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REPORT ON SUICIDE PREVENTION PRACTICES WITHIN THE WOMEN'S HURON VALLEY CORRECTIONAL FACILITY
Ypsilanti, Michigan

by

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A. INTRODUCTION

At the request of the Disability Rights Section of the U.S. Department of Justice, Civil Rights Division, the following is a summary of the observations, conclusions and remedies of Lindsay M. Hayes, Project Director of the National Center on Institutions and Alternatives, in regard to suicide prevention practices within the Women's Huron Valley Correctional Facility in Ypsilanti, Michigan.

The assessment was based upon a review of numerous Michigan Department of Corrections and Women's Huron Valley Correctional Facility policy directives, as well as documents relating to suicide prevention (e.g., intake screening and assessment forms, etc.); on-site review of physical plant and suicide prevention practices within the facility from January 24 thru January 26, 2011; case file reviews of four (4) inmate suicides in the facility during 2010 and 2011; case file reviews of selected inmates on suicide precautions; and interviews with numerous administrative, correctional, medical, and mental health personnel.

According to the Michigan Department of Corrections, the Women's Huron Valley Correctional Facility (WHVCF) has an operational capacity for 2,007 inmates, and held 1,834 inmates on January 24, 2011. As shown in Table 1 below, the WHVCF has experienced six (6) inmate suicides between January 1, 2008 and March 31, 2011, resulting in a suicide rate of 95.8 deaths per 100,000 inmates during this time period. According to the most recent national data, the suicide rate in federal, state, and private prisons throughout the country during 2007 was 16

deaths per 100,000 prison inmates.[1] As such, *the suicide rate within the WHVCF was six (6) times greater than the national average during this 4-year period.*

TABLE 1
INMATE SUICIDES AND AVERAGE DAILY POPULATION WITHIN THE WOMEN'S HURON VALLEY CORRECTIONAL FACILITY[2]
(January 2008 thru March 2011)

Year	Suicides	Average Daily Population	Rate
2008	2	857	233.3
2009	0	1,735	0
2010	3	1,834	163.6
2011(thru March)	1	1,834	54.5
2008-2011(thru March)	**6**	**6,260**	**95.8**

It is important to note that while suicide rates in correctional facilities may appear interesting, they are not the primary measurement of the adequacy of a correctional facility's suicide prevention program. As detailed in the following pages, the adequacy of a suicide prevention program can only be measured by a thorough review of suicide prevention practices (principally in the areas of training, identification/assessment, management, and emergency response), as well as review of any inmate suicides on a case-by-case basis.

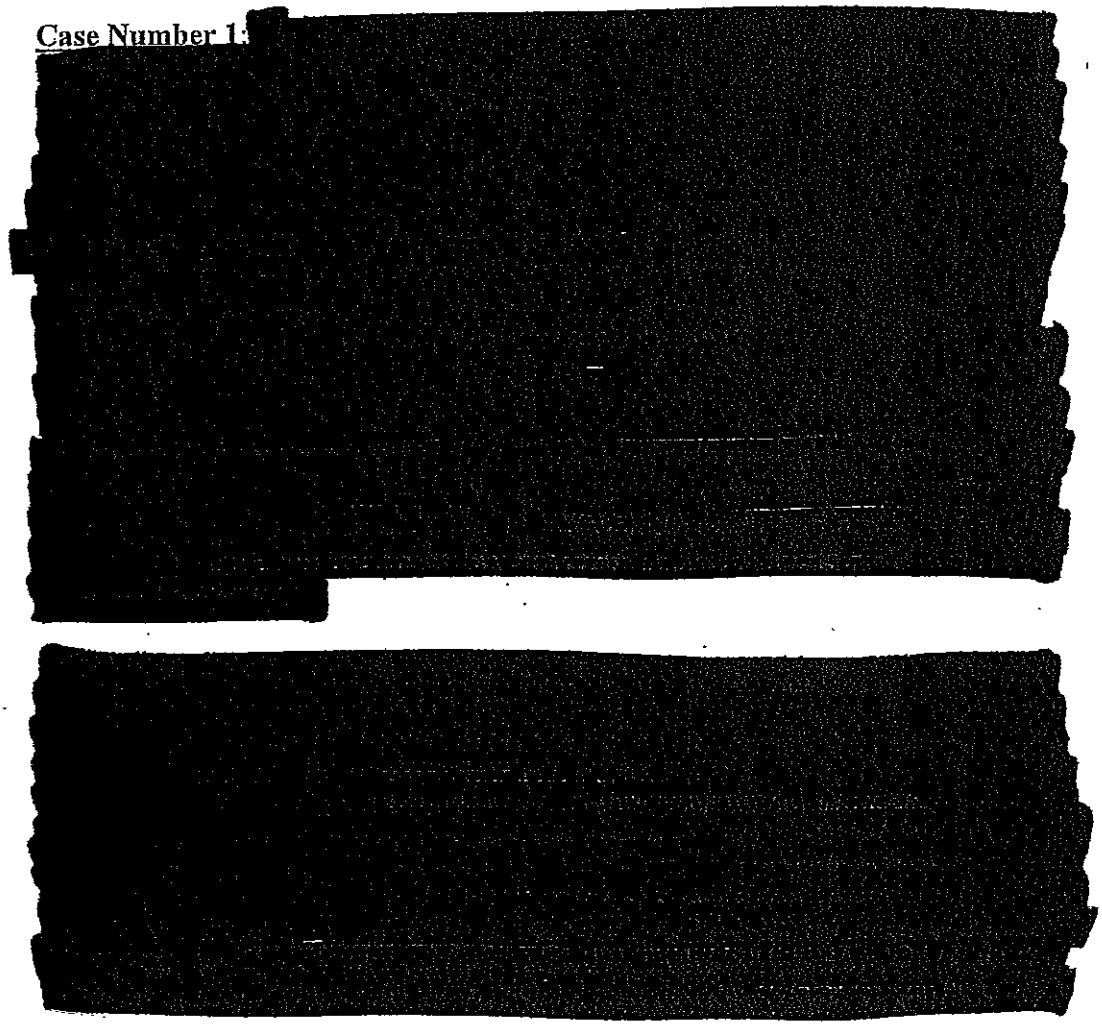
According to the Michigan Department of Corrections (DOC), inmates housed in the reception center, general population, or segregation unit at the WHVCF receive mental health services from the DOC's Bureau of Mental Health Services, Psychological Services Unit. The DOC contracts with the state Department of Community Health for the provision of services to

[1]Noonan, Margaret, E. (2010), *Deaths in Custody: State Prison Deaths; 2001-2007 - Statistical Tables*, Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
[2]Data provided by the Michigan Department of Corrections.

inmates deemed to be seriously mentally ill. These services are provided through the Corrections Mental Health Program (CMHP), and include both out-patient and in-patient mental health services. These CMHP services include the Residential Treatment Program and the In-Patient Acute Care Unit at the WHVCF. During the on-site assessment in January 2011, this writer was informed that the delivery of mental health services for all WHVCF inmates would be revised in March 2011.

Most recently, the WHVCF has experienced four (4) inmate suicides during 2010-2011. Each death is summarized below, as well as referenced later in this report:

Case Number 1:



B. FINDINGS AND RECOMMENDATIONS

Detailed below is this writer's assessment of suicide prevention practices within the Michigan Department of Corrections' Women's Huron Valley Correctional Facility (WHVCF). It is formatted according to this writer's eight (8) critical components of a suicide prevention policy: staff training, identification/screening, communication, housing, levels of supervision/management, intervention, reporting, and follow-up/morbidity-mortality review. This protocol was developed in accordance with both Standard 4-4373 of the American Correctional Association's *Standards for Adult Correctional Institutions* (2003) and Standard P-G-05 of the National Commission on Correctional Health Care's *Standards for Health Services in Prisons* (2008).[3]

[3]American Correctional Association (2003), *Standards for Adult Correctional Institutions*, 4th Edition, Lanham, MD: Author; National Commission on Correctional Health Care (2008), *Standards for Health Services in Prisons*, Chicago, IL: Author.

1) Staff Training

All correctional, medical, and mental health staff should receive eight (8) hours of initial suicide prevention training, followed by two (2) hours of annual training. At a minimum, training should include avoiding negative attitudes to suicide prevention, prison 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 suicides usually are attempted in inmate housing units, often during late evening hours and 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 4-4084 requires that all correctional staff receive both initial and annual training in the "signs of suicide risk" and "suicide precautions;" while Standard 4-4373 requires that staff be trained in the implementation of the suicide prevention program. As stressed in NCCHC Standard P-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."

FINDINGS: All correctional, medical, and mental health personal working within the Michigan Department of Corrections are required to complete both pre-service and annual in-service training in suicide prevention. Although no information was received regarding pre-service training curricula, this writer did review the DOC Office of New Employee Training and Professional Development's *Suicide Prevention 2011 In-Service Training, Training Manual.* Revised in June 2010, this 2-hour lesson plan includes classroom instruction on staff responsibilities for suicide prevention, signs and symptoms, referral procedures, interacting with suicidal inmates, and intervention into suicide attempts. The lesson plan contains important information (and also misinformation, e.g., suggesting that "generally self-injurious behavior is not suicidal behavior"), although it is difficult to imagine how all the material could be included in a 2-hour time frame. This writer also received and reviewed training records that indicated almost all (i.e., 99%) of both uniform and non-uniform WHVCF employees received this training within the past 12 months. Unfortunately, this writer was also informed that the annual suicide prevention training was converted into a computer-based training (CBT) during 2010-2011. Although use of CBT might demonstrate compliance (albeit wrongly) with a policy directive or an accreditation standard, it is not meaningful, nor helpful, to the goal of reducing inmate suicides. CBT is certainly not appropriate for the topic of suicide prevention, a critical issue that is all about attitude and collaboration, principles that are lost outside a classroom environment.

This writer was also informed that MHM Services, Inc. provided a 2-hour suicide prevention workshop that was open to any interested WHVCF staff on December 7, 2010, as well as to clinical staff on December 8, 2010. Approximately 100 correctional staff and 50 clinicians attended these workshops. MHM's *Advanced Suicide Assessment, Prevention and Intervention* curricula was reviewed and contained information on prevalence and trends, risk factors, the suicidal mind and self-injury, assessment and treatment, and litigation. The MHM curricula is excellent and includes an important section on suicidal and self-injurious behavior that warns participants that these behaviors are not mutually exclusive and can, and often do, exist in the same individual (in contrast to the above referenced DOC lesson plan which incorrectly suggests they are different behaviors).

CONCLUSION/REMEDY: This writer did not have an opportunity to review and critique the WHVCF's pre-service suicide prevention training program. However, the agency's conversion to a computer-based training program for suicide prevention is problematic and grossly inadequate for the provision of annual training. The Michigan DOC should discontinue use of any computer-based training program for suicide prevention. In addition, the agency should ensure that all correctional, medical, ands mental health personnel working at the WHVCF receive eight (8) hours of initial suicide prevention training. At a minimum, the program should include avoiding negative attitudes to suicide prevention, prison 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.

2) Identification/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.

Identification/screening is also critical to a correctional system's suicide prevention efforts. An inmate can attempt suicide at any point during incarceration -- beginning immediately following reception and continuing through a stressful aspect of confinement. Although there is disagreement within the psychiatric and medical communities as to which factors are most predictive of suicide in general, research in the area of jail and prison suicides has identified a number of characteristics that are strongly related to suicide, including: intoxication, emotional state, family history of suicide, recent significant loss, limited prior incarceration, lack of social support system, psychiatric history, and various "stressors of confinement."[4] 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

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

who have never made an attempt.[5] 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.

Both the ACA and NCCHC standards address the issue of assessing inmates assigned to segregation. According to ACA Standard 4-4400: "When an offender is transferred to segregation, health care personnel will be informed immediately and will provide assessment and review as indicated by the protocol as established by the health authority." NCCHC Standard P-E-09 states that "Upon notification that an inmate is placed in segregation, a qualified health care professional reviews the inmate's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation."

FINDINGS: The WHVCF has very good intake screening and assessment procedures to identify potentially suicidal inmates, but some of these procedures are in need of slight revision. Upon admission, a registered nurse (RN) in the Reception and Guidance Center completes an "Intake/Receiving" screening form that addresses various health related issues. In addition, a "Suicide Prevention Screening" form is completed. (This form, originally developed by the New York State Office of Mental Health and Commission of Correction in the 1980s, includes 17 areas of inquiry regarding potential suicide risk factors.) The intake nurse also conducts a brief

[5]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.

mental status examination. A "Sheriff's Questionnaire for Delivered Persons" form is also said to be received for each newly arrived inmate from county jails throughout the state. The form allows county jurisdictions to communicate the health care needs of newly arrived inmates. However, this writer's interview with one intake nurse revealed that, although the WHVCF averages approximately 15 new intakes per week, only about three (3) or 20 percent of the "Sheriff's Questionnaire for Delivered Persons" forms are received. Finally, within four (4) days of arrival, all newly arrived inmates are assessed by mental health staff utilizing a "Reception Mental Health Appraisal" form. When appropriate, a "Comprehensive Psychiatric Assessment/Reception Center" form is completed by a psychiatrist.

It should also be noted that mental health staff conduct daily rounds in the Segregation Unit, and a clinician conducts a brief mental status examination to all newly arrived inmates into the unit.

Although the identification and screening of potential suicidal behavior appears adequate, the criteria for admission into the mental health services program at WHVCF appears problematic. According to the Department of Corrections and Department of Community Health's Bureau of Hospital/Forensic Mental Health Services, Corrections Mental Health Program's *Out-Patient Mental Health Treatment Program Statement* (November 2006):

> The criteria and guidelines in this section are to be used in determining whether prisoners require a level of care provided by out-patient mental health teams..... The Out-Patient Mental Health Team is expected to permit individuals to their caseloads when the results of the Comprehensive Psychiatric Evaluation suggest uncertainty as to the symptomatology and behavior meeting corrections mental

health program entry/exit criteria. This admission will be done to allow further assessment and evaluation of the individual treatment needs.

1. Admission Criteria (Prisoners admitted for treatment by the Outpatient Mental Health Team must meet ALL three criteria A, B, and D or BOTH criteria C and D.

A. As determined by a comprehensive psychiatric evaluation, the prisoner/patient is judged to present with serious mental illness indicated by one of the following diagnoses or clinical conditions:

1) Schizophrenia
2) Bipolar disorder
3) Schizoaffective disorder
4) Major depressive disorder
5) Psychosis (psychotic disorder other than schizophrenia in DSM – IV)
6) Chronic brain disorder with significant fundamental impairment, absent complicating medical conditions
7) Other condition considered to be severe disorders or thought or mood that significantly impaired judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

B. Primary psychiatric symptoms associated with the condition are stabilized/in partial remission, as indicated by a GAF score in the 51 – 60 range (may be higher if secondary medication maintenance); the prisoner is determined to be capable of functioning in a correctional housing unit with regularly scheduled services provided by the Outpatient Mental Health Team.

C. Prisoners transferred from a hospital-based program or Residential Treatment Program, who continued to be diagnosed with conditions 1. – 6 above, must be followed for a minimum of eighteen (18) months; all others, including prisoners with NO RECOMMENDATION FOR TREATMENT, must be followed for a minimum of three months from the date of transfer/discharge. Prisoners whose maintenance regime of psychiatric medication has been discontinued must be followed for a minimum of six (6) months.

D. The patient provides voluntary written consent to treatment or is the subject of an Involuntary Treatment Order.

As shown above, the criteria for admission into out-patient mental health services at the WHVCF appears overly restrictive. A psychiatrist, following a comprehensive psychiatric evaluation, provides sole determination for mental health services. As one clinician told this writer, "if the psychiatrist does not believe mental health services are warranted, the inmate is not placed on the caseload, regardless of what other team members may think." Not surprisingly, all four (4) inmates that recently committed suicide in the WHVCF were not in the out-patient mental health services program, despite that fact that each demonstrated symptoms of mental illness and/or self-injurious/suicidal behavior, and/or had a prior history of mental illness.

CONCLUSION/REMEDY: The communication of information between county jurisdictions and the WHVCF regarding the health care needs of newly admitted inmates is problematic, and the state Department of Corrections should require that counties complete a "Sheriff's Questionnaire for Delivered Persons" form whenever an inmate is transferred from county to state custody. In addition, the WHVCF, through the Department of Corrections, should completely revise its criteria for an inmate/patient's for entry into the out-patient mental health services program to allow less restrictive criteria, as well as eliminating the provision that a psychiatrist is the sole determiner of services. (As previously noted, while on-site in January 2011, the director of psychiatric services for the state Department of Corrections informed this writer that the criteria for admission into out-patient mental health services was being revised.)

3) Communication

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

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

FINDINGS: This writer has previously addressed the inadequate communication between sending county jurisdictions and WHVCF in relating pertinent health care information of newly arrived inmates. 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 the file review revealed that management staff of the corrections, medical, and mental health divisions meet on a regular basis, review of the four recent inmate suicides found that inmates on suicide precautions are not seen daily, do not receive regularly scheduled follow-up assessments, nor have individualized treatment plans (see Section 5 of this report, pages 28-40). Especially problematic is that multiple agencies are providing mental health services at WHVCF: (1) clinicians (including some psychiatrists) from the Department of Community Health, (2)

clinicians from the Department of Corrections' Psychological Services Unit staff, and (3) several psychiatrists from MHM Services, Inc. Finally, it does *not* appear that WHVCF keeps a daily listing of inmates on suicide precautions, which not only impacts communication, but the ability to perform continuous quality improvement.

CONCLUSION/REMEDY: WHVCF officials should maintain a daily roster of all inmates on suicide precautions. The roster shall be distributed to appropriate correctional, medical, and mental health personnel.

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, to every extent possible, such inmates should be housed in suicide-resistant, protrusion-free cells. Further, cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), removal of clothing (excluding belts and shoelaces) and issuance of safety "smocks," as well as the use of physical

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

FINDINGS: Inmates identified as suicidal can be housed in various locations in the WHVCF which is primarily dependent upon their classification status and/or whether or not they are on the mental health caseload. Inmates classified as general population or "close custody" status who subsequently are placed on suicide precautions are housed in the Segregation Unit. While on suicide precautions, they are stripped naked and issued only a safety smock, prohibited from most other possessions, as well as showers or any other out-of-cell time. In many ways, *the conditions for inmates placed on suicide precautions in segregation are more restrictive then placement in segregation for a disciplinary sanction.* Inmates in disciplinary segregation are allowed an hour a day out of their cells, as well as showers three times per week. Of course, placing a general population inmate on suicide precautions in segregation and imposing overly restrictive conditions to those precautions is contrary to the standard of care that is summarized above. In addition, the Segregation Unit cells are not "suicide-resistant." Each bed contains iron eye bolts that are utilized for restraints. These bolts also could be used as an anchoring device in a suicide attempt by hanging. Although the ventilation grates do not initially appear hazardous, a grate was utilized as the anchoring device in both the May 2010 suicide of **Case Number 1** and the October 2010 suicide of **Case Number 2**.

The In-Patient Acute Care Unit contains two (2) observation rooms utilized for inmates placed on constant observation status. These rooms are fairly safe, with tall ceilings and few protrusions (with the exception of restraint hooks on the beds). Unlike inmates housed in segregation on suicide precautions, inmate/patients in the Acute Care Unit on precautions are on the mental health caseload and are provided with possessions and showers on a case-by-case basis.

The differences between how an "inmate" on suicide precautions in segregation is treated versus the "patient" on suicide precautions in the Acute Care Unit is striking and easily visualized by reviewing both the WHVCF's Suicide Prevention for Women in General Population (No. 04.06.115)" and "Suicide Prevention - In-Patient Units (No. 04.06.115A)" policies.

In addition, the Residential Treatment Program can be utilized as a transitioning unit for caseload inmates being stepped-down from suicide precautions in the Acute Care Unit. At the time of this writer's January 2011 tour, four (4) observation rooms were being renovated to install sink/toilet combination units. Further, although cells in the Reception and Guidance Center are not utilized to house inmates on suicide precautions, there are numerous safety hazards inside the cells, including window bars, bunk holes, and metal-framed bunks.

Finally, this writer would note that, in addition to the overly restrictive and seemingly punitive aspect of suicide precautions for inmates housed in the Segregation Unit, WHVCF officials and staff have previously discussed charging inmates for medical expenses incurred

from self-injurious behavior. According to the May 25, 2010 Monthly Performance and Improvement Meeting, "....Per PD 03.04.100, inmates may be charged for expenses incurred for self-injurious behavior. In an attempt to decrease frivolous hospital runs, Deputy Warden E____ will be given a statement from Healthcare showing dates and dollar amounts from hospital runs deemed due to self-injurious behavior. Inmate will be taken through the hearings process to determine if billing is appropriate and/or necessary."

The practice of punishing inmates for engaging in self-injurious behavior by charging them for medical expenses reflects both an antiquated and unsupported philosophy. Such a practice is also contrary to national correctional standards and practices. Inmates engage in self-injurious behavior for a multitude of reasons, including to cope with their environment, e.g., it temporarily relieves intense feelings, tension, pressure, anxiety, and anger; as an act of self-punishment in response to feelings of guilt, sexual or violent impulses, low self-esteem; as a way to control and manage pain (unlike the pain experienced through physical or sexual abuse); and to manipulate their environment. As indicated below, it is often difficult for mental health professionals to accurately differentiate between the reason(s) inmates engage in self-injurious behavior, and this writer saw no documentation in the reviewed case files to suggest that WHVCF clinicians even address the issue. Simply stated, punishing inmates for engaging in self-injurious behavior is simply unconscionable.

In sum, it is this writer's opinion that current management of suicidal inmates in the Segregation Unit of the Women's Huron Valley Correctional Facility is overly restrictive and seemingly punitive. Confining a suicidal inmate to her cell for 24 hours a day only enhances

isolation and is anti-therapeutic. Under these conditions, it is also difficult, if not impossible, to accurately gauge the source of an inmate's suicidal ideation. Take, for example, the scenario of a clinician interviewing an inmate on suicide precautions. The inmate has been in the cell for a few days (because clinicians do not always conduct daily assessments), clothed only in a smock. She rarely has been out of the cell that has an incredibly foul odor because the inmate had not showered. The clinician then asks the inmate: "Are you suicidal?" Given the circumstances she finds herself in, the likelihood of a truly suicidal inmate answering affirmatively to that question, the result of which will be her continued placement under these conditions, is highly questionable.

Therefore, it is writer's opinion that the overly restrictive and seemingly punitive environment of suicide precautions within the WHVCF influences an inmate's suicide risk assessment by mental health staff, as well as the suicidal inmate's willingness to self-report suicidal ideation. While WHVCF officials could argue that the conditions of suicide precautions are not intentionally punitive, but rather driven by concern for the safety of the inmate and staff assigned to the housing units, the state's responsibility for safety is not being challenged here. Safety of the inmate is, of course, of utmost concern when developing a suicide prevention program. But the number and types of restrictions imposed in the name of safety must be reasonable and commensurate with the inmate's level of suicide risk.

Officials might also argue that the rationale for these restrictions is that suicidal inmates are unpredictable and bad news received from a family or attorney visit, or from a telephone call, might result in an increased risk for suicide. This rationale, however, ignores the obvious. What

better opportunity is there to observe an inmate's reaction to potentially negative news than when she are on suicide precautions? Further, interaction with the outside world can be therapeutic and reduce isolation -- a leading cause for suicidal behavior. Staff might also argue that most inmates who are mentally ill and on suicide precautions are so debilitated by their illness that "they do not care" how they are treated (i.e., the withholding of basic privileges). Of course, this assumption is not only unsupported but ignores the real possibility that these measures are contributing to an inmate's debilitating mental illness.

In addition, it is often argued that these measures are effective in managing those inmates suspected of being manipulative. As should be discussed during suicide prevention training workshops, manipulative behavior and suicidal behavior, although distinguishable, are not mutually exclusive. Both types of behavior can occur (or overlap) in the same individual and cause serious injury and death. Several studies of self-harm and suicide in the correctional environment have found "substantial co-existence of manipulative motive with both suicidal intent and potentially high lethality of self-harming behavior."[6] As one observer has stated, "There are no reliable bases upon which we can differentiate 'manipulative' suicide attempts posing no threat to the inmate's life from those 'true, non-manipulative' attempts which may end in death. The term 'manipulative' is simply useless in understanding, and destructive in attempting to manage, the suicidal behavior of inmates (or of anybody else)."[7] Self-harm is often a complex, multifaceted behavior, rather than simply manipulative behavior motivated by secondary gain. At a minimum, any inmate who would go to the extreme of threatening suicide

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

or engaging in self-harming behavior is suffering from at least an emotional imbalance that requires special attention. They may also be mentally ill. Simply stated, inmates labeled as manipulative still commit suicide.

CONCLUSION/REMEDY: The state should embark upon an inspection and renovation program to ensure that suicidal inmates are housed in "suicide-resistant" cells, i.e., without any obvious protrusions that would easily enable an inmate to hang themselves. (Specific recommendations regarding the removal of obvious protrusions in cells can be found in the "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities," which is contained in Appendix A of this report.) Second, it is strongly recommended that the state reconsider its decision to use the Segregation Unit to house suicidal inmates that are on general population status. Third, correctional and mental health officials should work collaboratively to revise current practices for the management of suicidal inmates. The new procedures should include, but not be limited to, the following:

- All decisions regarding the removal of an inmate's clothing, bedding, possessions (books, shoes or slippers, 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. *There must be written justification as to why an inmate under constant observations needs to be issued a safety smock*;
- All inmates on suicide precautions shall be allowed all routine privileges (e.g., family visits, showers, telephone calls, recreation, etc.), unless the inmate has lost those privileges as a result of a disciplinary sanction;
- An inmate shall never receive a disciplinary sanction and/or be charged for medical services as a result of engaging in self-injurious behavior; and
- Safety smocks shall never be utilized to deter/punish perceived manipulative 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 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. Suicidal inmates should be assessed by a qualified mental health professional (or medical staff in their absence) on a daily basis. Treatment planning is provided to all inmates placed on suicide precautions for longer than 24 hours.**

Experience has shown that prompt, effective emergency medical service can save lives. Research indicates that the overwhelming majority of suicide attempts in custody is by hanging. 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." In addition, the component of "Levels of Supervision/Management" 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 (pursuant to an individualized treatment plan) following discharge from suicide precautions.

FINDINGS: According to the DOC's *Corrections Mental Health Program Guidelines, Suicide/Self-Injury Risk Assessment and Interventions* (date January 6, 2009)," there are four (4) suicide risk levels: High, Moderate, Intermediate, and Low. *High Risk* is the result of "self-injurious acts, especially if violent, near-lethal, or premeditated, which require emergency medical care." High risk inmates require "direct, continuous observation and a management plan." They are normally housed in the crisis stabilization program and seen by mental health clinicians at least once per day. *Moderate Risk* is the result of "threats of suicide or a serious self injury." These inmates are required to be observed every 15 minutes and have a management plan. They are seen by a mental health clinician every other business day. *Intermediate Risk* is a result of "movement downwards from higher levels of risk and interventions requires a transitional period of intermediate risk and heightened awareness." There is *no* frequency of observation associated with this level. Inmates are seen by a mental health clinician every other business day for one week, then weekly for two additional weeks. *Low Risk* is the result of a "history of suicide attempt or superficial self-injuries for secondary gain but no evidence of suicidal ideation or self-interest behavior in past month." A management plan is not required, and safety precautions are not utilized.

These risk levels, defined behavior, and frequency of observation and intervention by mental health staff are inconsistent with the standard of care, which requires all suicidal inmates to be observed in a range between constant observation and intervals of 10 to 15 minutes, as well as daily assessments by mental health staff.[8] In addition, although WHVCF's "Mentally Ill Women's Prisoners in Segregation" operating procedures (No. 04.06.1982) requires that mental health staff perform daily rounds of the Segregation Unit, not all inmates on suicide precautions in this unit are assessed daily by mental health staff. Given the well known fact that inmates housed in segregation are at increased risk of suicide, the practice of not assessing all suicidal inmates in segregation on a daily basis makes little sense.

An additional concern involves the quality of documentation found in medical charts as it relates to the assessment and treatment of suicide risk. Pursuant to WHVCF's "Suicide Prevention - In-Patient Units" operating procedures (No. 04.06.115A):

> Risk assessment shall be conducted in accordance with suicide/self injurious risk assessment guidelines....A broad view of all risk factors associated with suicidal behavior is important for the clinician to consider during the assessment. However, the most important risk factors for estimating the current and immediate risk are the personal risk factors, including the current mental state that are impacting on the individual's life it is time.
>
> The most important suicide risk factors are how depressed an individual is and whether they have made suicidal plans (as opposed to having passive suicidal thoughts). It is also important to note that a person may not reveal their plans or might try to hide their suicidal intent. Other personal factors include: recent major life events, especially involving loss or humiliation; 'at risk' mental states specially hopelessness, despair, agitation, shame, guilt, anger, psychosis; recent suicide attempt; personality/vulnerability, challenges to dependency, impulsivity.

[8]It should be noted that as a result of several recent suicides, the WHVCF warden initiated an order requiring observation of *all* WHVCF inmates at 15-minute intervals beginning in October 2010. It would be this writer's opinion that, given current staffing levels, the ability of correctional staff to observe all inmates in the WHVCF at 15-minute intervals is dubious, regardless of what correctional officers documented on observation sheets. See pages 43-44 of this report for examples. In April 2011, the directive was modified to require that inmates housed in the Segregation Unit continue to be observed at 15-minute intervals, whereas all other inmates were to be observed at 20-minute intervals.

or staff can take if suicidal thoughts do occur." According to mental health staff that were interviewed, "mental health management plans" are developed for each inmate that is placed on suicide precautions. However, this writer's review of several management plans, as well as the policy on management plans, indicates that these plans are simply a summary of the clinician's recommendations for frequency of observation, applicable restrictions, and frequency of clinical assessment of suicidal inmates. These are *not* treatment plans.

Upon further questioning of mental health staff, this writer was informed that treatment plans are *not* developed for inmates on suicide precautions unless they are housed in the In-Patient Acute Care Unit. Once again, this is an example of the differences between how an "inmate" on suicide precautions in segregation is treated versus the "patient" on suicide precautions in the Acute Care Unit. In fact, WHVCF's "Suicide Prevention - In-Patient Units" operating procedure (04.06.115A) makes a definitional distinction between "comprehensive individual treatment plan" and "management plan." This policy states that:

> "When a decision has been made to discharge an in-patient prisoner who had been treated for suicidality, there are several factors involved in the process. The decision to discharge a person is based upon the treating team's decision that further observation, care, and treatment are no longer necessary in the inpatient setting. Patients who have been at risk of suicide require follow-up and discharge from inpatient. The first 28 days following discharge from the mental health inpatient unit is recognized as a period of elevated suicide risk. Key management principles for this are: assertive follow-up; safety; dealing with triggers or other predisposing or related contributing to risk status; contingency and relapse prevention planning; continuity of service provision; working with the person and their family; consultation with the receiving team. Discharge planning should commence upon admission to an inpatient unit. A discharge summary and management plan must be documented for prisoners at risk of suicide. It must include the rationale for discharge and must be filed in the medical record."

The above narrative provides an adequate description of what treatment planning should entail for an inmate released from suicide precautions. It is consistent with national correctional

standards, including NCCHC standards (P-G-02). Not surprisingly, however, this narrative and treatment planning requirement is *absent* from WHVCF's "Suicide Prevention for Women in General Population" operating procedure (04.06.115) and "Mentally Ill Women Prisoners in Segregation" operating procedure (04.06.182). And as cited in the above case summaries (**Case Number 5** and **Case Number 6**), treatment planning was either grossly inadequate or not addressed at all, even with those inmates that were on the mental health caseload.

Finally, as indicated in several medical files reviewed by this writer, a number of mental health staff at the WHVCF utilize "contracts for safety" in assessing suicidal inmates. There are several problems associated with contracting for safety. First, there are *no* written WHVCF policies and procedures authorizing its use. In fact, the issue is not even addressed in any national correctional standards. Most correctional facilities do not utilize "safety contracts" because they have been found to be ineffective in the management of suicidal individuals. While there may be some positive therapeutic aspects to safety contracts, most clinicians agree that once a patient becomes suicidal, their written or verbal assurances are no longer sufficient to counter suicidal impulses. In addition, most legal experts opine that a no-harm contract is simply a self-serving sheet of paper that does *not* provide a correctional agency or mental health worker with any legal protection. As succinctly stated recently by several clinicians:

> "The contract for safety is an aspect of suicide risk management that has been given too much weight over the past several decades. What appears to have been created primarily as an assessment tool has become a sort of checkbox, detracting from the clinician's own judgment and formulation of risk. It has been taken out of its original context and is now used in virtually any setting, with any type of patient population despite the lack of clinical evidence to prove it is useful and an abundance of literature warning that it is not."[9]

[9]Garvey, K, Penn, J, Campbell, A, Esposito, C, and A. Spirito (2009), "Contracting for Safety With Patients: Clinical Practice and Forensic Implication," *Journal of the American Academy of Psychiatry and the Law*, 37:363-370.

CONCLUSION/REMEDY: The state should utilize only two suicide risk levels and require that suicidal inmates be observed in a range between constant observation and intervals of 10 to 15 minutes, as well as always receive *daily* assessments by mental health staff. Mental health staff should be required to "assess," not simply "see," suicidal inmates on a daily basis, and enter quality progress notes into the mental health section of the inmate's medical record. Suicide risk evaluations must always provide a sufficient description of the current behavior and justification for a particular level of observation and/or discharge from suicide precautions. "Cell-side" assessments should be avoided whenever possible, and justified in writing if utilized. Contracting for safety should be discontinued.

In order to safeguard the continuity of care for suicidal inmates, *all* inmates discharged from suicide precautions should receive regularly scheduled follow-up assessments by mental health staff until their release from custody. As such, unless an inmate's individual circumstances direct otherwise (e.g., an inmate inappropriately placed on suicide precautions by non-mental health staff and released less than 24 hours later following an assessment), it is recommended that the reassessment schedule following discharge from suicide precautions be as follows: within the first 24 hours, then within the next 72 hours, then within the next week, and then periodically until release from custody. Finally, mental health clinicians should develop treatment plans for *all* inmates held on suicide precautions greater than 24 hours, regardless of whether or not they are on the mental health caseload, 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.

6) Intervention

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

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

FINDINGS: According to WHVCF officials, all correctional officers are required to be trained and remain certified in first aid and CPR/AED. This writer received and reviewed

training records that indicated almost all of both uniform (99%) and non-uniform (93%) WHVCF employees, as well as 19 of 21 (90%) of Department of Community Health staff received such training within the past 12 months. In addition, there were emergency rescue kits (containing cut-down tools) on each housing unit toured by this writer, and correctional officers were observed to be carrying pouches on their belts that contained either a microshield or CPR pocket mask, and disposable gloves. There was no indication that "mock drills" were conducted during either the initial or refresher emergency response training for WHVCF staff. In fact, during the file review for **Case Number 3**, correctional staff reported that they tried to initiate CPR on the victim while she was still lying on the top bunk in the cell. This is an incorrect procedure for CPR initiation. CPR is required to be performed on a flat, hard surface (i.e., floor).

CONCLUSION/REMEDY: Although this writer found mostly adequate practices in the area of emergency intervention following a suicide attempt within the WHVCF, 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.

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.

FINDING: Following review of the case files for the four (4) recent inmate suicides, this writer would offer the following opinions. Although the Critical Incident Reports that were completed by staff who were involved in the emergency medical responses documented each officer's knowledge and involvement in the emergency response, the reports did *not* reflect when each victim was last observed alive. In addition, this writer was provided with the investigative reports from the Michigan Department of State Police on each of the four deaths. As previously noted, as a result of several suicides, the WHVCF warden initiated an order requiring observation of *all* WHVCF inmates at 15-minute intervals beginning in October 2010. According to the state police investigation of **Case Number 3** (which occurred after the directive was in place), the inmate was in rigor mortis, an indication she had been dead for several hours. However, the officer wrote a Critical Incident Report, as well as told investigators, that the victim was found hanging at 1:06am and last seen arrive at 12:36am, a span of 30 minutes. This, of course, is not possible for a victim that is in rigor. In **Case Number 4**, which occurred in March 2011while this directive was still in effect, the state police investigation determined that the victim was last observed by her cellmate 26 minutes prior to being found hanging in her cell, as well as last observed by correctional staff between 33 and 43 minutes prior to being found. In both **Case Number 3** and **Case Number 4**, correctional officers who found the victims were operating in violation of the WHVCF Warden's directive for 15-minute observation.

CONCLUSION/REMEDY: This writer was not informed as to whether or not any WHVCF staff were disciplined as a result of the recent inmate suicides and, therefore, would defer opinion regarding any corrective action for individual personnel. However, when writing a Critical Incident Report regarding an inmate's death, it is imperative that staff include the time that the inmate was last observed alive, and that any employee who violates a policy, falsifies a document, and/or impedes an investigation, should be subject to disciplinary action.

8) Follow-up/Morbidity-Mortality Review

Every completed suicide, as well as serious suicide attempt (i.e., incidents 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.

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

FINDINGS: The state Department of Corrections' "Mortality Review" operating procedures (No. 03.04.106), as well as "Mortality Review Outline" and "Mortality Review Worksheet," adequately summarize the required multidisciplinary process for reviewing inmate

suicides. Unfortunately, the effectiveness of the mortality review practices could not be critiqued because legal counsel for the state Department of Corrections refused to allow this writer to review the mortality reviews conducted on the four (4) recent inmate suicides. In addition, it was unclear if the process also included a morbidity review for serious suicide attempts (i.e., incidents requiring outside medical treatment).

In addition, this writer reviewed various quality assurance documents from the Department of Community Health, including the "Corrections Mental Health Program Performance Improvement Plan, 2009 – 2010" and "Corrections Mental Health Program Performance Improvement Plan, 2010 – 2011," as well as the "Corrections Mental Health Program Goals and Objectives, 2009 – 2010" and "Corrections Mental Health Program Goals and Objectives, 2010 – 2011." According to one performance improvement plan document:

> "The Department of Quality Management provides oversight and recommendations for all programs in the CMHP.... The DQM will conduct ongoing monthly and yearly performance reports, quarterly studies and studies as requested by the Program Directors. Results of all audits and surveys are evaluated and recommendations are made to improve performance. Training and resource need recommendations will be offered by the DQM to the director of CMHP as well as the program Directors to be handled at the program level."

To date, this writer was informed that the area of suicide prevention has *not* been included in any performance improvement plan.

CONCLUSION/REMEDY: The area of follow-up: morbidity/mortality review is deferred because, as noted above, this writer was not allowed to review the mortality reviews conducted on the four (4) recent inmate suicides, and it was unclear if the process also included a morbidity review for serious suicide attempts (i.e., incidents requiring outside medical

treatment). However, it is strongly recommended that the Michigan DOC include the area of suicide prevention in any future quality assurance and performance improvement plans.

C. CONCLUSION

It is hoped that the findings and the remedies contained within this report will be of assistance to Women's Huron Valley Correctional Facility officials and staff, as well as other state officials, in improving current suicide prevention policies and practices within the facility. Although numerous deficiencies were found and remedies offered in this report, this writer sensed that there were WHVCF personnel who seemed genuinely concerned about the steady increase in inmate suicides within the facility and committed to taking action to both correct existing deficiencies, some of which are inherently dangerous and harmful, and to work toward reducing the opportunity for inmate suicide in the future.

Respectfully Submitted By:

s/s Lindsay M. Hayes
Lindsay M. Hayes

June 9, 2011

APPENDIX A

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

Lindsay M. Hayes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10) Cells should have a smoke detector mounted flush in the ceiling, with an audible alarm at the control desk. Some cells have a security screening mesh to protect the smoke detector from vandalism. The protective coverings should be high enough to be outside the reach of an inmate and far enough away from the toilet so that the fixture could not be used as a ladder to access the smoke detector and screen. Ceiling height for new construction should be 10 feet to make such a reasonable accommodation. Existing facilities with lower ceilings should carefully select the protective device to make sure it can not be tampered with, or have mesh openings large enough to thread a noose through.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTE: A portion of this checklist was originally derived from R. Atlas (1989), "Reducing the Opportunity for Inmate Suicide: A Design Guide," *Psychiatric Quarterly*, 60 (2): 161-171: Additions and modifications were made by Lindsay M. Hayes, and updated by Randall Atlas, Ph.D., a registered architect. See also Hayes, L.M. (2003), "Suicide Prevention and "Protrusion-Free Design of Correctional Facilities," *Jail Suicide/Mental Health Update*, 12 (3): 1-5. Last revised in March 2011.