PREVENT SUICIDES, SAVE LIVES AND AVOID COSTLY LAWSUITS

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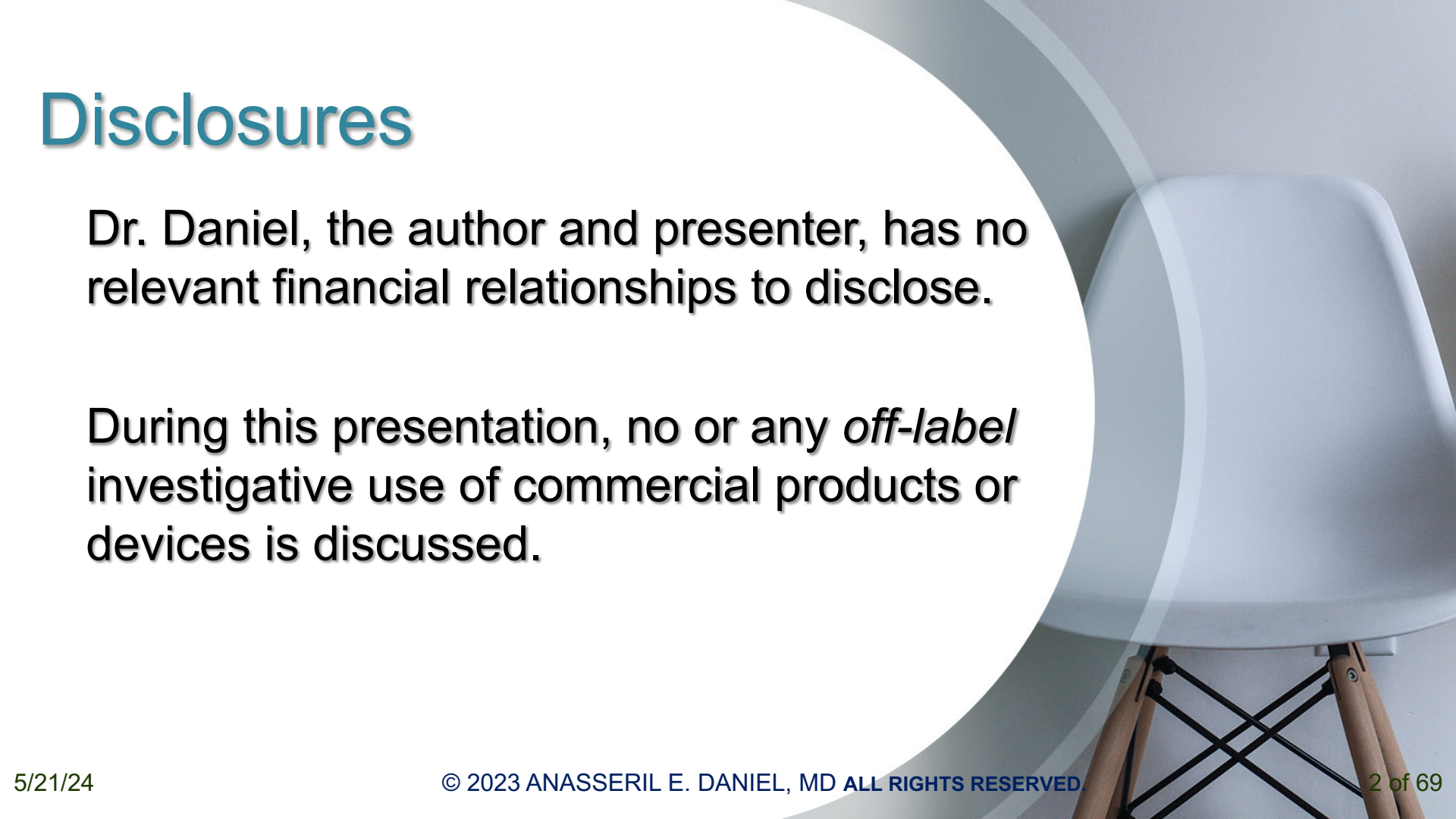
Tuesday, May 21, 2024

Disclosures

Dr. Daniel, the author and presenter, has no relevant financial relationships to disclose.

During this presentation, no or any *off-label* investigative use of commercial products or devices is discussed.



Objectives of the Talk

1. Common risk factors of suicide in jails and prisons
2. Suicide risk assessment
3. Best practices in suicide prevention
4. Medical Negligence and Deliberate Indifference lawsuits
5. Introduce a new approach to suicide prevention training

PRESENTER INTRODUCTION

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AUTHOR SUICIDE IN JAILS AND PRISONS: PREVENTIVE AND LEGAL PERSPECTIVES - A Guide for correctional and mental health staff, experts and attorneys

MEDIA NEWS HEADLINES

- Jail is a death sentence for a growing number of Americans[1]
- Suicide rate in Bristol County, MA jails has drawn criticism for a recent inmate suicide and an inmate who attempted suicide[2]. All 7 inmate suicides at Bristol County House of Correction since 2017 involved bunk beds[3].
- Troubled south Mississippi man becomes another casualty in rising number of jail suicides[4].

MEDIA NEWS HEADLINES

- 20-year-old female inmate died by "apparent suicide" in the Milwaukee County WI Jail[5].
- ‘State of despair.’ Inmate suicides approach historic high in North Carolina prisons[6].
- Suicide is the leading cause of Utah jail deaths[7].
- Alaska Corrections head says 18 in-custody deaths in 2022 were ‘too many’[8].

Definitions 1/6

Suicide

an intentional, self-destructive act that begins with **an idea of self-directed harm**, followed through with developing **a plan**, finding a **means**, and **making a self-harm attempt**. Intent is not always clearly identified. Intent however is usually assumed when a person develops a plan and seeks out a means to carry it out. An inmate, displaying **a combination of** suicidal ideation, a plan and access to means for the plan represents an **acute suicide risk**.

Definitions 2/6

Suicide Attempt

The Suicide Attempt definition and concept were probably introduced with the goal of communicating and signaling potential future behavior of a suicide survivor.

A Suicide Attempt has 2 major components, Intent and Outcome. If the Outcome is not death, the action becomes an "attempt".

Definitions 3/6

Suicide Attempt

The Intent has implications from the perspective of "prevention" - a person attempting suicide already gave up on life once. For the general population, one study found that 81.8% of suicide survivors completed suicide within a year of the attempt. [9]

This “abandonment of life” becomes apparent through actions such as giving up possessions or isolation, or even extremely violent behavior to increase the likelihood of demise.

Definitions 4/6

Suicide Attempt

The fact the Outcome was not the expected one (due to technical difficulties, outside interventions or an Act of God such as a misfire or broken rope due to weight) might not be an as important predictor as the Intent itself.

Definitions 5/6

Suicidal Ideation

CDC (Centers for Disease Control and Prevention) defines suicidal ideation as “Thinking about, considering, or planning suicide”.[10,11] An inmate may express suicidal ideation explicitly and directly by stating “I want to kill myself”, “I am suicidal” “I want to die” and “There is no point in living.”

Suicidal thoughts are often transient, making it difficult to identify and intervene.

However, risk factors usually provide clues to identify inmates at risk.

Definitions 6/6

Suicidal Ideation

Those who entertain suicidal ideation do not necessarily commit suicide. **Less than 50%** of those who have suicidal ideation attempt suicide.

Suicidal ideation however **may predict** future suicide attempts and therefore inmates who express suicidal ideation must be taken seriously, though suicidal ideation does not necessarily predict completed suicide.

Data Source

Number

- Retrospective review - 37
- Mortality and morbidity - 18
- Expert case analysis - 85

- Total 140

Data Source

Location

- Missouri DOC
- National
  - Lockups
  - Jails of all size
  - U.S. Marshals Service
  - Federal Prisons
  - Private Prisons

Data Source

Other sources

- Published Research
- Court Cases

High Risk Group for Suicide

- Young males
- Elderly, white, males
- Pre-trial detainees
- First time arrestees (particularly of higher social status
- Inmates/detainees with mental illness
- Inmates/detainees with substance abuse

High Risk Group for Suicide – ctd.

- Veterans/soldiers with a history of mental illness or substance abuse
- Detainees or inmates with past history of suicide attempts
- Inmates in restrictive housing

Five Challenges in Recognizing Suicidal behaviors

- Non-Suicidal Self-Injury (NSSI)
- Denial of suicidal ideation
- Manner of communication of suicidal ideation / behaviors
- Method of suicide
- Correctional officers' attitude

Case History

- KW, a high-profile, 58 year-old white male detainee, committed suicide in an urban jail three days after his admission.

- Jail census comprised 98% Blacks and Hispanics, with ages between 18 and 35.

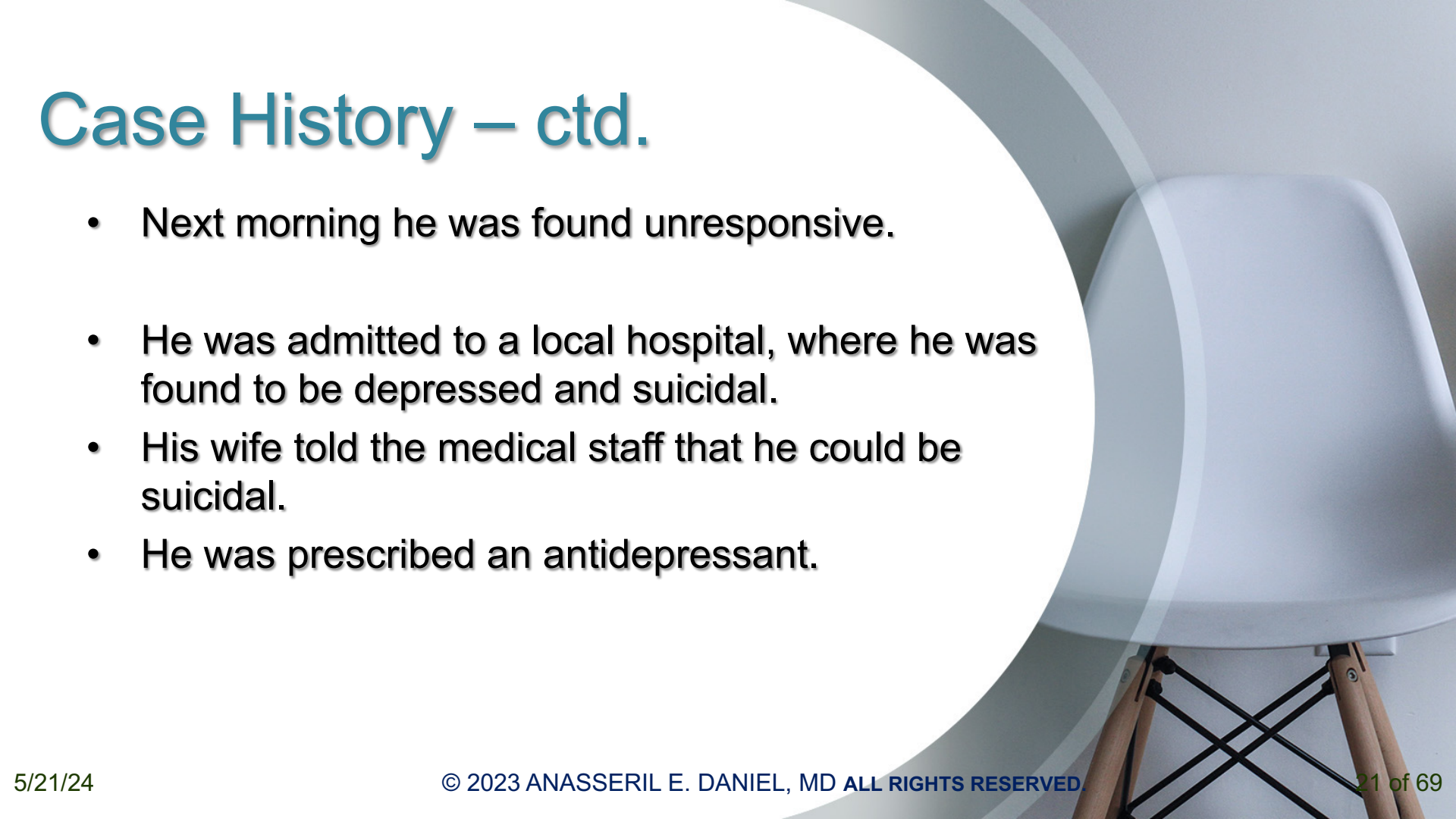
Case History – ctd.

- KW sexually assaulted a woman whom he had known for over 20 years.
- He had no history of sexual violence.
- After the incident, he went home, drank excessively and took an unknown amount of Tylenol and barbiturates.

Case History – ctd.

- Next morning he was found unresponsive.

- He was admitted to a local hospital, where he was found to be depressed and suicidal.
- His wife told the medical staff that he could be suicidal.
- He was prescribed an antidepressant.



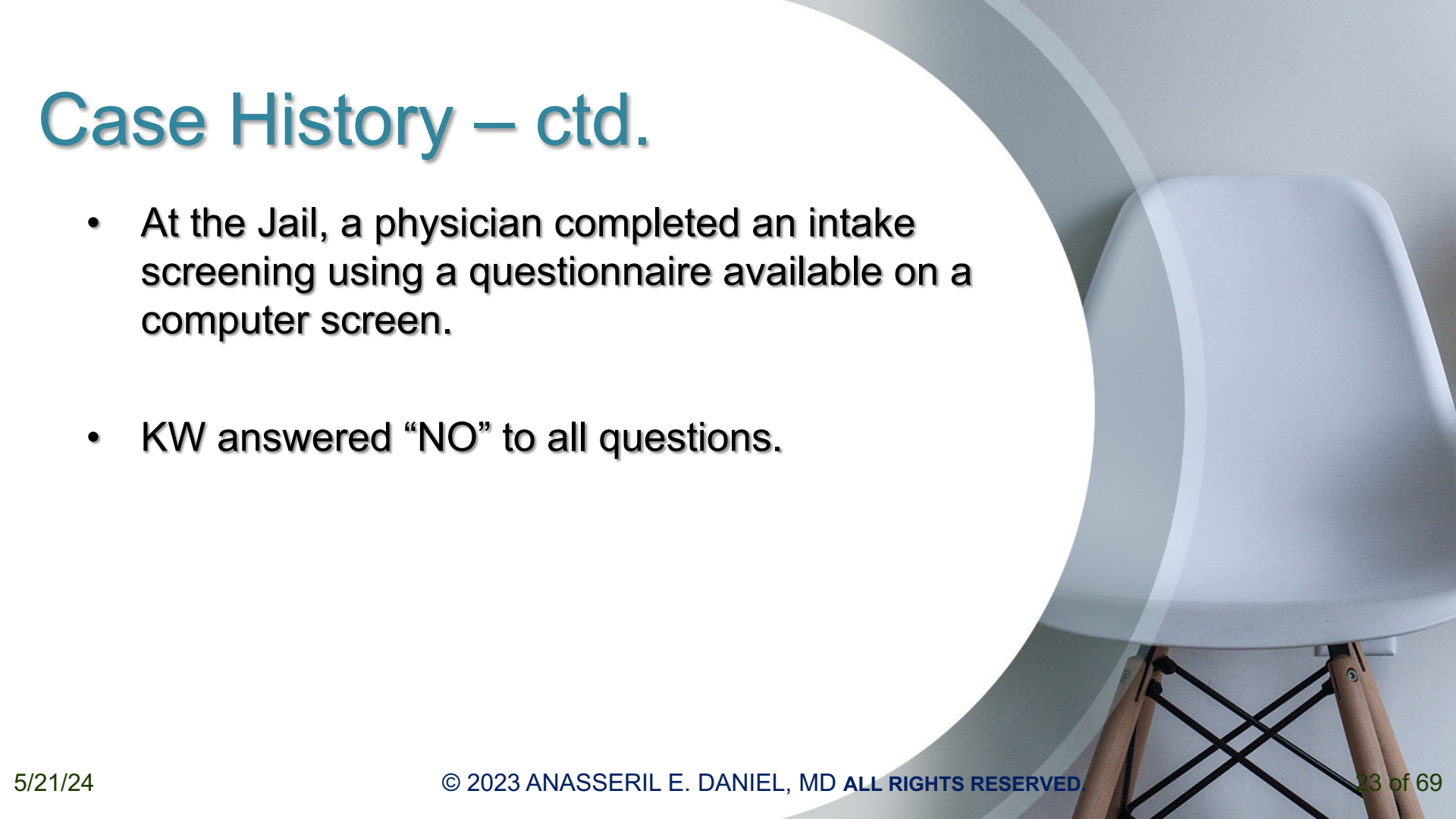
Case History – ctd.

- KW was arrested at the hospital on the third day of his hospitalization and taken into custody.
- He told the victim he would go home and shoot himself.
- Later, he was charged with second-degree sexual assault.

Case History – ctd.

- At the Jail, a physician completed an intake screening using a questionnaire available on a computer screen.

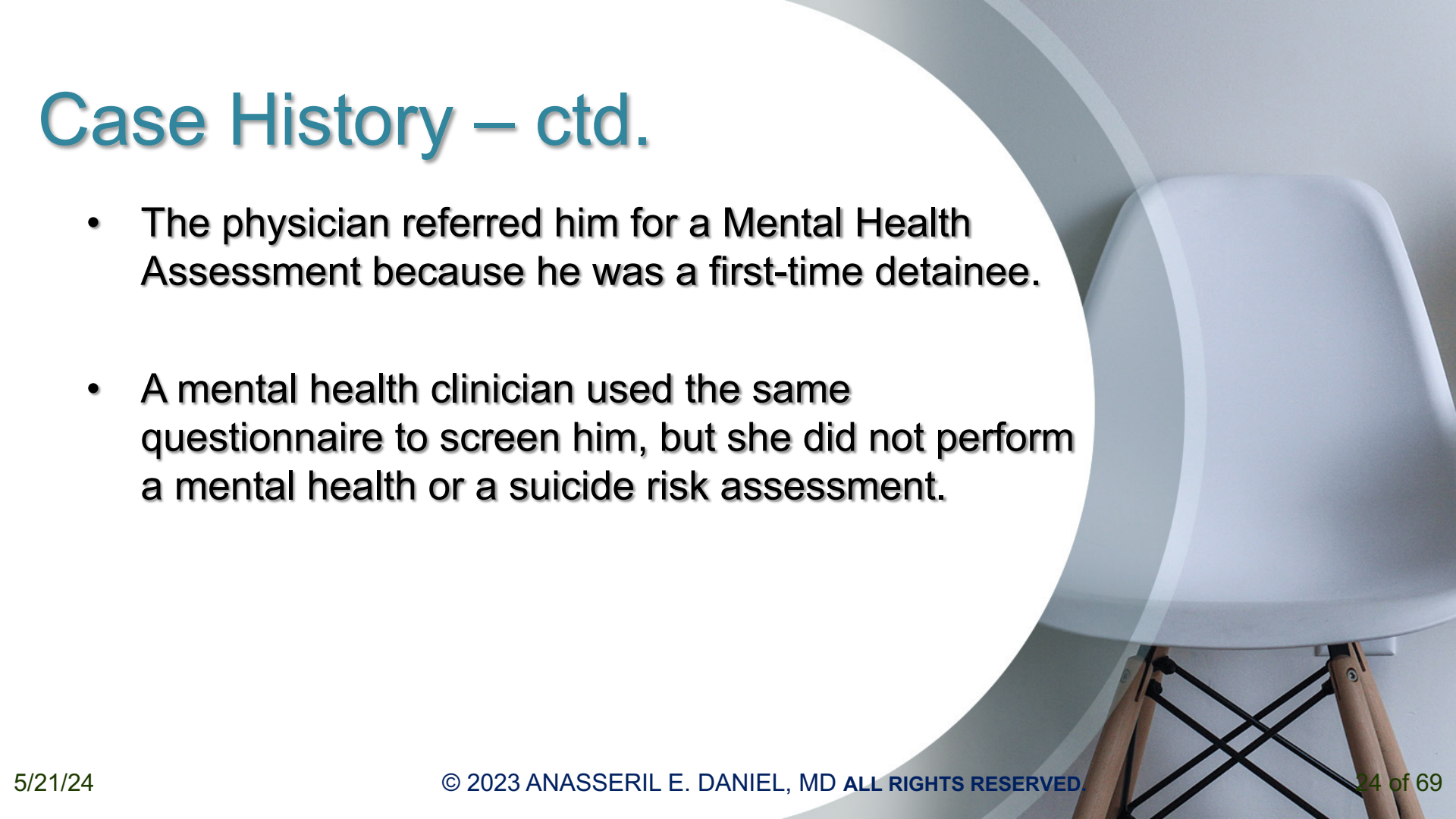
- KW answered “NO” to all questions.



Case History – ctd.

- The physician referred him for a Mental Health Assessment because he was a first-time detainee.

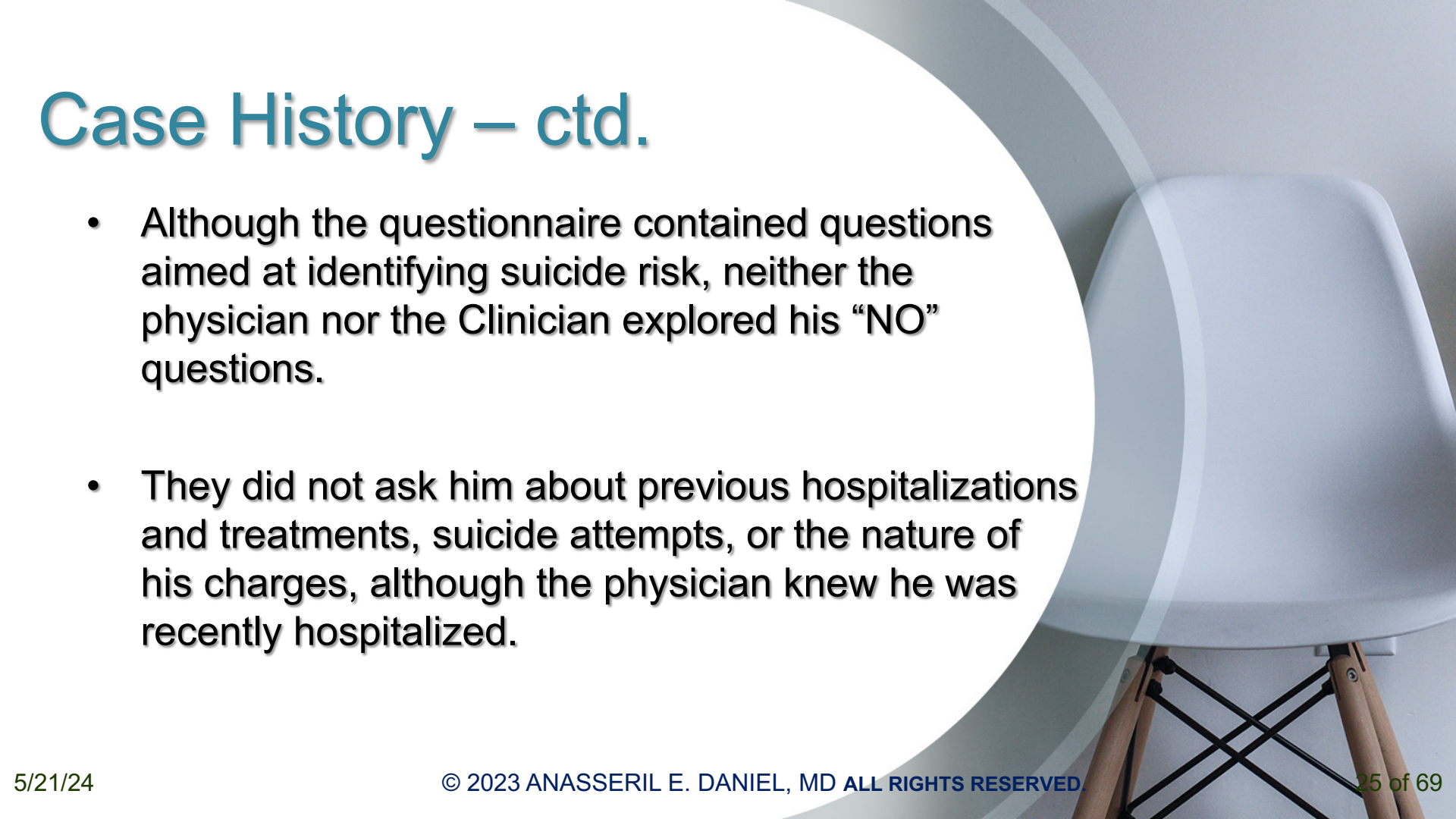
- A mental health clinician used the same questionnaire to screen him, but she did not perform a mental health or a suicide risk assessment.



Case History – ctd.

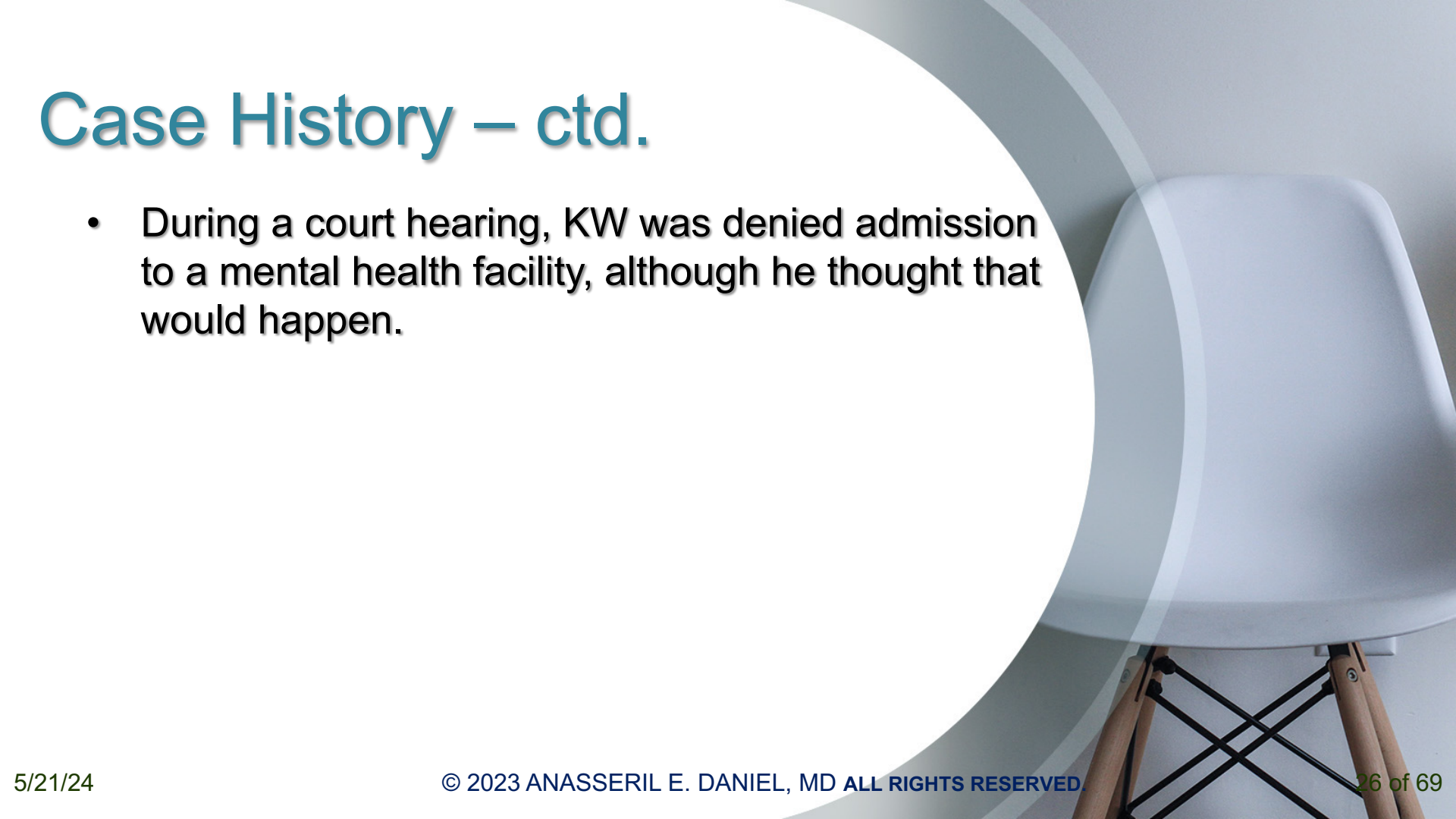
- Although the questionnaire contained questions aimed at identifying suicide risk, neither the physician nor the Clinician explored his “NO” questions.

- They did not ask him about previous hospitalizations and treatments, suicide attempts, or the nature of his charges, although the physician knew he was recently hospitalized.



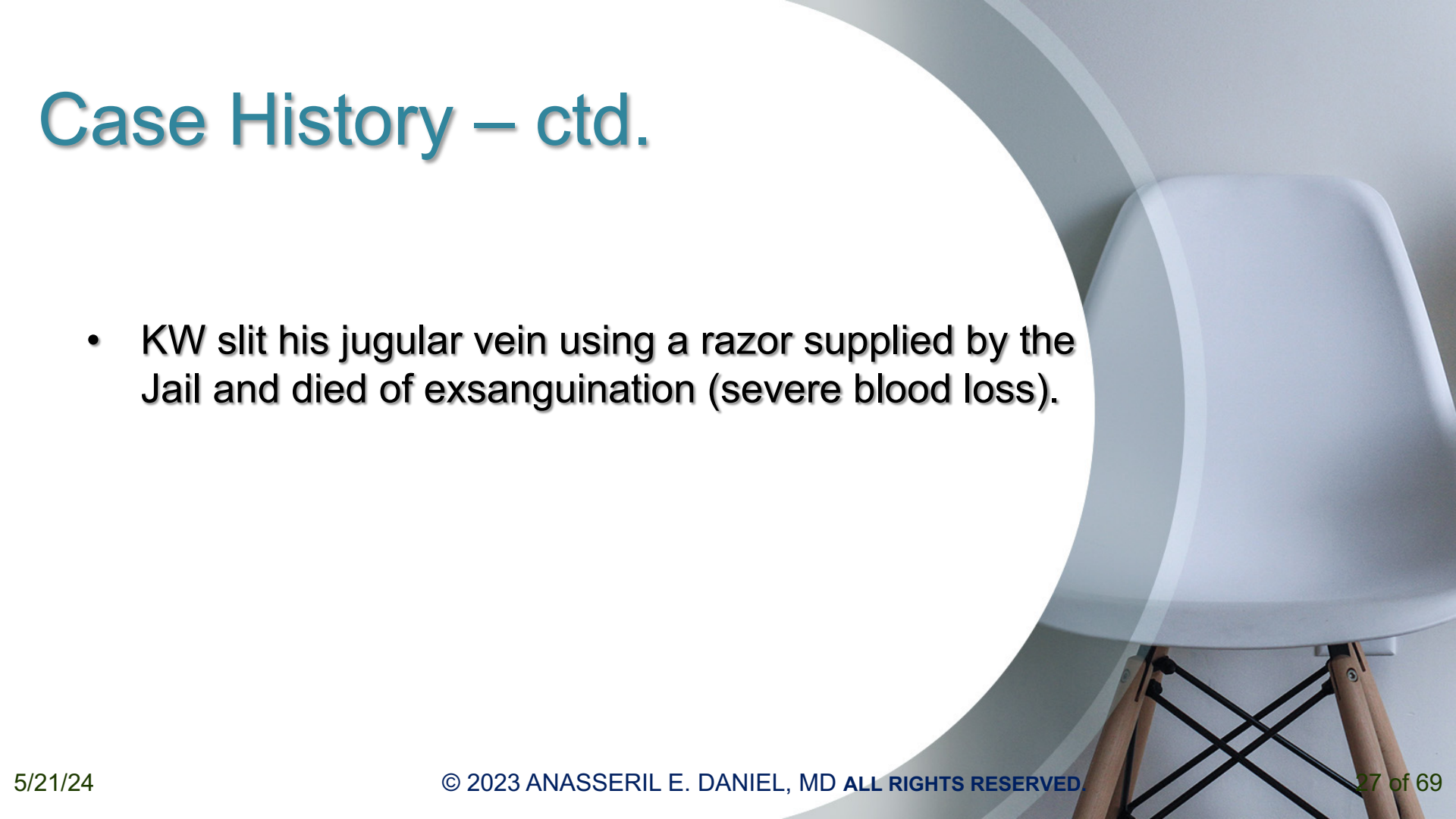
Case History – ctd.

- During a court hearing, KW was denied admission to a mental health facility, although he thought that would happen.



Case History – ctd.

- KW slit his jugular vein using a razor supplied by the Jail and died of exsanguination (severe blood loss).



Case History Questions

1. Was KW a suicide risk in Jail?

Please explain your reasoning.

If YES, why?

If NO, why not?

2. Was there any indication to place him on suicide watch despite his denial of suicidal ideation?

Case History Questions

3. What should the physician and the clinician have done differently?

4. Do you consider the physician or the clinician deviated from the standard of care? If so, how?

5. Using NCCHC (National Commission of Correctional Health Care) Mental Health Standards, identify the applicable standards in this case.

Suicide Prevention – A collaborative Responsibility

- Concept introduced by Daniel in 2006 [11] and expanded in 2009 [12] and 2022 [13]
- Medical, mental health, correctional staff and administration.

Suicide Prevention: Correctional Officers

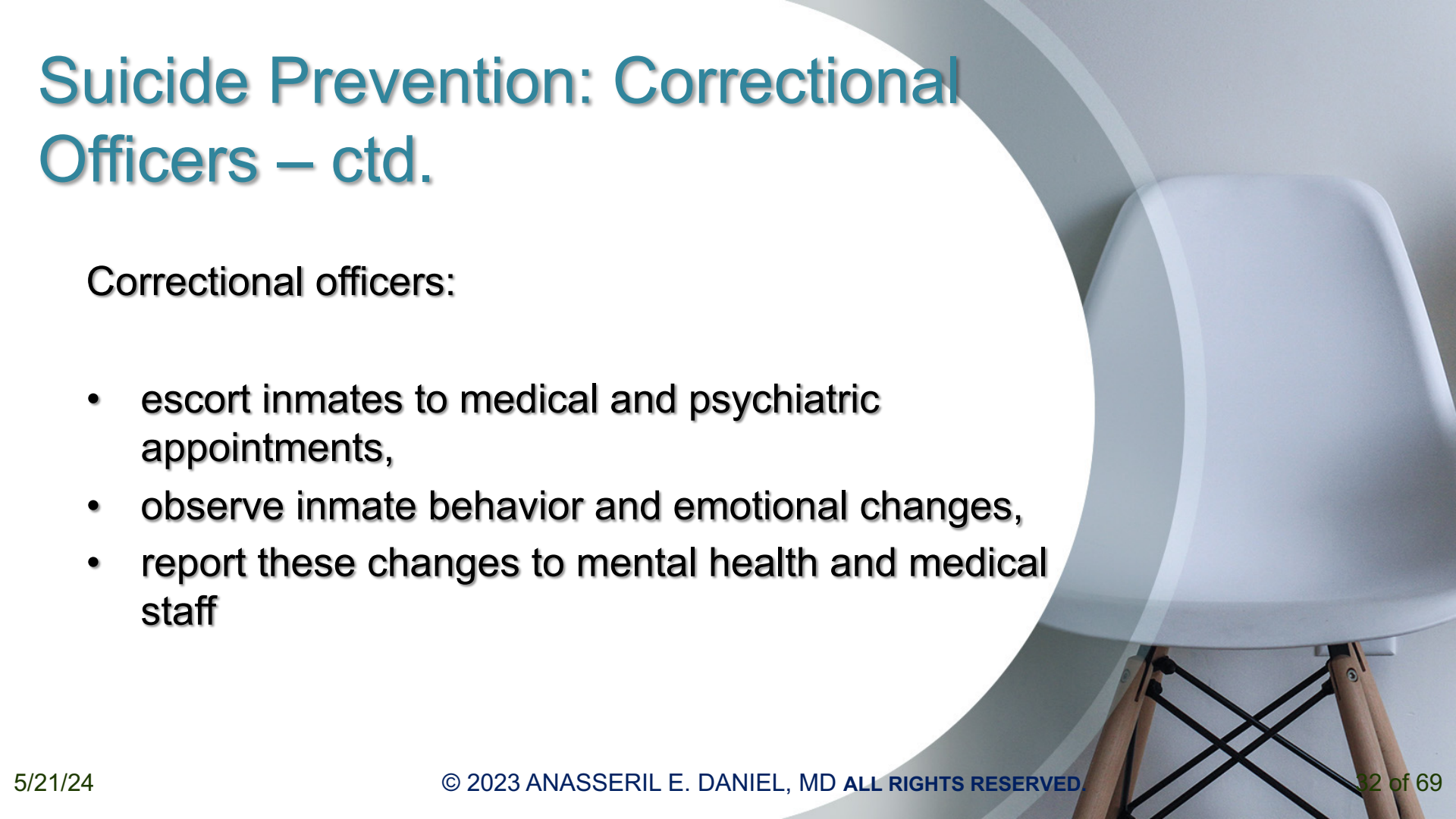
Correctional officers:

- perform screening at booking,
- assign housing,
- place suicidal inmates on suicide watch if indicated,
- monitor them at regular, but staggered, intervals

Suicide Prevention: Correctional Officers – ctd.

Correctional officers:

- escort inmates to medical and psychiatric appointments,
- observe inmate behavior and emotional changes,
- report these changes to mental health and medical staff



Suicide Prevention: Mental Health Professionals

Mental health professionals:

- perform routine mental health evaluations,
- suicide risk assessments,
- make decisions to discontinue suicide precautions,
- develop treatment planning,
- also evaluate the suitability of inmate placement on administrative segregation and monitor them on a weekly basis

Suicide Prevention: Psychiatrists

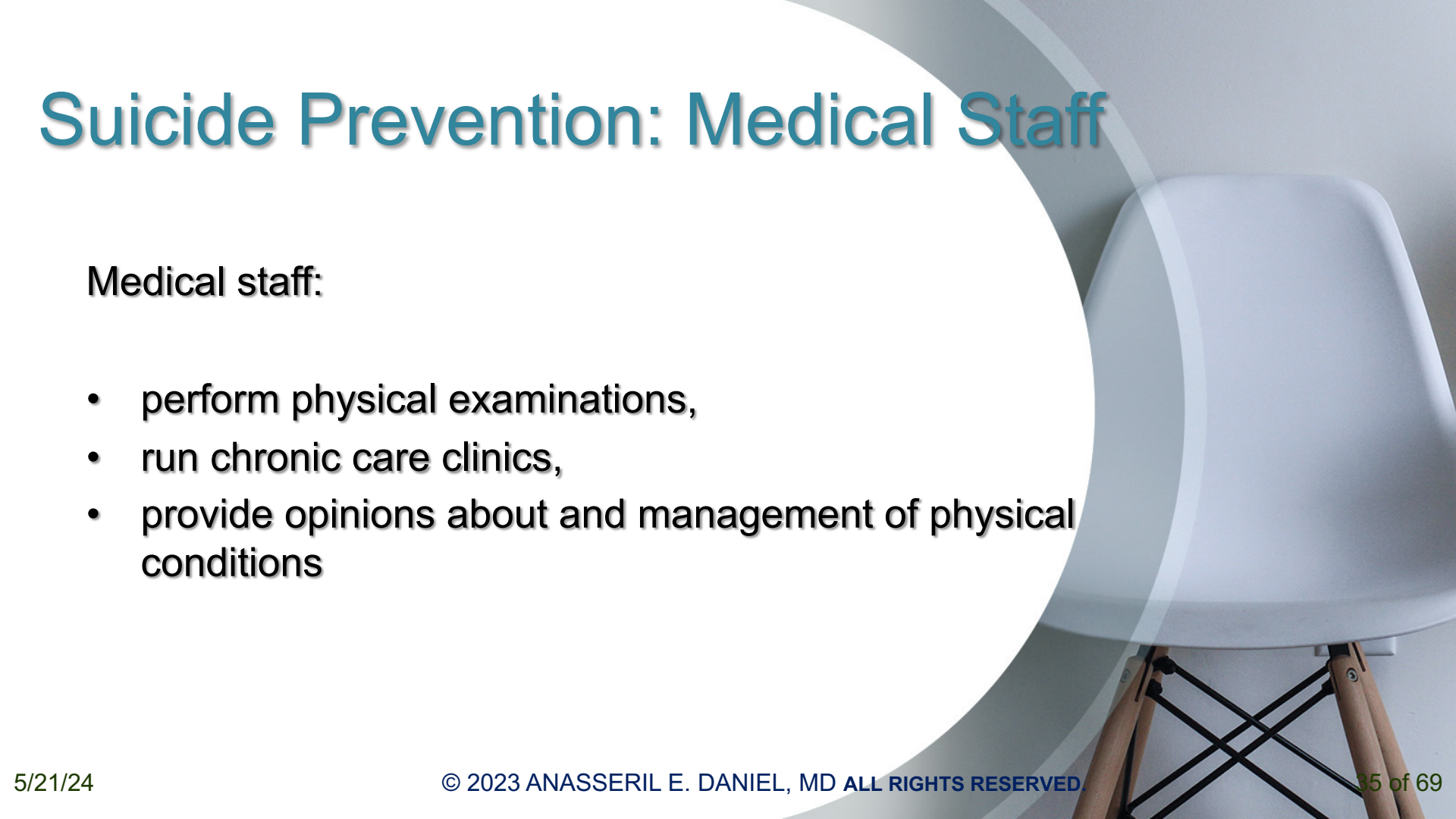
Psychiatrists:

- evaluate inmates' needs for medications,
- monitor inmates,
- perform psychiatric evaluations to determine diagnosis

Suicide Prevention: Medical Staff

Medical staff:

- perform physical examinations,
- run chronic care clinics,
- provide opinions about and management of physical conditions



Suicide Prevention: Nursing staff

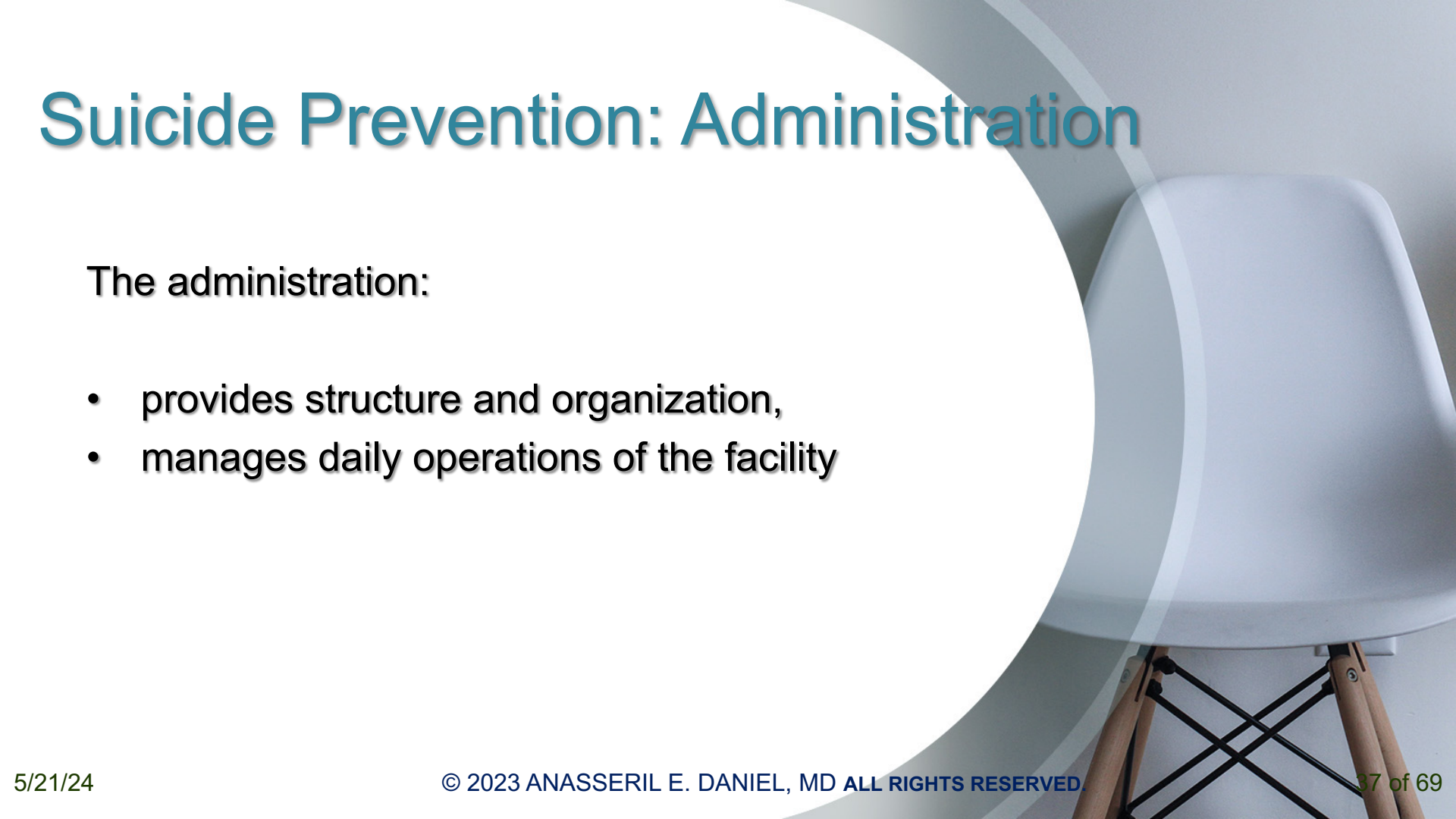
Nurses:

- manage emergency medical situations, including life saving measures given to an inmate found hanging,
- obtain medication orders from physicians,
- dispense medication

Suicide Prevention: Administration

The administration:

- provides structure and organization,
- manages daily operations of the facility



Types of litigated cases

- Medical Negligence
- Wrongful death
- Negligence
- Civil rights violation (1983 Claims)
- ADL related lawsuits

Suicide Prevention Training models

1. Traditional Suicide prevention training model

- currently used in the majority of correctional training approaches
- consists of
  - four hours of didactic lectures for new hires
  - two hours of annual refresher course

Is this adequate?

1. Traditional Suicide Prevention Training

Shortcomings of the Traditional Suicide Prevention Training model

- ineffective in addressing complex psychological factors involved in suicide
- insufficient in curbing the suicide problem in correctional settings
- inadequate, the majority of personnel lack the knowledge and the professional skills to successfully change the "*status quo*" in inmate suicide

1. Traditional Suicide Prevention Training – ctd.

Shortcomings of the Traditional Suicide Prevention Training model

- it employs the use of generalized protocols and standardized procedures (each situation leading to suicide is unique)

- it does not impart specific knowledge of what moves the court

1. Traditional Suicide Prevention Training – ctd.

Time for a change?

- in 1980, the 5th Circuit Court of Appeals (Ruiz v. Estelle) mandated the screening for inmates at risk of suicide
- after an initial significant drop of suicide rates in jails, data show a steady increase in the number of suicides between 2000 and 2019 [9].

Source: Bureau of Justice Statistics, Federal Law Enforcement Agency Deaths in Custody Reporting Program

1. Traditional Suicide Prevention Training – ctd.

Time for a change?

- in 2007, the International Association for Suicide Prevention Task Force published a suicide guideline as model for a suicide prevention program [10]
- Dr. Daniel co-authored this guideline
- key components of such program

training,

screening, observation, communication, modification of the physical environment, and mental health treatment

1. Traditional Suicide Prevention Training – ctd.

Time for a change?

- the National Commission for Correctional Health Care, requires facilities to have a suicide prevention program (which includes personnel training) as an essential element for accreditation

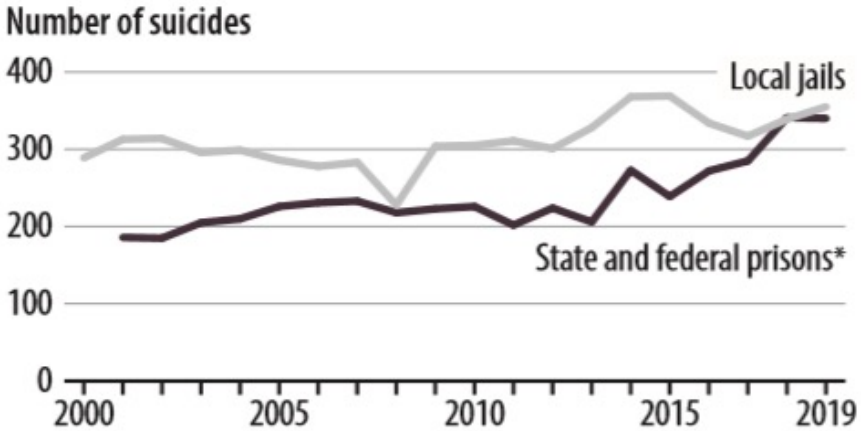
- Key question

How effective is the current training program model in attaining its goal?

1. Traditional Suicide Prevention Training – ctd.

Time for a change?

FIGURE 1
Number of suicides in local jails and state and federal prisons, 2000–2019



Source:

Bureau of Justice Statistics, Federal Law Enforcement Agency Deaths in Custody Reporting Program

Suicide in Local Jails and State and Federal Prisons, 2000–2019 – Statistical Tables,

1. Traditional Suicide Prevention Training – ctd.

It appears we reached a limit of diminishing returns with the current methods used in inmate suicide prevention training

and, to avoid a clinical diagnosis of

"Insanity, in repeating the same mistakes and expecting different results.“ by Anonymous

we might need to consider a change in our approach to suicide prevention training.

2. Case Law-based Suicide prevention Training

- rooted in legal precedents accumulated over 40 years
- provides guidance for the policies and procedures
- addresses specific issues related to the legal basis
- addresses the standard of care and civil rights violations
- easier to relate to

Time consuming

Budgetary constraints

Courts changing interpretation

Common Basis of Lawsuits

A review of several court decisions during the last four decades indicates that the common failures giving rise to 3rd party claims related to suicide in correctional settings occur at multiple points along the spectrum of

diagnosis, treatment and administrative functions [13].

Common Basis of Lawsuits – ctd.

1. Inadequate mental health and psychiatric examination

2. Failure to consider obvious and substantial risk factors in assessing potential for suicide

3. Failure to place an inmate on suicide precautions upon recognizing the obvious and substantial risk

Common Basis of Lawsuits – ctd.

4. Failure to communicate the action taken to other providers and/or to custodial/jail staff

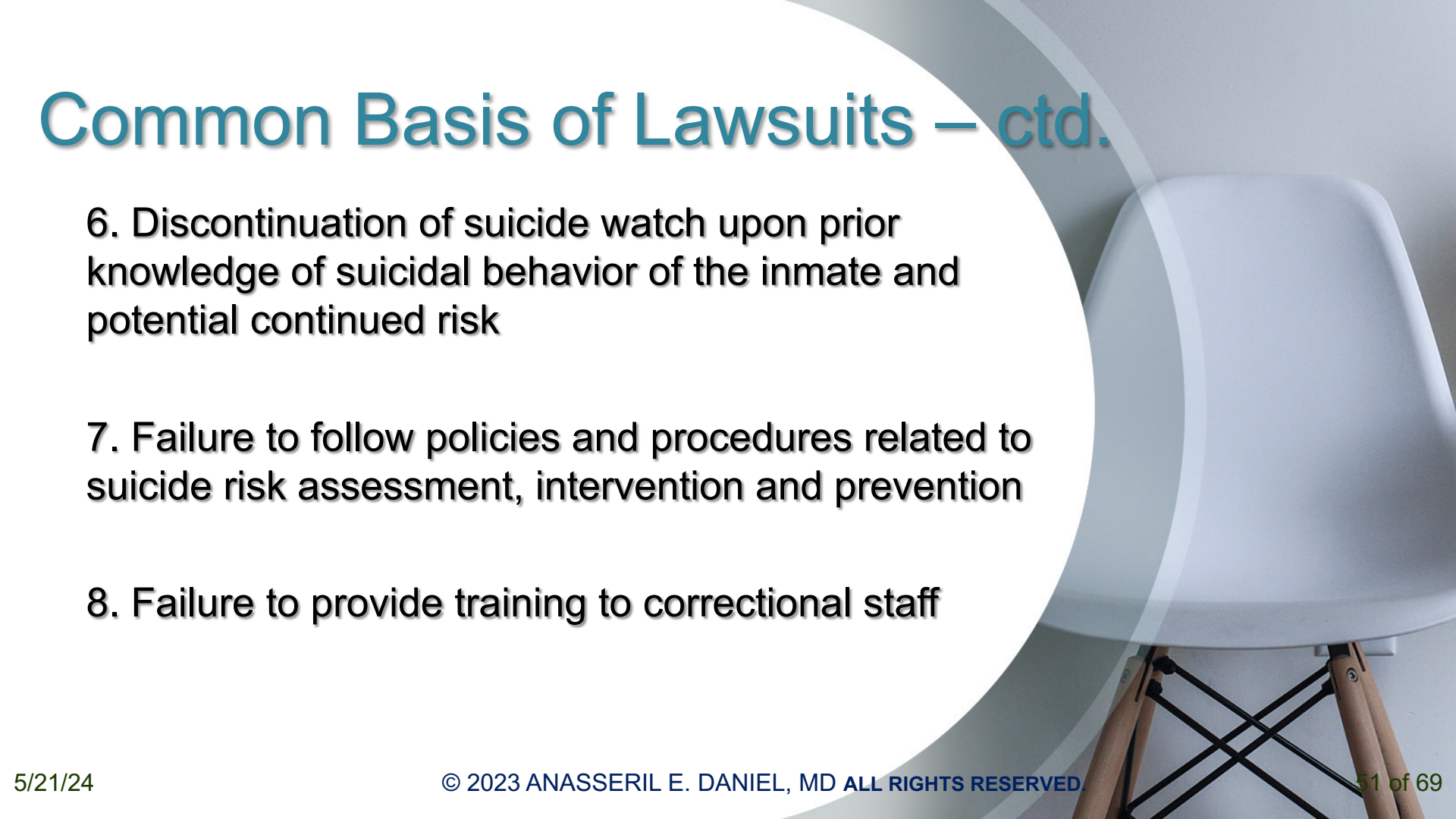
5. Failure to adequately monitor an inmate on suicide watch and to maintain appropriate observation logs

Common Basis of Lawsuits – ctd.

6. Discontinuation of suicide watch upon prior knowledge of suicidal behavior of the inmate and potential continued risk

7. Failure to follow policies and procedures related to suicide risk assessment, intervention and prevention

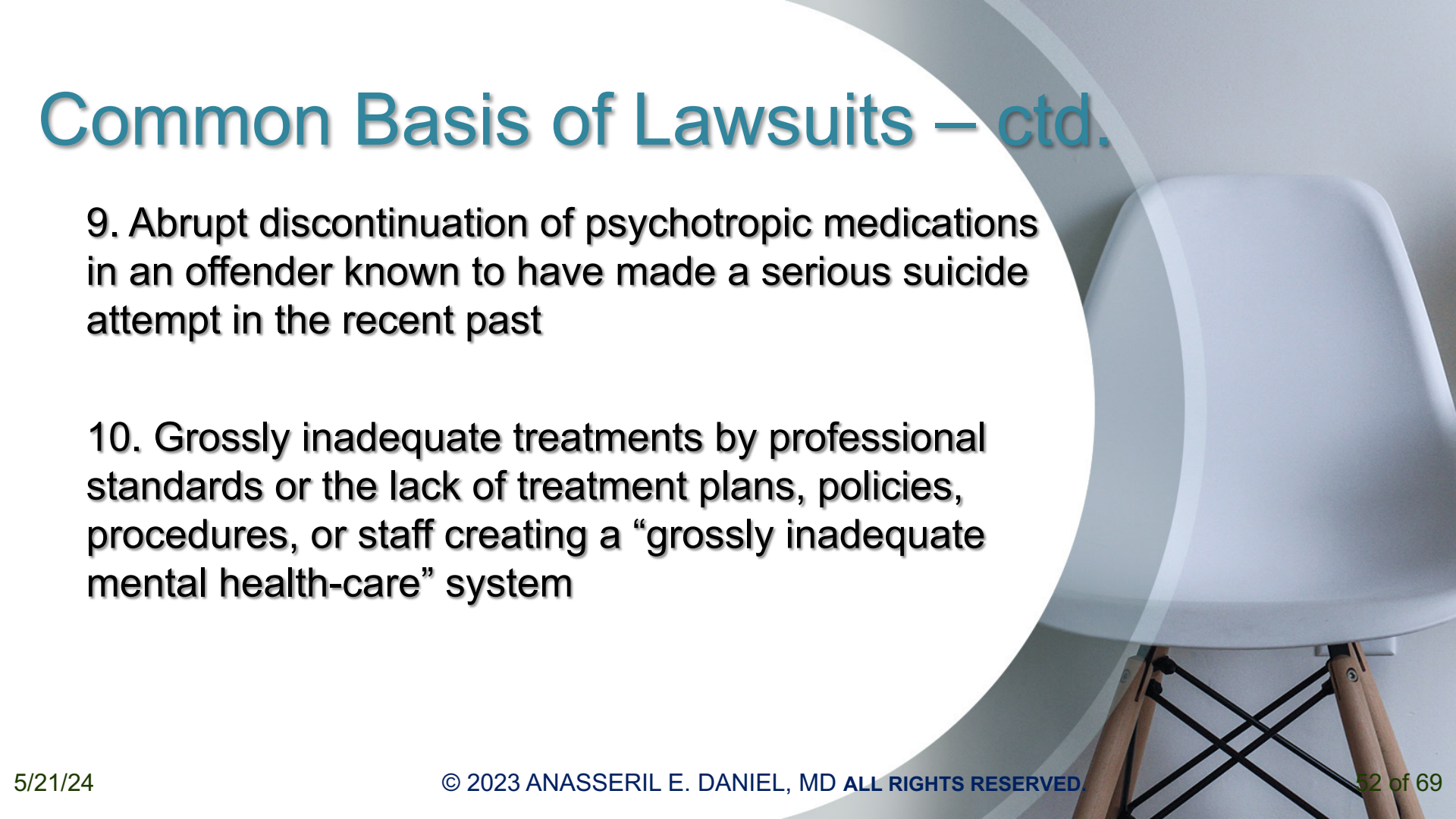
8. Failure to provide training to correctional staff



Common Basis of Lawsuits – ctd.

9. Abrupt discontinuation of psychotropic medications in an offender known to have made a serious suicide attempt in the recent past

10. Grossly inadequate treatments by professional standards or the lack of treatment plans, policies, procedures, or staff creating a “grossly inadequate mental health-care” system



Common Basis of Lawsuits – ctd.

12. Repeated examples of delayed or denied medical treatment.

Risk Management Strategies (General)

- provide suicide-prevention training and periodic refresher courses for all administrative, clinical, and custodial/jail staff
- consider suicide risk in offender housing, cell placement and work assignments
- Ensure prompt transfer of mental health records of high-risk inmates between facilities

Risk Management Strategies (General)

- obtain detailed information from jails at the time of admission to prisons
- develop procedures for handling verbal and nonverbal communications of intent to commit suicide
- ensure 24-hour access to emergency medical and mental health care

Risk Management Strategies (General) – ctd.

- Inmates on suicide watch to be placed in line of sight or special observation cell
- rigorous maintenance of observation logs
- obtain written clearance from mental health staff before transferring an offender on suicide watch to general population or to other cells

Risk Management Strategies for the Clinician

- Use information from the intake screening to develop an initial plan, including the placement of the inmate on suicide watch and cell assignment, and to communicate the same to all staff

- Gather inmate mental health history from outside sources
  - information regarding diagnosis, medication dose, form, and route of administration

- use this information in the selection of type, dose, method and route of administration of medications

Risk Management Strategies for the Clinician – ctd.

- Conduct mental health and psychiatric evaluations, including a detailed mental status examination consistent with professional standards and guidelines
- Avoid abrupt discontinuation of medications of incoming inmates
- Monitor all high-risk inmates and those on suicide watch regularly (daily), consistent with the suicide prevention policy of the institution and with professional standards

Risk Management Strategies for the Clinician – ctd.

- Perform suicide-risk assessment when any inmate returns from out-count

- Conduct weekly clinical and administrative rounds of offenders in solitary confinement and documenting mental status changes

Risk Management Strategies for the Clinician – ctd.

- Specify suicide-watch procedures and communicate them to the jail and/or to the custodial staff, as the case may be

- Facilitate timely admission/commitment to inpatient units for those at imminent risk of suicide

Risk Management Strategies for the Clinician – ctd.

- Specify suicide-watch procedures and communicate them to the jail and/or to the custodial staff, as the case may be

- Facilitate timely admission/commitment to inpatient units for those at imminent risk of suicide

Risk Management Strategies for the Clinician – ctd.

- Conduct suicide-risk assessment at every health-care encounter
- Treat “at-risk” individuals with appropriate clinical interventions, including crisis intervention and supportive therapy
- Minimize or avoid the use of psychotropic medications with lethal potential, especially TCAs (Tricyclic Antidepressants)

Risk Management Strategies for the Clinician – ctd.

- Monitor all offenders who are medication noncompliant
- Document all assessments, decisions, and actions

Risk Management Strategies for the Correctional Officer

- Monitor inmates for indications of suicide risk
- Minimize intimidation and sexual coercion
- Report behavioral changes and communications of suicidal intent to appropriate clinical personnel

Risk Management Strategies for the Correctional Officer – ctd.

- Recognize suicide risk among manipulators and attention seekers
- Facilitate medical and mental health evaluations
- Conduct and document suicide watch

References – Media News Headlines

1. Dewan S. Jail Is a Death Sentence for a Growing Number of Americans. *NY Times*. November 22, 2022. *Accessed September 4 2023*. https://www.nytimes.com/2022/11/22/us/jails-deaths.html.

2. Linton D. Jail suicide sparks renewed criticism of Bristol County sheriff's care of inmates. *The Sun Chronicle*. October, 4 2022. *Accessed September 4 2023*. https://www.thesunchronicle.com/news/local_news/jail-suicide-sparks-renewed-criticism-of-bristol-county-sheriffs-care-of-inmates/article_35a8fe61-7b27-5daa-abee-6b14c76cdf23.html.

3. Mulligan F. All 7 inmate suicides at Bristol County House of Correction since 2017 involved bunk beds. *Standard-Times*. April 14 2023. *Accessed September 4 2023*. *https://*www.southcoasttoday.com/story/news/2023/04/14/seven-consecutive-bristol-county-inmate-suicides-involved-bunk-beds/70112422007/.

4. Whitehead J. Troubled south Mississippi man becomes another casualty in rising number of jail suicides. *Mississippi Center for Investigative Reporting/Mississippi Today*. November 28 2022. *Accessed September 4 2023*. https://mississippitoday.org/2022/11/28/eli-marrero-jail-suicides/.

5. Swales V. 20-year-old woman dies by apparent suicide at the Milwaukee County Jail. *Milwaukee Journal Sentinel*. December 16 2022. *Accessed September 4 2023*. https://www.jsonline.com/story/news/2022/12/16/20-year-old-woman-dies-by-apparent-suicide-at-milwaukee-county-jail/69736002007/.

References – Media News Headlines – ctd.

6. Alexander A. ‘State of despair.’ Inmate suicides approach historic high in North Carolina prisons. *The Charlotte Observer*. October 5 2022. *Accessed September 4 2023*. https://www.charlotteobserver.com/news/state/north-carolina/article266543526.html.

7. Harkins P. Suicide is the leading cause of Utah jail deaths. *The Salt Lake Tribune*. March 3 2023. *Accessed September 4 2023*. https://www.sltrib.com/news/2023/03/03/after-alarming-rise-utah-jail/.

8. Phu L. Alaska Corrections head says 18 in-custody deaths in 2022 were ‘too many’. *Anchorage Daily News*. Published February 3 2023. Updated February 4 2023. *Accessed September 4 2023*. https://www.adn.com/alaska-news/2023/02/03/alaska-corrections-head-says-18-in-custody-deaths-in-2022-were-too-many/.

9. Carson A. Suicide in Local Jails and State and Federal Prisons, 2000–2019 – Statistical Tables. *Bureau of Justice Statistics*. Published October 7, 2021. Accessed September 10 2023. https://bjs.ojp.gov/library/publications/suicide-local-jails-and-state-and-federal-prisons-2000-2019-statistical-tables.

10. Daigle MS, **Daniel AE**, Dear GE, et al. Preventing Suicide in Prisons, Part II. *Crisis*. 2007;28(3):122-130. doi:https://doi.org/10.1027/0227-5910.28.3.122. Accessed September 10 2023.

References – Media News Headlines – ctd.

11. **Daniel AE**. Preventing suicide in prison: a collaborative responsibility of administrative, custodial, and clinical staff. *The Journal of the American Academy of Psychiatry and the Law*. 2006;34(2):165-175. Accessed September 10 2023. https://pubmed.ncbi.nlm.nih.gov/16844795/.

12. **Daniel AE**. *Suicide-Related Litigation in Jails and Prisons: Risk Management Strategies*. *Journal of Correctional Health Care*. 2009;15(1):19-27. Accessed September 10 2023. doi:https://doi.org/10.1177/1078345808326618

13. **Daniel AE**. Chapter 6: Litigation related to suicide and suicide attempts. In: Daniel AE. SUICIDE IN JAILS AND PRISONS: PREVENTIVE AND LEGAL PERSPECTIVES - A Guide for correctional and mental health staff, experts and attorneys. 2022:153-188 Chapter 7: Legal liability risk management. In: In: Daniel AE. SUICIDE IN JAILS AND PRISONS: PREVENTIVE AND LEGAL PERSPECTIVES - A Guide for correctional and mental health staff, experts and attorneys. Legal liability Risk Management. 2022:191-224

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