DOWNLOAD PDF SUICIDE PREVENTION AND DESIGNING SAFER PRISON CELLS LINDSAY M. HAYES

Chapter 1 : CDCR Tried to Conceal Report on Prisoner Suicides | Prison Legal News

Suicide prevention and designing safer prison cells / Lindsay M. Hayes Self-harm of juvenile and young adult prison inmates: conditions and consequences / Werner Greve, Daniela Hosser, and Christiane Bosold.

Preventing Crisis ; Vol. Dear4, Patrick Frottier5, Lindsay M. In there are new epidemiological data on prison suicide, a more detailed discussion of risk factors accounting for the generally higher rate of suicide in correctional settings in comparison to the general population, and several strategies for developing screening instruments. A second paper, by the same Task Force, will present some international comparisons of suicide prevention services in correctional facilities. Each Suicide is often the single most common cause of death of these factors may influence suicide rates in different in correctional settings. Jails, prisons, and penitentiaries are ways. Further fueled by media interest, a suicide in a correctional facility can easily escalate into a political Inmates Are a High-Risk Group scandal. Moreover, suicidal behavior by custodial inmates means a stressful event for officers and for other prisoners. Accordingly, pretrial detainees pleby, , often within the first few hours because of have a suicide attempt rate of about 7. A second period of risk Jenkins et al. These facts also indicate a basic prob- for pretrial inmates is near the time of a court appearance, lem with regard to the causes of suicide in custody: In addition, being imprisoned Profile 2: Sentenced Prisoners is in itself another stressful event even for healthy inmates as it deprives the person of important resources. Compared to pretrial inmates, those who commit suicide in prison are generally older 30â€”35 years , violent offenders who commit suicide after spending considerable time in custody often 4 or 5 years. Their suicide may be precip- Suicide Prevention in Correctional itated by a conflict within the institution with other inmates Settings or with the administration, a family conflict or breakup, or a negative legal disposition such as loss of an appeal or the denial of parole. Incarceration may represent a loss of free- A number of jails and prisons have undertaken comprehen- dom, loss of family and social support, fear of the un- sive suicide prevention programs and in some countries na- known, fear of physical or sexual violence, uncertainty and tional standards and guidelines for suicide prevention in fear about the future, embarrassment and guilt over the of- correctional settings have been established. Significant re- fense, and fear or stress related to poor environmental con- ductions in suicides and suicide attempts can be accom- ditions. While the specifics of these programs differ in re- crease with length of stay Frottier et al. Risk Factors Common to Jails and Development of Suicide Profiles Prisons A first important step toward reducing inmate suicide is to In addition to the specific profiles identified above, re- develop suicide profiles that can be used to target high-risk manded and sentenced suicidal inmates share a number of groups and situations. For example, studies show that pre- common characteristics that can be used to help guide sui- trial inmates differ from sentenced prisoners with respect cide prevention programs. Situational Factors Suicides tend to occur by hanging, when the victims are Profile 1: Pretrial Inmates being held in isolation or segregation cells, and during times when staffing is the lowest, such as nights or week- Pretrial inmates who commit suicide in custody are gener- ends. There are many suicides when prisoners are alone ally male, young 20â€”25 years , unmarried, and first-time even if they are technically sharing a cell Hayes, ; offenders who have been arrested for minor, usually sub- Liebling, There is also a strong association between stance-related, offenses. They are typically intoxicated at inmate suicide and housing assignments. An inmate placed the time of their arrest and commit suicide at an early stage in and unable to cope with administrative segregation or Crisis ; Vol. Preventing Suicide in Prisons, Part I other similar specialized housing assignments especially Profiles Can Change over Time if single celled may also be at increased risk of suicide. Such housing units usually involve an inmate being locked Profiles may be useful for identifying potentially high-risk in a cell for 23 h per day for significant periods of time groups that may need further screening and intervention. As successful suicide prevention programs are implement- ed, high-risk profiles may change over time Frottier et al. Similarly, unique local conditions may alter the tra- Psychosocial Factors ditional profile of high-risk inmates in any particular cor- rectional setting. Therefore, profiles should be used

only as Poor social and family support, prior suicidal behavior es- an aid to identify potentially high-risk groups and situa- pecially within the previous 1 or 2 years , and a history of tions. Whenever possible, they should be developed to re- psychiatric illness and emotional problems are common flect local conditions, and regularly updated to capture any among inmate suicides. Moreover, suicidal inmates often changes that may occur. Therefore, individuals who voice feelings of hopeless- ness or admit to suicidal intent or suicidal plans should be Key Components of a Suicide considered at high risk of suicide. Prevention Program Women All correctional facilities, regardless of size, should have a reasonable and comprehensive suicide prevention policy Although the vast majority of suicides that occur in correc- that addresses the key components noted in the following tional settings are committed by men because the vast ma- sections. While more specif- outside the purview of program staff. These incidents, ic risk profiles of pretrial and sentenced women are still therefore, must be thwarted by correctional staff who have lacking, women with poor social and family supports, prior been trained in suicide prevention and have developed an suicidal behavior, a history of psychiatric illness, and emo- intuitive sense about the inmates under their care. All cor- tional problems should be targeted for suicide prevention rectional staff, as well as health care and mental health per- programs. Distressed young prisoners are espe- staff Hayes, Therefore, separating and isolating young prisoners may lead to additional risk for suicidal actions, Intake Screening which can happen at any time of their confinement Hayes, Juveniles who are placed in adult correctional facil- Since suicides in jails may occur within the first hours of ities should be considered to be at particularly high risk of arrest and detention, suicide screening must occur almost suicide Winkler, Preventing Suicide in Prisons, Part I tive. Every new inmate should be screened at intake and evaluation, they act as a memory aid for busy intake again if circumstances or conditions change. Therefore, there is a need for uncomplicat- health care and mental health staff. Finally, suicide checklists may be used professionals. For example, within the context of a correctional- ; Daigle et al. Unfortunately, there is only lim- setting assessment, affirmative answers to one or more of ited information about potential protective factors Bonner, the following items could be used to indicate an increased â€” this knowledge could facilitate risk assessment and risk of suicide and a need for further intervention: Fam- â€” Facility records indicate that the inmate was assessed as ilies should be encouraged to notify staff if they fear that a suicide risk during a prior confinement. Preventing Suicide in Prisons, Part I the prisoner that will facilitate that prisoner disclosing cility officials should ensure that appropriate staff are prop- his or her distress and despair if and when it arises. Multidisciplinary team meetings to include correctional, health care, and mental health personnel Management Following Screening should occur on a regular basis to discuss the status of an inmate on suicide precautions. In addition, the authoriza- Following screening, adequate and appropriate monitoring tion of suicide precautions for an inmate, any changes to and follow-up is necessary. Therefore, a management pro- those precautions, and observation of an inmate placed on cess must be established with clearly articulated policies suicide precautions should be documented on designated and procedures outlining responsibilities for placement, forms and distributed to appropriate staff. Such documen- continued supervision, and mental health intervention for tation should be both thorough and immediate, as well as inmates who are considered to be at high risk of suicide. Such documentation, if comprehensive and accurate, also protects the practitioner against professional negligence lit- Monitoring igation see Allan et al. Adequate monitoring of suicidal inmates is crucial, partic- ularly during the night shift when staffing is low and in Social Intervention facilities where staff may not be permanently assigned to an area such as police lockups. The level of monitoring Social and physical isolation and lack of accessible sup- should match the level of risk. Inmates judged to be active- portive resources intensify the risk of suicide. Therefore, ly suicidal require constant supervision. If segregation is the only available option vision but will need to be observed more frequently e. Ideally the suicidal intervals. However, considering a suicide attempt by hang- inmate should be housed in a dormitory or shared-cell set- ing can take just 3 minutes to result in permanent brain ting. Prisoners at risk family visits may also be used as a means to foster social should not be left alone, but observation and companion- support. For example, highly suicidal inmates who are placed in shared cells have

better access to lethal instruments. Unsympathet- Communication ic cellmates may not alert correctional personnel if a sui- cide attempt is made. Therefore, placement of a suicidal Certain behavioral signs exhibited by the inmate may be inmate into a shared cell must never be considered as a indicative of suicidal behavior and, if detected and commu- substitute for careful monitoring and social support by nicated to others, may prevent a suicide. The scene of arrest trained facility staff Liebling, Prior behavior can also be confirmed by onlookers such as Most inmates commit suicide by hanging using bedding, family and friends. Any pertinent information regarding the shoelaces, or clothing. Because an inmate can become suicidal at any point dur- Actively suicidal inmates may require protective clothing ing incarceration, correctional officers must maintain or restraints. Because of the controversial nature of re- awareness, share information, and make appropriate refer- straints, clear policies and procedures must be in place if rals to mental health and medical staff. At a minimum, fa- they are to be used. Preventing Suicide in Prisons, Part I which restraints are appropriate and inappropriate, methods logical disorder, the likelihood of further self-harming in for ensuring that the least restrictive alternatives are used the short-term e. With increasing use of technology, camera observation has become a popular alternative to the direct observation by correctional staff in some locales. However, camera So-Called Manipulative Attempts blind spots coupled with busy camera operators can lead to problems. Tragically, there are numerous examples of sui- In some situations, inmates who make suicidal gestures cides that occur in full view of camera equipment. More- or attempts will be viewed as manipulative. The possibility of a staged sui- observation of staff. Once an inmate is iden- Self-mutilation and suicide attempts are not easily tified to be at high risk of suicide, further evaluation and differentiated, even if the inmate is questioned about treatment by mental health staff is indicated. However, suicide attempts, whatever their If a suicide attempt occurs, correctional staff must be suf- motivation, can result in death, even if this was not the ficiently trained to secure the area and provide first aid to original intent. Because of the limited number of methods the inmate while they are waiting for facility-based or available, inmates may choose very lethal methods e. Comprehen- with less suicidal intent should be seen as expressive rath- sive psychological assessment of the inmate should also er than purposive, i. The correct response would be to ask ble after the incident. In- ducted in a private area where an unhurried interview will attention to the self-destructive behaviors or punishment not be interrupted and where the prisoner and the inter- of self-destructive inmates through segregation may wors- viewer can be physically comfortable Dear, The en the problem by requiring the inmate to take increasing- assessment should clarify the factors that precipitated the ly more dramatic risks. Thus, for acting-out, potentially self-harming, the degree of suicidal intent, the underlying self-injurious inmates, programs that foster close supervi- problems both chronic and acute with which the prison- sion, social support, and access to psychosocial resources er is grappling, whether or not the prisoner has a psycho- are just as crucial. Suicide and Life-Threatening Behavior, 35, 63â€” Bullying If a suicide occurs, procedures must be in place to officially and suicidal behaviour in jails. Criminal Justice and Behav- document and report the incident, as well as provide the con- iour, 28, â€” Correctional suicide prevention in the year vention activities. In addition, correctional and other facility- and beyond. Suicide and Life-Threatening Behavior, 30, based staff who have experienced the suicide of an inmate, â€” Self-inflicted deaths of prisoners serving life of feelings from anger and resentment to guilt and sadness. British Journal of Forensic Practice, 4, These individuals may benefit from more detailed debriefing 30â€” Suicide intent and accurate expectations of lethality: Predictors Although rare, correctional facilities provide one of the of medical lethality of suicide attempts. Journal of Consulting environments in which suicide clusters may occur Paton and Clinical Psychology, 72, â€” The examination of inmate suicide clus- Cox, B. Contagious suicide in prisons and ters has suggested that the increased risk of subsequent sui- police cells.

Chapter 2 : Preventing suicide and other self-harm in prison (edition) | Open Library

Suicide Prevention in Correctional Facilities: Reflections and Next Steps 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.

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.

Chapter 3 : Table of Contents: Preventing suicide and other self-harm in prison /

Suicide prevention and designing safer prison cells. In Dear, G. (Ed.), Preventing suicide and other self-harm in prison (pp. -). New York, NY: Palgrave MacMillan.

Reports of apparent suicides and attempted suicides populate the pages of newspapers and other media outlets almost daily. But despite the abundance of such reports, suicide rates have dropped at state prisons and local jails during the last 20 years, according the U. A recent report revealed that jail suicide rates have declined from per , inmates in to 47 per , inmates in State prison suicide rates dropped from 54 per , in to 14 per , in Hayes, project director of the National Center on Institutions and Alternatives, who has researched suicide at correctional facilities for nearly 25 years, says the drop in suicide rates can be attributed to several different factors, including increased awareness of the issue through reports and the development of more responsive policies and procedures, more training, new intake screening forms, and more mental health and medical staff. Attitude Hayes says jail administrators or sheriffs who take a proactive approach and a "whatever it takes" attitude toward suicide prevention will have far fewer suicides than facilities that have administrators who believe suicides are unavoidable. However, that attitude must also be substantiated by action and program components that will reduce suicides: Staff must receive training each year to remain updated on methods of suicide prevention and detecting potentially suicidal inmates. Intake screening questions should be asked when inmates are booked into the facility and recorded on intake forms to help determine any mental health issues and factors that might predispose them to suicide. A safe housing environment should be provided to inmates. Inmates that show signs of suicidal behavior should be put on suicide watch. Observation should be constant or guards should check on a potentially suicidal inmate at least every 15 minutes. Policies and procedures for suicides should be clearly stated. Although there is no guaranteed way to eliminate inmate suicides, Hayes says having safeguards in place before suicides occur is an effective approach to reducing them. Several jurisdictions are struggling to prevent inmate suicides: There were 29 self-inflicted inmate deaths in California during the first nine months of the year. Lawyers who represent nearly 26, mentally ill inmates say classification flaws that put mentally ill inmates in more secure facilities with violent inmates could lead to suicides because inmates spend more time in their cells and have less human interaction. With five inmate suicides in Ohio as of press time this year and a record 11 suicides in , officials are working to curb self-inflicted deaths. A new policy requires all inmates held in segregation cells be screened for suicide risk. Previously, only inmates with mental illness or inmates who appeared to be at risk were screened. Since April at least 13 inmates have committed suicide in Connecticut. A new unit designed to improve living conditions for mentally ill inmates in Iowa has been the site of four inmate suicides during the last two years. Correctional officers have stepped up patrols of the unit and now check suicidal inmates every five minutes instead of every 15 minutes. The Utah County Jail in Provo, has experienced a record number of suicides this year, with four inmates killing themselves as of press time. In order to curb the number of suicides at the facility a committee has been formed to re-evaluate jail protocol and personnel training. Additional screening procedures have also been implemented during the booking process. If there were mistakes, change the suicide prevention program so they do not occur again, Hayes says. Communication Suicides can be avoided through effective communication from the time of an arrest until an inmate is released from the facility, Hayes says. If an arrestee is crying or acting despondent while being arrested or transported, that information should be reported to jail personnel during the booking process. Tips from family members or other people at the scene of an arrest can also help determine if an arrestee is suicidal. Once an inmate is housed within the jail, any unusual activity or signs that he is potentially suicidal should be relayed during shift changes. A shift supervisor should also be aware of any signs of suicidal behavior. There should also be a clear channel of communication between facility personnel and a suicidal inmate. Correctional staff should use active listening and make eye contact, and if the inmate is in immediate danger stay with him.

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

Opportunity for Inmate Suicide: A Design Guide," Psychiatric Quarterly, 60 (2): Additions and modifications were made by Lindsay M. Hayes, and updated by Randall Atlas, Ph.D., a registered architect.

The guards have been doing so since October, when the prison system instituted a series of reforms to cut the high rate of inmate suicides. The measures, which include screening inmates for potential suicidal tendencies and training guards how to intervene, appear to be making a difference. Last year, a record 43 inmates killed themselves in California prisons. Through Friday, 13 inmates had committed suicide, compared with 19 during the same period a year ago. Three were in the segregation units, down from seven in those cells at the same time last year. The reduction in suicides so far this year marks a rare hint of success for a prison system beset by multiple crises and one that has seen many of its operations placed under the authority of federal courts. Guards have reported preventing more than 60 suicides in segregation cells so far this year. They start to recognize the signs. They know to check on them more frequently. He recalls friends who took their own lives, often after receiving bad news or being cut off from their families. One gave up after his wife divorced him and as he was about to be moved to a new cell, Garfield said. He had every drug you can think of. He did it on purpose, and off he went. Each time something like that happens, it puts another spike in a guy. In a report this month to U. But he also praised officials for expanding the use of the minute checks to the first three weeks after an inmate is placed in segregation, instead of just the first 72 hours, when the danger is highest. Some inmates also are now allowed to have radios or televisions while in isolation. That program, coupled with transferring thousands of inmates to private prisons in other states, will free space for treatment and rehabilitation programs, Tilton said. Kahn is less enthusiastic because she said the program involves too little for improving mental health care. Isolation terms average 68 days but can stretch for months. The sudden isolation, the stress from whatever incident prompted their transfer and the accompanying loss of possessions and privileges were found to be triggers for suicidal behavior, said Dr. Shama Chaiken, a chief psychologist with the corrections department. To save inmates from themselves, guards sometimes use pepper spray to incapacitate those who are trying to hang or cut themselves. They also will handcuff unconscious inmates, in case they are faking death. Some inmates thought to be suicidal are placed in barren cells and clothed only in quilted, smock-like garments that cannot easily be ripped and used as a noose. They are watched around the clock until their medications can be adjusted or mental health workers deem them no longer a risk. While prison experts welcome the new procedures and additional spending, they also wonder what took California so long to get serious about addressing its inmate suicide problem. California is far behind other states that have long been screening inmates for mental illness and suicidal intentions, said Lindsay M. Hayes, a suicide prevention expert with the National Center on Institutions and Alternatives. He said training employees to watch for and respond to suicide attempts also has lagged. He predicted it could be five years before the department sees consistent results.

Chapter 5 : Preventing suicide and other self-harm in prison (Book,) [racedaydvl.com]

Preventing suicide and other self-harm in prison / Bibliographic Details; Other Authors: Dear, Greg E., Format: Book: Suicide > prevention & control.

Chapter 6 : Preventing Suicide in Prison Inmates

Lindsay M. Hayes, MS. policies encompassing all of the components of a suicide prevention program (Hayes, Suicide prevention and designing safer prison cells.

DOWNLOAD PDF SUICIDE PREVENTION AND DESIGNING SAFER PRISON CELLS LINDSAY M. HAYES

Chapter 7 : Staff View: Preventing suicide and other self-harm in prison /

Lindsay M. Hayes â€" a leading voice in jail suicide prevention and Project Director at the National Center on Institutions and Alternatives (NCIA) in Mansfield, Massachusetts â€" unveiled results.

Chapter 8 : Library Catalogue

The high rate of suicide and self-harm in prisons around the world is of major concern to prison administrators, coroners, all those who work in prisons, observers of the justice system as well as prisoners and their families.

Chapter 9 : Preventing Suicide in Prisons, Part I | Ad Kerkhof and Lindsay Hayes - racedaydvl.com

"The term we like to use is 'suicide resistant' not 'suicide-proof'", says Lindsay Hayes, one of the top experts on suicide prevention in US prisons and jails. committing suicide." Not every.