SUICIDE PREVENTION IN CUSTODY pdf

1: Suicide Prevention | NCIA

Suicide continues to be a leading cause of death within jails, prisons and juvenile facilities throughout the country. Since , landmark studies from NCIA's Suicide Prevention in Custody Services have found that the suicide rate in county jails is several times greater than that of the general population, while the suicide rate in prisons remains slightly higher than in the community.

Reflections and Next Steps [1] by Lindsay M. Hayes Abstract Data from a recent national study of inmate suicides indicates that the suicide rate in county jails throughout the United States has steadily decreased. Despite this progress, the author argues that rather than developing and maintaining comprehensive policies and practices, policymakers and correctional administrators appear preoccupied with the notion that suicides can only be prevented when inmates are on suicide precautions. Measures such as closed-circuit television monitoring, suicide-resistant jail cells, safety smocks, and new technology are popular tools to keep certain inmates safe. There is more to suicide prevention than simply observing suicidal inmates and waiting for them to attempt suicide. The author argues that suicides are prevented and suicide rates reduced when correctional facilities provide a comprehensive array of programming that identifies suicidal inmates who are otherwise difficult to identify, ensures their safety on suicide precautions, and provides a continuity of care throughout confinement. Perhaps the most significant finding was that the suicide rate in detention facilities throughout United States has been substantially reduced during the past 20 years, dropping from county jails suicides per , inmates in to 38 suicides per , inmates in Hayes ; There may be several explanations for this reduced suicide rate, including the fact that national studies of jail suicide conducted over this time period gave a face to this long-standing and often ignored public health issue, recurring research has been incorporated into suicide prevention training curricula, increased awareness about the problem of suicide among jail inmates is now reflected in national correctional standards that advocate comprehensive suicide prevention programming, and inmate suicide litigation has persuaded or forced counties and facility administrators to take corrective action in reducing the opportunity for future deaths. A review of many suicide prevention policies will find a disproportionate amount of narrative regarding the conditions of a suicide precautions, i. More times than not, correctional, medical, and mental health personnel do a fine job of safely managing inmates identified as suicidal and placed on precautions. After all, few inmates successfully commit suicide while on suicide precautions Hayes The correctional field has long been obsessed with trying to thwart suicide attempts and manage suicidal inmates with technology and short-sighted responses. Back in , I received correspondence from a police officer who fancied himself as the inventor of a system of placing a series of sensory strips on the floor and bed of the jail cell. With the weight off the floor, the sensory strips would trigger an alarm in the main control station of the jail. Although this young inventor obtained a patent, [2] his discovery literally never got off the ground presumably because many inmates were found to commit suicide by hanging in either the standing or sitting position on the floor Hayes ; More recently, I received correspondence from a research professor who was looking to patent a device that an inmate would wear as an earpiece on suicide precautions to monitor their pulse and oxygen level. Of course, if the inmate simply removed the earpiece, an alarm would presumably go off and an emergency response would also be called. Safety smocks and blankets, made of heavy nylon fabric that is very heavy and difficult to tear, have become standard issue for suicidal inmates in correctional facilities throughout the country. The mental health director of a large county jail once called to ask who sold the best safety smock on the market? A particular manufacturer once claimed to be in the final design stage of a line of anti-suicide underwear. Fiberglass-molded bunks in these cells have rounded edges and no tie-off points. Clothing hooks are now collapsible and towel racks, sinks, radiator vents have been modified to reduce their use as anchoring devices for hanging Atlas Used predominantly in jail and prison facilities that choose not to provide a constant observation option for inmates at high risk for suicide, closed-circuit television CCTV has become a popular, although deadly form of inmate supervision i. Similarly, the use of inmate companions to observe other inmates on suicide precautions has also become popular in some jurisdictions throughout the country struggling with overtime budgets, although national

correctional standards advocate that their use should only be a supplement to, and not a substitute for, correctional officer monitoring National Commission on Correctional Health Care In addition, mental health clinicians often develop contracts with suicidal inmates, seeking assurances that their patients will not engage in self-injurious behavior as a condition of discharge from suicide precautions. Correctional agencies might, in turn, request that each incoming inmate sign a standard letter as an apparent shield against liability. Of course, although there may be many positive therapeutic aspects to no-harm contracts, most experts agree that once an inmate comes acutely suicidal the written or verbal assurances are no longer sufficient to counter suicidal impulses Garvey et al Similar to the argument that use of CCTV or inmate companions can alleviate correctional staff responsibilities for suicide precautions, a research arm National Institute of Justice of the U. Alarms are activated when the system detects suspicious changes in heart rate, breathing rate or body motion that are typically found when an inmate is engaging in a suicide attempt. Suicide-resistant architecture and other environmental safeguards are critically important to ensuring the safety of individuals housed in correctional facilities and other settings see, for example, Watts et al However, what inmate companions, CCTV, contracting for safety, range controlled radar systems, pulse oximetry, and anti-suicide products all have in common is the further separation of correctional, medical, and mental health personnel from the inmate that has already been identified as suicidal. These quick-fix responses also have little to do with the most important aspects of suicide prevention: When an inmate self-reports suicidal ideation, the system easily responds appropriately: What we continue to struggle with is the ability to prevent the suicide of an inmate who is not on suicide precautions. These are inmates that might not be easily identifiable as being at risk for self-harm. These are inmates that emphatically deny they are suicidal, they may even contract for safety, but their actions and history suggest otherwise. These are inmates who are not on suicide precautions, but should be. With this in mind, several guidelines for better identification and management of suicidal inmates are offered. Recent research found that less than a quarter of all inmates who committed suicide were dead within the first 24 hours of confinement, and half were dead between two days if four months of confinement Hayes The availability of better screening to identify suicide risk during the initial booking process, coupled with increased staff awareness and emphasize on the first few hours of confinement as a high risk period for suicide was probably responsible for this changing pattern. As such, the assessment of suicide risk should not be viewed as a single opportunity at intake, but as an on-going process. Because an inmate may become suicidal at any point during confinement, suicide prevention should begin at the point of arrest or transfer to the correctional facility and continue until the inmate is released. We should be creating more opportunities to gather information, as well as periodically assess inmates at risk. So, for example, there should be a formalized process by which intake staff ask arresting or transporting officers whether the newly arrived inmate is at risk for suicide, as well as a determination as to whether the inmate had been on suicide precautions during a previous confinement in the facility. Once an inmate has been successfully managed on, and discharged from, suicide precautions, they should remain on a mental health caseload and assessed periodically until release pursuant to a thoughtful treatment plan. Following an inmate suicide, it is not unusual for the mortality review process to focus exclusively upon whether the victim threatened suicide during the initial intake stage, a time period that could be far removed from the date of suicide. If the victim had answered in the negative to suicide risk during intake, there is often a sense of relief expressed by participants of the mortality review process, as well as a misguided conclusion that the death was not preventable. Most suicide prevention policies are heavy on explaining the intake screening process, but light on most of the other critical areas of identification. In addition to early stages of confinement, many suicides occur in close proximity to a court hearing. We must begin to devise ways to be more attentive to this risk period. In another, inmates arrested for murder, domestic violence, or child molestation receive similar scrutiny. Some jurisdictions add a secondary layer of assessment for inmates charged in highly publicized cases. One effective prevention strategy is to create more interaction between inmates and correctional, medical and mental health personnel in these housing areas by: Few, if any, correctional policies address the identification of mental illness and suicide risk during confinement, but the need to. The most common reason might be they are committed to ending their life and do not want to be stopped. For others, however, they might be unable or unwilling to articulate their thoughts, or the lack of

privacy offered when the questions are asked, or the manner in which the questions are asked, or fear of being ostracized by other inmates, or the perceived punitive aspects of suicide precautions. Take, for example, the inmate who is on suicide precautions for attempting suicide the previous day. He is now naked in a cell with only a suicide smock, given finger foods, and on lockdown status. The mental health clinician approaches the cell and asks the inmate through the food slot within hearing distance of others on the cellblock: Can you contract for safety? How would any of us respond? It is not all that surprising that some preventable deaths often escape our detection. The booking area of any jail is traditionally both chaotic and noisy; an environment where staff feel pressure to process a high number of arrestees in a short period of time. Two key ingredients for identifying suicidal behavior â€" time and privacy â€" are at a minimum. The ability to carefully assess the potential for suicide by asking the inmate a series of questions, interpreting their responses including gauging the truthfulness of their denial of suicide risk , and observing their behavior is greatly compromised by an impersonal environment that lends itself to something quite the opposite. As a result, the clearly suicidal behavior of many arrestees, as well as circumstances that may lend themselves to potential self-injury, are lost. In another example, a suicidal inmate sent to the local hospital for an assessment may appear to be stable in front of an emergency room physician, even deny suicide risk, only to be discharged from hospital and returned to jail where they again revert to the same self-injurious behavior that prompted the initial referral. Given such a scenario, healthcare and correctional staff should not assume that the hospital was cognizant or even appreciative of this cyclical behavior. Simply stated, correctional staff, as well as medical and mental health personnel, cannot detect, make an assessment, nor prevent a suicide for which they have little, if any, useful training. All suicide prevention training must be meaningful, i. Training should not be scheduled to simply comply with an accreditation standard. A workshop that is limited to an antiquated videotape or DVD, or the reciting of current policies and procedures, might demonstrate compliance albeit wrongly with an accreditation standard, but is not meaningful, nor helpful, to the goal of reducing inmate suicides. The topic of suicide prevention is one that is best provided in a live, interactive environment amongst correctional, mental health, and medical personnel. Suicide prevention is all about collaboration, and training that is reduced to an individual sitting alone and watching a DVD or webinar-based workshop or e-learning instruction on a desktop screen has questionable value. In reviewing a litigation case recently, I came across this rather interesting deposition testimony. You have to, like, judge that person when they come inâ€¦. Should he always be treated as a suicidal person for the rest of his life? For example, if an acutely suicidal inmate requires continuous, uninterrupted observation from staff, they should not be monitored only by CCTV simply because that is the option jail officials choose to offer. I was conducting an assessment of a county jail a few years ago and, while interviewing a mental health clinician, the telephone rang. It was the head nurse. Apparently a female detainee had just arrived into the clinic from booking. During booking, the intake nurse had scored the inmate high on a suicide risk screening form for loss of relationship, psychiatric history, drug history, displaying signs of depression, anger, incoherence, and inability to focus. Now the head nurse was calling to ask the mental health clinician to assess and basically clear the detainee from the clinic. I followed the clinician to the clinic and came upon a female detainee sitting in a chair surrounded by the head nurse and several officers. The detainee was barely conscious, appeared incoherent, and should not even have received medical clearance into the facility without a thorough examination. In any event, the clinician tried to talk to the detainee, but it was pointless. She could not respond to any questions and had to be held up from falling off the chair. The clinician clearly could not conduct the assessment and told the head nurse that the detainee would need to be placed on suicide precautions until such time as she could be interviewed. The clinician and I returned to her office. My interview continued until there was a knock on the door. It was the shift supervisor who wondered aloud how long it would take to assess the detainee. In other words, how long would an officer need to be assigned to provide constant observation? The clinician calmly responded that the assessment could not be conducted until the detainee became coherent and could understand the screening questions. The supervisor thought about it for a moment, glanced at me, then departed. The interview continued again for a few minutes until the telephone rang. This time it was the jail commander. I only heard half of the conversation, but it seemed to be of similar content to that of the shift supervisor. Again the clinician

responded politely that the assessment would occur only when the detainee was coherent enough to understand the questions. The telephone conversation ended and my interview continued.

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2: Suicide Prevention in Custody Staff | NCIA

Suicide prevention in custody This landing page for National Center on Institutions and Alternatives' (NCIA) Suicide Prevention in Custody provides access to curricula and other publications as well as other services provided through the NCIA.

This article has been cited by other articles in PMC. Studies conducted in several countries have found an increase in suicide rates in custody than the general population. The aim was to assess the trends of suicide in custody and to identify characteristics. We examined all available files of the death of people in custody through to Information collected included age, sex, type of custody, place of death, presence of any associated disease, history of any psychiatric illness, substance abuse, and cause of death. A total autopsies was performed out of which 14 cases were of suicide. The mean age was Hanging was the common method of suicide followed by poisoning. Suicide in custodial setting is preventable problem in India. Preventing suicide in custody needs cooperation and coordination from various agencies. When such death is unnatural one then the ramifications are wide and ranged from violation of human rights to torture and causing death. Suicide in custody is a well-established problem. Studies conducted in several countries have found an increase in suicide rates in custody over the last five decades. However, for this purpose updated data of mortality pattern in custody are required. Considering India, such data are lacking. The present study was undertaken to assess the trends of suicide in custody and to identify characteristics that can be utilized to prevent such deaths. We examined all available files of inquest papers, autopsy reports, toxicological analysis reports, histopathology reports, and case papers into the death of people in custody through to A standard proforma was designed to collect the information to ensure consistency for the whole sample. Only deaths due to suicide, confirmed after investigation and evaluation of circumstances, were included in the study. The year-wise distribution of the custodial death and suicide is presented in Figure 1.

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3: Suicide Prevention in Custody: Self-instructional Course - Joseph R. Rowan - Google Books

Lindsay M. Hayes is a Project Director of the National Center on Institutions and Alternatives, with an office in Mansfield, Massachusetts. He is nationally recognized as an expert in the field of suicide prevention within jails, prisons and juvenile facilities.

Hayes was able to identify problems and offer realistic solutions. His people skills and subject matter knowledge were first-rate. We are taking the first step in the process by establishing a new suicide prevention program. Once this is accomplished we will be seeking Mr. All staff who come into contact with inmates, including correctional, medical, and mental health personnel, should receive basic and recurring suicide prevention training. Seminars typically encompass eight 8 hours of instruction on all aspects of suicide prevention in correctional facilities including, but not limited to, negative attitudes and obstacles to prevention, 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, guiding principles to suicide prevention, components of an effective suicide prevention policy, mortality reviews, and liability issues. Hayes was well-informed and had his information well organized. He was very articulate, knowledgeable, and managed the time well for the amount of material that was presented. The whole training workshop was excellent. Hayes has consulted in hundreds of jail, prison, and juvenile suicide litigation cases throughout the country, and has been qualified as an expert in both state and federal court. In addition, he has been appointed as a federal court monitor, as well as assisted in the development and implementation of suicide prevention policies in correctional systems under court jurisdiction. One of the reasons my case did not go to trial was because the Plaintiffs became extremely reasonable in their settlement demand in the face of Mr. I would not hesitate to call upon him again when the need arises. His expertise in jail suicides, along with his willingness to answer my questions and lead us in the right direction, were immeasurably significant to the cases. He provided valuable information which assisted me in preparing my defense, resulting in a favorable resolution of the case. I would not hesitate to utilize him again. Hayes did an excellent job at trial in a very difficult case. The jury certainly listened to his testimony and fully accepted his opinion that our case involved a preventable suicide. I would certainly highly recommend Mr. Hayes to anyone who needs the preeminent expert in the field. Hayes in identifying potential areas of liability and defenses to that exposure were of invaluable assistance to me in successfully representing my client. Should I ever be faced with the difficult task of defending a jail suicide lawsuit in the future, the first person I would reach out to would be Mr. Hayes at lhayesta msn.

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4: Suicide Prevention in Correctional Facilities: Reflections and Next Steps | NCIA

The key to any suicide prevention program is staff training - which is also a highly effective shield against liability. All staff who come into contact with inmates, including correctional, medical, and mental health personnel, should receive basic and recurring suicide prevention training.

Messenger Getting released from prison or police custody can be a huge shock to those who have been incarcerated. Our new research gives an indication of just how vulnerable these people can be. We found that over a seven-year period, people died of a suspected suicide within 48 hours of leaving police detention. The number of people dying in prisons and in police custody has been increasing for several years. There is, rightly, a statutory obligation for every death that occurs within a state institution to be investigated by an independent body. But for people who die shortly after release from police or prison custody, their deaths are not subject to statutory investigation and are too often invisible. A dangerous transition Our research, published by the Equality and Human Rights Commission , looked into non-natural deaths of people who have been released from police detention or prison custody. We found that the data on these deaths is contingent upon the relevant institutions prisons, police or probation finding out about the death in the first place â€" and this can be difficult. We examined two sets of data: IPCC data on suspected suicides that occurred within 48 hours of release from police detention and data from the National Offender Management Service on deaths of people under probation supervision, which includes those released from prison. We also conducted interviews with 15 custody sergeants â€" police officers who are responsible for the welfare of a detainee while in a police station â€" prison officers and others such as representatives of police and crime commissioners PCCs and Public Health England. The IPCC data suggest that people died between and of a suspected suicide within 48 hours of release, although this number declined between the years and , as the graph below shows. We also examined a selection of 41 investigations and summaries of investigations into apparent post-release suicides that were provided to us by the IPCC. Half of these people had pre-existing mental health conditions. These referrals also pointed to inadequate risk assessment, record keeping and onward referral to relevant community-based care providers such as mental health or drug treatment providers. We then looked at deaths that had occurred within 28 days of release from prison. Despite some issues with the accuracy and completeness of the data, we identified 66 people between and who had died from non-natural causes within 28 days of leaving prison. The numbers are small and so it is difficult to draw wider conclusions, but we found that 44 of those 66 died from a drug-related death. Of the 66, 35 had served a sentence for an acquisitive offence such as theft, shoplifting or robbery, offences which are commonly associated with drug use. We also analysed investigations conducted between and by the PPO into deaths that occurred in approved premises, also known as bail hostels, within 28 days of release from custody. These investigations seek to understand what, if anything, could have been done to prevent the death. This highlighted problems with supporting drug-using offenders, a lack of confidence among staff and a failure to create a smooth transition from prison into the community. Staff under strain These analyses only tell part of the story. Our discussions with custody officers painted a complex picture. They argued that they were getting better at identifying people in custody with mental health conditions but that their ability to deal with them effectively was restricted by factors beyond their control such as a lack of appropriate treatment for people after leaving their care and an inadequate number of beds in mental health hospitals. They told us that the risk assessment tool they use for identifying such people was not fit for purpose because it did not go into enough detail and that they would benefit from additional mental health training. They were also strongly in favour of the responsibility for healthcare commissioning in police stations being handed to the NHS, rather than PCCs, a proposal which was dropped in December The story from prison staff was similar, but they also talked about the use of new psychoactive substances and the negative effects these substances are having on mental health and safety in the prison. Problems also exist when it comes to the provision of community-based care after people are released. Such reforms have made communication between prisons and probation providers more difficult. These budget cuts and public sector reforms are having a serious impact on the ability of criminal justice

agencies to deal with these issues and prevent any future deaths. There needs to be an improvement in the way in which data on non-natural deaths is collected. Deaths post-detention should also be subject to similar levels of investigation as those that occur in police custody and prison. It would be naive to suggest that all deaths of people leaving state detention can be investigated, but there is scope for more oversight from both the IPCC and PPO, at least while they are adjusting to life back in the community. At the same time, the government must maintain investment in mental health and drug services to help prevent those most vulnerable when they are released from detention from taking their own life.

5: Suicide behind bars: A year retrospective study

NCYC/NPJS Suicide Prevention 2/15 2 The NCYC/NPJS Youth Care Curriculum Series is made up of a collection of modules designed to develop or enhance the skills and knowledge of those working with youth in.

6: Suicide Prevention in Custody Services | NCIA

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7: Item Detail - Suicide Prevention in Custody DVD

adequate suicide prevention and intervention services is both beneficial to the prisoners in custody, as well as to the institution in which the services are offered.

8: The criminal justice system is failing to prevent suicides among people released from custody

The current prison suicide prevention policy aims to monitor risk and plan the care of at-risk individuals using the Assessment, Care in Custody, Teamwork (ACCT) plan.

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