SUICIDE PREVENTION AND INTERVENTION

Standard

Suicides are prevented when possible by implementing prevention efforts and intervention.

Compliance Indicators

1. The responsible health authority and facility administrator approve the facility's suicide prevention program.
2. A suicide prevention program includes the following:
   a. Facility staff identify suicidal inmates and immediately initiate precautions.
   b. Suicidal inmates are evaluated promptly by the designated health professional, who directs the intervention and ensures follow-up as needed.
   c. Acutely suicidal inmates are monitored by facility staff via constant observation.
   d. Nonacutely suicidal inmates are monitored by facility staff at unpredictable intervals with no more than 15 minutes between checks.
3. The use of other inmates in any way (e.g., companions, suicide-prevention aides) is not a substitute for staff supervision.
4. Treatment plans addressing suicidal ideation and its reoccurrence are developed.
5. Patient follow-up occurs as clinically indicated.
6. All aspects of the standard are addressed by written policy and defined procedures.

Definitions

Acutely suicidal (active) inmates are those who are actively engaging in self-injurious behavior and/or threaten suicide with a specific plan.

Nonacutely suicidal (potential or inactive) inmates are those who express current suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or have a recent history of self-destructive behavior.

Discussion

Although many suicides are unpredictable, a suicide prevention program can help reduce risks. Inmates may become suicidal at any point during their stay, but high-risk periods include the following:
   a. Upon admission (e.g., 2 to 14 days following incarceration)
   b. Following new legal problems (e.g., within 48 hours of a court appearance, new charges, additional sentences, institutional proceedings, denial of parole)
   c. After admittance to segregation or single-cell housing
   d. After the receipt of bad news regarding self or family (e.g., serious illness, the loss of a loved one)
e. After suffering humiliation (e.g., sexual assault) or rejection
f. Pending release after a long period of incarceration

In addition, juveniles in an adult correctional setting and inmates in the early stages of recovery from severe depression may be at risk.

A treatment plan should be developed or revised for any inmate expressing suicidal ideation. This treatment plan should be developed by the mental health staff in conjunction with the patient to address relapse prevention and initiate a risk management plan. The risk management plan should 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.

Key components of a suicide prevention program include the following:

a. Training. 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 annual training is provided.

b. Identification. The receiving screening form contains observation and interview items related to potential suicide risk. If a staff member identifies someone who is potentially suicidal, the inmate is placed on suicide precautions and is referred immediately to mental health staff (see E-02 Receiving Screening).

c. Referral. There are procedures for referring potentially suicidal inmates and those who have attempted suicide to qualified mental health professionals or facilities. The procedures specify a time frame for response to the referral.

d. Evaluation. An evaluation, conducted by a qualified mental health professional, determines the level of suicide risk, level of supervision needed, and need for transfer to an inpatient mental health facility or program. Patients are reassessed regularly to identify any change in condition indicating a need for a change in supervision level or required transfer or commitment. The evaluation includes procedures for periodic follow-up assessment after the individual’s discharge from suicide precautions.

e. Treatment. Strategies and services to address the underlying reasons (e.g., depression, auditory commands) for the inmate’s suicidal ideation are to be considered. The strategies include treatment needs when the patient is at heightened risk for suicide as well as follow-up treatment interventions and monitoring strategies to reduce the likelihood of relapse.

f. Housing. Unless constant supervision is maintained, a suicidal inmate is not isolated but is housed in the general population, mental health unit, or medical infirmary and located in close proximity to staff. All cells or rooms housing suicidal inmates are as suicide-resistant as possible (e.g., without protrusions that would enable hanging).

g. Monitoring. There are procedures for monitoring an inmate identified as nonacutely suicidal. Unpredictable, documented supervision is maintained, with
irregular intervals no more than 15 minutes apart. Although several protocols exist for monitoring suicidal inmates, when an acutely suicidal inmate is housed alone in a room, continuous monitoring by staff should be maintained. Other supervision aids (e.g., closed circuit television, inmate companions or watchers) can supplement, but never substitute for, direct staff monitoring.

h. Communication. Procedures for communication between mental health, medical, and correctional personnel regarding inmate status are in place to provide clear and current information. These procedures include communication between transferring authorities (e.g., county facility, medical/psychiatric facility) and facility correctional personnel.

i. Intervention. There are procedures addressing how to handle a suicide attempt in progress, including appropriate first-aid measures.

j. Notification. Procedures state when correctional administrators, outside authorities, and family members are notified of attempted or completed suicides.

k. Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides are detailed, as are procedures for reporting a completed suicide.

l. Review. There are procedures for mental health, medical, and administrative review, including a psychological autopsy, for completed suicides. For details, see A-09 Procedure in the Event of an Inmate Death.

m. Debriefing. There are procedures for offering timely debriefing to all affected personnel and inmates. Debriefing is a process whereby individuals are given an opportunity to express their thoughts and feelings about an incident (e.g., suicide or attempt), develop an understanding of stress symptoms resulting from the incident, and develop ways to deal with those symptoms. Debriefing can be done by an in-house response team or outside consultants prepared to handle these highly stressful situations.

An active approach to the management of suicidal inmates is recommended. In facilities where 24-hour mental health staff coverage is not present, designated health and/or custody staff should be able to initiate suicide precautions until the qualified mental health professional on call can be contacted for further orders. Only designated qualified mental health professionals should be authorized to remove an inmate from suicide precautionary measures.

A suicide or suicide attempt can be a stressful event for staff and other inmates. Where feasible, persons trained in debriefing procedures should be used. Practical guidelines on the debriefing process are available from organizations such as the International Critical Incident Stress Foundation.