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U.S. Department of Justice

Federal Prison System

Washington, D.C. 20534

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March 3, 1980

Ms. Chris Lundy
N.C.J.R.S.
Box 6000
Rockville, Maryland 20850

Dear Ms. Lundy:

As a follow-up to your conversation earlier today with Dr. Thomas Caffrey, Chief of Psychology Services, New York Metropolitan Correctional Center, we are forwarding a copy of the suicide prevention project report.

We hope you will consider this report for inclusion in your NCJRS files. The study has already been distributed in-house to Wardens, Regional Directors, and Research Administrators. We understand there are no plans to publish this report.

Although no author is listed, many New York MCC staff members took part in the project, and Dr. Caffrey served as project director and author of this final version of the report.

If you have any questions, please feel free to contact Dr. Caffrey at 212-791-9130.

Thank you for your consideration.

Sincerely,

Harriet Lebowitz for

Howard L. Kitchener
Director of Research

Enclosure

cc: Dr. Thomas Caffrey, NYMCC

NEW YORK M.C.C. SUICIDE PREVENTION PROJECT

Revised Final Report

Prepared for:

Gerald M. Farkas
Northeast Regional Director
Federal Prison System

March 9, 1979

CONTENTS

I. INTRODUCTION

From 1976 to 1978 the New York Metropolitan Correctional Center carried out a four-phase project to prevent and understand suicidal actions by its inmates. An institutional policy statement on suicide prevention launched the project as its first phase* and provided M.C.C. staff with practical guidance during the project's exploratory and experimental phases. In the pages that follow, the exploratory and experimental findings of the project will be presented, and recommendations for improving suicide prevention procedures at the M.C.C. will be offered. This report is based on the project's 155-page Final Report of December 20, 1978.

* For copies of the policy statement contact Executive Assistant, Metropolitan Correctional Center, 150 Park Row, New York, N.Y. 10007.

II. FINDINGS

A. EXPLORATORY FINDINGS

1. Setting of M.C.C.

The New York Metropolitan Correctional Center is a modern building constructed by the Federal Prison System to house prison inmates close to the federal courts of New York and New Jersey. The institution's inmate population reflects the building's court-related purpose, with one-third of the population awaiting trial or sentencing, another third serving sentences while being held for court-related reasons or while awaiting to be moved to another federal institution, and a final third being housed for a wide variety of other reasons. The building has room for 448 inmates, about 100 inmates arrive at the institution each week (at all times of day and night), and the average stay, per inmate, is 26 days. Thus, with 5000 new inmates passing through the institution each year, and with major court decisions being made about them while they are living there, the M.C.C. cannot help but reverberate with the constant physical and emotional activity characterizing the lives of its inmates.

During the M.C.C.'s first year its Research Department found that the institution's inmates are typically male (92%), 32.7 years old, Christian (68%), married (54%), and white or black (42% each). The typical inmate reports having an 11th grade education and being incarcerated for narcotics or bank robbery charges. It was also found that while incarcerated, the typical inmate feels generally

depressed and perceives his most important problems, after his legal concerns, to be his family and related financial pressures.

2. Patterns of Suicidal Behavior at M.C.C.

Medical Injury Reports for the 18 months preceding much of the Suicide Prevention Project, and for the first 18 months of the M.C.C.'s existence, revealed that of the inmates' 361 general injuries there were one (1) suicide and forty-four (44) self-inflicted wounds (parasuicides). Thus 12.5% of the injuries during the 18 months constituted suicide, suicide attempts, or self-inflicted wounds. Although only one of the 45 self-destructive acts constituted an actual suicide, 32 (or 73%) of the other actions can be considered serious to the extent of having brought about either hospitalization (6) or some kind of suturing (26).

a. Inmates

Thirty inmates committed the 45 self-destructive acts. The 30 self-destructive inmates resemble the M.C.C.'s general population in most ways. They differ, however, in that there is a high proportion of whites in the self-destructive group, a low proportion of married persons and narcotics violators, and a disproportionately large number of inmates charged with threats against the life of the President.

b. Method

Although the medical records did not always describe how the

suicidal acts were committed during the M.C.C.'s first 18 months, in 18 of the instances the instrument that was used was recorded. Sixteen of the 18 incidents involved sharp penetration of the skin (by razor blade, glass, knife, and ball-point pen), with razor blades accounting for 10 of the 16 penetrations. The primary medical treatment reports, moreover, indicate that skin penetration accounted for at least the great majority of the 45 suicidal acts: 26 required "sutures," 10 "antiseptic dressing," and one a "tetanus shot."

The one successful suicide, by the way, was accomplished with a ball-point pen (while in a private room on "15-minute suicide watch," and after having been recently sent to an outside medical emergency ward for serious suicide attempts by cutting). Finally, 11 of the 12 self-destructive acts that occured during Phase IV of the Suicide Prevention Project (mid-1978) were accomplished by cutting, with the razor blade being the instrument of choice in at least 10 of the 11 instances.

Thus clearly the method of choice at the M.C.C. has been cutting, and usually with a razor blade. Since hanging is the most common method reported in other studies, it may be that the M.C.C.'s modern design (with no bars and few protrusions) has forced inmates who may otherwise have tried hanging to resort to cutting.

c. Time of Day

In a study of successful suicides in the federal and Maryland prison systems, it was found that the early morning (3:00 A.M. -

9:00 A.M.) and evening hours (7:00 - 12:00 P.M.) account for most cases. In a study of suicides in the New York City prison system, 5:00 - 6:00 A.M., 10:00 - 12:00 P.M., and 4:00 - 5:00 P.M. were the most common times. The suicidal actions at the M.C.C. followed the same "off-hours" pattern. Seven (16%) were bunched into the 2-hour period following the exit of many M.C.C. staff from the institution (5:00 - 7:00 P.M.). Another 16 (36%) occurred during the 3-hour period from 10:00 P.M. to 1:00 A.M. -- when most inmates are retiring for the night. Fourteen others (31%) occurred during the remaining off-hours of the evening and very early morning. And only 8 (18%) of the 45 acts occurred during the 10-hour daytime period between 7:00 A.M. and 5:00 P.M. Thus with 37 of its 45 self-destructive acts -- 82% -- occurring during off-hours, the M.C.C.'s time pattern falls clearly in line with that of other institutions studied.

d. Place

Exactly two-thirds, or 30, of the 45 self-destructive acts of the M.C.C.'s first year and a half (1975-76) occurred in the institution's high security unit, Unit 9 South. The unit, with a total capacity of 48, houses inmates who require added supervision for any of a number of reasons. An inmate may have a history of erratic or dangerous behavior, he may be serving a very long sentence, or he may be facing especially serious charges (and may have very high bail). The inmate may require individual isolation from other inmates (in the Administrative Detention or Disciplinary

Segregation sections of 9-South), or may require increased supervision for other management, legal, or medical reasons. The proportion of the 30 self-destructive acts on 9-South that occurred within the Administrative Detention and Disciplinary Segregation sections of the unit was not recorded. However, during the experimental Phase IV of the Suicide Prevention Project, two-thirds of the M.C.C.'s self-destructive acts again occurred in Unit 9-South (8 of 12), and this time all eight of the 9-South acts were found to take place within the Administrative Detention and Disciplinary Segregation sections of the unit. In these sections, inmates' movements are strictly controlled and their contact with other inmates and staff are limited. Considering the time (off-hours) and place (in socially limited areas) patterns of suicidal actions at the M.C.C., it is clear that the actions have tended to occur at the times and places where the presence of or accessibility to other persons has been significantly reduced.

3. Early Detection Opportunities at M.C.C.

The short-term, high-turnover nature of the M.C.C.'s inmate population makes systematic early detection of suicidal tendencies essential. Two parts of the M.C.C.'s structural and operational life lend themselves to decisive early detection: the Receiving and Discharge (R&D) area of the institution and the M.C.C.'s Admission and Orientation (A&O) program conducted on Unit 9-North. In these two places M.C.C. staff come into early and immediate contact with the new inmates.

a. Receiving and Discharge Area

New inmates usually arrive at the M.C.C. under escort of U.S. Marshals. The inmate is transferred formally from the Marshals' custody to that of the M.C.C. when the M.C.C.'s Records Officer in the Receiving and Discharge area signs the Remand form (Form 9), and gives a copy of the form to the escorting Marshal. Periodically a Marshal informs the Records Officer of unusual behavior by his charge, or delivers a letter from a judge, alerting the M.C.C. to the new inmate's suicidal or otherwise dangerous tendencies. When received, such information has been very useful to M.C.C. staff. However, the information has been rare. This has been because it has not been sought systematically by the M.C.C. and partly, perhaps, out of concern by Marshals that dramatization of an inmate's emotional problems may move M.C.C. staff to decline to accept the inmate and insist instead that he be taken to a psychiatric hospital.

When the inmate has been received by the M.C.C., it is the R&D staff, especially the Records and Clothing Room Officers, who have the first contact with him. The contact is often mediated through inmate workers in the area, rushed because of sudden influxes of new inmates, or minimal for other reasons. Nonetheless these M.C.C. staff establish the first official contact between the M.C.C. and the new inmate.

While the inmate is still in the Receiving area, there are several more points at which M.C.C. staff come into direct personal

contact with him. An officer completes with the inmate his Personal Property Record, and gives him a receipt for money and other valuables transferred to the M.C.C. An officer examines all parts of the inmate's body ("shakes him down") to prevent contraband from entering the M.C.C., and then supervises the issuance of institutional clothing, bedding, and toilet articles to him. An officer at least supervises 1) the photographing (for the Commitment Summary, Form 31) and fingerprinting (for form FD-249) of the inmate, and 2) the issuance and completion of the Medical Department's Report of Medical History (Standard Form 93), on which five questions directly relevant to suicidal risk are asked ("attempted suicide?"; "depression or excessive worry?"; "nervous trouble of any sort?"; "Have you ever been treated for a mental condition?"; "Have you ever been a patient in any type of hospitals?") and two are asked that refer to "mental" reasons for rejection or discharge from military service.

When the Physician's Assistant arrives to examine the new inmate in the R&D area, he reviews Standard Form 93 and carries out a direct physical examination while filling out the relevant, second, medical form, Form 600. The second form draws explicit attention to "Medication," "Drug Abuse," "Hallucinogens," "Psychiatric History and/or Suicide Attempts," "Inmate's Complaints," and "Physical Examination" of parts of the body, including "Extremities."

In an effort to determine the extent to which warnings of

self-destructive behavior have actually been recorded during the early processing of the 30 inmates who injured themselves during the M.C.C.'s early months, it was impossible to survey either of the medical forms (SF 93 and SF 600), since full medical records accompany inmates when they are moved to other institutions. The effort did reveal, however, that it had been noted on the Commitment Summaries filled out, or supervised, by an R&D officer, that 6 of the 30 inmates, or 20%, had scars on their wrists or forearms. These notations were found on the line labeled "Scars, Tatoos, etc.," intended more for legal identification than for warning purposes. Clearly the Receiving phase of an inmate's stay at the M.C.C. is rich in opportunities both for direct personal contact and for the recording of signs of possible self-destructive behavior.

b. Admission and Orientation

The second opportunity M.C.C. staff have for contact with new inmates, and for detecting suicidal tendencies, is the institution's Admission and Orientation program. A&O has taken three successive forms since the M.C.C. has opened. Most recently, after having been processed in the Receiving area, new inmates are first designated to one unit, Unit 9-North. There, within a day or two, they are informed about M.C.C. procedures by staff from departments most relevant to their needs. Then the new inmates are transferred to one of the other seven units in the institution. On some of

these units, new inmates receive a second briefing about the specific unit's procedures.

Thus, after the Receiving and Discharge staff have completed their contacts with new inmates, it is the staff of the Admission and Orientation Unit, Unit 9-North, who come into direct contact with the new inmates most regularly. The A&O staff include, first, the Unit Officer who is on duty when the new inmate arrives at Unit 9-North. The Unit Officer's position is critical because: 1) he is the first A&O staff member to encounter the new inmate -- an officer is on duty during all hours, and is therefore available to admit the inmate to the unit whenever he arrives; 2) the inmates on Unit 9-North are more visible to the Unit Officer than they are to other Unit-9 staff whose offices are slightly removed from the inmates; 3) the officer witnesses a greater variety of inmate behaviors, a greater number of interactions between and among inmates, and the inmates' repeated, routine activities (like lining up for meals) against which he can contrast unusual individual behavior at a given time; and 4) the officer's immediate availability and his modest place within the institution's administrative hierarchy permits inmates to identify with and relate to him in a way that they cannot with other staff.

During regular hours the Unit Manager of Unit 9 provides general direction for the unit and for the A&O information sessions. He is available to the inmates during working hours, and serves as liason between Unit 9 and other M.C.C. departments and the M.C.C.

Administration. The Unit Manager is assisted by 1) a Correctional Counsellor, a career correctional staff person designated, and promoted, to attend to individual, personal needs of inmates; 2) a Unit Clerk; 3) a Case Manager, part-time, who coordinates the inmates' legal status within the Prison System and in relation to other agencies. During the final, experimental, phase of the Suicide Prevention Project, a full-time Psychologist has been participating in the Unit 9 A&O program by screening all new inmates for suicidal and other seriously problematic tendencies. Thus, the staff of this second place, the A&O unit, where warning signs might be detected and acted upon consists of a Unit Manager, Unit Officer, Correctional Counsellor, Case Manager, Unit Clerk, and, recently, a Psychologist.

B. EXPERIMENTAL FINDINGS

The exploratory findings outlined above contributed to the design of a two-part experimental prevention strategy. Most pertinent to the experiment were 1) the high rate of arrivals and unpredictable arrival times of new inmates at the M.C.C.; 2) the off-hours pattern of self-destructive behavior at the M.C.C.; and 3) the potential in the R&D and A&O sections for detection of behavior problems. The second part of the prevention strategy engaged the third finding, the detection potential among R&D and A&O staff, to help overcome the constraints necessitated by the

unpredictable arrival times and off-hours suicidal pattern at the M.C.C., the first and second pertinent findings.

The first part of the experiment tested the extent to which direct interviews of some incoming inmates, and referrals of those at risk of becoming problematic, could reduce problematic behavior among them. When Part 1 had scientifically established the impact of such steps, Part 2 sought to expand that impact by using the information available among R&D and A&O staff about all new inmates to determine which ones might best profit from the direct interview and possible referral. As the following pages describe in more detail, the two parts of the experiment reveal that suicidal and other problematic inmate behaviors can be anticipated and prevented -- and especially when the initiatives of staff in different areas of M.C.C. life are engaged.

1. Part 1: Effect of Interviewing and Referring

The purpose of Part 1 of the experiment was to determine whether and to what extent the direct interviewing of new M.C.C. inmates, and the referring of those judged problematic, might reduce the number of suicidal and other disruptive acts by the inmates. With this experimental question in mind, the inmates arriving at the M.C.C. during seven weeks of the Spring of 1978 were randomly labeled as either "experimental" or "control" inmates. The 287 inmates labeled experimental were given a personal interview by a psychologist shortly after their arrival

at the M.C.C., and the 55 that he judged to be at a moderate or serious degree of risk of problematic behavior were referred to other staff for help, usually to Correctional Counsellors. The 278 inmates randomly identified as "control" were not interviewed, and none of them, therefore, was referred in the way the experimental inmates were.

The chief experimental criterion used to determine that an inmate committed a problematic or disruptive act was his being locked into the Disciplinary Segregation or Administrative Detention section of the M.C.C. During the seven weeks of Part 1, 19 acts by experimental inmates led to Disciplinary Segregation or Administrative Detention, whereas 34 by the control inmates resulted in the use of the increased security area. Thus the control inmates -- those who had received no psychological interview upon their arrival at the M.C.C. -- committed almost twice as many seriously problematic acts as did those who had been interviewed. Analysis of this difference by statistical, χ-square, computation indicates that the difference is scientifically significant (at the .05 level of probability). It was found, too, that the predictive strength of the interviews was three times as effective as chance prediction would have been, a difference that is also statistically significant. Thus prediction and prevention of problematic behavior were both accomplished with sufficient scientific certainty to predict comparable success in other comparable settings.

With respect to specifically self-destructive, or suicidal,

actions, five such acts were committed by control inmates whereas only one was committed by an inmate who had been interviewed. Though these numbers are too small for statistical computation, their difference, coupled with the scientifically significant difference between control and experimental inmates in their problematic behavior in general, strongly suggests that the interviewing and referring did reduce self-destructive behavior among the experimental inmates.

The scientifically significant reduction in problematic behavior accomplished in Part 1 of the experiment appears to have resulted, in part, from the counselling provided by Correctional Counsellors to inmates referred to them by the psychologist. This conclusion is suggested ironically from the following. The general rate of adequate counselling accomplished by Correctional Counsellors for inmates referred to them as possibly problematic was 47%. However, the rate of adequate counselling accomplished for those who were both referred to a Counsellor and subsequently locked into Administrative Detention or Disciplinary Segregation for actual problematic behavior was only about 20%. Therefore it appears that the rate at which the Correctional Counsellors acted on the referrals they received partially determined the extent to which the suicidal and other problematic actions were reduced. The clear moral, as articulated in positive terms by a psychologist studying these results, is, "Even a little bit of the right kind of human attention can go a long way!"

2. Part 2: Screening All New Inmates

Part 2 of the experiment aimed to expand the impact of the interview-referral sequence to include all the new M.C.C. inmates. Information was sought from U.S.Marshals delivering the inmates, R&D staff (including medical personnel working there), and A&O staff to determine which of all incoming inmates might be in greatest need of the psychologist's interview and possible referral. It was not only the limited resources of the Psychology Services Department that led to this means of screening all new inmates. As stated earlier, the real potential for valuable information among other personnel, the need to underscore this value of other staff's observations, and the differing and unpredictable times, places, situations, and personalities that may move inmates to disclose seriously problematic aspects of themselves all led to using the wider screening approach.

To determine which inmates to interview, the psychologist entered fifteen pieces of information, obtained daily from eight separate sources about each new inmate, onto a "Data Sheet".

The eight sources of information were U.S.Marshals, R&D staff, medical staff, Unit 9 (A&O) staff, and an "A&O Scale" about suicidal and assaultive propensities devised by the psychologist and administered to all new inmates.

Of the eight potential sources of information, only four were available consistently as bases for judgments about the inmates' levels of risk. These were the two medical forms, the "medical

condition claimed" on the 5x8 card filled out by R&D staff, and the psychologist's scale. On the basis of the information received from these sources, the psychologist judged the inmate's level of risk as "no risk," "moderate," or "high risk." Those inmates judged to be of moderate or high risk -- about 140 or the 515 new admissions entered on the Data Sheet -- were given relatively thorough interviews about their suicide and assault potential, and about their chief complaint and emotional reaction to their incarceration. Of the 140 interviewed, 56, or approximately 11% of the 515 new admissions, were referred to other staff as potentially problematic.

What was the result of Part 2's wider screening and referring method? First, 23 acts serious enough to merit Administrative Detention or Disciplinary Segregation were committed by the 515 inmates screened through the sequence of the Data Sheet, selective interviews, and referrals. Statistical (χ-square) comparison of this 23/515 ratio with the 34/278 ratio of the uninterviewed, control, inmates in Part 1 of the experiment reveals a scientifically significant difference (at .001 level of probability) between the two ratios. The Part 2 screening method, therefore, was found to be highly successful in reducing overt problematic behavior among inmates. As in Part 1, moreover, the predictive strength of the interviews was again found to be significantly more accurate than chance prediction would have been. Prediction and prevention were again confirmed scientifically as accomplished, and therefore

as repeatable in other comparable settings.

Secondly, of the 515 inmates screened during the seven summer months of 1978, not one committed a self-destructive, or suicidal, action. Again, as in Part 1, statistical comparison of this "0" with the 5 suicidal acts committed by the 278 unscreened inmates in Part 1 is impossible because the numbers are too low. Nonetheless: 1) the 0-5 difference carries emotionally suasive weight, especially considering that the 5 acts were committed by about one-half the number of inmates screened in Part 2 of the experiment; 2) the 0-5 difference almost duplicates the 1-5 difference between the experimental and control groups' self-destructive acts in Part 1; and 3) the 0-5 parallels and is consistent with the scientifically substantiated difference between the two groups' generally problematic actions.

Just as Part 1 of the experiment disclosed the importance of the extent to which Correctional Counsellors contacted the inmates referred to them, Part 2 confirmed the expectation that information obtained by non-psychological staff is directly useful in the prevention of suicidal and other problematic actions. Both findings underscore the critical part that correctional and other "non-mental health" staff play in the detection and prevention of problematic inmate behavior. The experiment serves, therefore, not only to demonstrate that suicidal and other problematic actions can be predicted and and prevented; it also strongly suggests that the institution-wide strategy, rather than the narrowly professional one, most effectively accomplishes the predictive and preventive objectives. The recommendations for the Metropolitan Correctional Center that follow reflect this general conclusion that it is the institution as a whole that will most effectively predict and prevent suicidal and other problematic actions.

III. RECOMMENDATIONS

1. Standard razor blades should be prohibited throughout the institution, with R&D and Commissary serving as the control points; moreover, only cordless electric, or safety-lock, razors should be available in Administrative Detention and Disciplinary Segregation.

2. As a general rule, suicidal inmates should not be secluded from others; housing settings should be used in which the suicidal inmate is highly visible to others.

3. The institution-wide screening procedure tested in Part 2 of this project's experiment should be implemented on a permanent basis.

4. The four sources of early information not yet incorporated into the screening procedure should be activated.

5. Receiving and Discharge staff and the staff of the Admission and Orientation unit should receive special training in the detection of suicidal and other potentially problematic behavior, and in initial intervention techniques.

6. Correctional Counsellors roles should be clarified administratively, and their training should be increased, to better enable them to provide counseling for inmates identified through the screening system as problematic.

7. Supervisory staff should be rewarded for developing line staff who are responsive in suicide prevention and in the prevention of other problematic actions..

8. The "manipulator" framework for understanding suicidal actions should be systematically eliminated; in its place, a simple, neutral understanding should be sought regularly as to why someone--whoever he or she is --is behaving in a self-destructive fashion.

END