

PrimeCare Medical, Inc.

**Summary: Technical Assistance
Report: Suicide Prevention Practices
Lancaster County Prison**

Todd W. Haskins, RN, BSN, CCHP

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Introduction

- Suicide Facts re: Correctional Environments
- Community Suicide Rates
- Lancaster County Prison (LNCP) Healthcare Statistics
- PrimeCare Medical, Inc. (PCM) Medical/Mental Health Staffing Levels
- Technical Review Summary
- Conclusion

Factual Information

- Suicide continues to be the leading cause of death among inmates in the nation's jails
- Certain features of the jail environment may increase suicidal behavior:
 - Fear of the unknown
 - Distrust of an authoritarian environment
 - Perceived lack of control over the future
 - Isolation from family and significant others
 - Shame of being incarcerated
 - Perceived dehumanizing aspects of incarceration

Suicide Facts

New Frontier for Suicide Prevention

- Fact: Suicide rates in detention facilities over the last 20 years have decreased from 107 suicides per 100,000 to 38 per 100,000 inmates — a three-fold decrease.
- 75% of jail suicides now take place after the first day behind bars.
- Suicide attempts can be triggered by:
 - Court hearings
 - Family issues (Divorce, Custody issues, etc.)
 - Classification Changes - Administrative segregation placement

The Changing Face of Jail Suicide

- Twenty years later, Hayes found:
- Substantial changes in the demographic characteristics who committed suicide.
- In past “Minor Other” offenses were highest risk and now those charged with “personal and/or violent” charges are at highest risk.
- Intoxication was previously a leading precipitant to inmate suicide - Now data indicates far fewer cases.

The Changing Face of Jail Suicide

- Time of suicide
 - Less than one-quarter of all suicides occur in the first 24 hours
 - An equal number of deaths occurring between 2 and 14 days of confinement
 - 3:00pm to 9:01pm is greatest risk of suicide time periods
- Suicides occur far less frequently, for those housed in isolation than was previously reported.
- Unknown reasons -less likely they are found within 15 minutes of the last observation by staff
- Written Policy – Facilities continue to experience Suicides – comprehensiveness may be an issue?

Suicide – Rankings Cause of Death

In Pennsylvania Suicide by age*: (2011)

- 4-24 years Suicide is ranked the **3rd** leading cause of death
- 25-44 years Suicide is ranked the **4th** leading cause of death
- 45-64 years Suicide is ranked the **5th** leading cause of death
- Nationally: (2009) Suicide **10th** leading cause of death

* Pennsylvania Vital Statistics County and State Death Rates/Rank

LNCP Mental Health Statistics

2011

- 15,869 patient contacts
- 6,312 New intakes
- 18,927 doses of medications
- 2,941 Psychiatrist / MH CRNP Seen
- 31.7% of Inmates on Psychiatric Medication
- 935 Seriously Mentally ill
- 730 Suicide Watches

Current Mental Health Staffing

- Psychiatrist (Up to 16 Hours/Week)
- Certified Psychiatric Nurse Practitioner (up to 4 hours/week)
- 1 Psychologist
- 1 Licensed Counselor
- 1 Licensed Social Worker
- 1 Masters Level Counselor
- 1 Mental Health Nurse
- Mental Health Team Cover M-F 8 AM – 8PM
Saturday 8AM – 4PM

Technical Review

- Lindsay M. Hayes, Project Director of the National Center on Institutions and Alternatives
- Reason for Evaluation:
 - Suicide Cluster
 - External Policy Review (PCM)
 - Physical Plant Evaluation (LNCP)
 - Suggestions / Recommendations (PCM/LNCP)
 - Program Change / Recommendations (PCM/LNCP)

8 - Components for Suicide Prevention

1. Staff Training
2. Identification / Screening
3. Communication
4. Housing
5. Levels of Supervision / Management
6. Intervention
7. Reporting
8. Follow-up Morbidity – Mortality Review

Finding & Recommendations

- Evaluation According to Hayes 8 Critical Components – Suicide Prevention
- ACA Performance Based Standards for Adult Local Detention Facilities (2004)
- NCCHC J-G-05 Standards for Health Services in Jails (2008)
- U.S. Department of Homeland Security's Operation Manual ICE Performance-Based National Detention Standards (2008)

Assessment Components

■ Facility Tour

- Intake Unit
- Classification Unit
- Medical Housing Area
- Suicide Locations
- Suicide Watch Cells

■ Interviews

- Administration Members
- Correctional Staff
- Medical Staff
- Mental Health staff

■ Documentation

- Policies and Procedures
- Screening Process and Tools
- Education
- Medical Charts
- Investigative Reports
- Mortality Reviews

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 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.

1. Staff Training

Findings:

- LNCP and PCM Suicide Prevention Training – was found to have good practices
- 200 hour new officer training
- 4 hour pre-service training workshop on suicide prevention
- Annual training for PCM and LNCP staff
- Additional education / training when needed
- Lesson plans very comprehensive

Recommendations: NONE

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.

2. Intake Screening / Assessment

Findings:

- Very good practices noted
- Officers questions have several questions related to mental illness / suicide risk. (concern questions are asked in a non-private setting)
- PCM Staff conduct medical and mental health screening at time of intake (private area)
- PCM Staff again within 14 days complete another mental health screening

2. Intake Screening / Assessment

Findings: (Continued)

- M.H. referred Patients are further assessed if not immediately within 24-48 hours from referral placement
- Offense specific - sexual offenses and high profile charges are now placed on watch status
- Court Returns – suicide risk questions (three) when returning from court hearings

2. Intake Screening / Assessment

Recommendations:

- Two minor recommendations to further strengthen an already very good intake screening process.
 1. PCM should correct glitch within EMR that allows personnel to close-out suicide precaution status when status has been discontinued. (Corrected Immediately)
 2. PCM to strengthen priority mental health triage system with assessment timeframes for Emergent (Immediate), Urgent (24 hours) & Routine referrals (72 hours).

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)
3. Between staff and the suicidal inmate.

3. Communication

Findings:

- Noted positive relationships with Correctional, Medical, and Mental Health personnel
- PCM CorEMR - effective communications between Medical & Mental Health
- Daily listings – communication of watch inmates
- Interdisciplinary Team Meetings – weekly meetings for SMI / Concerned patients
- Effective Communication between healthcare team and members of administration

Recommendations: NONE

4. Housing

Isolation should be avoided. Whenever possible, house in general populations, 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.

4. Housing

Findings:

- Current Management of suicidal inmate is restrictive
- SW Locations: MHU, Pod 2-5, Pod 3-5, and Classification Unit
- All males on SW are locked down 23 hours per day
- Male SW's are prohibited from reading materials, out-of-cell time, telephone calls, and shower time
- Female inmates are out-of-cell two hours each day, with ample opportunity for exercise, telephone and shower time.

4. Housing

Findings: (Continued)

- MHU Correctional Officer added 10/31/11 should eliminate and improve out-of-cell time issues
- High # threaten and/or engage in superficial self-injurious behaviors for housing transfers – LNCP very unique
- Severe Concerns re: Manipulation Status Policy (Security assigned)

4 Housing

Recommendations:

1. Embark on Inspection & Renovation program to ensure cells are suicide-resistant
 - Remove all items causing Protrusions
 - Cover bunk holes
 - Remove Bookshelf/clothing hook
 - See Attachment A “Checklist for the Suicide-Resistant Design of Correctional Facilities”
2. Privileges should be consistent for males and females

4. Housing

Recommendations: (Continued)

3. Review / Revise Current LNCP and PCM Suicide Prevention Policy,

- Provide greater description of three level watch system
- All decisions for clothing and privileges should be commensurate with suicide risk
- All inmates should be allowed routine privileges unless contraindicated
- All inmates should be allowed to keep their mattress unless they tamper with or block cell views
- Safety Smocks should never be used to deter perceived manipulative behavior

4. Housing

Recommendations: (Continued)

4. Unit Workers – Trustees who provide services in the MHU should be assigned from an outside unit.
5. Strongly Recommended the Manipulation Status Policy never be utilized for inmates who threaten and/or engage in self-injurious behavior

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 the 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.

5. Levels of Supervision / Management

Findings:

- LNCP & PCM's Suicide Status do not provide a description of behavior type for the status level
- Mental Health staff at times do not assess the inmate on a watch daily. Charts reviewed indicated every-other-day assessments
- Non-Licensed Mental Health staff were assessing and making changes for Level II and Level III status changes.

5. Levels of Supervision / Management

Findings: (Continued)

- Charting for suicide risk patient should include reasons for downgrade and/or upgrade with risk status
- Treatment plan regimens were not consistently written when placed on suicide watch status
- When released from suicide watch status, some inmates were not routinely followed by the mental health department.

5. Levels of Supervision / Management

Recommendations:

1. Strongly recommended LNCP and PCM officials develop a three level system which includes behavior and/or circumstances that necessitates a specific level system
 - **Level I** – Reserved for Actively suicidal (Constant Watch)
 - **Level II** – Reserved for the inmate who is not actively suicidal but has ideation or recent destructive behavior (10- Minute Checks)
 - **Level III** – Psychiatric Observation is reserved for the inmate who is not suicidal but behavior warrants closer observation (up to 30 Minute Checks)

5. Levels of Supervision / Management

Recommendations: (Continued)

2. Consistent with national standards, CCTV is only a supplement not a replacement for direct observation
3. Change PCM policy minimum Suicide Watch LOS – should be commensurate with the level of risk
4. LNCP Officials should discontinue use of the Close Proximity Observation Policy when inmates on SW are placed in a non-CCTV cell

5. Levels of Supervision / Management

Recommendations: (Continued)

5. Correctional Officers should also document observation checks of inmates on Level III and Psychiatric Observation status
6. PCM Mental Health staff should evaluate on a daily basis all inmates on a Level I, II, or III status inmates. Cell-Side assessments should be avoided
7. Suicide Watch downgrades or removals should only occur after a confidential assessment is completed by a licensed mental health professional

5. Levels of Supervision / Management

Recommendations: (Continued)

8. Mental Health Professional should carefully document their reasons for downgrade or upgrade of suicide precautions
9. Continuity of Care: SW patients should receive follow-up assessments. (24 hours, 72 hours, & Periodically) after removal from SW
10. Treatment Plan Development for inmates who will be on suicide watch longer than 24 hours

6. Intervention

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

6. Intervention

Findings:

- All correctional staff are required to be trained in first aid, CPR & AED
- AED's are strategically located throughout the jail
- Microshields are contained on key chains carried by many CO's
- Sergeants who supervise housing units carry cut down tools

6. Intervention

Recommendations:

- Strongly recommended that emergency response bags be available in control booths at all housing units (completed)
- Contents should include:
 - First aid kits, emergency rescue knives or cut-down tools, CPR masks or Ambu bags

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.

7. Reporting

Findings:

- Hayes reviewed prior inmate suicides
 - Investigative reports
 - Medical charts
 - Reviews

Recommendations: None

8. Follow-up / Morbidity - Mortality Review

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

8. Follow-up / Morbidity - Mortality Review

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?

8. Follow-up / Morbidity - Mortality Review

Findings:

- LNCP and PCM have very good review practices
- Involve – Investigative (Lancaster City Police, County Coroner, Etc.)
- LNCP Prison Security Review
- PCM Corporate – Medical/Mental Health Review
- Reviews conducted with LNCP Administrative staff, LNCP Security, PCM Corporate, PCM On-Site staff

8. Follow-up / Morbidity - Mortality Review

Recommendation:

One Minor recommendation – PCM Mental Health Director not use Psychological Autopsy term and replace with Comprehensive Clinical Review as part of mortality review process

Conclusion

- Confidentiality – Peer Reviews
- Continuous Quality Improvement
- Process & Outcome Studies
- Community Involvement

Questions

