



## Suicide Prevention Program Assessment

# ALLEGHENY COUNTY BUREAU OF CORRECTIONS

**OCTOBER 2019**

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*This report details findings from a consulting project that took place in September and October 2019.*

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BUREAU OF CORRECTIONS  
Suicide Prevention Program Assessment

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## Executive Summary

The Allegheny County Bureau of Corrections is reviewing and revising the suicide prevention practices at Allegheny County Jail with the goal of developing a comprehensive program that is compliant with national best practices, to include the standards of the National Commission on Correctional Health Care. In June 2019, the agency contracted with NCCHC Resources, Inc., to conduct an assessment of the jail's suicide prevention program and to make recommendations for improvement.

NCCHC Resources assembled a four-person expert team: a national expert in jail suicide prevention, a correctional health design consultant, a custody relations consultant and retired warden, and an executive physician consultant. This report is based on our findings.

### KEY FINDINGS AND RECOMMENDATIONS

We were impressed with the support and openness we received from both administrative and line staff during our review of the suicide prevention practices at Allegheny County Jail. All of our requests for information were addressed in a timely, professional manner. As noted above and as illustrated in this report, changes to enhance suicide prevention were underway before our arrival. It was clear from Day 1 that suicide prevention is a priority.

Major areas where we recommend further changes are as follows:

1. The facility has features that impose obstacles to visibility, supervision, and suicide prevention. For example, the iron enclosures in the segregation dayroom are necessary for recreational purposes, but they obscure the view of the cells from officers doing their routine duties. In some housing areas, such as the medical unit, cells in the corners are difficult to monitor (see the section on Architectural and Environmental Considerations). The observation windows in the medical housing control center are covered with a screen, impeding the view of the housing units. This is a critical area for observation of the cells and dayroom due to the nature of the patients housed here, some of whom are undergoing substance withdrawal or have other health concerns.
2. Medication pass in the regular housing units is done appropriately, but because of where it takes place, it occupies the observation abilities of the officer who must assist with security for the nurses. As a result, the officer's back is turned away from view of the cells for several minutes, which could give a good window of time for those intent on harming themselves.
3. Lack of privacy and interview space conducive to effective health screening is a concern throughout the facility, especially at intake.

4. Officer and nursing rounds are being done, but a greater focus on effective interpersonal communication is needed to reduce inmate feelings of emotional isolation and to foster communication on sensitive issues like thoughts of self-harm.
5. No cells are designed to be suicide-resistant. In areas where inmates are specifically being monitored because of suicide risk, cells should be modified to reduce the likelihood of completion. The modifications should include replacing any deficient fixtures or furnishings (e.g., as described above) with a suicide-resistant model.
6. Increase medical leadership and safe housing for inmates withdrawing from substances.
7. Enhanced policies are needed in the areas of staff orientation, mental health services, mental health programs and residential units, and infirmary care.
  - a. Existing policies on staff orientation and mental health services need to be enhanced.
  - b. A policy needs to be developed on mental health programs and residential units to address both the stepdown and acute units, in compliance with NCCHC standard MH-G-02.
  - c. The newly developed policy on infirmary-level care is under review by the facility leadership team.
8. Problem lists facilitate continuity of care by providing a comprehensive and accessible list of patient medical and mental health problems in the medical record. Currently health staff are not effectively using the problem list to promote early identification of inmates who may be at risk of decompensating or suicide.
9. Current assigned health staffing must be reassessed in line with the population's medical and mental health care needs. Staffing challenges were reported in medical nursing as well as screening and treatment services by mental health specialists.
10. Greater integration of behavioral care with primary care is needed. This integration is essential for identifying persons at high risk from suicide behavior in the community and in corrections.
11. Therapeutic programming on mental health residential units is limited. It needs to support a therapeutic environment that lends itself to treatment and recovery.
12. Treatment plans for suicidal inmates were incomplete and did not meet NCCHC standards.
13. Systemic barriers to the overall training of nursing staff affect their training in suicide prevention. Additionally, important content areas are missing from existing suicide prevention trainings, specialized training is not available for staff assigned to more critical tasks related to suicide prevention, and mock drills to reinforce the response to a suicide or suicide attempt are not practiced.

## Introduction

### Project Objectives

The NCCHC Resources team conducted an on-site analysis focused on policy, procedure, assessment, intervention, and training as well as architectural design with the aim of providing observations and recommendations in the following areas:

- Policies and procedures related to suicide prevention and observation
- Identification, screening, and assessment forms related to suicide prevention
- Scope and content of suicide prevention training offered to staff
- Housing/environment of inmates who are acutely/actively suicidal
- Interventions provided to individuals who are identified at risk for suicide
- Improvements based on NCCHC standards and best practices of the American Institute of Architects for justice-oriented facility design with respect to suicide prevention

### Method

The assessment project began with a telephone meeting between administrative staff and the consultant team followed by extensive document review, an on-site analysis (September 15-17, 2019), discussion with administrative staff during an exit conference, and follow-up telephone interviews with clinical and security staff. The on-site analysis focused on policy, procedure, assessment, intervention, and training, as well as the architectural design of the facility. The facility tour concentrated on critical areas of concern, including cells where suicides had occurred.

The NCCHC *Standards for Health Services in Jails* (2018) and *Standards for Mental Health Services in Correctional Facilities* (2015) were used as a guide in reviewing policies, procedures, suicide prevention practices, jail management, and staffing and workflow that affect suicide prevention. Key custody, medical, and mental health personnel assisted with department-wide assessment and evaluation. Multiple interviews were conducted during the on-site analysis, including with the health services administrator, responsible physician, deputy wardens, a psychiatrist, mental health specialists, the mental health director, medical and mental health nurses, correctional officers, a correctional major, and inmates.

### ABOUT NCCHC RESOURCES

With our roots in the National Commission on Correctional Health Care – the nation’s leader in setting standards for correctional health services – NCCHC Resources, Inc., provides customized consultation, technical assistance, accreditation readiness, training, and other services to correctional facilities interested in health care quality improvement. A nonprofit organization, we work to strengthen NCCHC’s mission: to improve the quality of health care in prisons, jails, and juvenile detention and confinement facilities.

## Observations

Allegheny County Jail opened in May 1995. It is a mostly linear-style design, with direct supervision. Its approved capacity is 3,182 inmates. At our visit the census was 2,338. There are 35 living units or “pods” on eight dual-level floors. The standard pod has 56 cells surrounding a central day area where meals are served, and leisure time is spent. The daily routine is typically busy with many functions occurring simultaneously such as recreation, medication pass, sick call, classes, movement, laundry, and feeding.

Facility leadership is working very hard to address areas of vulnerability with regard to suicide prevention. Among the many strategies implemented to date are the use of suicide-resistant blankets, architectural repairs, further training on suicide topics, use of electronic health records, a roaming officer position in booking to enhance inmate monitoring, increased out-of-cell program activity on the acute and nonacute mental health units, and availability of Narcan upon release, as well as inviting NCCHC Resources to assess the facility’s suicide prevention efforts.

### INTAKE

We observed the intake and booking area including the sally port, a pre-booking area, a pre-arraignment area, and the booking unit holding cells. About 40% of all admissions get released before booking.

The intake/booking area is busy and at times there are significant backlogs. Policy dictates that inmates in intake are not placed one per cell unless there is a medical or security need. We observed all staff to be fully engaged in the intake operations. Staff interviewed reported that due to the busy intake process they encounter times when they do not have enough time for gathering sufficient information on inmate health.

Inmates come into the pre-booking area under several jurisdictions. Some are newly arrested by local law enforcement and others come in from different counties or the state. We learned that medical emergencies occur frequently in the processing areas, and the jail is able to shut down the booking area to allow health staff to respond to the emergency.

Information regarding police officer statements of the inmate’s condition at arrest and health information from transfer facilities is not always given to the nurse doing the receiving screenings.

An electronic health record was implemented on July 25, 2017. Five forms are used to screen for health care needs during intake and booking:

- Medical clearance by an RN
- Receiving screening by an RN (usually the same RN who does the medical clearance)
- Booking observation report by correctional staff
- Mental health screening by one of seven mental health specialists

- Physical assessment by an RN

Pending the mental health screening, an inmate could be referred for a mental health evaluation. This could be completed by the same mental health specialist who conducted the mental health screening.

*40% of suicides occur in the early days of incarceration*

We observed an RN nurse completing the medical clearance and receiving screening forms. This was done in an open area that was not conducive to screening and the eliciting of accurate responses from the inmate.

We observed the booking observation report being conducted in the booking area within a large room with a plexiglass front facing the cell area. The room has two stations. In the first station inmates answered the initial booking questions from the officers. The second station was used for mental health screening.

We observed the booking observation questions being asked by officers sitting at their station with a computer. The inmate is in front of the officer on the other side of the podium. The questions were asked quickly, loudly, and robotically, with the officer looking at the computer screen rather than observing the inmate for affect or critical red flag behaviors. The series of questions takes about half a minute.

We observed a female being queried. She was crying and had remarked earlier that she was in withdrawal from fentanyl. She appeared to be ill and was shaking. The officer asked the questions without attention to her behavior. We stood approximately 10 feet from the officer and heard the questions and the answers clearly. Due to the speedy nature of the process, it seemed like the purpose of the questions was being overlooked.

Privacy was inadequate due to the sensitive nature of the series of questions being asked. These questions are difficult to answer honestly with an audience of other people waiting in the booking area. Some questions of concern are as follows:

- Have you ever been sexually assaulted?
- Have you ever sexually assaulted anyone else?
- Do you have any current illnesses?
- Have you ever attempted suicide?
- Do you feel like harming yourself now?

These inquiries are critical to screening for risk and should not be asked in a way that would embarrass the inmate or elicit a deceptive response. A suicidal patient might be too embarrassed to reply affirmatively in the presence of others who may overhear. It is essential that in nonemergency situations, all health information be protected from discovery or access. No conversations concerning health status, diagnosis, or treatment should occur in areas where they can be overheard by other inmates, staff, or visitors.

Until recently, the completed booking form was not viewed by the clinicians performing the mental health screening. Now a mental health specialist who conducts the mental health screening is given the booking form, which is a card with the inmate's picture stapled to it. However, this form is not part of the electronic record.



Therefore, it is not likely that clinicians conducting the physical assessment or staff conducting the mental health evaluation outside the intake area are able to view this information. Additionally, the receiving screening nurse does not see the form because the receiving screening precedes these booking inquiries.

We observed a mental health specialist conducting the mental health screening. It was done in the same room where the correctional officer conducted the booking observation but at a separate station. We talked to an RN who conducts physical assessments following the mental health screening. She told us her findings are reviewed by a provider.

In both intake areas, we observed screening (medical clearance, receiving screening, booking observations, and mental health screening) taking place in crowded areas that are very noisy due to the volume of intake. They offer insufficient privacy and noise control for the both the staff administering health and mental health screening and the inmate being screened. The problem was worse in the pre-booking area. Physical assessments are conducted in an office area, but space is very tight.

## HOUSING UNITS

### Segregation

The inmates living in restrictive housing units are monitored by health care staff in accordance with national standards (NCCHC standard J-G-02). The degree of isolation is not solitary and provides limited contact with staff and other inmates. We were told that most health care monitoring required by J-G-02 for these inmates occurs cellside, and if there is clinical indication of decompensation (as measured by objective criteria) the inmate is interviewed outside the cell in a private area.

We did not assess treatment interviews that are prescribed by the treatment plans for inmates with mental illness. These interviews need to be in a private area.

Inmates in restrictive housing are checked by medical staff three times per week and by mental health staff at least three times per week. When medical staff conduct daily health rounds, they check for manifestations of mental health issues and likewise mental health staff check for medical issues. The system appears to work well, and the two disciplines collaborate well with each other. The officers we spoke to who were working on the unit seemed to be professional and engaged. We asked a floor officer about his training and response to suicidal issues, and his responses were appropriate. He did say, however, that only a few officers have received crisis intervention team (CIT) training. It would be prudent to train more staff in CIT in order to de-escalate agitated inmates and enable them to calm down.

### Mental Health Housing

The four mental health residential units are 5C male acute care (includes patients in withdrawal with serious mental health conditions), 5D male subacute/chronic care, 5F male stepdown, and 5MD female acute and stepdown. We observed minimal program activity and therapies. We did not see activity schedules on units 5C,



5D, or 5MD. We did see an activity schedule in the interview room on the stepdown unit. It was not visible to the inmates. Reportedly two schedules had been in the pod area, but they had been removed. The schedule we saw mostly addressed meals, recreation time, count, and bedtime. It listed only 1 hour of individual sessions and three group session for the entire week These were all conducted by a bachelor's-level intern. Reportedly it is only recently that staff-patient interviews can be conducted at tables in the pod area on the acute/nonacute mental health units versus cellside. We were not able to determine how frequently interviews outside of the cell occur.

Staff who were present on the residential units reported having attended suicide prevention and intervention training during pre-service training, and some reported additional training. We observed minimal staff-inmate contact, but for the contact we did observe, the inmates seemed to enjoy cordial and respectful interactions with the staff. We asked the custody staff if they received any specialized training in order to work on this unit. They did not. However, some officers had attended training in effective communications. It would be valuable to develop a training module that covers critical areas of mental health behaviors and make it mandatory for officers who work in the mental health unit.

### Medical Housing

The medical housing unit provides care for a variety of patients: those who require observation and extra treatment for medical issues; those returning from off-site or hospital treatments; those whose care is better accomplished in the medical housing setting; and those with medical conditions who are undergoing severe withdrawal. In addition, patients who require infirmary level of care can be housed in this unit, which requires adherence to national standards. It is a vulnerable population.

One suicide occurred in the female medical housing pod. [REDACTED]  
[REDACTED] The ceiling vents have been modified to prevent that from occurring. However, we noted red flag items. First, there are two isolated rooms off of the female pod. [REDACTED]  
[REDACTED] A half dome security mirror could be affixed outside the rooms to help staff to see into them. [REDACTED]  
[REDACTED] That problem will be difficult to solve. One suggestion is to install an observation camera and equip the room with privacy stalls. Also, it should be standard procedure that patients who reside in that room undergo a complete mental health assessment to ensure they do not have a mental illness, are undergoing withdrawal, or present other concerns that increase their risk for suicide.

The control center seems to be a very busy workstation, with health and custody staff posted there. [REDACTED]  
[REDACTED]  
[REDACTED] Considering the nature of the patients residing there, and the suicide that occurred, as well as the national standard that requires infirmary patients to be within sight or hearing of health professionals, we suggest that the windows be made clear for full visibility.

## Findings and Recommendations

Findings and recommendations are presented in six sections: policies, identification of suicide risk, training, intervention for inmates identified as suicidal, best practices, and architectural design. The table below lists key areas addressed in each section.

Summary of Findings and Recommendations					
Policies	Identification	Training	Intervention	Best Practice	Architectural
Suicide prevention policy and need for training	Use of problem list	Barriers	Policies on mental health services and residential units	Wellness programming and effective therapeutic approaches	Facility overview
SPIT expansion of role and members	Tracking inmates with chronic mental health conditions and risk factors	Changes to existing pre-service	Programming	Primary care and behavioral care	Inmate housing and holding areas
– Mental health services – Mental health programs and residential units – Orientation for health staff	Tracking high-risk inmates referred to 5C housed in 5F	Specialized training	Staffing	Emotional isolation	
	Increased leadership from the medical director	Root cause analysis	Treatment planning	Preincarceration/ presentencing	
	Renewal of staff expectations in identifying higher risk inmates via mentoring and modeling		Interview space conducive to therapeutic relationship	Training inmates to identify and refer	
	Primary care screening for depression and suicide risk	Mock drills	Criteria for discharge from mental health housing	NCCHC Suicide Prevention Resource Guide	
	Adequate space/ conditions for health screening and assessment	Training requested	Housing for medically supervised withdrawal		
	Additions to screening forms		Utilization of cells not in direct view of officer		
	Staff who administer screenings/assessments are informed by findings on prior screenings				
	Hospital discharge information is shared with mental health				

	Sharing information				
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## POLICIES AND PROCEDURES RELATED TO SUICIDE PREVENTION AND OBSERVATION

We reviewed the Allegheny County Bureau of Corrections suicide prevention policies and other policies pertinent to suicide prevention:

- 304 Suicide Behavior Detection and Prevention
- 305 Mental Health Screening and Commitments
- 608 Training and Staff Development
- 2103 Administrative Meetings and Reports
- 2105 Continuous Quality Improvement Program
- 2109 Procedure in the Event of an Inmate Death
- 2112 Health Record Format and Contents
- 2207 Communication on Patient Health Needs
- 2211 Suicide Prevention and Intervention (7/10/19)
- 2304 Medication Administration Training
- 2501 Medical Clearance and Receiving Screening
- 2502 Transfer Screening
- 2503 Initial Health Assessment
- 2506 Mental Health Screening and Evaluation
- 2508 Nonemergency Health Care Requests and Services
- 2514 Treatment Plans
- 2600 Patients With Chronic Disease and Other Special Needs
- 2615 Medically Supervised Withdrawal and Treatment
- 2701 Patients With Special Health Needs
- 2702 Segregated Inmates

In conducting this review, we compared the Allegheny policies to the corresponding standards in the NCCHC *Standards for Health Services in Jails* (2018) and the *Standards for Mental Health Services in Correctional Facilities* (2015).

### Revised Suicide Prevention Policy

The jail’s revised suicide prevention policy is excellent and mirrors the NCCHC standard. However, we observed that more training is needed to familiarize staff with the policy and their role in its application.

### SPIT Committee and Program Review Committee – Mental Health

The SPIT Committee was appointed to support suicide prevention. The Program Review Committee - Mental Health reviews all discharges from acute and nonacute mental health housing.

In implementing change, it is important to have a designated leadership body as the core supporter for the change. One of these committees would be a natural body for that function. Both committees are comprised of health and custody administrators. The addition of two line officers to the committee would be valuable, considering their expertise with the units' daily operations. An officer from Unit 4A and the officer who saved seven inmates from suicide may be good choices. We recommend that the appointed committee to this role provide quarterly progress reports regarding implementation of the revised suicide prevention policy across the essential components of a suicide prevention program (e.g. training, evaluation).

#### Policy Revisions

Policy #304 uses the term "actively" suicidal, not the "acute" and "nonacute" classifications used in the NCCHC suicide prevention standard. However, policy #2211 does use the NCCHC classifications.

The NCCHC standards require policies on mental health programs and residential units (MH-G-02) for facilities that operate such housing and on infirmary-level care (J-F-02) if care is provided to patients with an illness or diagnosis that requires daily monitoring, medication and/or therapy, or assistance with activities of daily living at a level needing skilled nursing intervention. The policy on mental health programs and residential units need to be developed. We saw that a policy on infirmary-level care was developed in late October 2019 and is under review by the facility leadership team. The policy needs to be enhanced to clarify procedures for integrating mental health and medical staff regarding treatment and suicide risk observation for inmates with mental illness who need medical housing/ sheltered care or infirmary-level care. As this policy is operationalized, staff training will be needed.

Facility policy 608 on staff orientation needs to be strengthened consistent with NCCHC's J-C-09 Orientation for Health Staff. J-C-09 requires completion of basic orientation before the first day of on-site service and in-depth orientation within 90 days of employment.

Facility policy 305 Mental Health Screening and Commitments needs to be strengthened consistent with NCCHC's J-E-05 Mental Health Screening and Evaluation, J-F-03 Mental Health Services, and MH-G-03 Treatment Plans. These are examples of some areas that need to be clarified:

- Documented training is provided for the qualified staff who conduct mental health screening (J-E-05).
- Individual treatment planning is initiated when the individual enters into treatment with a qualified mental health professional (MH-G-03).
- The responsible physician periodically reviews all treatment plans (MH-G-03).
- Individual and group counseling are provided as clinically indicated (J-F-03).
- Medical, mental health, and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, medical and mental health needs are met, and the impact of these conditions on each other is adequately addressed (J-F-03).

## SUICIDE PREVENTION PRACTICES: IDENTIFICATION, SCREENING, AND ASSESSMENT

Identifying inmates at risk of suicide is best accomplished through an integration of trained law enforcement officials, facility staff who have inmate contact, judicial staff, family members, the inmate at risk of suicide and other inmates at the facility.

Formal screening is required at booking, but in the housing area prevention largely relies on the keen observations of custody and nursing staff and follow-up for those inmates identified at intake with mental health conditions. As noted above, we observed inadequate conditions for health screening and assessment in the pre-booking and booking areas. The physical assessment is done in a separate office, but space is very tight.

### Know the Inmate

*Know the inmate* is an essential principle in risk reduction. Staff assigned to housing areas need to know the inmates they monitor, and inmates need to feel comfortable in talking with staff. Staff are then more likely to recognize suicide risk indicators that are less obvious, and inmates more likely to communicate their real feelings. We identified two major opportunities for staff to better understand these risk indicators.

1. Health staff should use information that is already known about an inmate's suicide risk and mental health history. For these staff—especially nurses, medical assistants, and psychiatric aides—routine review of the problem list in the health record will inform them of the person's mental health condition. It is important that health staff know how to navigate the electronic record to review mental health concerns.
2. More custody and health staff need to take the time to establish rapport and trust with the inmate. It will lead to the inmate feeling comfortable in talking about recent losses, feelings, and fears that can elevate into thoughts of suicide. Effective interpersonal communication will minimize the sense of emotional isolation, a critical risk factor often leading to suicide. We observed and were told that communication is largely at cellside. This is not conducive to establishing rapport and trust.

### Integrating Behavioral and Primary Care

The integration of behavioral care with primary care has become an essential tool for identifying persons at high risk from suicide behavior in the community and in corrections. Research suggests up to 45% of individuals who die by suicide seek attention for a medical problem from their primary care physician within a month of their death and a large number of those who attempt suicide receive medical attention as a result of their attempt. Primary care involvement is a screening opportunity for mental health conditions associated with suicide risk. The jail's responsible physician has said that it "is important to recognize that some suicides are from those with a low index of suspicion. After housing assignment not everyone will see a mental health provider, but most inmates have contact with the physical providers." We found that staff welcomed this team approach to the whole person.

### Problem Lists

Problem lists facilitate continuity of care by providing a comprehensive and accessible list of patient problems in one place. They are an important communication vehicle used throughout the health care continuum. Effective use of the problem list at this facility by all medical and mental health staff is an opportunity for staff to know their patient's previously identified mental health and medical needs. Use of the problem list is best started in intake and focuses on the whole person.

Our review of patient records found that mental health conditions were not routinely entered on the problem list and, therefore, the problem list was not regularly used to flag inmates with significant mental health conditions. It would be helpful to conduct a quality improvement study to review mental health conditions identified at intake and entered on the problem list and those identified but not entered.

There is some discussion as to which mental health problems should be on the problem list and which conditions warrant a referral to mental health. We recommend that these conditions be defined by the responsible physician, the chief psychiatrist, and the mental health director. The electronic health record system will need to be revised so that when intake screening identifies mental health conditions, they populate into the problem list.

Community providers who serve clients with severe and persistent mental illness (SPMI) may be contacted for their problem list. We understand that arrangements are being made for these providers to share data on these patients. Once there is agreement as to what conditions will be put on the problem list, staff should receive training, including how to access the problem list on the electronic record. We heard that some staff still need training in using the electronic record. Health staff understanding of the medical and mental health conditions of the inmates they treat and those they make rounds on will promote more effective early identification of inmates who are decompensating.

### Tracking Inmates with Chronic Mental Health Conditions and Risk Factors

Follow-up of inmates identified at intake with nonacute mental health conditions and those who fall into other risk categories listed in J-B-05 is essential to a comprehensive suicide prevention program. Use of the electronic record to schedule these inmates for clinical follow-up in their housing area would be a good practice.

### High-Risk Inmates Referred to 5C but Housed in 5F

A concern was reported regarding a subset of inmates identified as suicidal. Suicide queue can start in intake. This results in 1-hour observation by a mental health specialist and irregular checks by an officer roaming within the intake area. Sometimes when these inmates are released from booking, the acute mental health housing unit is full and so they are housed on 5F. All staff need to understand that these inmates have the same monitoring requirements as those on the acute unit.

### Increased Leadership from the Medical Director

We recommend increased leadership guidance from the medical director in order to encourage improvements in quality of care, especially for inmates who are withdrawing from substances. Examples offered by the medical director himself include reducing back-log in clinic visits, more health care involvement in observation of suicidal patients, and physician-led training and education on suicide risk and prevention.

### Primary Care Screening

Screening for depression by primary care clinicians is very solid strategy to further identify inmates at risk for suicide who may not be identified at intake. We suggest providers and nursing staff, including the RN doing the physical assessment, use the Patient Health Questionnaire–2 (PHQ-2) for this purpose and have advanced training in mental health and medical conditions associated with suicide risk. Another tool that would be helpful for nurses is a cheat sheet on psychotropic medications (purpose and side effects). For nurses who pass medications, this understanding is required by J-C-05. We recommend that the chief psychiatrist create such a cheat sheet that highlights the common medications inmates receive in the local community and those on the facility's formulary.

We observed two other areas to integrate primary and behavioral care for inmates undergoing withdrawal from substances:

1. For inmates in medical/mental health housing or 4A or 4F and who have mental health symptoms: A preventive strategy is to have mental health clinicians evaluate them before release to general housing. These inmates may have underlying mental illness like depression, which surfaces when withdrawal is controlled.
2. For inmates housed on 5C, the acute mental health unit: Medical and mental health nurses and providers complete rounds on this unit. We were told that smoother coordination between medical and mental health in sharing their observations would be helpful in treating the whole person. A recommendation was made for brief weekly meetings at least among the nurses to share observations.

A related complaint that was raised several times is that medical nurses are sometimes called to the unit to provide nursing services that could be done by the mental health nurses. We recommend addressing concerns that cause division and making accommodations that promote a team approach to suicide prevention, which is built on treatment of the whole person.

### Adequate Space/Conditions for Health Screening and Assessment

A temporary solution to this problem in pre-booking and booking areas may be to extend plexiglass dividers to create or expand cubicles where health screening occurs. All mental health residential units have interview rooms, but from our observations and conversations with staff we do not think they are used regularly. Finally, in the other housing areas we toured, the interviews are cellside. A change in this practice is an opportunity for health and custody staff to minimize the person's sense of emotional isolation and create an environment where therapeutic relationships can be enhanced. Staff may feel pressured to make brief contacts during rounds and thus not connect with the inmate, but this often results in a failure to effectively assess risk.



### Additions to Screening and Assessment Forms

We have several recommendations regarding these forms:

- Medical clearance: Add “transporting officer observed or third parties (e.g., family) reported to officer concerns that inmate may be suicidal/mentally ill (yes/no).” Document officer’s statements on form.
- Transfer reports: Conduct a quality improvement study to verify that patient health data is arriving on inmates transferred from other facilities and is reviewed by the mental health specialist who conducts mental health screening at intake.
- Receiving screening: Replace items 1 and 3 with the PHQ-9. Keep the box under current self-harm or suicide ideation so interviewer can describe it, as currently required. Expand mental health history to include total number of hospitalizations and date of last discharge.
- Booking observation: Add this form to the electronic record so that staff who conduct the health and mental health screenings and assessments have access to the findings and can make more informed decisions on risk.
- Mental health screening: Require that when a mental health evaluation is requested, the reason be specified, including the chief complaint/presenting problem. This information is what the person conducting the evaluation is asked to document on the current mental health evaluation form.
- Mental health evaluation: Enter the diagnostic findings and suicide risk finding from this assessment on the health record problem list.
- NCCHC standards do not require specific forms for the mental health assessment. In October 2019 NCCHC released the Suicide Prevention Resource Guide: National Response Plan for Suicide Prevention in Corrections. This guide will be very helpful in supporting clinicians to assess risk and to develop treatment plans. Download it at [ncchc.org/suicide-prevention-plan](http://ncchc.org/suicide-prevention-plan).

### Intake Staff Are Informed by Findings From Previous Screenings

The facility is attempting to ensure that at each successive screening during intake, findings from the previous screenings are reviewed—for example, the clinician who does the mental health screening reviews the findings on the medical clearance, receiving screening, and behavior observation. We think this a good practice. Several forms need the confirmation boxes to ensure this practice is followed; we recommend adding the following checks to the respective electronic forms:

- Mental health screening: Confirm review of the medical clearance form, booking observation findings, and health reports on transferred inmates
- Physical assessment: Confirm review of the booking observation
- Mental health evaluation: Confirm review of findings on the medical clearance, booking observation, receiving screening, mental health screening, and physical assessment

### Hospital Discharge Information Is Shared With the Mental Health Office

Some of the documentation we reviewed indicated that the mental health department is not always informed regarding discharge summaries from hospitals or emergency care settings that include mental health concerns. We were informed that this concern was addressed.

### Sharing Information With Custody Staff

Discussions with custody staff revealed some frustration with health staff about sharing information. We recommend that the facility investigate this. The policy does not describe any particular method for communicating critical mental health information that might result in better monitoring and outcome with regard to accommodations for special needs, including mental illness and suicide risk. We recommend revising policy #2207 to include direction for staff followed by training of custody and health staff using case examples.

### Renew Staff Expectations in Identifying Higher Risk Inmates via Mentoring and Modeling

Supervisors can have an extremely positive influence in supporting staff to improve communication and observation skills directed at suicide prevention. This can be done using a mentoring approach during their routine contacts with staff. We like the employee engagement model of the Henry Miller Group.

Keeping employees engaged with the facility's goals, ensuring they feel respected, and giving them personal attention are strategies to boost performance. We recommend that managers (majors, captains, sergeants, and health supervisors) use these strategies in their daily interactions with staff to renew a focus on communication and observation related to suicide prevention. Again, when inmates who are experiencing emotional crisis have an opportunity to talk about their difficult feelings, they are less likely to act out those feelings.

We observed officers and health staff working very hard, but we did not see sufficient time being taken to communicate with the inmates. Some officers said they have observed minimal staff interaction with inmates among some of their colleagues. In our review of documents, we saw opportunities to better engage inmates during health staff and officer rounds. We support the facility's efforts to increase staff activities in the acute and nonacute pod housing areas.

We observed some officers and nurses firmly expressing a belief that "an individual who wants to complete suicide will do it and there is nothing that can be done to intervene." This belief likely undermines one's focus on suicide prevention and understanding of how communication with inmates will reduce their risk. Such comments present an opportunity for on-the-job mentoring and education about the importance of staff members' role in suicide prevention. During our tour we met an officer who said he had saved seven inmates from suicide. Supervisors could have this officer talk to staff who have these doubts. For inspiration, see Stories of Hope and Recovery at [suicidepreventionlifeline.org/stories](http://suicidepreventionlifeline.org/stories).

## SCOPE AND CONTENT OF TRAINING

On-site we interviewed the facility captain, the health services administrator, and several correctional officers and nurses regarding staff training on suicide prevention topics. By phone we talked to the Bureau of Corrections training director. We also reviewed the three suicide prevention training programs for employees:

Suicide Prevention and Intervention (pre-service), Suicide Prevention and Intervention (annual), and Suicide Assessment and Prevention in Jail: For Mental Health and Medical Staff: Avoiding Obstacles to Prevention.

Below are the training objectives for the pre-service and annual programs:

**4 PERFORMANCE OBJECTIVES**

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- Identify the **myths and facts of suicide** in custody.
- Recognize the **demographic and cultural parameters of suicidal behavior**.
- Identify the **warning signs and symptoms**.
- List **factors and stressors** that can increase an inmate's thoughts of suicide.
- Identify **how to respond** to suicidal inmates.

**5 PERFORMANCE OBJECTIVES**

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- Identify **referral procedures**
- Identify **housing observation** and suicide watch level procedures.
- Describe follow-up **monitoring of inmates** who make a suicide attempt.
- Explain **communication** between correctional and health care personnel.
- Explain the **rules of good discipline techniques** for managing suicidal offenders.
- Self-care** for staff.

### Pre-Service Training

The Suicide Prevention and Intervention training is part of a mandatory 8-hour classroom pre-service training program for all civilian staff as well as cadets. The training is provided at the correctional academy, and employees cannot work in the jail without this training. The program has five components: PREA, Fire, Safety, Suicide Prevention, Policies. The policies component does not include the suicide prevention policy. The 2.5-hour Suicide Prevention and Intervention component is taught using a PowerPoint by the mental health director, whom the academy has certified as a training instructor. The training for correctional officers includes a 4-week classroom training, 1 week of observation, and 4 week of on-the-job shadowing. Attendance records are maintained. Some correctional facilities include orientation to mental health services (developed by the mental health director) as part of officer shadowing. This is a good practice.

### Annual Training

Annual suicide prevention training is a computer-based training that uses a modified version of the pre-service PowerPoint and has a quiz at the end. It is sent electronically to all corrections and civilian staff 8 months in advance, so they have sufficient time to complete it. After completion of the test they return their results electronically to the training director. Staff completion of the annual training is tracked on an Excel sheet. We reviewed annual training data for 2019 and 2018. The 2019 data showed that as of October 31, a significant number of staff had not completed the training. These staff include security, health care, program, and civilian employees. Of the 625 employees assigned to the annual training in 2019, 487 have passed and 130 have not yet completed it. However, the deadline for completion is December 31.

In 2018 most staff completed the training: Of 548 employees assigned to the training, 487 passed, 4 failed, and 57 did not complete it. The disciplines and number of staff were as follows: medical nurses (LPN, RN, ADON), 37

assigned, 6 did not complete or failed; mental health nurses, 13 assigned, 1 did not complete; providers/physicians, 5 assigned, 5 did not complete; security staff (administrators, line officers), 418 assigned, 20 did not complete. The remainder were chaplain, other program, and civilian staff.

We also confirmed that only 55% of the correctional officers had CPR training. This is out of compliance with J-C-04 Health Training for Correctional Officers, which requires that 75% of the staff present on each shift be current in their health-related training.

### Training for Mental Health and Medical Staff

The third training was Suicide Assessment and Prevention in Jail: For Mental Health and Medical Staff. This 3-hour training focuses on avoiding obstacles to prevention and was written by suicide prevention expert Lindsay Hayes (see [www.ncianet.org/wp-content/uploads/2015/05/Avoiding-Obstacles-to-Prevention.pdf](http://www.ncianet.org/wp-content/uploads/2015/05/Avoiding-Obstacles-to-Prevention.pdf)). The training offers more details on identification and response to suicide risk and includes case studies and role playing. It was administered to approximately 20 mental health nurses, psychiatric aides, and mental health specialists across two shifts: 15 staff on 10/30/17 and 5 staff on 6/1/18.

### Our Observations

Training is an important way to promote and model staff communication skills. We found the facility to be committed to staff training as illustrated by the programs discussed above and by the two positions focused on training, i.e., facility director of training and nurse educator. We observed that the individuals in these positions were motivated and qualified.

We did observe concerns with staff training in suicide prevention. These included what appear to be systemic barriers to the training of nursing staff; key content areas that were missing from pre-service suicide prevention training; a lack of specialized or advanced training for staff assigned to more critical areas or tasks related to suicide prevention; a more effective use of the annual training; a lack of cross-training for primary and behavioral health care in identifying and responding to inmates at risk of suicide; and a lack of mock drills to reinforce the response to a suicide or suicide attempt.

Before offering specific recommendations, we will share our observations of systemic barriers to nurse training. We observed or were informed of three significant obstacles:

- Employees can choose not to train other employees, which appears to greatly affect the quality of orientation training for nurses; this causes barriers to staff shadowing, which is an especially effective training process for new employees
- Poor health staff attendance at staff meetings, which are a critical vehicle for training and building a unified approach to suicide prevention
- Employees can choose not to train other employees, which appears to greatly affect the quality of orientation training for nurses; this causes barriers to staff shadowing, which is an especially effective training process for new employees.

### Orientation Training

Well-trained nursing and officer staff are key to suicide prevention. They are the primary gatekeepers for identifying inmates at risk. Suicide prevention in corrections is greatly enhanced via a unified approach of trained nursing and security staff.

The correctional environment can be frightening for new nursing staff until they understand normal daily operations and the processes for solving routine problems. We were told that turnover is high and that some nursing staff quit in the first weeks because they feel isolated and are uncertain of their responsibilities. Job shadowing with experienced facility nurses is a critical intervention in addressing this problem. Officers at this facility receive 4 weeks of shadowing.

Some staff indicated that their shadowing was unstructured and did not support a successful transfer of skill expectations or nursing cohesiveness. Job shadowing can help health staff to understand the importance of their role and responsibility in the care of inmates at risk for suicide and other health conditions. It builds their confidence in their ability to do this job and supports their understanding of staff safety precautions. Equally important, it enables them to build rapport with other employees and mentors and helps staff feel welcomed and integrated into a professional health care team.

Another concern is the time frame and content of the basic orientation training. NCCHC essential standard J-A-05 Policies and Procedures requires that all health staff receive basic orientation on the first day of on-site service. At a minimum, basic orientation addresses relevant security and health services policies and procedures, response to facility emergencies, staff member functional description, and inmate–staff relationships. In addition, within 90 days of hire health staff must receive an in-depth orientation that includes all health policies not covered in the basic orientation, as well as other critical topics. Although facility policies 2104, 608, and 204 have specific training requirements, we could not determine if they were fully met and consistent with NCCHC policies. This would require a quality improvement study.

A summary of some key components of facility policies 2104 and 608 is as follows:

#### Policy 2104:

- All newly hired staff members will review the health care policies during orientation and will indicate their review and understanding of the policies and procedures by signing the review sheet within the first 30 days of employment.
- Policy updates are shared with health staff at roll call and monthly staff meetings and staff are notified via email of new policies and/or policy revisions that are accessible for review and signature in PowerDMS.

#### Policy 608:

- All new professional and support employees, including contractors who have inmate contact, receive 40 hours of training prior to being independently assigned to a particular job and 40 additional hours of training each subsequent year. Among the 17 training areas to be covered in the first year are staff rules and regulations, facility organizational chart, recruitment and promotion, safety and security

procedures, supervision of inmates, job specifications, signs of suicide risk and precautions, inmate rights and responsibilities, interpersonal communication, working conditions, and counseling techniques.

The nurse educator informed us that she was working on the following:

- A more formal orientation curriculum to effectively on-board new staff
- A way for all nursing staff to acknowledge and understand policies that pertain to their daily functions. For example, orientation checklists are now distributed for some job titles to guide new staff and their trainers in tasks that should be covered within that job.

Her major training goal is to increase staff retention. The plan is to team up new hires with the best staff available to train them, and to conduct audits and implement remediation to ensure staff are competent in jail practices and are imparting accurate training knowledge to new staff.

### Staff Meetings

Ongoing training of nursing staff largely occurs in staff meetings. For example, staff meetings are where new policies on suicide prevention or findings from root cause analyses are discussed. Attendance at staff meetings has been a problem, reportedly more so for the medical nursing staff. For example, we were informed that a 2019 meeting was attended by only one nurse despite [REDACTED] and the DON announcing it far enough in advance. The mental health staff is smaller and meeting attendance is better. Staff meetings for medical nurses are not in compliance with J-A-04 as they do not occur monthly or more frequently. It was reported that administration has offered incentives for attendance, but this has not been successful.

Administration works to inform nursing staff of operational issues by holding roll calls before shifts, disseminating meeting notes, and sharing notes on a computer drive, but this is not enough. Essential standard J-A-04 Administrative Meetings and Reports is critical to support a healthy working environment and to facilitate health care delivery. Some nurses said they are not informed of operational issues and the reasons why operational processes are being done a certain way. This is likely the result of poor attendance at staff meetings. The meetings are meant to be where problems are identified, corrective actions initiated, brief training occurs (e.g., review of medication lists), and policies explained (e.g., the revised suicide prevention policy). Communication among staff members is necessary to promote a healthy environment and to facilitate a comprehensive, unified staff approach to suicide prevention.

### Formal Training

We were told it is very difficult to schedule staff training. Facility training for staff assigned to shifts is usually arranged by shift overlap schedules so that two training times encompass all staff. Current shifts are 6–2:30, 2–10:30, and 10–6:30.

## Recommendations

### Orientation Training for Nurses



A nurse educator has been hired to enhance nurse orientation and other training. She will need the support of facility administration, the SPIT team, and the facility training director. For suicide prevention it is critical that nurses work as unified team with correctional and mental health staff to identify and respond to inmates at risk of suicide. This requires not only suicide prevention training on identification and response but also that newly hired nurses are acclimated to their work in the correctional environment and understand the importance of their roles and responsibilities in suicide prevention.

We recommend conducting a study that includes nurses hired in the first 3 months of 2019 to track:

- What training they received and how it compared to J-C-09 Orientation for Health Staff, J-B-05 Suicide Prevention and Intervention, and policies 608, 2104, and 304
- The time frame (from point of hire) in which they received training
- Which nurses from this cohort are still employed and which have resigned

After this study, enhance the orientation program for all nurse employees consistent with J-C-09, J-B-05, and facility policies.

#### Pre-Service Suicide Prevention Training

We recommend that the 2.5 hour training be expanded to an 8-hour program that maintains a mix of custody and health staff in a classroom setting. It should incorporate other critical knowledge areas to support staff understanding of suicide risk in the jail setting and their role. Current training does not seem to cover the following areas:

- Guiding principles to suicide prevention
- Inmate suicide research
- Staff attitudes about suicide
- Why correctional environments are conducive to suicide behavior
- The facility suicide policy and critical roles of custody and health staff (e.g., staff referral of inmates who inform them they have an experienced a loss)
- Practicing effective communication skills
- Proper role of staff in responding to a suicide attempt
- Emergency rescue tools needed by custody and health staff at the scene of a suicide attempt: Where is the cutting knife? What is in the ambu-bag?

#### Specialized Training for Medical, Mental Health, and Custody Staff at Intake

Early identification of risk depends largely on effective screening at intake by trained staff. In addition to the basic suicide prevention training, these staff need greater proficiency in screening skills and practice that promotes inter-rater reliability. It is critical that the most qualified security and health staff are assigned to intake as this is the first opportunity to identify high-risk inmates. The absence of qualified staff presents a risk that these inmates may not be properly assessed, resulting in a suicide that could have been prevented.



We recommend that the mental health director, with support from the training director and the staff educator, develop specialized training for staff who conduct the screenings. This training should be a prerequisite for working in the intake area. Elements to include in the training are follows:

1. The importance of effective intake screening to the suicide prevention policies and goals
2. Practice using the screening form they are assigned to complete
3. The intent of the inquiries on these forms (e.g., recent release from psych hospital is because this is a high suicide risk period)
4. Effective communication and interviewing skills that convey compassion
5. Use of case studies to practice identifying symptoms of depression and other mental illnesses and signs of emotional response to incarceration
6. Common psychotropic medications and their purpose
7. Criteria for referral to mental health
8. Personal biases that may hinder objective risk screening and assessment
9. Periodic observation of screening performance by the mental health director and custody and health training directors

#### Advanced Training for Staff in Critical Areas for Suicide Prevention

We commend the facility for offering the excellent Avoiding Obstacles to Prevention training program to mental health staff. It would be highly beneficial to extend that training to custody supervisors (majors, captains, sergeants), all medical staff, and custody staff who work on medical, mental health, withdrawal, and segregation housing units, as well as medication administration. This could be used to meet the annual training requirements. However, if this is done, we recommend supplementing it with additional training in communication, de-escalation skills, and staff-specific roles in these areas. Classroom training with a mixture of custody and health staff is a best practice.

#### Cross-Training for Providers

To further integrate behavioral and primary care, we recommend cross-training for mental health and primary care managers and providers where the chief psychiatrist addresses mental health symptoms and the responsible physician addresses medical conditions. This could be presented as a lunchtime series of modules. In addition, we recommend that the mental health director and the chief psychiatrist provide a series of trainings on mental health symptoms for the physicians and mid-level staff who provide medical services.

### Annual Training

The annual training presents an opportunity to reinforce areas critical to suicide prevention, especially those that have become apparent in the previous year. For example, reinforcing staff vigilance in observing inmates during busy times on the housing units and during intake screening. When the training is conducted online we recommend combining it with management staff follow-up to reinforce the training goals. We recommend this training be presented in a classroom setting with mixed custody and health staff and offer two options for the training in 2020.

- Training on the New Suicide Prevention Policy: Use the annual training to educate staff on their roles and responsibilities under the new policy and to ensure that managers meet with staff to reinforce their valued roles. For example, in a staff meeting the mental health director could reinforce evaluation requirements to remove an inmate from acute care status.
- Corrective Actions Learned From the Root Cause Analyses: In the trainings, reinforce corrective strategies identified in the root cause analyses. These analyses are conducted via a multidisciplinary approach and are comprehensive and excellent. Knowledge of the corrective actions presents another opportunity for managers to support their staff in making needed improvements for suicide prevention (e.g., inmates not blocking cell windows) through case studies.

### Mock Suicide Prevention Emergency Drills

Mock suicide emergency drills on suicide prevention should be conducted at least annually. The drills should review problems typically associated with response to suicides (e.g., access to medical equipment, access through the facility, dull cut down tool) as well as those documented in findings from the root cause analyses.

### Staff Training Requests

Staff also informed us of these additional training requests:

- How mental health specialists should handle manipulative inmates to avoid inappropriate housing
- Explanation of what administration means in terms of improving services. For example, we were told that nobody knew what NCCHC Resources is and why the consultants were here. This communication would promote more cooperation in supporting administration goals.
- Postpartum depression
- Understanding people who attempt suicide vs. those who complete suicide
- Providing the annual training in a classroom setting, as noted by some correctional staff. Although online training is useful and efficient, a critical topic such as suicide prevention is better discussed in an environment that allows for questions and sharing of ideas and examples.
- More officer training on identifying crises, first aid, and communication skills
- Clarification on what can be communicated to housing officers by health staff
- CIT training for those who work in segregation

## INTERVENTION

The facility's mental health residential units are describe in the Mental Health Housing section. Inmates in the other housing areas access mental health services through the health care request system unless they present an emergency. The nonemergency system reportedly includes daily submission of requests and pick up by health staff. Within 24 hours staff provide a face-to-face response at cellside. We were told this process was just being implemented, so we did not review data on responses to nonemergency requests. We learned that in 2018 it was decided that mental health sick call requests should prompt a meeting with a mental health professional within 24 hours of receipt. We were told that most of the mental health visits in the other housing areas are at cellside, which presents a barrier to the therapeutic relationship, as discussed above.

Our record review found that treatment plans were incomplete or not well documented, and group and psychosocial programming was minimal. The male stepdown unit had an activity schedule, but it was in the back office not in view of the inmates. Reportedly there were two schedules on the pod, but they had been removed. The bedtime reported on the schedule was 8 pm and the morning count was 7 am. This lack of evening activity likely exacerbates feelings of emotional isolation.

The scope of care and types of general mental health services required for patients on the residential units were not defined in policy. We were told that the mental health director is developing facility policies compliant with NCCHC standards on these issues. The relevant NCCHC standards are MH-G-02 Mental Health Programs and Residential Units, MH-G-01 Basic Mental Health Services, and J-F-03 Mental Health Services.

Key elements of the NCCHC standards for acute and nonacute care residential units and mental health services are as follows:

MH-G-02: Acute care residential units are for inmates who pose a serious risk to themselves or others but are not in immediate need of inpatient hospitalization. Management of these units should incorporate the following:

1. Staffing is sufficient to enable each resident to have daily contact with a qualified mental health professional who orders needed therapeutic interventions, coordinates patient care, and recommends discharge from the unit.
2. The staffing plan addresses the number of patients, the severity of their illnesses, and the number of mental health staff to manage the level of care.
3. When clinically indicated, psychotropic medications is made available.
4. Patients have increased monitoring and attention, individual and group therapies, and psychosocial activities. Their environment should be clean, safe, and adequate to meet their needs.
5. Custody staff receive specialized training that includes de-escalation skills and treatment team participation.

M-G-02: Nonacute care residential units are short-term or permanent housing areas that provide mental health services for chronically mentally ill patients or inmates experiencing situational stress. Their management should incorporate the following:

1. Patients receive mental health programming and supervision, but to a lesser degree than in the acute care unit
2. Mental health treatment staff have weekly case conferences to review patient progress, coordinate services, and propose modifications in treatment strategy where necessary. This does not require that every patient be discussed every week but that specific patients are discussed as clinically indicated.
3. Treatment goals are documented and focus on reducing or stabilizing symptoms, attaining appropriate functioning, preventing relapse, and supporting patients in developing and pursuing personal recovery plans.
4. Custody staff receive special training so that they can be active contributors to the therapeutic goals of the unit

MH-G-01 and J-F-03 Basic/Mental Health Services standards require that mental health services are available for all inmates who need them. There are six compliance indicators:

1. Patients' mental health needs are addressed on-site or by referral to appropriate facilities.
2. Outpatient services include, at a minimum: identification and referral of inmates with mental health needs; crisis intervention services; psychotropic medication management, when indicated; individual counseling; group counseling and/or psychosocial/psychoeducational programs; and treatment documentation and follow-up.
3. When commitment or transfer to an inpatient psychiatric setting is clinically indicated, required procedures are followed, the transfer is timely, and the patient is safely housed and adequately monitored until the transfer occurs.
4. Outpatients receiving mental health services are seen as clinically indicated and as prescribed in their individual treatment plans.
5. Mental health, medical, and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, medical and mental health needs are met, and the impact of these conditions on each other is adequately addressed.
6. All aspects of the standard are addressed by written policy and defined procedures.

We also observed staffing challenges related to multiple employers. Reportedly, the providers, physicians, and psychiatrists are employed by the hospital, while nurses are employed by either the county or staffing agencies, which account for about 60% of nursing staff. This organization can create many challenges to building a unified team approach to a comprehensive suicide prevention program that integrates primary and behavioral care. It is important that administrators be sensitive to these challenges and promote a unified approach via staff and administrative meetings, training case studies that illustrate suicide prevention via effective coordination of disciplines, and quality improvement studies.

### Policies on Mental Health Services and Residential Units

Policies have not been developed that are consistent with NCCHC MH-G-02, MH-G-01, and J-F-03, which clarify the scope of care, programming, and staffing, and support practice being implemented consistent with the intent of the standard. This is an opportunity for the chief psychiatrist and the mental health director to provide clear directions for staff and to develop a staffing plan based on inmate needs that will guide funding requests.

### Programming

Programming on residential units needs to support a therapeutic environment that lends itself to treatment and recovery. We did not observe sufficient programming. Only recently have staff been able to interview patients at tables in the acute unit housing pods. Staff now work with patient on activities like crossword puzzles. These activities are important but not sufficient in frequency or type. In the stepdown units, inmates told us programming opportunities were limited. They did appreciate the work of the student intern. The stepdown unit activity schedule listed bedtime at 8 pm and morning count at 7 am. This is a long time to be isolated in a cell. Evening activities would contribute to a therapeutic environment. We were told that more mental health specialist were being hired to provide these services (groups and individual therapies). These would include evening activities.

We offer suggestions for expanding these programs once the scope of care is defined:

1. It would be helpful to review the program modules used by community agencies that serve SPMI patients and, wherever possible and within the scope of care, to mirror their interventions. This would also further continuity of care upon release to the community.
2. Tools for structured programs are available online and many are available at no cost. Some of these tools are listed below:
  - Illness Management and Recovery tool kit  
[store.samhsa.gov/system/files/practitionerguidesandhandouts.pdf](https://store.samhsa.gov/system/files/practitionerguidesandhandouts.pdf)  
Developed by the Dartmouth Psychiatric Research Center, this resource presents training in skills that patients with serious mental illness said they need to further their recovery. Staff can easily be

trained to deliver the modules, which cover topics such as recovery strategies, stress-vulnerability treatment strategies, building social support, and more.

- Wellness Recovery Action Plan (WRAP)

[mentalhealthrecovery.com/wrap-is](http://mentalhealthrecovery.com/wrap-is)

This program supports patients in a creating wellness process to get well, stay well, and make their life the way they want it to be. WRAP is listed in the National Registry of Evidence-based Programs and Practices.

- Anger Management for Substance Abuse and Mental Health Clients: A Cognitive–Behavioral Therapy Manual (plus workbook)

[store.samhsa.gov/product/Anger-Management-for-Substance-Abuse-and-Mental-Health-Clients-A-Cognitive-Behavioral-Therapy-Manual/PEP19-02-01-001](http://store.samhsa.gov/product/Anger-Management-for-Substance-Abuse-and-Mental-Health-Clients-A-Cognitive-Behavioral-Therapy-Manual/PEP19-02-01-001)

The manual contains a 12-week cognitive–behavioral group treatment model. The content includes specific instructions and suggested remarks for group leaders, and exercises for group members.

3. Methodologies considered more effective in treating a suicidal client include cognitive therapy, dialectical behavior therapy, and mentalizing treatment. An American Psychological Association article by Lisa Firestone, PhD, presents a good summary of these treatments.  
[www.apa.org/education/ce/suicide.pdf](http://www.apa.org/education/ce/suicide.pdf)
4. Involvement of the inmate’s family to provide needed support is a best practice that also can decrease emotional isolation. Clinicians are encouraged to explore this involvement when evaluating patients. Signs in the visiting room that encourage family members to notify the facility if they observe indicators of depression or suicide risks are effective. We did not note whether these signs were present.

### Staffing

We did not assess all of the health staffing needs. However, we did observe shortages in medical nursing and mental health specialists. Supervisors report a high attrition rate, especially among medical nurses. This needs to be evaluated and based on findings develop corrective actions. Medical nursing was described as understaffed, and we observed that nursing staffing was low in the intake areas. We were told that when there is an emergency, the intake process is often shut down to enable the intake nurse to leave the area and respond to the emergency.

Staff voiced another nursing-related concern that the nurse position for 5F was vacant. Currently nurses are assigned to 5MD, 5C, 5D and 5F. When 5C (acute) is full, inmates are housed on 5F. We understand that this position has been filled. It is a critical position to ensure continuity of care.

We were also concerned with the availability of mental health specialists to provide individual and group counseling consistent with effective methodologies, psychosocial/ psychoeducational program services, intake mental health screening on days/evenings when there is an influx of arrests, and follow-up on inmates in the other housing areas.

For the intake area, the busiest days and evenings were reported to be Wednesday through Sunday. The mental health director estimates that 3 PRN mental health specialists are needed to cover these busy shifts. We think this estimate may be low based on comparison of mental health screenings completed to booking admissions. In 2018, there were 13,947 commitments. Reportedly, all of these inmates received mental health screening, with 1,894 (approximately 14%) referred to mental health. The Bureau of Justice Statistics (BJS; 2017) reported that 26% of people incarcerated in jail met the threshold for serious psychological distress. Torrey et al. (2014) found that 20% of jail inmates have a serious mental illness. Steadman (2009) found that 14.5% of males and 31% of females had a serious mental illness. The prevailing view now is that the prevalence is closer to 30% of the jail population. Applying the BJS prevalence estimates to the above data suggests that a large number of inmates with mental illness may not be identified in intake. However, it is possible that a significant number of inmates may be symptomatic after they are in the housing areas and then referred to mental health. Removing barriers such as allowing more time to conduct screening and the environmental conditions discussed earlier may increase early identification of inmates with serious mental health conditions at booking and in the housing areas. It would be useful to compare total admission to mental health with these prevalence estimates.

We observed potential concerns with the follow-up of inmates not showing acute symptoms but identified in intake with historic factors related to risk (e.g., prior psychiatric hospitalization, recent loss). Our record review found three inmates who fell into this category. There was no documentation of follow-up appointment. We previously suggested that a follow-up appointment be made at intake for these inmates via the electronic record system. Tracking these inmates is important to early identification of suicide risk. It will likely require more mental health specialist time being assigned to the other housing areas. It also means that the inmate will need to be interviewed, not at cellside but in a private area to accurately evaluate the need for mental health services.

Finally, once the scope of care is defined and programming established to meet patient needs, more mental health specialists will likely be needed to provide psychoeducational groups and treatment services. The mental health director reported that in addition to the 7 mental health specialists, most of whom provide screening and response to mental health requests, there is a need for 3 PRN specialists assigned to intake and 2 more full-time positions to provide treatment on the residential units. In hiring the additional staff, this would be a good opportunity to fill the positions with people who are skilled in effective therapeutic approaches in treating a suicidal client.

### Health Record/Treatment Plans

Treatment plans for suicidal inmates were initiated in 2019. We reviewed 11 treatment plans and found plans that are incomplete and lack documentation required in J-B-05, J-A-08, and MH-G-03. We recommend consideration of a SOAP format. We also heard that inmates in 5C cannot have reading material in their cells. Clinical decisions regarding patient restrictions should be individual and are the responsibility of qualified mental health professionals. The treatment plans we reviewed had discrepancies between NCCHC standards language and what is documented here in terms of “acute” vs. “nonacute” suicide risk. In addition, suicide checks were either not being done appropriately or not recorded accurately. Corrections officer checks appear to be prefilled



with intervals and potentially don't represent checks as required by the standards. However, we asked multiple staff how they were filled out and were told intermittent checks, no more than 15 minutes.

We saw language that suggested use of "no-harm contracts." These are not used in decision making regarding suicidal risk. They lack validity and often influence clinicians to make inaccurate decisions regarding risk

Our review of the medical record raised other concerns. First was continuity of care and clinical information shared between touchpoints along the care process. For example, medications logged at medical clearance should be documented and verified to the extent possible, as should the indications for these medications. Changes should be justified and documented, and the reasons for new medications indicated. We recommend that staff who document mental health or clinical care should at least refer to the care given in the other disciplines. Second, the primary care team could make general comments about awareness of mental health treatment and vice versa. Two examples highlight this need:

- 5C – Admitted 10/18, negative medical clearance screen but taking Haldol and Cogentin and no mention of MH. History begins to solidify during the MH screening (an LSW) handout about 16 hours later. Then admitted to MHU (5C) then he received a nursing screen. Documentation indicates different medications. Now Lithium and Risperidone added and older meds presumably D/C'd. This admission note was about 24 hours after admission. Psych eval about 48 hours after admission. No general medical evaluation that was able to be located. Many contact points but touchpoints not well articulated.
- West 5C – Admitted 1/5/19 10:37, negative medical clearance. Receiving screening @ 12:18. Mental health screening 1/5/19 @ 11:13. Clearly stated depressive symptoms. Suicide gown due to "fighting." Feels sad, no support system. Psychiatric evaluation on 1/6/19. Psychiatric PA. Treatment plan and medication not documented. Very limited coordination with medical despite an active Rx for Ventolin.

### Interview Space Conducive to a Therapeutic Relationship

We were told that most patients interviews are at cellside, creating privacy issues and barriers to clinical/client relationships. Reportedly all residential units have an interview room. Individual interviews in these rooms is an opportunity to strengthen the therapeutic relationship, thus resulting in a more accurate assessment of the patient. It also decreases emotional isolation and encourages patient to participate in treatment. Bringing inmates out of their cells for health care should be a focus of planned intervention in the residential units as well as the other housing areas. This article is a great tool for increasing staff awareness of the negative impact of emotional isolation and how to decrease it: [www.correctionsone.com/correctional-healthcare/articles/preventing-suicides-simple-ways-to-stop-inmate-self-harm-naJaR4XEI8xQixbw](http://www.correctionsone.com/correctional-healthcare/articles/preventing-suicides-simple-ways-to-stop-inmate-self-harm-naJaR4XEI8xQixbw)

### Discharge Criteria

A program review committee was recently instituted to monitor appropriate housing changes for inmates released from acute or nonacute mental health housing. There is concern regarding justification of inmates being transferred from these units. To address this, the above oversight committee reviews and approves these movements. In our review of clinical records, we found the major issue was that treatment plans did not document change in the inmate's risk or include a risk management plan with follow-up required. These plans were not consistent with policy #2211 nor with NCCHC standards MH-G-04 and J-B-05 with regard to evaluation

and treatment. An informative article on this subject is Correctional Suicide Risk Assessment and Prevention by James Knoll, MD, *Correctional Mental Health Report*, Vol. 10, No. 5, January/February 2009.

We recommend that staff are supported and required to comply with the documentation required in policy #2211 evaluation section, which would meet the NCCHC standard. This lack of documentation may also reflect a staffing problem among mental health providers. The oversight committee should assess this need before moving forward. When staff is sparse, the provider may not give sufficient attention to critical documentation. However, documentation is especially critical to the safety of high-risk patients and future legal complications for the facility.

Policy #2211 is consistent with the Federal Bureau of Prisons' Suicide Prevention Program Statement (P5324.08) on suicide watch, termination of watch, and post watch report. Policy #2211 requires an initial treatment plan, regular reassessments to identify change that indicates need for change in supervision level, and documentation upon clearance from mental health professionals that the following factors were considered:

- Change in risk factors since the onset of the suicide watch
- Reasons for removal from the watch
- Response to treatments
- Mental status examination
- Protective factors
- Follow-up recommendations, frequency of follow-ups
- An initial follow-up appointment by a mental health specialist, mental health RN, or provider

NCCHC's Suicide Prevention Resource Guide: National Response Plan addresses key areas in suicide prevention. It will be very helpful in supporting clinicians to assess risk and to develop treatment plans. [ncchc.org/suicide-prevention-plan](http://ncchc.org/suicide-prevention-plan).

### Housing for Substance Withdrawal

People who abuse alcohol and/or drugs, or are dependent on them, attempt suicide nearly 6 times more often than those without substance use disorder (SUD). By gender, the rates of completed suicide are 2-3 time higher among males with SUD and 6.5 to 9 times higher among women with SUD (see [www.ncbi.nlm.nih.gov/pmc/articles/PMC4499285](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4499285)).

The housing for managing inmates undergoing withdrawal is on 4F and 4A. Withdrawing inmates who also have serious health problems are housed on 5B, and those with serious mental health problems on 5C. Withdrawing inmates are not housed in a safe location that allows for effective monitoring, nor in suicide-resistant cells. They are doubled celled and sleep on bunkbeds (reportedly some still have a ladder). Staff report that inmates have fallen from the top bunk. This can result in injuries that present risk for seizures. These practices are not adequate for these patients. It is critical to create an environment where the staff have good visibility and can effectively monitoring the inmates. Some correctional facilities house withdrawal patients in a dormitory setting with beds close to the floor.

We also observed cells located in the back corner hallways of some housing units, including withdrawal housing. Each side of these cells has a blind corner that prevents direct observation from the housing officer workstation. These do not provide safe housing for inmates in general, and especially those with known high-risk indicators, e.g., substance withdrawal, past suicide attempt, depression, and other mental health conditions.

Concerns were expressed regarding better coordination between medical and mental health for withdrawing inmates. It was reported that it is not uncommon for inmates on these units to be identified with mental health problems. This can happen through the intake screening process or after the inmate is housed. Collaboration between primary and behavioral care is important to facilitate assessment of mental health condition and suicide risk before release to another housing unit. For those identified at intake with a nonacute mental health condition and housed on 4F or 4A, an appointment for this assessment could be made via the electronic record. An example is an inmate recently discharged from a psychiatric hospital who shows no acute mental health problems at intake and, due to substance abuse, requires withdrawal housing.

We were not able to complete a thorough review of services for inmates undergoing withdrawal. However, based on our findings, especially the health risk presented by the bunk beds and visibility, we recommend that the responsible physical and the chief psychiatrist review current practices against the requirements of J-F-04 Medically Supervised Withdrawal and Treatment to ensure proper management and housing. This review would support the facility's suicide prevention efforts.

## BEST PRACTICES

Allegheny County's commitment to developing a comprehensive suicide prevention program provides an opportunity to incorporate best practices in the care of inmates at risk for suicide and in the support of staff who respond to suicides. We have identified six best practices to assist in achieving this goal. Many of them have been discussed above.

1. Employ best practices in the treatment of mental illness, such as the Dartmouth wellness and recovery modules, as well as effective therapeutic approaches to treating the suicidal patient, described in the Intervention section of this report.
2. Address the impact of emotional isolation on suicide risk. In all housing areas increase opportunities for interpersonal communication outside the cell environment, making structural changes, infusing training programs with this subject, and even having staff tour the facility focusing on emotional isolation in corrections and the many opportunities in the cells to complete suicide. Custody and health staff often become desensitized to emotional isolation and the many other barriers to suicide prevention in the correctional environment.

3. Integrate primary care and behavioral care via cross-training, team building, and integration of best practice tools (PHQ 9 and 2) to identify inmates who appear depressed during visits to their physical health care providers.
4. Continue and increase involvement with best practice programs that work to appropriately keep people with lesser crimes and mental illness out of the jail or reduce time served. We were told that Allegheny County has a mental health court, and the National Support Bureau reports that Pittsburgh is exploring creating a diversion program. We commend the facility for participation in county initiatives such as Stepping Up!, the Sequential Intercept Model, and the MacArthur Grant, and partnership with Allegheny County Department of Human Services Pretrial Services and Justice Related Services. We recommend continued tracking of jail admissions for people with lower level charges and mental illness who may be better served in community programs and sharing this data on a regular basis with prosecutors and key administrators working on diversion programs in the county.
5. Train inmates to recognize signs of suicide risk among others on the same housing unit and to refer them for health services. One program that could be easily applied at the jail is [www.take5tosavelives.org/learnthesigns](http://www.take5tosavelives.org/learnthesigns).
6. Learn from the NCCHC Suicide Prevention Resource Guide, which offers best practices in screening and assessment, treatment, training, facility design, and more.

## ARCHITECTURAL AND ENVIRONMENTAL CONSIDERATIONS

The Allegheny County Jail was constructed in 1995. It has eight floor levels of housing with different classifications for males, females, and juveniles. Our assessment includes each housing floor and housing unit types, as well as the intake and booking area.

Due to the age and intense use of the facility, many aspects of housing units and inmate spaces show signs of deterioration. The facility management team is in the process of making several improvements and modifications. These include repairing and covering cracks in cells that have developed due to differential settlement of the structure, adding more screens over vents to prevent ligature completion, providing accessible showers in some housing units, and modifying cell bunks to close off vent holes in the steel frames.

## Inmate Housing and Holding Areas

### Booking and Intake

The booking and intake area is a very active space. It has cells for prebooking, pretrial services, and medical assessment. One cell, [REDACTED], is identified as "suicide." The cell is visible from the booking desk and is monitored by roving staff [REDACTED], staggered intervals.

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

### Medical Housing

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

On both the male and female sides of medical housing, the units are laid out in a manner that creates a blind spot to two cells, including cell 5B.

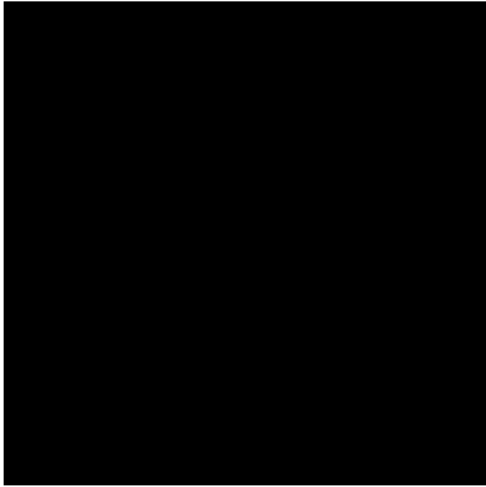
### General Population Housing

These housing units are organized with cells forming a perimeter around large, open dayrooms. The housing officer occupies a desk in the dayroom that has good visibility to the cellfronts and to support spaces that include showers, visiting, medical exam, and outdoor recreation.

The layout of some of the housing units creates a "blind corner" for two cells on each side. This prevents direct observation from the housing officer workstation but does not impede regular checks into the cells by officers on rounds.

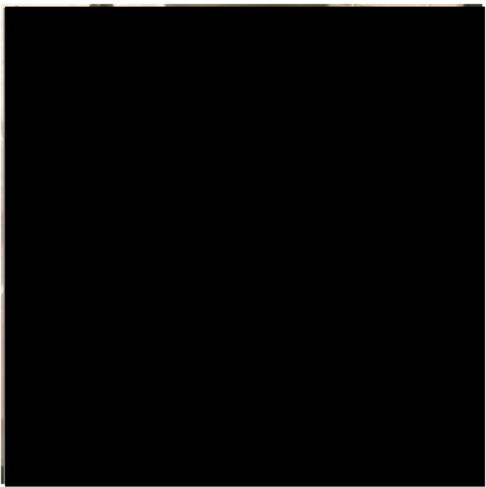
The cells are primarily double-bunked and have similar standard features:

- [Redacted]



- [Redacted]

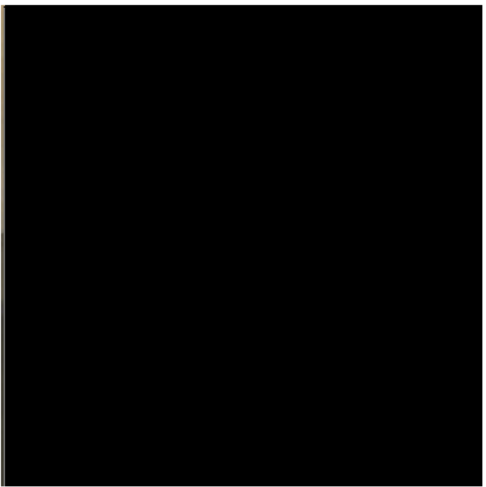
[Redacted]



- [Redacted]

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- [Redacted]



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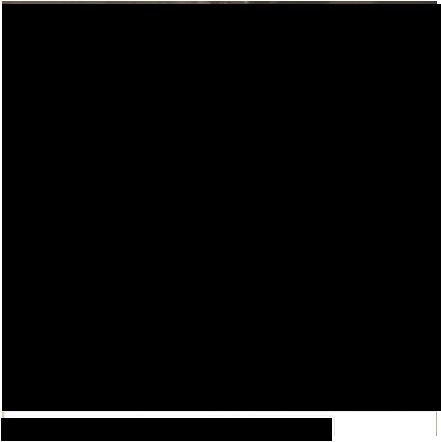
### Recommendations

There is no way to design or implement a “suicide-proof” jail, but steps can be taken to mitigate risk through planning and design. Physical plant modifications should be always be considered alongside operation and administrative procedures when developing a suicide prevention plan. Because of the age and size of the Allegheny County Jail, it is not realistic to propose modifications to the entire facility. Instead, it will be critical to identify and prioritize areas of primary concern so that changes can be made effectively and efficiently.

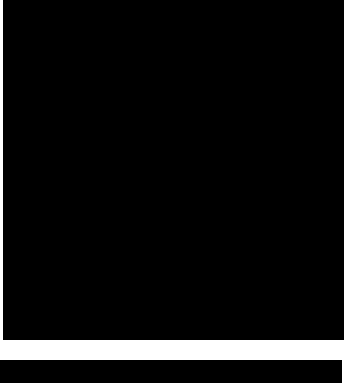
At a minimum, the following issues should be acknowledged:

- The facility has no suicide-resistant cells. In areas where inmates are specifically being monitored because of suicide risk, cells should be modified to reduce the likelihood of completion. The modifications should include replacement of any deficient fixtures or furnishings with a suicide-resistant model.

- Inmates who are specifically being monitored because of suicide risk should not be placed in cells that do not directly face the housing dayroom and housing officer’s workstation. Unless absolutely necessary, use of those cells should be avoided altogether.
- In single-occupancy cells that have two bunks, we recommend that the upper bunk be removed. Because of its height and the gaps between the bunk and wall, the upper bunk presents a serious risk.
- [REDACTED]



- [REDACTED]



- The overarching issue related to the settlement of the structure is not being addressed. [REDACTED]

The environmental characteristics of a space can have a significant impact on health and on stress. Best efforts should be made to ensure that any inmate space has access to abundant daylight and as well as acoustical treatments that provide a sense of privacy and enhance communications between inmates and staff. Spaces should be free of obstructions and visibly open.

When considering paint colors, avoid dark and highly saturated colors. While there is no scientific consensus on the impact of color on mental health, lighter colors ranging from blues and purples to greens have been shown to have positive benefits on stress. The jail already has many wonderful painted murals, and the inclusion of landscape imagery in the medical and mental health units would provide benefits for inmates and staff alike.