

22 Years of Data on *Enola* : Exploring this Paradoxical Prison Suicide Risk Factor

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Educational Objectives

- 1.) Analyze historical suicide data from Pennsylvania Department of Corrections
- 2.) Identify and discuss the main categories of how individuals are celled in Pennsylvania State prisons.
- 3.) Synthesize operational implications of each of the main housing categories and solutions to mitigate suicide risk in prison.

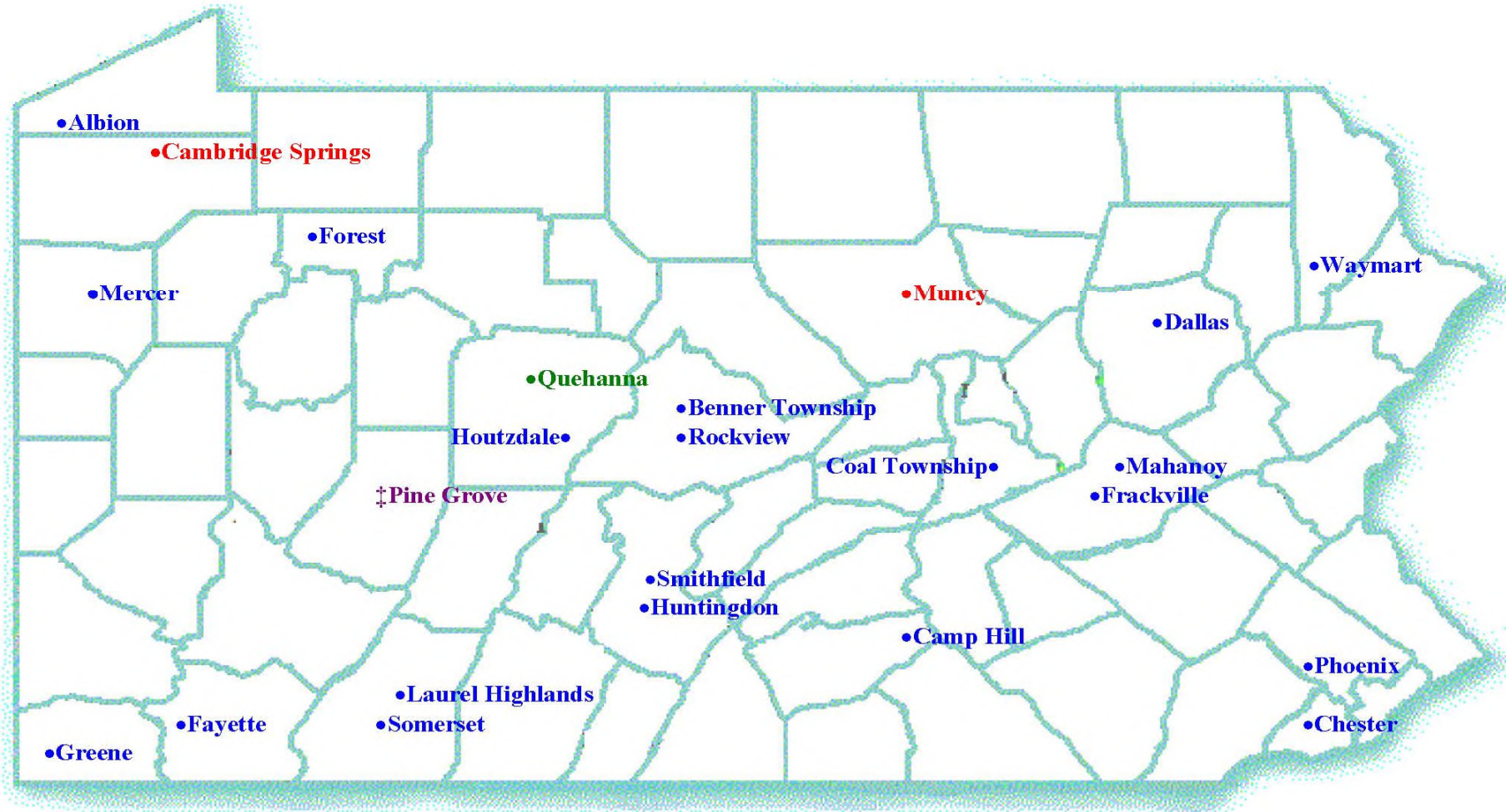
Issues to address up front:

**Challenge yourself to believe that
there is more to learn about
Suicide Prevention in Corrections
than we already know.**

Issues to address up front:

I'm not suggesting that everything else related to Suicide Prevention (Hayes, 1999) simply stops.

▶ Pennsylvania Department of Corrections



•Male Institution •Female Institution ‡Young Adult Offender Institution •Co-ed Institution

Locations depicted on map are approximate

Overview of PA DOC Population by Mental Health Roster

Mental Health/Intellectual Disability (MH/ID) classification rosters: A. B. C. D.

Total Male Population:	34,184	or	95%
<u>Total Female Population:</u>	<u>1801</u>	<u>or</u>	<u>5%</u>
Total Population:	35,985		

Males on MH/ID (C+D) Roster: 12,333/34,184 = 36.1%

Females on MH/ID (C+D) Roster: 1162/1801 = 64.5%

Total MH/ID (C+D) Roster: 13,495/35,985 = 37.5%

Seriously Mentally Ill (D) Males: 2576/34,184 = 7.5%

Seriously Mentally Ill (D) Females: 233/1801 = 12.9%

Total Seriously Mentally Ill Patients: 2809/35,985 = 7.8%

Data as of 1.31.2022

Suicide Risk

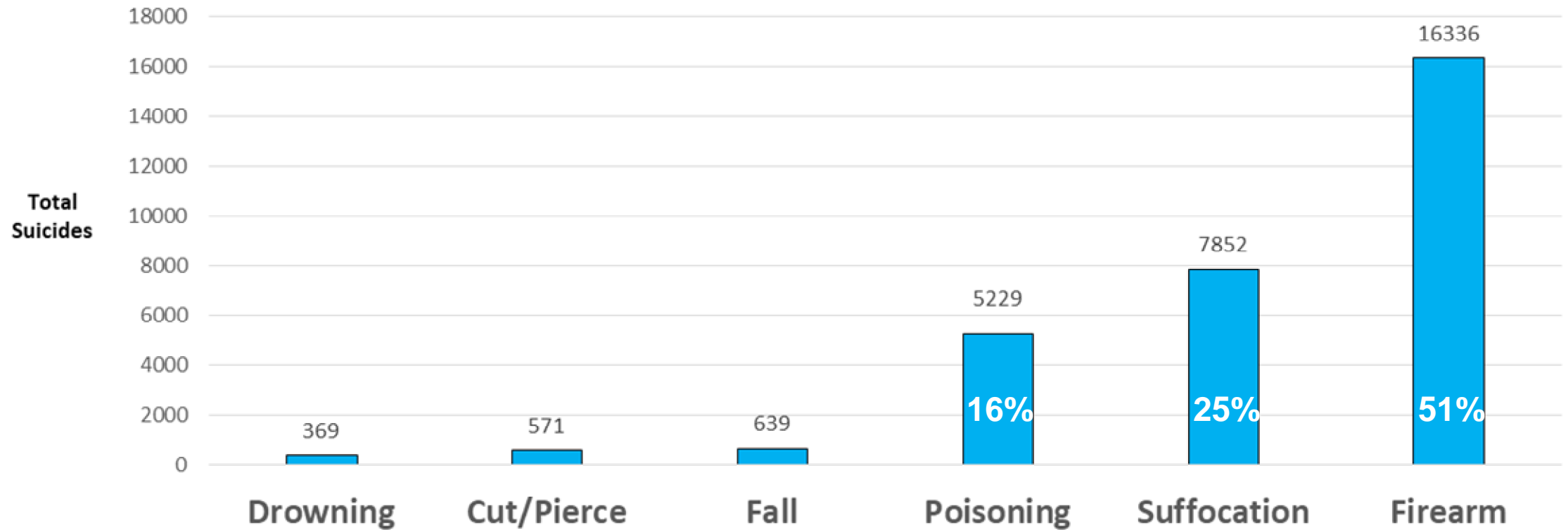
- What is Suicide Risk?
- How do we complete a Suicide Risk Assessment?
- In general, why is Suicide Risk Assessment difficult?
- Why is Suicide Risk Assessment difficult with a prison population?
- SRAs: Finding the people “*who aren’t raising their hand.*”

The Prison Setting and Suicide Risk

- Importation vs. Deprivation
- Although similar, Suicide Prevention interventions, especially those targeted at the *environment of prison*, must be different than those established in the community.
- **Prison is not the community.**

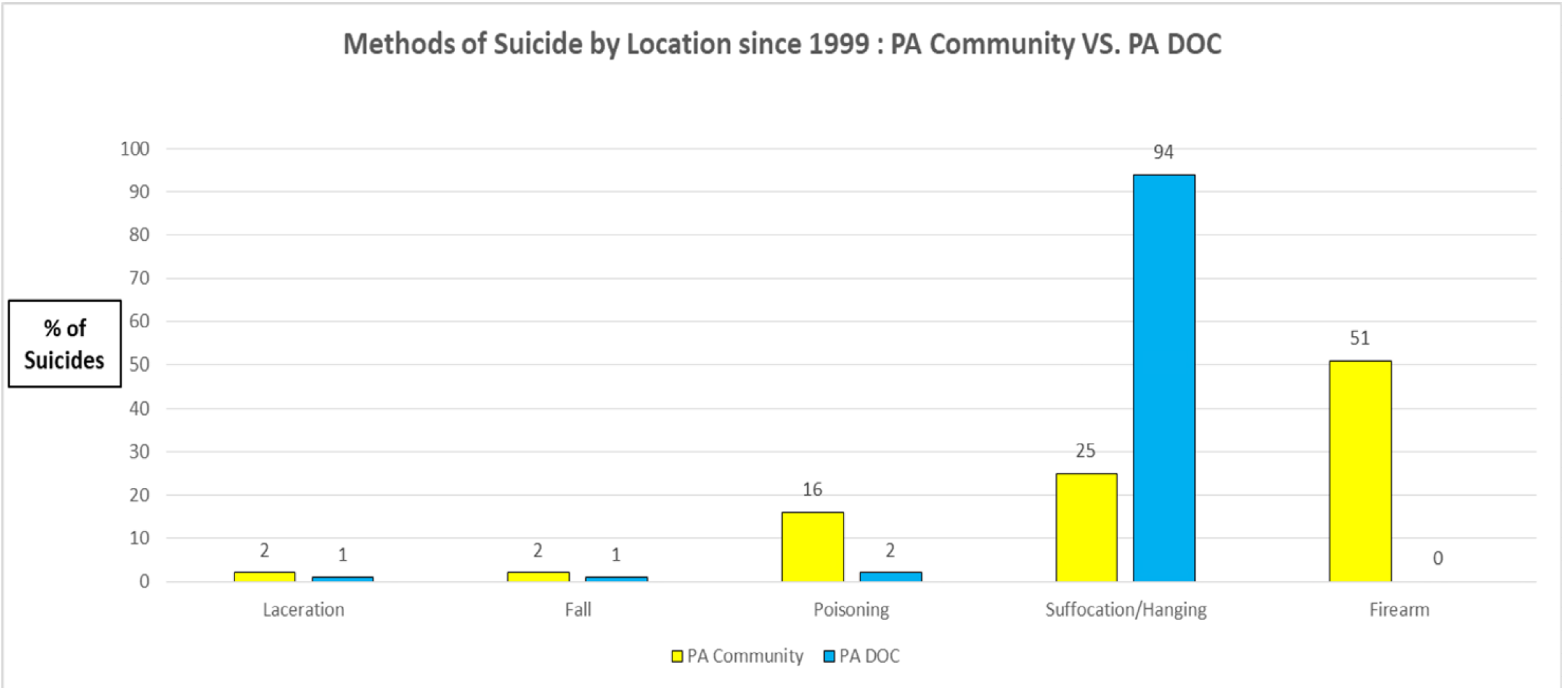
Suicides in the Pennsylvania *Community*

Top 6 Methods of Suicide in Pennsylvania : 1999-2018



Method of Suicide: PA Community vs. PA DOC

Methods of Suicide by Location since 1999 : PA Community VS. PA DOC

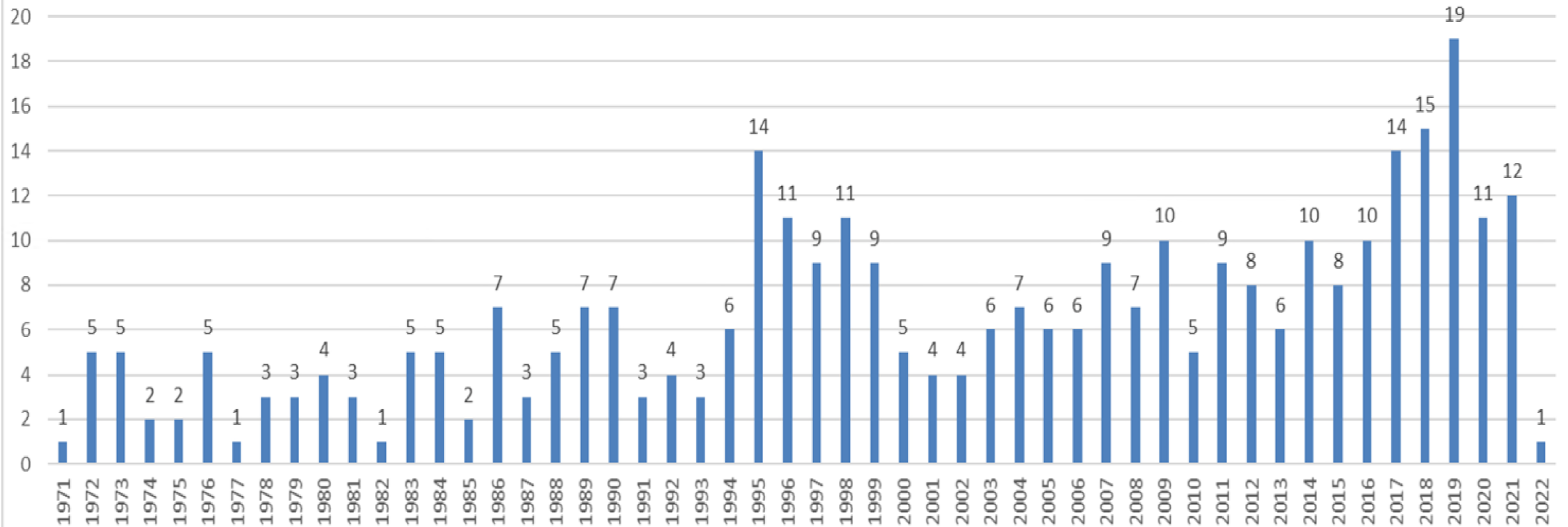


What was the Problem?

- In the first 90 days of 2018, the PADOC had a “cluster” of suicides.
- External experts retained to review the cases. Reports and recommendations generated.
- Simultaneously, the DOC Psychology Office did a comprehensive review of existing (i.e., and mined non-existent) system data to determine if we were missing something.

Suicides in PADOCC During the Past 50 Years

Suicides in the Pennsylvania Department of Corrections 1971-2022



Suicide Prevention Data Analysis

PA DOC Suicides since 2007 : 154

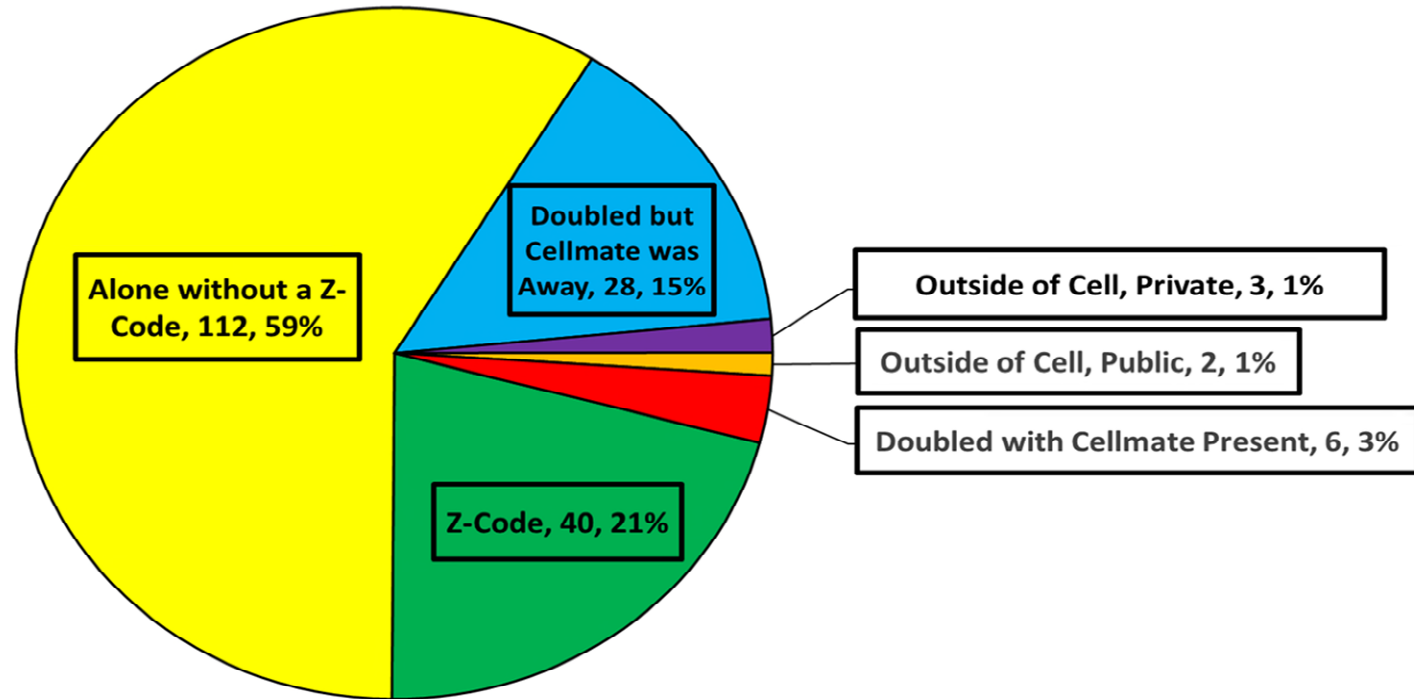
- **History of psych treatment: 74%**
- **Time between last MH contact and suicide: 72%** (occurred in less than 30 days)
- **History of substance abuse: 70%**
- **Object used for suicide - bedsheet: 71%**
- **Individual on MH caseload: 69%**
- **Individual on psychotropic: 58%**
- **History of SSA or SIB: 50%**
- **General Population: 48%**
- **Restricted Housing Unit: 46%**
- History of trauma or abuse: 34%
- Psych turmoil: 31%
- Other stressors: 27%
- Recent change in psych meds: 24%
- Double Cell: 23%
- Depressive symptoms: 22%
- Agitation at time of suicide: 18%
- Recently received bad news: 17%
- SIB prior to suicide: 15%
- Recent conflict with other individuals: 12%
- Hopelessness at time of suicide: 12%
- History of family suicide: 8%
- Alienation: 7%
- Psychotic symptoms: 5%
- Sudden change in MSE: 5%
- Suicide plan identified: 5%

Misunderstanding of “Double Celled”

- Initial review of Suicide Cluster = 40% (i.e., 2/5) were double celled.
- Double checked work, and it turned out that only 1/5 were double celled, at the time of death.
- Discovery of “**Double Celled but Cellmate Away**”. What is this?
- Re-reviewed all suicide cases to determine celling status at the time of death.

PA DOC Suicides since 2000

PA DOC Suicides since 2000 = 191



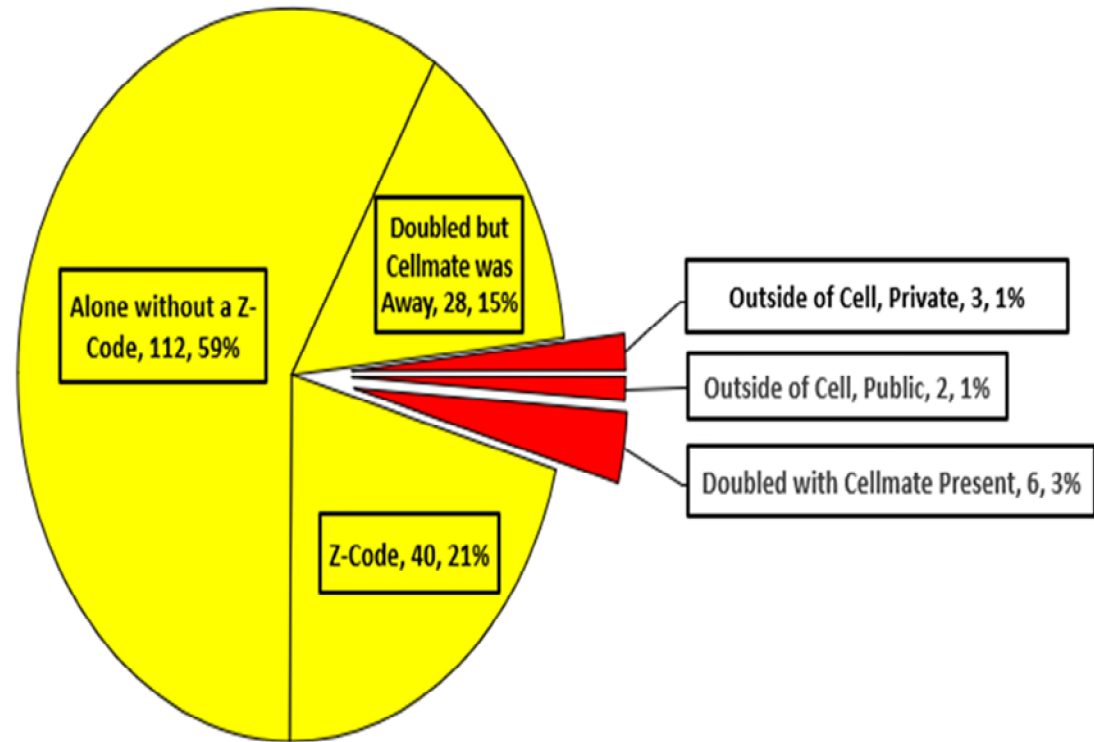
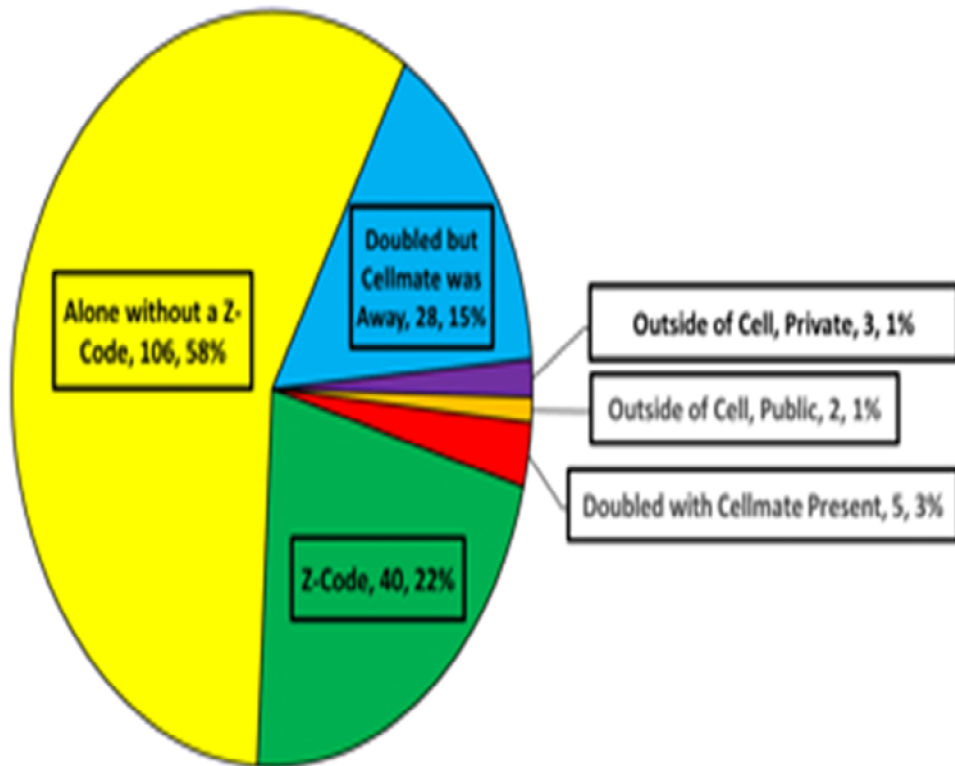
Brief Historical Review of Z-Code Policy

*11.2.1, Reception and Classification Procedures Manual
Section 5 – Single-Celling (“Z” Code) and Double-Celling Housing*

C. Evaluating and Processing Inmates for Single Cell Status (“Z” Code)

1. Any inmate who meets any of the following criteria shall be carefully reviewed by staff and considered for Program Code “Z” housing classification.¹
 - a. An inmate who is evaluated by psychiatric or psychological staff as having mental health problems.² Examples include the following:
 - (1) dangerous to self;
 - (2) dangerous to others;
 - (3) self-mutilative; and/or
 - (4) unable to care for self.
 - b. An inmate with certain medical conditions (an infectious disease, colostomy, etc.), indicating a possible need for a single cell.³
 - c. An inmate who staff believes may be victimized as a result of double-celling, multiple celling, or placement in a dormitory.⁴
 - d. An inmate who has a documented history of aggressive or predatory behavior towards cell partners or who staff have reason to believe would exhibit assaultive or predatory behavior towards cell partners.⁵

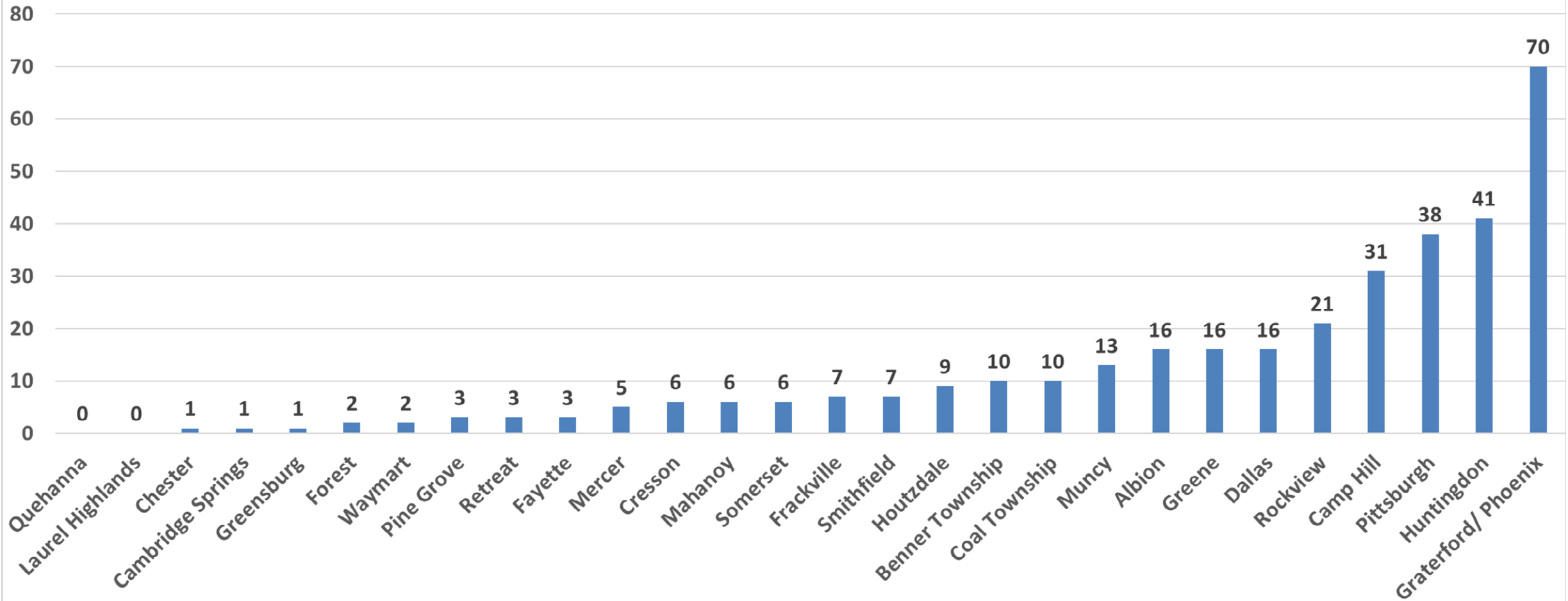
PA DOC Suicides and Being *Alone in a Cell*



94% of all 191 Suicides (i.e., 180 of 191) that have occurred in the PA DOC since 2000, were housed *ALONE in a Cell* at the time of their Suicide.

Suicides by SCI from 1971-2022

Suicides by SCI within the Pennsylvania Department of Corrections since 1971



Awareness of Physical Plant



▶ Physical Plant Limitations that Create *Alone*



Implications of Covid-19 Pandemic

(**PRE-COVID**) October 29rd of 2018 to February 29th of 2020 (~16 months: **25 Suicides**)

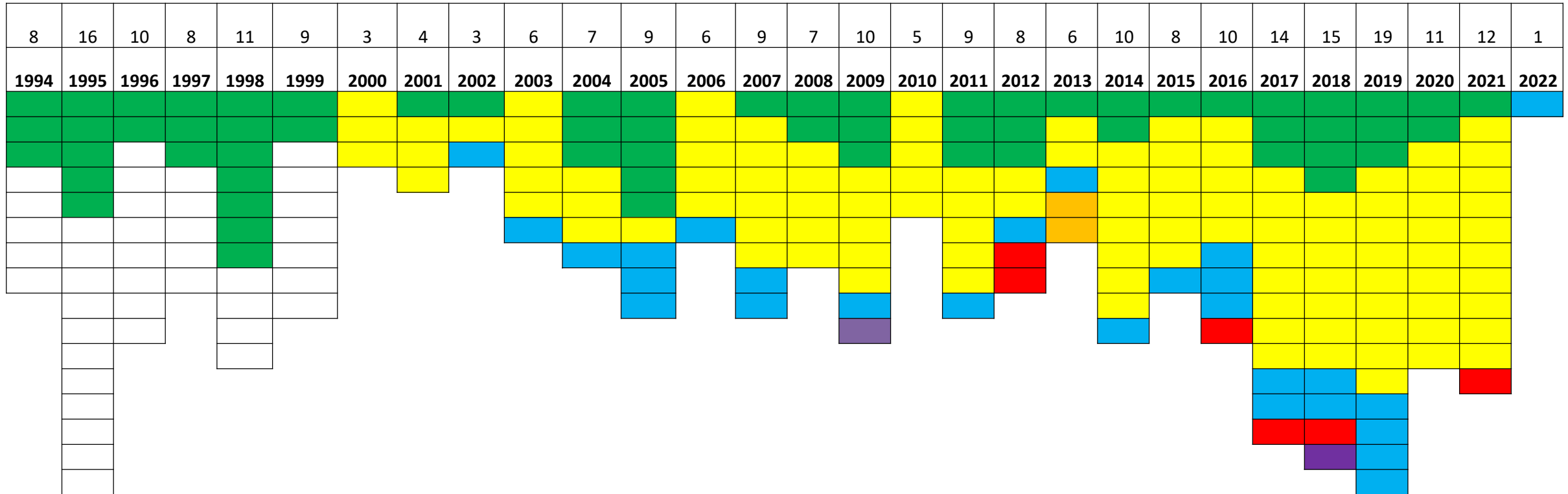
vs.

(**Life of COVID**) March 1st of 2020 to June 9th of 2021 (~16 Months: **12 Suicides**)

25 Suicides vs. 12 Suicides

**How do we explain this MORE THAN 50% reduction in Suicides,
during arguably one of the most stressful times in history?**

Suicides per Year, per ALONE TYPE



- Z-Code
- Alone without a Z-Code
- Doubled but Cellmate Away
- Outside of Cell, Private
- Doubled and Cellmate Present
- Outside of Cell, Public
- Unknown

Housing for those at Highest Suicide Risk

How does “*Suicide Watch*” help explain or contradict the findings being presented today?



▶ Housing for those at Highest Suicide Risk



Well, why?

Why do we think prison suicides happen in this setting so rarely?



- 1.) Cellmate may Rescue/Intervene
- 2.) Cellmate may Call for Help
- 3.) Cellmate Companionship may develop
- 4.) Protection created by cellmate's presence
- 5.) Protection against fluctuating risk of suicide & inaccurate assessments of risk
- 6.) Protects against *false deniers*

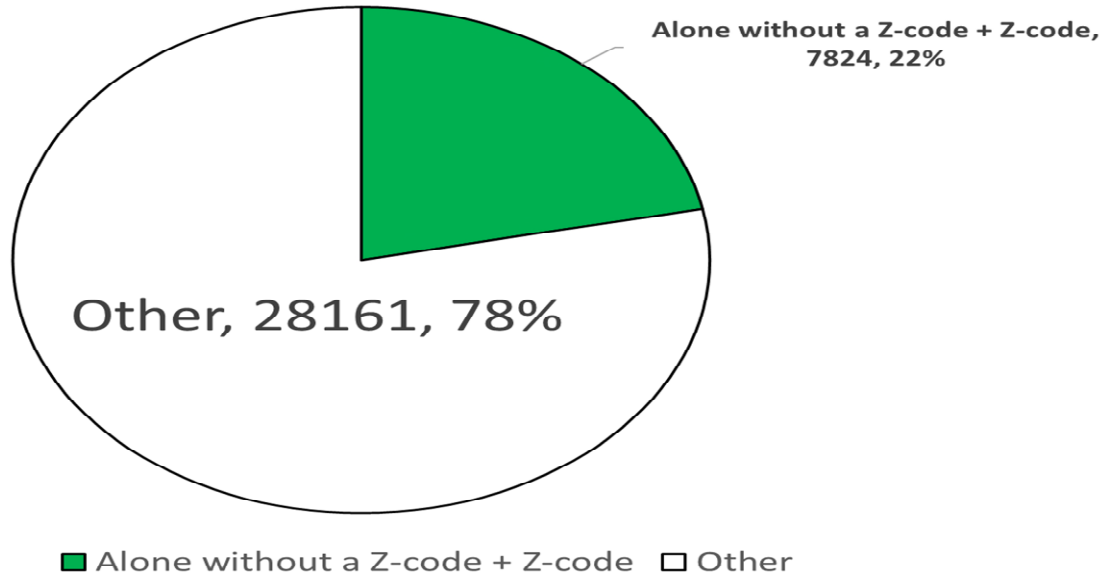
Why do we think prison suicides happen in this setting so often?



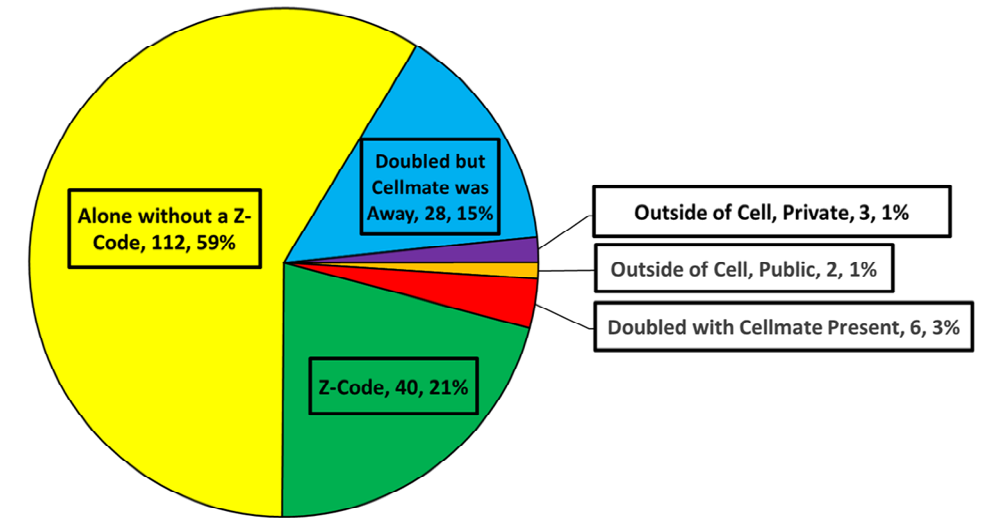
- 1.) **No** Cellmate Rescue Opportunity
- 2.) **No** Cellmate Call for Help Opportunity
- 3.) **No** Cellmate Companionship Opportunity
- 4.) **No** Cellmate Protection through their Presence
- 5.) **No** protection against fluctuating risk of suicide & inaccurate assessments of risk
- 6.) **No** protection against *false deniers*
- 7.) Hanging, as a suicide method, is very lethal.
- 8.) Violent people are at increased risk for suicide
- 9.) Other

The Protective Strength of Having a Cellmate...and that Cellmate being PRESENT

Percentage of Total Population that is "Alone without a Z-Code and Z-code"



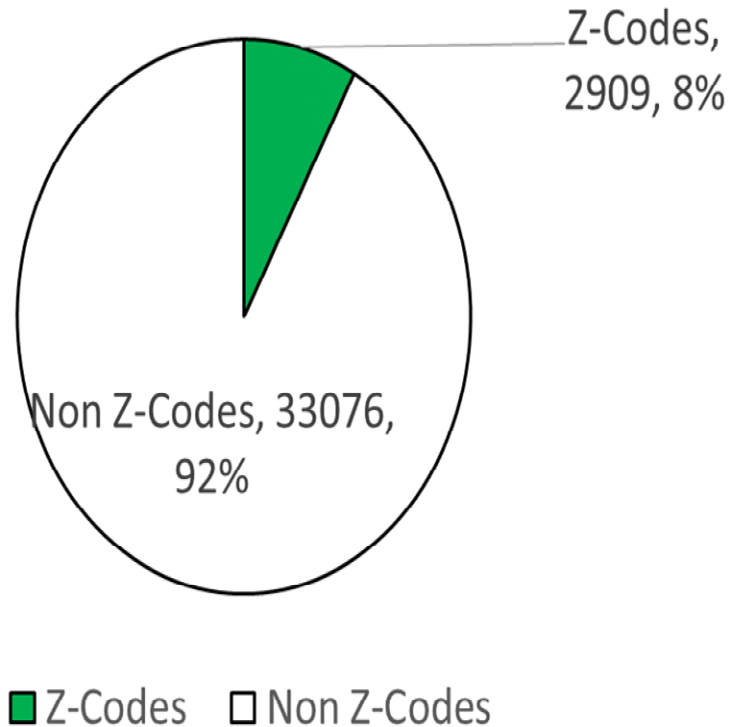
PA DOC Suicides since 2000 = 191



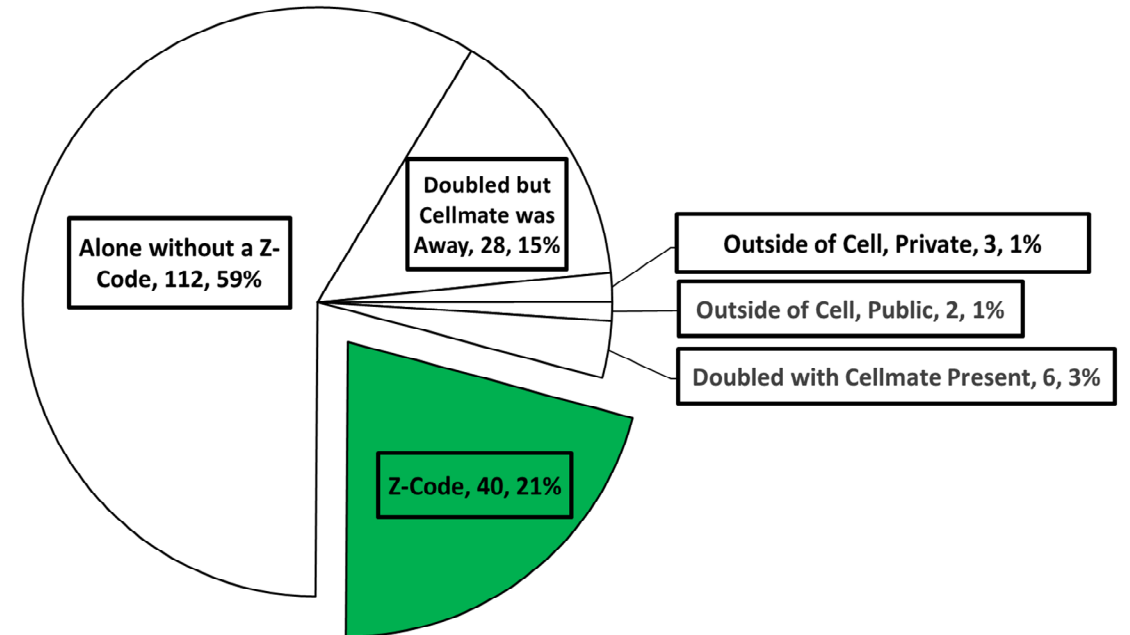
- Together, individuals that are either housed **Alone without a Z-Code** or with a **Z-code**, account for **22%** of our population, but account for **80%** of our suicides.
- Similarly, those individuals that are **Double Celled**, make up approximately **78%** of our population, but only account for approximately **18%** of Suicides.

Z-Codes in Population vs. Z-Code Suicides

Current Z-Codes in the PA DOC Population



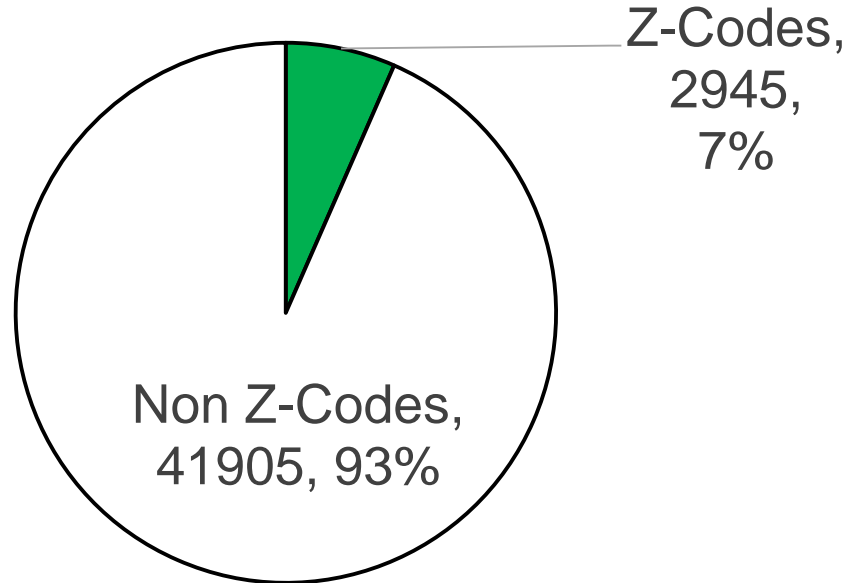
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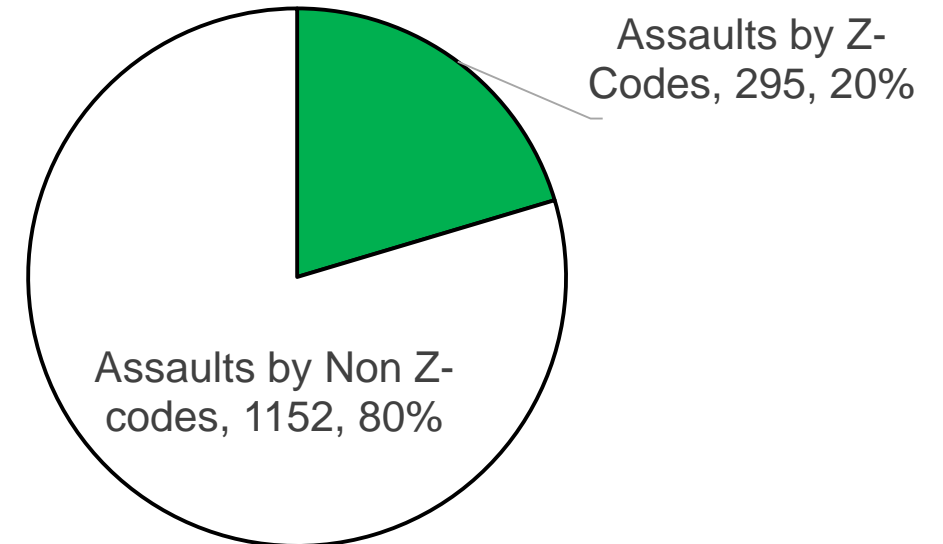
This ~8% of our Population has accounted for ~21% of Suicides

Z-Codes in Population vs. Assaults by Z-Codes (after having the Z-Code)

Current Z-Codes in the PA DOC Population



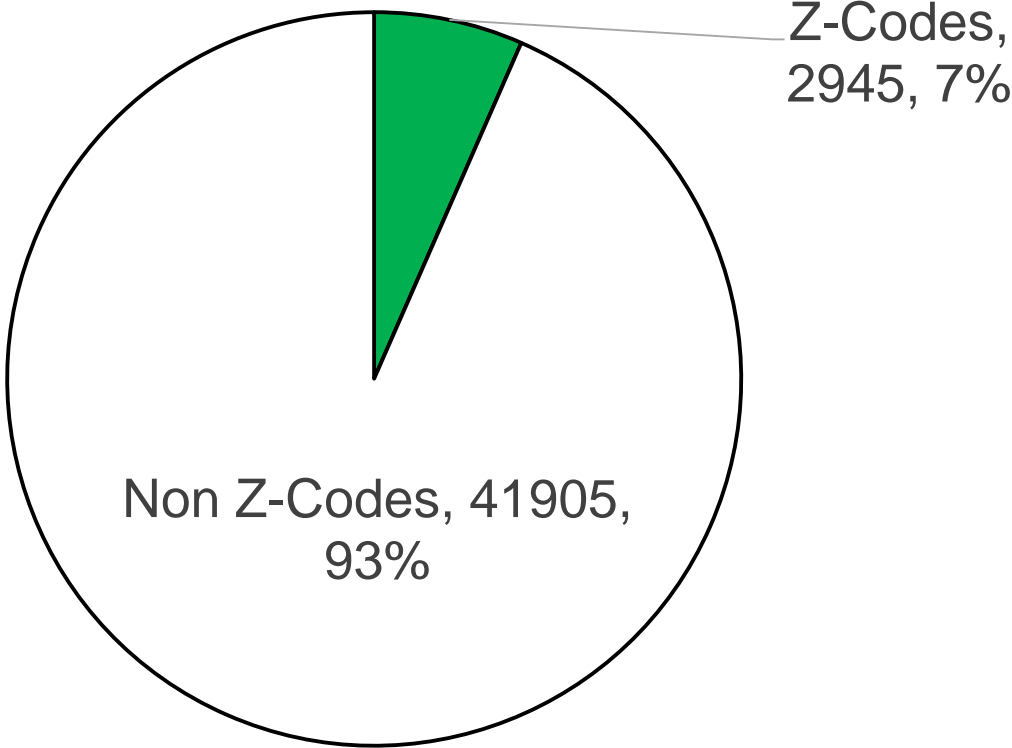
Assaults by Z-Codes in the Past Year
Total Assaults: 1447



This 7% of the Population accounted for 20% of Assaults (2019).

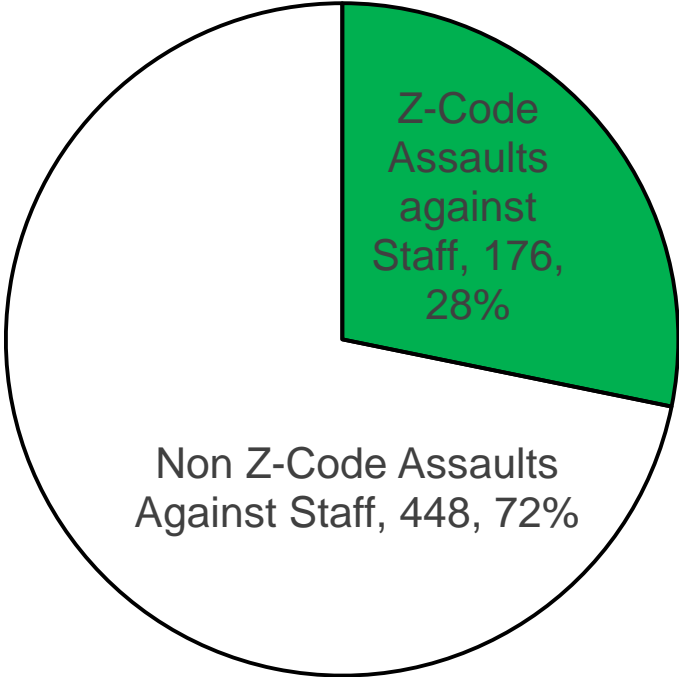
Z-Codes in Population vs. Staff Assaults by Z-Codes

Current Z-Codes in the PA DOC Population



■ Z-Codes □ Non Z-Codes

Z-Code Assaults Against Staff
Total Assaults Against Staff in last year: 624



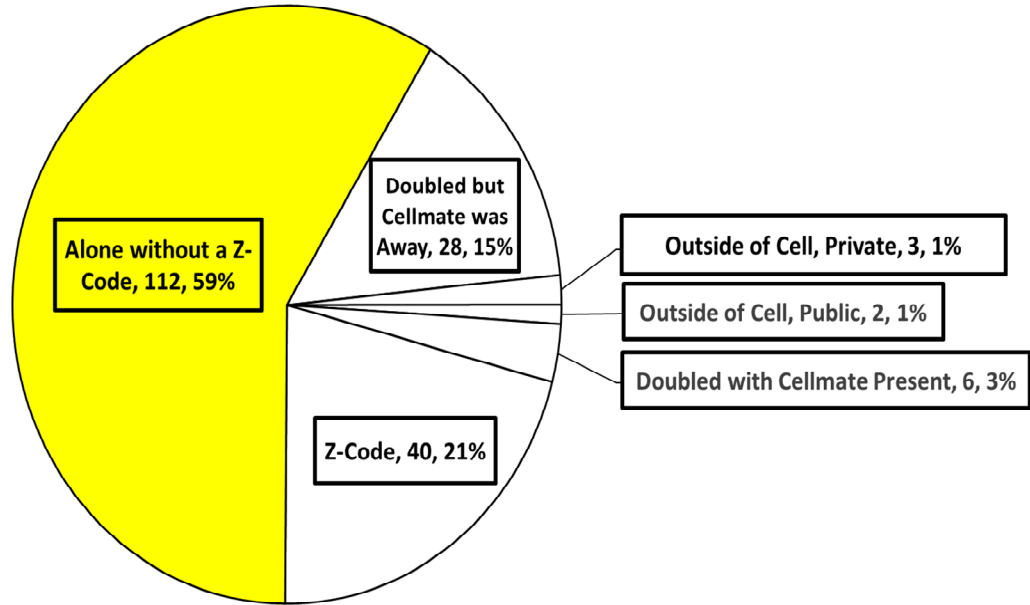
■ Z-Code Assaults against Staff
□ Non Z-Code Assaults Against Staff

This 7% of the Population accounted for 28% of Assaults against Staff.

Alone without a Z-Code

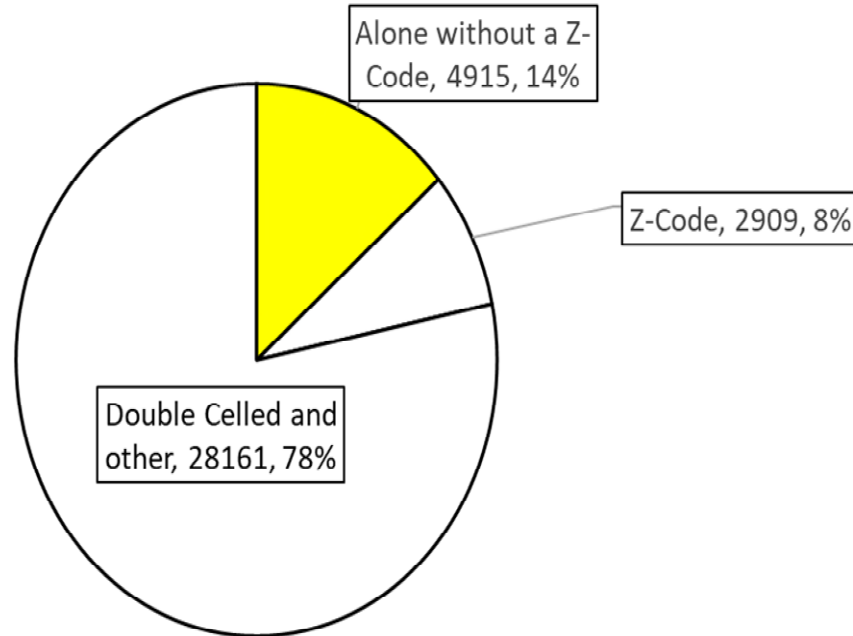


PA DOC Suicides since 2000 = 191

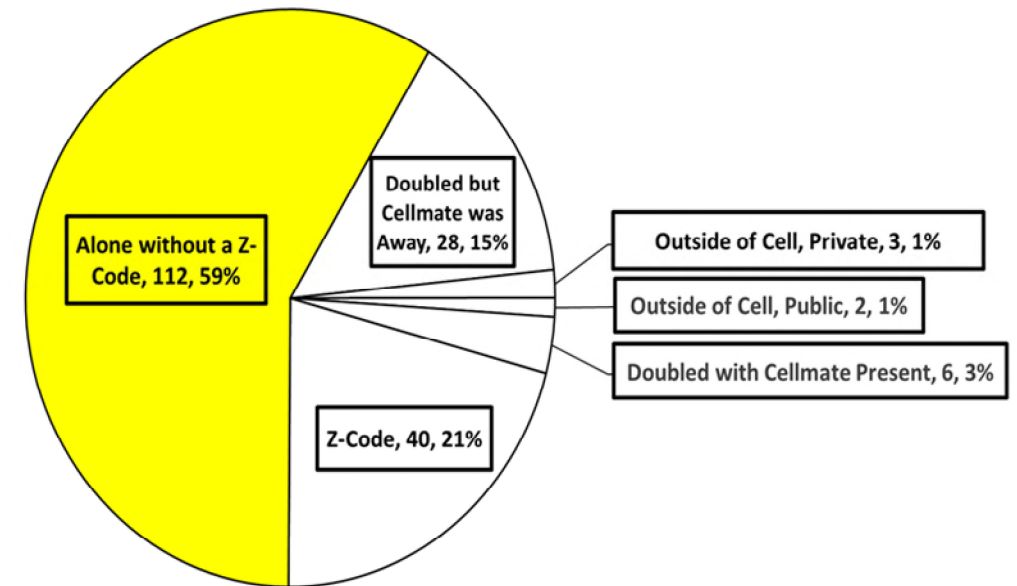


ALONE without a Z-Code

Percentage of Total Population that is "Alone without a Z-Code"



PA DOC Suicides since 2000 = 191



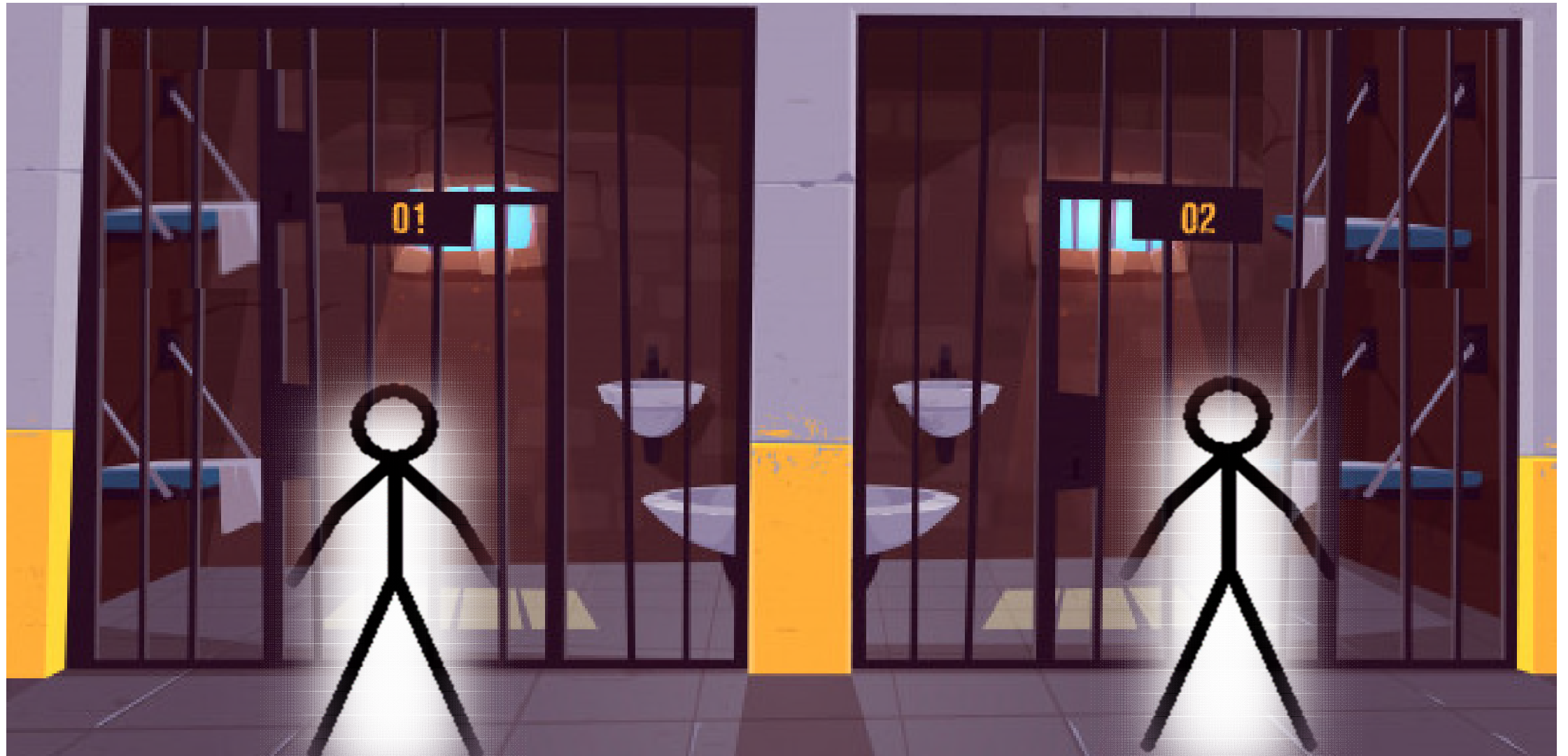
■ Alone without a Z-Code □ Z-Code □ Double Celled and other

This ~14% of our population has accounted for 58% of our Suicides.

Prison Housing Dilemma



PhD-Option 1



PhD-Option 2



What should we be considering when we decide to put someone ALONE?

When faced with the *PRISON HOUSING DILEMMA*, what *primary* questions need to be analyzed to make a **SAFE** housing decision ?



What should we be considering when making housing decisions?

QUESTION 1:

Is at least *one person* deemed to be *too dangerous towards others* to be celled with another person?



What should we be considering when making housing decisions?

QUESTION 2:

Is at least *one person* deemed to be too dangerous towards *themselves* to be housed ALONE?



Question 1 (YES, at least one is too Dangerous towards OTHERS)



Question 1 (NO. Neither are too Dangerous towards OTHERS)



Question 2: YES, at least one is too Dangerous towards THEMSELVES



▶ Question 2: NO. Neither are too dangerous towards THEMSELVES.



What should we be considering when making housing decisions?

QUESTION 1 & 2 Together:

Is at least *one individual* deemed to be too dangerous towards others to be housed together OR too dangerous towards themselves (i.e., too high of a suicide risk) to be housed alone?



▶ Main Takeaway from Prison Housing Dilemma

When making prison celling decisions, we can't simply assess **risk of dangerousness to others** and make a decision to mitigate risk of dangerousness to others without simultaneously contemplating **risk of suicide** into this analysis, as **our primary tool of mitigating risk of dangerousness to others is single cell placement**, which appears to *unintentionally and inadvertently* **contribute to increased risk of suicide.**

Homicides in the **Community** vs. Suicides in the **Community**

Homicides from 1981-2019

1981-1998: 397,912

1999-2019: 372,186

770,098 Homicides

Suicides from 1981-2019

1981-1998: 542,952

1999-2019: 792,871

1,335,823 Suicides

In the community within the United States, over the last 40 years, there have been twice as many suicides as homicides (CDC, 2021).

Some context of the TWO QUESTIONS...CORRECTIONS

Number of deaths in state and federal correctional facilities, by cause of death, 2001-2016 (Bureau of Justice Statistics, 2016)

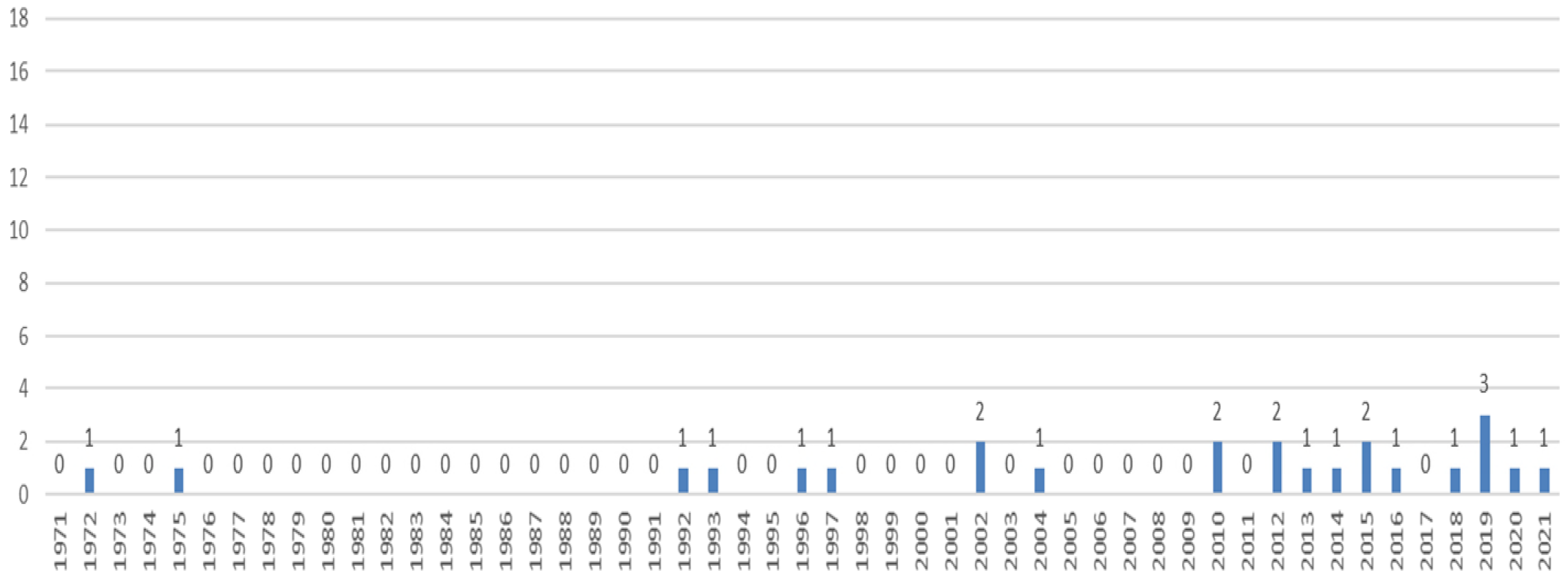
Suicides: 3300

Homicides: 1024

Across the United States and all (i.e., reporting) state Departments of Corrections during a recent 16 year period, there have been **three times as many suicides as homicides.**

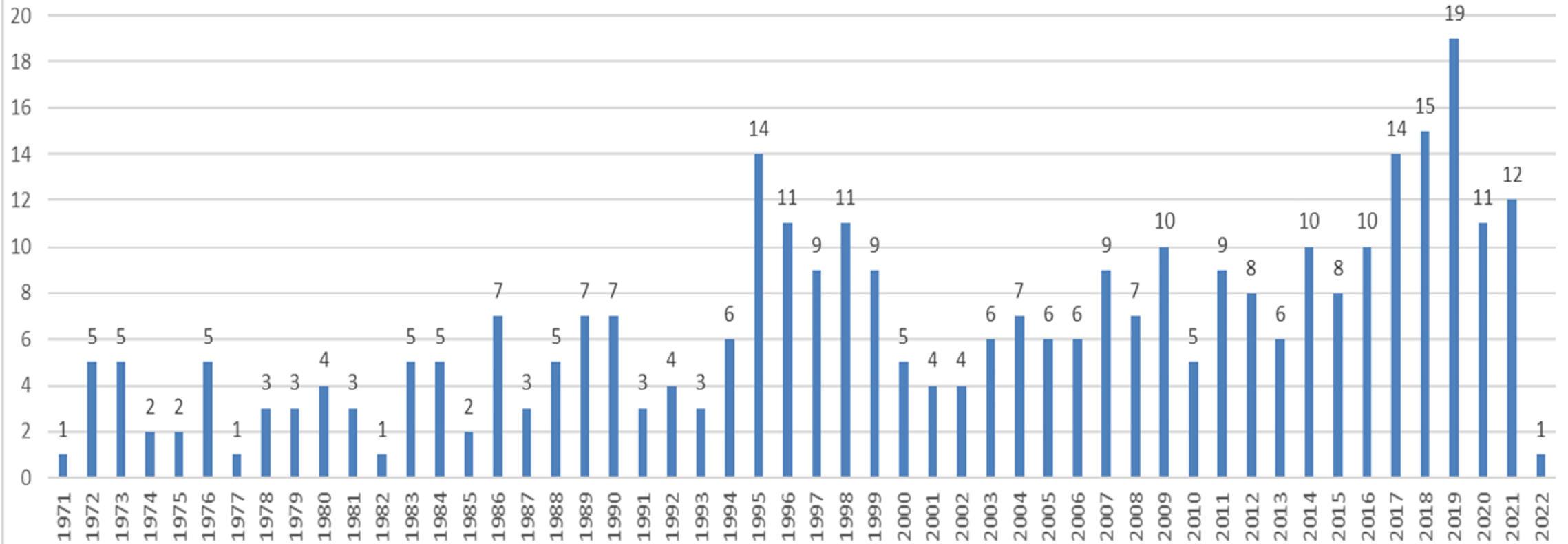
Question 1: Is at least one person too dangerous towards others to be celled with another person?

Inmate on Inmate Homicides in the Pennsylvania Department of Corrections 1971-2021

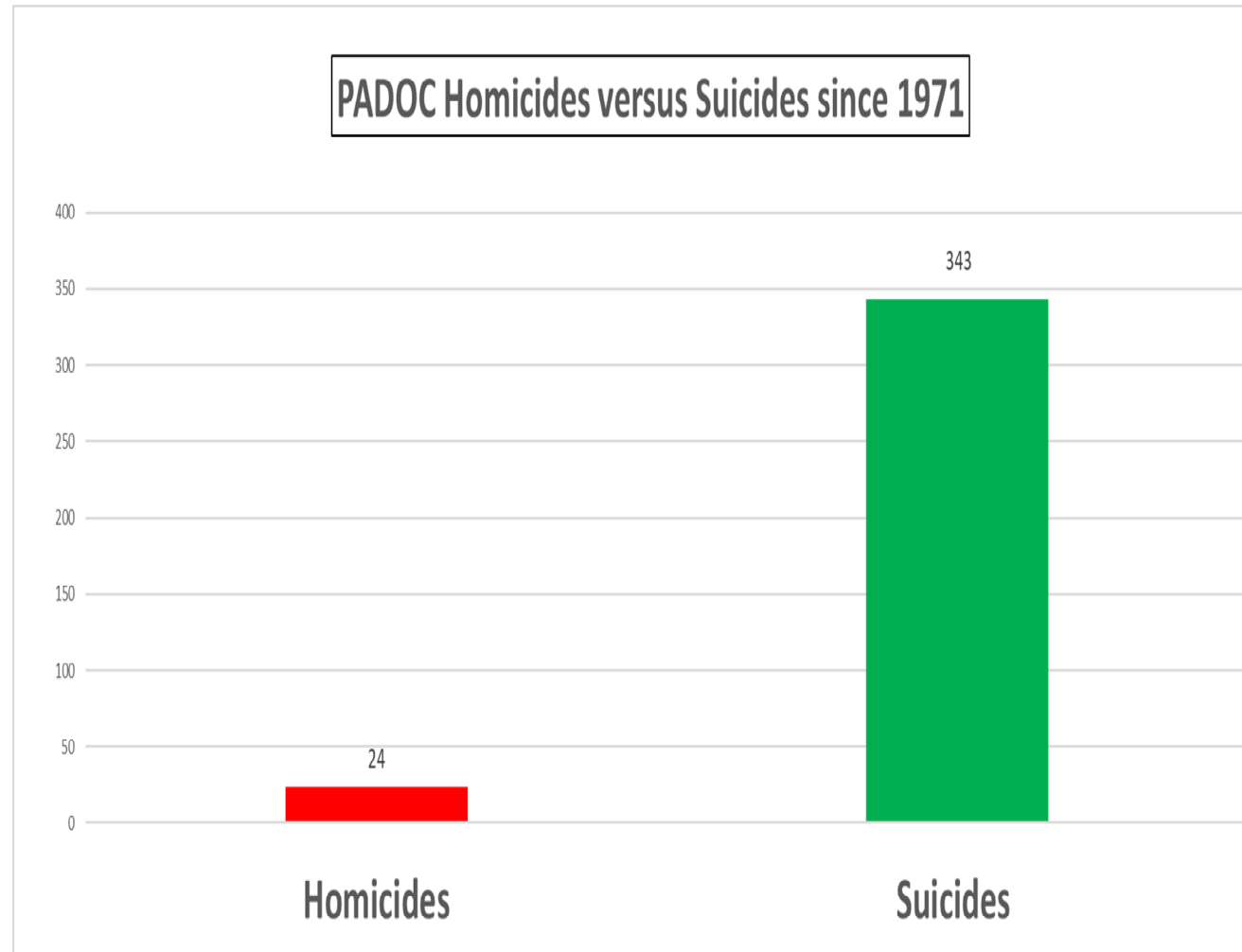


QUESTION 2: Is the individual too dangerous towards themselves to be alone?

Suicides in the Pennsylvania Department of Corrections 1971-2022



Some context of the TWO QUESTIONS...



Operational issues that we need to further contemplate:

- 1.) Despite existing safeguards and procedures for monitoring safety, **suicide risk** (i.e., known or unknown) **appears to be highest among those individuals housed alone in a cell.**
- 2.) Even when an individual is **double celled**, there are many instances when an individual's cellmate leaves the cell, which results in an individual being ALONE.
- 3.) The protective factor of being double celled is strongest when both individuals are present in the cell and weakest (i.e., though its still helps) when one individual is away.
- 4.) Individuals **rarely** die by suicide when under close or constant observation by DOC staff and **rarely** die by suicide when their cellmate is present.
- 5.) Doubling **everyone** up or believing that no one will ever be alone, is **NOT feasible or practical...**and actually, doubling everyone up would not completely solve our problem because of general movement in prison.

Operational issues that we need to further contemplate:

**6.) HOW DO WE ENHANCE
THE SAFETY OF
INDIVIDUALS THAT ARE
HOUSED ALONE?**

Systemic Changes related to Single Celling and Alone

- Individuals may no longer be given a **Z-code** for reasons related *only* to mental illness.
- Individuals may no longer be given a **Z-code only** because of any type of **self-injury, self-mutilation, assessment of dangerousness to self, or inability to care for self**; these are reasons individuals should **not** be celled alone.
- Institutions are to commence meaningful reviews of individuals single celled **without** a Z-code, for the purpose of identifying individuals that can be **safely** double celled instead of being celled ALONE out of convenience.
- **Increased frequency of security rounds** on all L-5 Units statewide, to once every 15 minutes (i.e., intermittently, so as not to develop a pattern) with special emphasis on those individuals housed alone.
- **Increased offering of out of cell, clinical encounters with *individuals housed alone*** on L-5 units by assigning additional Psychology staff to these units.
- **Development of enhanced Psychological Evaluation for Z-Codes**, which includes a SRA, Violence Risk Assessment, Review of Objective Testing, Review of Records, Patient Interview, and discussion with other staff members who know the patient.

Best Practices

1. **Safely** double cell when we can (i.e., consider as a default practice), and strive to avoid housing alone out of convenience.
2. Unit Managers **MUST** communicate (i.e., **BETWEEN** blocks) in order to facilitate **safe** double celling, when indicated.
3. Encourage informal resolution for *refusing to take a cellmate*
4. Review the frequency of rounds in **ALL** post orders.
5. If possible, congregate singles, then enhance frequency of rounds.
6. CO's doing security rounds are encouraged to pay extra attention to those who are housed alone.

Best Practices

7. Understand the consequences of a Z-Code and realize we have options.
8. Know our cells, (e.g., ADA, Single Beds, MOC/POC, Camera, etc.), know our vulnerabilities (Z-Codes & Alone without a Z-Code), and monitor them regularly. Discuss and report during department meetings.
9. During our weekly tours, make this issue part of our review. Check the boards and ask: “Show me your Z’s and Alone out of Convenience”.
10. During tours and department meetings, emphasize to our staff, including UMs and COs, the serious risk associated with housing individuals ALONE. Emphasize that “easier” (i.e., convenience) is not better.

Best Practices

11. Be strategic with **dorm style** housing selections. Use this to our advantage, when possible.
12. Set the tone from reception: (**safely**) double celling should be expected.
13. Know who is alone: Focus and Inform Rounds.
14. Reward people for taking a cellmate. Be creative.
15. If we have a block with single cells only (i.e., due to physical plant or otherwise), post orders should reflect more frequent rounds than blocks with double cells.
16. If you have cells with only one bed in them (i.e., and they are not ADA cells, etc.), consider whether or not these cells need to be online/consider installing second bed.
17. Consider taking a “Universal Precautions” approach to understanding suicide risk within Prison, when it comes to basic housing decisions.

References

- Centers for Disease Control and Prevention. (2021). Web-based injury statistics query and reporting system (WISQARS). *Fatal injury reports, national, regional and state, 1981-2019*. Retrieved from <https://webappa.cdc.gov/sasweb/ncipc/mortrate.html>
- Hayes, L.M. (1999). Suicide in adult correctional facilities: Key ingredients to prevention and overcoming the obstacles. *The Journal of Law, Medicine, & Ethics*, 27 (3), 260-268.
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