smock, safety blanket, and mattress, and observed at 15-minute intervals.[11] This practice closely resembles the "Close Supervision - Suicide Precautions (CSP/15/S)" level within the VCDOC suicide prevention policy. Constant or continuous observation is rarely ordered for a suicidal inmate. In addition,

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[11] In addition, this writer was informed that "periodic watch" within the VCDOC policy has been converted into "close monitoring," with observation at 30-minute intervals.

although Armor's suicide prevention policy provides specific definitions for "acutely suicidal" and "non-acutely suicidal" requiring two different levels of observation, presumably, "continuous observation" or "close observation," the VCDOC policy does not define the specific behaviors that necessitate each level of four levels of observation.

Finally, a mental health clinician is required to assess an inmate on suicide precautions on a daily basis. Currently, SMA provides seven days of mental health coverage to the VCDOC (including full-time coverage Monday through Friday), with four (4) full-time clinicians or "screeners," three (3) of whom are licensed, as well as the mental health supervisor, who is also licensed and provides both administrative and direct care services. As indicated below, either a "Mental Health Initial Evaluation" form or "Mental Health Rounds/Contact Form" is utilized to initially assess suicide risk, as well as use to justify downgrading and/or discontinuing suicide precautions. Although not clearly articulated in the Armor suicide prevention policy, each inmate discharged from suicide precautions is provided follow-up by an SMA clinician normally within seven days. Finally, as stated in the Armor policy, "it is advisable that a patient on observation status not be released from custody in the middle of the night or without adequate discharge planning." In practice, this writer was informed that an inmate on suicide precautions would never be released from custody until they were assessed by a SMA clinician. This is an excellent practice.

This writer had an opportunity to observe a few SMA clinicians as they conducted daily rounds of inmates on suicide precautions in both the Branch Jail and Correctional Facility. The clinicians appeared to be very competent, conscientious, and displayed very good interpersonal

skills when meeting cell-side with each inmate on suicide precautions. There were, however, several concerns observed during the process. First, whereas the SMA psychiatrist meets with each patient at a table situated in the hallway between A-Block and B-Block at the Branch Jail (and in a private room at the Correctional Facility), thus ensuring privacy and confidentiality, SMA clinicians conducting rounds in the same units meet cell-side with each patient. As observed by this writer, these housing units can become very loud when one or more boisterous inmates begin to act out, making it virtually impossible for a clinician to conduct an adequate assessment of suicide risk by speaking and listening to an inmate through a closed door or food port.

Second, this writer observed that SMA clinicians were not always conducting thorough assessments of suicide risk during these rounds, and often times simply asked the inmate whether they were "eating, sleeping, having any thoughts of self-harm, taking your meds?" In a few cases, a clinician might ask a few additional questions regarding the inmate's legal case and/or family background. The inadequacy of this process could be caused by difficult environmental conditions, such as the noise level and having to interact with an inmate cell-side through the cell door or food port, the lack of an adequate suicide risk assessment tool, or other reasons.

The standard of care requires that documentation of a comprehensive assessment of suicide risk includes 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 (MSE), listing of chronic and acute risk factors

(including prior history of suicidal behavior), listing of any protective factors, level of suicide risk (e.g., low, medium, or high), changes in behavior since the last assessment to warrant change in observation, and a treatment plan. According to national correctional standards, a mental health clinician should develop a "treatment plan" for an inmate discharged from 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, 2014).

It was noteworthy that because the CorEMR utilized by Armor did not contain a suicide risk assessment form template, SMA clinicians were utilizing either a "Mental Health Initial Evaluation" (MHIE) form to initially assess suicide risk (unless the inmate had a MHIE completed within the past 90 days) or a "Mental Health Rounds/Contact Form" to document their assessment of suicide risk. Neither was an adequate suicide risk assessment form. Although the MHIE was adequate for the initial assessment of mental illness, it did not contain inquiry regarding chronic and acute risk factors nor listing of any protective factors. The Mental Health Rounds/Contact Form simply contained a MSE template and did not include any suicide risk inquiry. In addition, as noted above, although the Armor policy did not include a formalized schedule for follow-up once an inmate was discharged from suicide precautions, most inmates were said to be assessed within seven days. Finally, contrary to the standard of care and national correctional standards, treatment/safety plans were *not* developed for inmates released from suicide precautions in an effort to reduce the likelihood of the reoccurrence of suicidal ideation.

This writer reviewed the medical charts of all six (6) inmates who committed suicide within the VCDOC during 2015 and 2016. Of those six (4) cases, four (4) inmates were placed on suicide precautions at some point during their VCDOC confinement. A review of these cases found that some, but not all, involved: 1) inadequate documentation of a suicide risk assessment, 2) documentation did *not* provide a sufficient description of the current behavior and justification for discharge from suicide precautions, 3) a lack of follow-up following discharge from suicide precautions, and 4) documentation did *not* provide a viable treatment/safety plan for reducing future suicidal ideation.

Finally, given the strong association between inmate suicide and segregation placement, the standard of care and standard correctional practice require that healthcare personnel conduct regular rounds of a facility's segregation units. This writer was informed that nursing staff conduct cell-to-cell rounds in the segregation units three times a week (Monday, Wednesday, and Friday), and SMA clinicians conduct weekly rounds of segregation units. These are both very good practices.

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 VCDOC.

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, Ambu bag or CPR mask, 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: VCDOC's "Suicidal Inmates" policy (No. 305.04) briefly addresses the requirements for the proper emergency medical response following in inmate suicide by stating

that "When an inmate is discovered attempting to commit suicide, the officer finding the inmate shall merely initiate a 'Code White;'" whereas Armor's "Suicide Prevention Program" policy (No. J-G-05) requires that "When a suicide attempt is reported or identified, it will be treated as a medical emergency and medical staff shall respond immediately with appropriate emergency equipment....Every effort will be made to stabilize or resuscitate a patient who has attempted suicide while emergency medical support is summoned immediate transport if necessary." Both policies are in need of revision.

During a tour of both the Branch Jail and Correctional facility, this writer observed that *none* of the toured housing units had an Ambu-bag (or CPR mask) to provide rescue breathing, automated external defibrillators (AEDs), or emergency rescue tools (utilized to quickly cut through fibrous material in a suicide attempt by hanging). Following the tours, a correction supervisor informed this writer that he had found a CPR mask in one of the fire extinguisher boxes near one of the housing units, but was unsure if his officers were aware of its location. In addition, this writer observed that several correctional officers have emergency rescue tools on their belts and was informed that emergency rescue tools had previously been ordered (but not yet received) for placement on all housing units. According to Armor's health services administrator (HSA) at the VCDOC, the emergency response bag utilized to respond to Code White emergencies included an oxygen tank and AED.

Further, according to training data reviewed by this writer, 100 percent of both correctional and medical personnel were currently certified in cardiopulmonary resuscitation (CPR). Such a high compliance rate was commendable.

Finally, in review of the medical charts and incident reports of all six (6) inmates who committed suicide within the VCDOC during 2015 and 2016, this writer did not find any glaring deficiencies in the emergency medical response to each incident.

RECOMMENDATIONS: A few recommendations are offered to further improve emergency response efforts within the VCDOC. *First*, it is strongly recommended that the VCDOC and Armor revise their respective policies to provide adequate descriptions of the proper emergency medical response to a suicide attempt. All staff should be trained in the use of the emergency equipment know its location. At a minimum, the revised policies should include the following procedures:

1) All staff who come into contact with the inmate should be trained in standard first aid procedures and CPR;

2) Any staff member who discovers an inmate engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. If facility policy prohibits an officer from entering a cell without backup support, the first responding officer should, at a minimum, make the proper notification for backup support and medical personnel, secure the area outside the cell, and retrieve the housing unit's emergency response bag (that should include a first aid kit, Ambu-bag or CPR mask, and rescue tool);

3) Correctional staff should never presume that the victim is dead, but rather should initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, medical personnel should ensure that all equipment utilized in responding to an emergency within the facility is in working order on a daily basis.

Second, it is strongly recommended that an Ambu-bag (or CPR mask) and emergency rescue tool be placed in an emergency response bag and located in each housing unit.

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: Although this writer reviewed various documentation regarding each of the six (6) inmate suicides within the VCDOC during 2015 and 2016, several case files were missing both incident reports written by responding staff and investigative reports from the Volusia County Sheriff's Office. As such, this writer could not opine as to whether or not appropriate reporting requirements were exhibited in each case.

RECOMMENDATION: Deferred

8) Follow-up/Morbidity-Mortality Review

Every completed suicide, as well as serious suicide attempt (i.e., requiring outside medical treatment and/or 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.

8 **FINDINGS:** VCDOC's "Suicidal Inmates" policy (No. 305.04) briefly addresses the requirements for review of an inmate suicide by simply stating that "The Suicide Task Team

shall conduct a review of the incident and prepare a report;" whereas Armor's "Suicide Prevention Program" policy (No. J-G-05) requires that "Appropriate health care staff will participate in the medical and administrative review of suicides or attempted suicide within 30 days following the event. This will include a Psychological Autopsy completed by the psychiatrist. Mortality or morbidity review is a part of the CQI process."

Although both policies are in need of revision, this writer found that there were various layers of review following an inmate suicide and/or serious suicide attempt. For example, all inmate suicides are reported to the Volusia County Sheriff's Office who assign an officer to investigate the circumstances surrounding the incident. Similar to standard correctional practice found in other county jails, such investigations look at the cause of death, and whether it was suspicious, and do not result in a critique of an agency's policies, procedures, and practices applicable to the death. In addition, *if* it appears that there are preliminary concerns regarding individual staff misconduct in the case, and internal affairs investigation by the Volusia County Department of Public Protection would be initiated.

Further, the VCDOC previously developed a Suicide Task Team that convenes approximately 2 to 3 weeks following either a serious suicide attempt or suicide. The multidisciplinary team is comprised of six or seven members that represent VCDOC case management and custody, Armor medical, and SMA mental health. A member of the Suicide Task Team completes a "Suicide Task Team Checklist" form prior to the meeting that includes demographic and classification information regarding the suicide victim and basic information regarding the incident. The form is then summarized during the meeting and input is solicited

from various members. When appropriate, recommendations for corrective action are issued by the Suicide Task Team and subsequently forwarded to the VCDOC Director for review.

Finally, Armor Correctional Health Services also has various layers of review following a serious suicide attempt or suicide. First, a "sentinel event" telephone call is held between corporate officials at Armor headquarters and the HSA and select medical staff at the VCDOC. The intent of the telephone call is to gather and share basic preliminary information regarding the incident. In addition, a "psychological autopsy" is required for each completed suicide and normally completed by Armor's corporate clinical coordinator for mental health. Although inappropriately referred to as a "psychological autopsy,"[12] this writer reviewed four (4) psychological autopsy reports on the inmate suicides during 2015 and 2016 and found them each to include very comprehensive clinical reviews of the medical chart, as well as summaries of pertinent telephone calls between the decedent and family members.[13] Finally, Armor conducts a Mortality and Morbidity Review on each serious suicide attempt and suicide within 30 days of the incident. A review team, comprised of both corporate officials and on-site health care staff (including the HSA and SMA supervisor) discuss the case in detail, including a summary of the psychological autopsy. This writer reviewed the reports comprised from the findings of the Mortality and Morbidity Review team in each case and found them to be very comprehensive. The reports include a "brief medical history of the decedent, current medication, providers involved in the patient's care during the previous six months, discussion of the management of

[12]According to NCCHC standards, Section J-G-05, "The typical psychological autopsy is based on a detailed review of all file information on the inmate, a careful examination of the suicide site, and interviews with staff, inmates, and family members familiar with the deceased." The Armor reports reviewed by this writer did not include interviews with non-health care staff, inmates, or family members of the decedent.

[13]Psychological autopsy reports were not available in two of the cases. It was unknown as to whether such reports were either not developed or simply not available for review.

on-site clinical issues and/or presentation within 24 hours preceding death or hospitalization, names of medical staff interviewing any affected inmates, names of mental health staff providing stress and grief counseling, findings of additional investigation, and discussion of management and suggestions for alternative strategies were needed improvements."

RECOMMENDATION: One recommendation is offered. It is strongly recommended that both VCDOC's "Suicidal Inmates" policy (No. 305.04) and Armor's "Suicide Prevention Program" policy (No. J-G-05) be revised to articulate procedures for both the administrative review and Mortality and Morbidity Review processes as described above. It would also be advisable that the procedures contain the following narrative regarding the Mortality and Morbidity review process: "The review, separate and apart from other formal investigations that may be required to determine the cause of death, should include a critical inquiry of: 1) the circumstances surrounding the incident; 2) facility procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; 5) possible precipitating factors leading to the suicide or serious suicide attempt; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures."

D. SUMMARY OF RECOMMENDATIONS

Staff Training

1) It is strongly recommended that all new correctional, medical, and mental health personnel receive 8 hours of initial instruction on jail suicide prevention. At a minimum, the following topics should be included in the initial training:

- 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 VCDOC's suicide prevention program
- liability issues

The 8-hour workshop should be conducted by a mental health clinician. Armor's 54-slide PowerPoint entitled "Suicide Prevention in the Jail Setting" and developed by its corporate mental health director could be slightly revised to ensure it includes the above topics. As an alternative, this writer's *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities*, which was previously purchased by the VCDOC, could be utilized for this training.

2) It is strongly recommended that all current jail and healthcare (medical and mental health) personnel receive 2 hours of annual suicide prevention training conducted by a mental health clinician. The following topics should be included in the annual training:

- obstacles to prevention
- warning signs and symptoms/high-risk periods
- identifying suicide risk despite the denial of risk
- review of any recent suicides and/or serious suicide attempts
- review of any changes to the suicide prevention policy

Although Armor's current 2-hour "Suicide Prevention in Correctional Setting" workshop, currently delivered in an 18-page lesson plan to its medical staff is adequate, it is preferable that all correctional, medical, and mental health personnel receive the same training together in a collaborative workshop. The annual training should also include general discussion of any recent suicides and/or serious suicide attempts in the VCDOC. The training should be conducted "live" by a mental health clinician utilizing a PowerPoint slide format. This writer's *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities* could also be utilized for annual training.

Intake Screening/Assessment

3) Although it is strongly recommended that all of the behaviors listed within the "emergent issues" box of the current "Mental Health Referral Form," as well as affirmatively responses to 8 or more questions, or affirmative answers questions No. 1, 8, 9a, or 15, on the "Mental Health Intake Screening' form should result in a mental health referral, not all such behaviors require immediate placement on suicide precautions if mental health staff are on duty. As such, when mental health clinicians are on duty, correctional and/or medical staff should first initiate an emergency mental health referral prior to placing the inmate on suicide precautions. Mental health staff, in turn, should prioritize the referral by immediately responding to provide a suicide risk assessment. In addition, when mental health staff is not on duty, correctional and/or medical staff should place inmates presenting as suicidal on suicide precautions and then initiate a mental health referral.

4) It is strongly recommended that VCDOC officials consult with the SMA clinical supervisor and other SMA officials to revise the "Mental Health Referral Form" to ensure that it accurately reflects behaviors that necessitate both "emergent" and "routine" referrals. For example, currently listed "emergent" referrals such as presenting as "confused/disoriented - gets lost on the unit, doesn't know current time/location," "bizarre, odd, unusual behavior," and "doesn't make any sense when talking" are certainly concerning behaviors that require a mental health referral, but not necessarily an emergent referral. Likewise, a behavior listed as "states not suicidal or homicidal" should be deleted as a "routine" referral from the form because it is not an indication of any concerning behavior.

5) Regardless of the detainee's behavior or answers given during intake screening, an immediate referral to mental health staff should always be initiated based on documentation reflecting suicide risk and/or mental health treatment during their prior confinement within the VCDOC. As such, the blue colored alert flag labeled "suicide risk" in the JMS should be activated according to the following procedures:

- Any inmate placed on suicide precautions should be tagged on the "alert" screen of the JMS with a simple notation (e.g., "suicide precautions-April 2017") by booking or classification staff;

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

- 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 suicidal behavior/placement on suicide precautions during an inmate's prior confinement within the VCDOC; and

- Referral to mental health staff for further assessment does not automatically require that the inmate be placed on suicide precautions unless their current behavior dictates such.

6) It is strongly recommended that the current practice of only completing a "Mental Health Initial Evaluation" for new patients and/or patients who have not received a similar assessment in more than 90 days be revised to delete the "90-day" criteria. Because an individual's mental health status, diagnosis, history, psychotropic medication, etc. can change in less than 90 days, the "Mental Health Initial Evaluation" should be completed on all newly referred patients.

Communication

None

Housing

7) It is strongly recommended that the currently designated cells for housing inmates on suicide precautions (i.e., A-Block and B-Block in the Branch Jail, H-Unit in the Correctional Facility, and four cells in the Medical Unit) be renovated to ensure that they are suicide-resistant and do not contain any obvious protrusions that could be utilized in a suicide attempt by hanging. To assist VCDOC officials in identifying the requirements of a suicide-resistant cell, this writer's "Checklist for the Suicide-Resistant Design of Correctional Facilities" is attached as Appendix A for consideration.

8) It is strongly recommended that the current practice of automatically placing BMU inmates in four-point restraints while on suicide precautions be prohibited. The VCDOC policy on the use of restraints for suicidal inmates should be extremely restrictive, and any type of restraint should be utilized as a last resort when the inmate is physically engaging in suicidal and/or other self-injurious behavior and other less restrictive measures have failed to stop the behavior. In addition, any decision regarding the placement of a suicidal inmate in restraints must be done in collaboration with both mental health and medical personnel.

9) In conjunction with the above recommendation to retrofit designated cells so that they are suicide-resistant and protrusion-free, thus allowing discretion regarding the issuance of clothing, it is strongly recommended that VCDOC, Armor and SMA officials instruct their respective staff on the appropriate use of safety smocks, i.e., they should not be utilized as a default, and not to be used as a

tool in a behavior management plan (i.e., to punish and/or attempt to change perceived manipulative behavior). Rather, safety smocks should only be utilized when a clinician believes that the inmate is at high risk for suicide by hanging. Should an inmate be placed in a safety smock, the goal should be to return full clothing to the inmate prior to their discharge from suicide precautions. Finally, custody personnel should never place an inmate in a safety smock unless it had been previously approved by medical and/or mental health personnel.

10) Because both the VCDOC and Armor suicide prevention policies do not clearly articulate and/or individualize procedures for deciding which possessions and privileges are provided to inmates on suicide precautions, it is strongly recommended that the policies be revised to 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 and as documented in the medical chart;

- 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 always 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 and/or out-of-cell access commensurate with their security level and clinical judgment of mental health staff.

Levels of Observation/Management

11) It is strongly recommended that the VCDOC's "Suicidal Inmates" policy (No. 305.04) be consolidated into two levels of observation for suicidal inmates that is consistent with Armor's "Suicide Prevention Program" policy (No. J-G-05). The Armor suicide prevention policy provides the following reasonable definitions for two levels of observation:

> ***Actively Suicidal*** (active) inmates are those who engage in self-injurious behavior or threatened suicide with a specific plan. These inmates should be placed on ***constant observation***.
>
> ***Non-Actively Suicidal*** (potential or inactive) inmates are those who express current suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or have a recent prior history of self-destructive behavior. In addition, inmates who deny suicidal ideation or do not threaten suicide but demonstrate other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury should be placed on suicide precautions and observed at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes). Also referred to as ***close observation***.

12) It is strongly recommended that observation at 30-minute intervals never be associated with a level of observation for a suicidal inmate. Although "mental health observation" at 30-minute intervals might be an acceptable level of observation for some inmates, e.g., for inmates being transitioned back to general population from a level of suicide precautions, it is not appropriate for a suicidal inmate, regardless of their level of acuity. Suicidal inmates should only be placed on either close observation or constant observation status. If mental health observation status is utilized within the VCDOC, and it certainly might be appropriate for inmates that are currently inappropriately being placed on suicide precautions for displaying concerning, yet non-suicidal behavior (e.g., "confused/disoriented - gets lost on the unit, doesn't know current time/location," "bizarre, odd, unusual behavior," and "doesn't make any sense when talking" as currently contained on the "Mental Health Referral Form") an operational definition for its use should be created within both the VCDOC and Armor suicide prevention policies as follows:

> ***Mental Health Observation*** is reserved for the inmate who is not suicidal, but assessed to be in need of closer observation based upon their behavior and/or serious mental illness. This observation level is normally reserved for inmates displaying concerning, non-suicidal behavior, or inmates adjusting to the initiation of, or change in, psychotropic medication. It can also be utilized as a step-down from suicide precautions. This inmate should be observed by staff at staggered intervals not to exceed every 30 minutes, with documentation as the check occurs. Inmates placed on this level of observation shall be issued regular clothing and have full access to other possessions and privileges (unless serving a disciplinary sanction).

13) By far the most important and clinically challenging responsibility in the area of suicide prevention is the determination to discharge an inmate from suicide

precautions. That determination, as well as the initial assessment of suicide risk, should always be performed within area of privacy and confidentiality. As such, it is strongly recommended that "cell-side" assessments be avoided and, at a minimum, all initial suicide risk assessments, as well as determinations to either downgrade or discharge an inmate from suicide precautions, be conducted outside an inmate's cell and in a private and confidential environment.

14) It is strongly recommended that licensed SMA clinicians document thorough suicide risk assessments of all inmates identified as potentially suicidal and initially placed on suicide precautions. The current forms utilized by SMA, including the "Mental Health Initial Evaluation" form and "Mental Health Rounds/Contact Form" embedded within CorEMR were both inadequate for documenting a comprehensive suicide risk assessment. As such, documentation of such assessments could be included in a suicide risk assessment form or a SOAP-formatted progress note that allows for 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), changes in behavior since the last assessment to warrant change in observation, and a treatment plan.

15) It is strongly recommended that, consistent with national correctional standards (including NCCHC standards), SMA clinicians develop treatment plans for inmates on suicide precautions for longer than 24 hours 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, 2014).

16) 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. 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 inmates discharged from suicide precautions receive follow-up within 24 hours, again within 72 hours, again within 1 week, and then periodically until release from custody.

Intervention

17) It is strongly recommended that the VCDOC and Armor revise their respective policies to provide adequate descriptions of the proper emergency medical response to a suicide attempt. All staff should be trained in the use of the emergency equipment know its location. At a minimum, the revised policies should include the following procedures:

- All staff who come into contact with the inmate should be trained in standard first aid procedures and CPR;

- Any staff member who discovers an inmate engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. If facility policy prohibits an officer from entering a cell without backup support, the first responding officer should, at a minimum, make the proper notification for backup support and medical personnel, secure the area outside the cell, and retrieve the housing unit's emergency response bag (that should include a first aid kit, Ambu-bag or CPR mask, and rescue tool);

- Correctional staff should never presume that the victim is dead, but rather should initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, medical personnel should ensure that all equipment utilized in responding to an emergency within the facility is in working order on a daily basis.

18) It is strongly recommended that an Ambu-bag (or CPR mask) and emergency rescue tool be placed in an emergency response bag and located in each housing unit.

Reporting

Deferred

Follow-Up/Morbidity-Mortality Review

19) It is strongly recommended that both VCDOC's "Suicidal Inmates" policy (No. 305.04) and Armor's "Suicide Prevention Program" policy (No. J-G-05) be revised to articulate procedures for both the administrative review and Mortality and Morbidity Review processes as described above. It would also be advisable that the procedures contain the following narrative regarding the Mortality and Morbidity review process: "The review, separate and apart from other formal investigations that may be required to determine the cause of death, should include a critical inquiry of: 1) the circumstances surrounding the incident; 2) facility procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; 5) possible precipitating factors leading to the suicide or serious suicide attempt; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures."

E. 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 the Volusia County Division of Corrections, Armor Correctional Health Services, and Stewart-Marchman-Act. This writer met numerous agency officials and supervisors, as well as officers, nurses, 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.

In fact, even prior to this writer's on-site assessment, various suicide prevention initiatives had either been discussed and/or implemented. For example, the VCDOC had implemented an inmate companion program to provide supplemental observation of inmates going through the detoxification process. In addition, an electronic surveillance system (Guard 1) was implemented to provide better staff accountability for inmate supervision. A step-down housing unit for female inmates transitioning from suicide precautions was implemented, with plans to expand the process to male inmates. Further, the VCDOC and Armor have begun to collaborate on a suicide prevention awareness initiative to better educate the inmate population, family and friends of inmates, and the general community by providing informational materials via the VCDOC website, television and kiosk equipment throughout the facilities, and during video visitation. Although still in the early stages of development, this initiative is very commendable and, if successful, should result in better identification of potentially suicidal inmates (and more mental health referrals).

In addition, although an analysis of staffing needs to maintain an effective suicide prevention program based upon current practices, as well as staffing needs following implementation of this writer's recommendations, was outside the scope of this suicide prevention assessment, it was apparent from this writer's observation and discussions with various officials and staff that there was a need for additional mental health clinicians within the Branch Jail and Correctional Facility. As detailed earlier in this report, a flawed Mental Health Referral Form, as well as the current practice of non-mental health personnel automatically placing inmates on suicide precautions without consultation with a mental health clinician despite their potential on-site availability, has resulted in a high number of inappropriately placed inmates on suicide precautions. In addition to the recommendation for additional suicide prevention training which invariably might result in an increase of mental health referrals, as well as the potentially successful suicide prevention awareness campaign which could also result in additional mental health referrals, the immediate availability (during regular Monday through Friday business hours) of mental health clinicians to respond to emergency mental health referrals to assess potentially suicidal inmates and avoid the inappropriate placement of inmates on suicide precautions will be critical and require additional mental health staff. This writer would defer to SMA officials to determine the appropriate number of staffing hours required to complete this task.

Finally, although there are several recommendations contained within this report, with many focused on revisions to the VCDOC suicide prevention policy (No. 305.04), this writer found that the Volusia County Division of Corrections had the foundation for a good suicide prevention program. To assist both VCDOC and Armor officials in revising their respective

suicide prevention policies, this writer's "Guide to Developing and Revising Suicide Prevention Protocols Within Jails and Prisons" is attached in Appendix B. When revising the respective suicide prevention policies, it is strongly recommended that both VCDOC and Armor collaborate with the SMA, its mental health provider.

In conclusion, this writer would be remiss by not extending sincere appreciation to VCDOC Acting Director Mark Flowers, Lieutenant Christopher Stormer, Sergeants Faircloth and Isaac, HSA Tish Wright, and Mental Health Supervisor Nancy Valdes. Without the total candor, cooperation and assistance from these individuals, as well as from all other personnel that were interviewed, this writer would not have been able to complete this technical assistance assignment.

Respectfully Submitted By:

/s/ Lindsay M. Hayes
Lindsay M. Hayes

May 31, 2017

APPENDIX A

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

Lindsay M. Hayes

The safe housing of suicidal inmates and juveniles 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 and juvenile suicides occur by hanging, it is certainly reasonable to ensure that all cells utilized to house potentially suicidal inmates and juveniles 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 and juveniles 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) If cells have floor drains, they should also have holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch (inmates have been known to weave one end of a ligature through the floor drain with the

other end tied around their neck, then lay on the floor and spin in a circular motion as the ligature tightens);

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

5) 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;

6) 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;

7) 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 individual attaches the noose from above, runs it under his neck, turns over on their stomach and asphyxiates themselves within minutes.);

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

9) 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;

10) 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;

11) 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 individual 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;

12) Cells should have an audio monitoring intercom for listening to calls of distress (only as a supplement to physical observation by staff). While the individual 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.);

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

14) 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;

15) Some individuals 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;

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

17) 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;

18) A mattress should always be issued to an individual on suicide precautions unless the individual is observed to be utilizing it in ways in which it was not intended (i.e., attempting to tamper with/destroy, utilizes to obstruct visibility into the cell, etc.). 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;

19) 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;

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

21) 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. Because padded cells do not contain a sink or toilet, they should not be primarily utilized for suicidal inmates, but, if utilized, the duration should be limited to a few hours; and

22) 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. Last revised Lindsay M. Hayes in January 2017.

APPENDIX B

GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS WITHIN JAILS AND PRISONS

Lindsay M. Hayes

All correctional facilities, regardless of size, should have a comprehensive suicide prevention program that addresses the following critical components.

Staff Training

The essential component to any suicide prevention program is properly trained staff, who form the backbone of any correctional facility. Very few suicides are actually prevented by mental health, medical or other professional staff because suicides are usually attempted in housing units, and often during late evening hours or on weekends when they are generally outside the purview of program staff. These incidents, therefore, must be thwarted by correctional staff who have been trained in suicide prevention and have developed an intuitive sense about suicidal inmates. Correctional staff is often the only personnel available 24 hours a day; thus, they form the front line of defense in preventing suicides.

All correctional, medical, and mental health personnel, as well as any staff who have regular contact with inmates, should receive eight (8) hours of initial suicide prevention training, followed by two (2) hours of refresher training each year. The initial training should include administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, guiding principles to suicide prevention, inmate suicide research, why the environments of correctional facilities 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 facility's suicide prevention policy, and liability issues associated with inmate suicide. The two-hour refresher training should include a review of administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, predisposing risk factors, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, and review of any changes to the facility's suicide prevention plan. The annual training should also include general discussion of any recent suicides and/or suicide attempts in the facility.

In addition, all staff who has routine contact with inmates should receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff should also be trained in the use of various emergency equipment located in each housing unit. 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.

Identification/Referral/Evaluation

Intake screening and on-going assessment of all inmates is critical to a correctional facility's suicide prevention efforts. It should not be viewed as a single event, but as an on-going process because inmates can become suicidal at any point during their confinement, including the initial admission into the facility; after adjudication when the inmate is returned to the facility from court; following receipt of bad news or after suffering any type of humiliation or rejection; confinement in isolation or segregation; and following prolonged a stay in the facility.

In addition, although there is no single set of risk factors that mental health and medical communities agree can be used to predict suicide, there is little disagreement about the value of screening and assessment in preventing suicide. Research consistently reports that approximately two-thirds of all suicide victims communicate their intent some time before death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt.

Intake screening for suicide risk may be contained within the medical screening form or as a separate form. The screening process should 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; and arresting/transporting officer(s) belief that the inmate is currently at risk. Specifically, inquiry should determine the following:

- Was the inmate a medical, mental health or suicide risk during any prior contact and/or confinement within this facility?

- Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates inmate is a medical, mental health or suicide risk now?

- Have you ever attempted suicide?

- Have you ever considered suicide?

- Are you now or have you ever been treated for mental health or emotional problems?

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

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

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

- Are you thinking of hurting and/or killing yourself?

Although an inmate's verbal responses during the intake screening process are critically important to assessing the risk of suicide, staff should not exclusively rely on an inmate's denial that they are suicidal and/or have a history of mental illness and suicidal behavior, particularly when their behavior and/or actions or even previous confinement in the facility suggest otherwise.

The process should include reasonable privacy and confidentiality, as well as include referral procedures to mental health and/or medical personnel for a more thorough and complete assessment.

The intake screening process should be viewed as similar to taking your temperature, it can identify a current fever, but not a future cold. Therefore, following the intake screening process, should any staff hear an inmate verbalize a desire or intent to commit suicide, observe an inmate engaging in any self-harm, or otherwise believe an inmate is at risk for suicide, a procedure should be in place that requires staff to take immediate action to ensure that the individual is constantly observed until appropriate medical, mental health, and/or supervisory assistance is obtained.

Finally, given the strong association between inmate suicide and isolation/special management (e.g., 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 medical or mental health staff upon admission to the placement.

The screening and assessment process is only one of several tools that increases the opportunity to identify suicide risk in inmates. This process, coupled with staff training, will only be successful if an effective method of communication is in place at the facility.

Communication

Certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and communicated to others, can reduce the likelihood of suicide. In addition, most suicides can be prevented by correctional staff who establish trust and rapport with inmates, gather pertinent information, and take action. There are essentially three levels of communication in preventing inmate suicides: between the arresting/transporting officer and correctional staff; between and among facility staff (including correctional, medical and mental health personnel); and between facility staff and the suicidal inmate.

In many ways, suicide prevention begins at the point of arrest. At Level 1, what an arrestee says and how they behave during arrest, transport to the facility, and at intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the

individual. Arresting officers should pay close attention to the arrestee during this time; suicidal behavior may be manifested by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers such as family members and friends. Any pertinent information regarding the arrestee's well-being must be communicated by the arresting or transporting officer to correctional staff. It is also critically important for correctional staff to maintain open lines of communication with family members who often have pertinent information regarding the mental health status of inmates.

At Level 2, effective management of suicidal inmates is based on communication among correctional personnel and other professional staff in the facility. Because inmates can become suicidal at any point during confinement, correctional staff must maintain awareness, share information and make appropriate referrals to mental health and medical staff. At a minimum, the facility's shift supervisor should ensure that appropriate correctional staff are properly informed of the status of each inmate placed on suicide precautions. The shift supervisor should also be responsible for briefing the incoming shift supervisor regarding the status of all inmates on suicide precautions. Multidisciplinary team meetings (to include correctional, medical and mental health personnel) should occur on a regular basis to discuss the status of inmates on suicide precautions. Finally, the authorization for suicide precautions, any changes in suicide precautions, and observation of inmates placed on precautions should be documented on designated forms and distributed to appropriate staff.

At Level 3, facility staff must use various communication skills with the suicidal inmate, including active listening, staying with the inmate if they suspect immediate danger, and maintaining contact through conversation, eye contact, and body language. Correctional staff should trust their own judgment and observation of risk behavior, and avoid being misled by others (including mental health staff) into ignoring signs of suicidal behavior.

Poor communication between and among correctional, medical, and mental health personnel, as well as outside entities (e.g., arresting or referral agencies, family members) is a common factor found in the reviews of many custodial suicides. Communication problems are often caused by lack of respect, personality conflicts and boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides.

Housing

In determining the most appropriate housing location for a suicidal inmate, correctional facility officials (with concurrence from medical and/or mental health staff) often tend to physically isolate (or segregate) and sometimes restrain the individual. These responses might be more convenient for all staff, but they are detrimental to the inmate since the use of isolation escalates the sense of alienation and further removes the individual from proper staff supervision. To every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. Further, removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, handcuffs, straitjackets) should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Housing

assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten depersonalizing aspects of confinement.

All cells designated to house suicidal inmates should be as suicide-resistant as is reasonably possible, free of all obvious protrusions, and provide full visibility. These cells should contain tamper-proof light fixtures, smoke detectors and ceiling/wall air vents that are protrusion-free. In addition, the cells should not contain any live electrical switches or outlets, bunks with open bottoms, any type of clothing hook, towel racks on desks and sinks, radiator vents, or any other object that provides an easy anchoring device for hanging. Each cell door should contain a heavy gauge Lexan (or equivalent grade) clear panel that is large enough to allow staff a full and unobstructed view of the cell interior. Finally, each housing unit in the facility should contain an emergency response bag that contains, at a minimum, a first aid kit, Ambu-bag or CPR mask, and rescue tool (to quickly cut through fibrous material). Correctional staff should ensure that such equipment is in working order on a daily basis.

Levels of Observation/Management

In regard to suicide attempts in correctional facilities, the promptness of the response is often driven by the level of supervision afforded the inmate. The planning of and preparation for suicide can take several minutes; brain damage from strangulation caused by a suicide attempt can occur within 4 minutes, and death often within 5 to 6 minutes. 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 (e.g., expressing a wish to die without a specific threat or plan) 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. Staff should observe such an inmate in a protrusion-free cell at staggered intervals not to exceed every 10-15 minutes (e.g., 5, 10, 7 minutes).
>
> ***Constant Observation*** is reserved for the inmate who is actively suicidal, either threatening or engaging in suicidal behavior. Staff should observe such an inmate on a continuous, uninterrupted basis. In some jurisdictions, an intermediate level of supervision is utilized with observation at staggered intervals that do not exceed every 5 minutes.

Other aids (e.g., closed-circuit television, cell mates) can be used as a supplement to, but never as a substitute for, these observation levels.

Because death from a suicide attempt can occurs within a short duration, observation of a suicidal inmate at intervals less frequent than continuous observation can only be successful if the observation is staggered and the cell is suicide-resistant.

In addition, mental health staff should assess and interact with (not just observe) the suicidal inmate on a daily basis. The daily assessment should focus on the current behavior, as well as changes in thoughts and behavior during the past 24 hours (e.g., "What are your current feelings and thoughts?" "Have your feelings and thoughts changed over the past 24 hours?" "What are some of the things you have done or can do to change these thought and feelings?," etc.)

An individualized treatment plan (to include follow-up services) should be developed for each inmate on suicide precautions. The plan should be developed by qualified mental health staff in conjunction with not only the inmate, but medical and correctional personnel. The treatment plan should describe signs, symptoms, and the circumstances under which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the inmate and staff will take if suicidal ideation reoccurs.

Finally, due to the strong correlation between suicide and prior suicidal behavior, 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 personnel until their release from custody. Although there is not any nationally-acceptable schedule for follow-up, unless otherwise specified in an individual treatment plan, a suggested assessment schedule following discharge from suicide precautions might be: 24 hours, 72 hours, 1 week, and periodically until release from custody.

Intervention

Following a suicide attempt, the degree and promptness of the staff's intervention often foretells whether the victim will survive. National correctional standards and practices generally acknowledge that a facility's policy regarding intervention should be threefold. First, all staff who come into contact with the inmate should be trained in standard first aid procedures and CPR. Second, any staff member who discovers an inmate engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. If facility policy prohibits an officer from entering a cell without backup support, the first responding officer should, at a minimum, make the proper notification for backup support and medical personnel, secure the area outside the cell, and retrieve the housing unit's emergency response bag. Third, correctional staff should never presume that the victim is dead, but rather should initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, medical personnel should ensure that all equipment utilized in responding to an emergency within the facility is in working order on a daily basis.

Finally, although not all suicide attempts require emergency medical intervention, all suicide attempts should result in immediate intervention and assessment by mental health staff.

Reporting

In the event of a suicide attempt or suicide, all appropriate 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