



Controversial Issues in Suicide Prevention

by Lindsay M. Hayes, MA

What anti-suicide interventions have in common is the further separation of correctional, medical and mental health staff from the inmate

Suicide continues to be one of the leading causes of death in our nation's jails. Although the rate of suicide has substantially declined since the 1980s, it remains a sizable public health problem. In the quest to prevent suicides, various interventions sometimes spark controversy—either because of their unconventional nature, quick-fix philosophy or concern for liability. Offered below is a sampling of several controversial approaches found in the area of inmate suicide.

Suicide Precautions Are Often Overly Restrictive and Seemingly Punitive

In many ways, the conditions for inmates placed on suicide precaution are harsher than for those on segregation status. It is not uncommon for suicidal inmates to be locked down in their cell, clothed only in a safety smock. Yet confining suicidal inmates to their cell for up to 24 hours a day only enhances isolation and is anti-therapeutic. Limiting their clothing to only a safety smock is not always necessary.

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 locked down for a day or two, with no access to a shower, mattress, reading materials, telephone/visiting privileges or any out-of-cell activities. The clinician approaches

the inmate cellside and asks, "Are you suicidal?" Given the circumstances, the likelihood of an inmate answering affirmatively is highly questionable, since the result will be continued placement under these conditions.

Recent research suggests that suicidal inmates are often reluctant to discuss their suicidal thoughts because of the likelihood of being exposed to the harsh conditions of suicide precautions, with the vast majority (75%) of inmates reporting that they did not want to be transferred to an observation cell. According to the authors:

"Possible reasons inmates dislike observation cells are numerous. For GP patients they can suffer taunting from other inmates with the identification of being in a mental health crisis after they return from the OB (observation). Further, an inmate-patient is removed from his more familiar surroundings of a single cell with his books, writing material, and own clothes, and his normal routine of recreation and work assignment. In the OB he often can no longer wear his clothes, and books and recreation are limited. In an OB cell a patient often is dressed in a special gown and the room may only contain a special mattress. Privacy is limited, since often all four sides of the OB are available for observation whereas in his own cell only one side is open for observation. Finally, admission in an OB can create anxiety and fear for the patient as it may be an unknown environment, and because the OB is the place the psy-

chiatrists decide if patient is to be involuntarily transferred to the distant inpatient unit.” (Way et al., 2013)

These conclusions were illustrated in a 2016 investigative report in *The Boston Globe*: “At times, Nick contemplated death himself. But he learned to avoid being placed on suicide watch, which meant isolation in a dark and filthy cell, without pen or paper, soap or socks, he said. Sometimes his ‘brain felt sick,’ but he kept quiet: ‘If you say you’re hurting, they’ll punish you for it,’ he said.”

Several years ago I was investigating suicide prevention precautions in a county jail. Both the sheriff and medical director separately boasted that their jail had not had a suicide in several years because they housed their suicidal inmates in small booking cages. Inmates called them “squirrel cages.” To me, the cage closely resembled a telephone booth made of sturdy chain-link fencing, measuring approximately 3 by 3 feet in diameter and 7 feet in height.

It was not uncommon for an inmate to be placed in these cages for more than 24 hours. Several inmates who had been placed in these cages on suicide precautions were interviewed. Most confided that they were still experiencing suicidal ideation, but refused to self-report their ideation to staff for fear of being placed back in these cages. An extreme example? Yes, but, the point remains: If we treat suicidal inmates with punitive or overly restrictive measures, we run the risk of creating barriers to mental health services.

Many correctional and mental health professionals have told me that the conditions of suicide precautions were not intentionally punitive, but driven by concern for the safety of the inmate. The commitment to safety was not being challenged here. Safety of the inmate is, of course, of utmost concern when developing a suicide prevention policy. But the number and types of restrictions (e.g., overreliance on safety smocks, denying visitation and telephone privileges) imposed in the name of safety must be reasonable and commensurate with the inmate’s level of suicide risk.

Officials have often argued that the rationale for these restrictions was that suicidal inmates were unpredictable and bad news received during a family visit or telephone call might trigger suicidal ideation and 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 he is on suicide precautions? Interaction with the outside world also can be therapeutic and reduce isolation, which is a leading cause of suicidal behavior.

I have occasionally been told that most inmates who were mentally ill and on suicide precautions were so debilitated by their illness that “they did not care” how they were treated (i.e., the withholding of basic privileges). This assumption was not only unsupported but ignored the real possibility that these measures were contributing to an inmate’s debilitating mental illness.

Of course, it is often argued that these highly restrictive measures are effective in managing or “weeding out” those inmates suspected of being manipulative or malingering. As should be discussed during suicide prevention training workshops, although distinguishable, manipulative behavior and suicidal behavior are not mutually exclusive. Both types

of behavior could occur (or overlap) in the same individual and cause serious injury and death.

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

Contracting for Safety

Invariably I come upon a correctional facility that has a “no-harm” contract embedded into its intake screening form. The contract might read, “I promise not to harm myself while confined at the Smith County Detention Center. If I should have any tendency to harm myself, I will immediately alert the staff.”

There are several problems associated with contracting for safety. First, most correctional systems do not have any written policies and procedures authorizing its use. In fact, the issue is not even addressed in NCCHC and national correctional standards. Most systems do not use no-harm contracts because they have been found to be ineffective in the management of suicidal individuals. While there may be some positive therapeutic aspects to contracting for safety, most clinicians agree that once a patient becomes suicidal, her 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 an agency or mental health clinician with any legal protection. As succinctly stated 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.” (Garvey et al., 2009)

Pulse Oximetry and Other Anti-Suicide Technology

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 1986, 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. The system operated on the principle of “weight off,” in which an inmate confined to his cell, but not laying on his bunk or standing on the floor, would presumably be hanging from a ligature off the floor. With the weight off the floor,

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the sensory strips would trigger an alarm in the jail's main control station. Although this inventor obtained a patent, his discovery literally never got off the ground, presumably because many inmates were found to commit suicide by hanging in the standing or sitting position on the floor.

More recently, I received correspondence from a research professor seeking to patent a device that an inmate on suicide precautions would wear as an earpiece to monitor pulse and oxygen level. If the vital signs were detected as being outside the normal range, an alarm would presumably go off and an emergency response would be called. Of course, if the inmate simply removed the earpiece, an alarm would presumably go off and an emergency response would be called. This pulse oximetry technology has been used in a psychiatric setting for restrained patients.

Similar to the argument that use of closed-circuit television monitoring or inmate companions can alleviate correctional staff responsibilities for suicide precautions, a research arm (National Institute of Justice) of the U.S. Department of Justice funded an evaluation of equipment that can measure an inmate's heart rate, breathing rate and body motions. A wall-mounted range-controlled radar system, originally designed for home security motion detectors, measures subtle motions on the body's surface caused by heart and lung activity. Alarms are activated when the system detects suspicious changes that are typically found when an inmate is engaging in a suicide attempt. In a 2012 program bulletin, the NIJ acknowledged a declining inmate

suicide rate, but complained that "it remains a troubling problem and traditional suicide watch requires dedicated staffing, taking officers away from other duties," suggesting that there are other more important duties than keeping inmates safe from themselves.

What range-controlled radar systems, pulse oximetry and other anti-suicide technology all have in common is the further separation of correctional, medical and mental health personnel from the inmate who has been placed on suicide precautions. And because very few inmates commit suicide while on suicide precautions, and these gadgets would normally be deployed only after an inmate has been placed on suicide precautions, their use would have no effect on suicide prevention. These quick-fix responses also have little to do with the most important aspects of suicide prevention: how we identify the suicidal inmate who is not easily identifiable.

Rating Scales

Some facilities use a numerical scale to rate signs and symptoms of potential suicidal behavior. The sum of points corresponds with a risk level (e.g., "low, medium or high"; "caution or warning") and an inmate is either placed on suicide precautions or not based on this rating. One scale even equates "manipulative behavior" with "low" suicide risk.

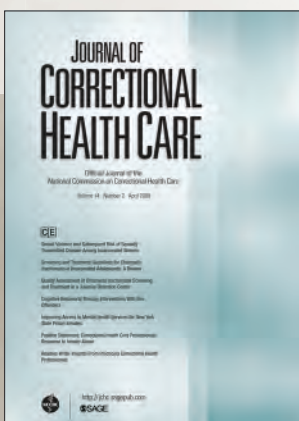
Most experts are suspicious of this approach, stressing that no rating scale is skillful enough to precisely determine levels of potential lethality. This approach also violates the principle that all threats of suicide and self-injurious behavior, expression of ideation and so forth, must be taken seriously. Does one rate the ninth "crying wolf" the same as the first? Lawsuits are brought because an individual's so-called "manipulation" was not taken seriously. Finally, while many of these rating scale forms are popular, and even validated, for community use, they lack the sensitivity to identify risk factors specific to the correctional environment (e.g., sex offense, safety concerns, disciplinary sanctions). It is generally recommended that correctional facilities allow their staff wide discretion in referring all potentially suicidal inmates (and not just those meeting rating scale criteria) to a qualified mental health professional for a comprehensive suicide risk assessment.

Conclusion

While some may argue that overly restrictive suicide precaution measures, contracting for safety, anti-suicide technology and rating scales are nothing more than typical controversial issues in suicide prevention, they are arguably also examples of interventions that further separate staff (correctional, mental health and medical) from suicidal inmates.

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