The Challenges of Assessing and Treating Prison Suicidality: A Possible Solution with CAMS-care

Jennifer Crumlish Ph.D.
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Suicide Prevention in Jails

The correctional officers (COs) told their supervisor they had had it with Inmate Roy Jones (a fictional composite of real incarcerated individuals). During a busy change of shift, Roy told his CO that an hour earlier he had swallowed a razor blade and pieces of scavenged metal, and now was regretting that he had done so. Taken by a CO to the infirmary, the nurse on duty assessed Roy and noted his blood pressure was high, he looked pale, and he was spitting up blood. Due to a recent high-profile suicide in the facility that had brought unwanted publicity, pressure on staff to avert additional incidents increased tension among CO managers and mental health supervisors. As a result, being cautious, the nurse recommended that Roy be transported to the local hospital. After a 6-hour wait in the emergency department, diagnostic imaging conducted at the hospital revealed no evidence of a razor blade or metal, and Roy was transported back to the prison. Needless to say, the amount of time spent at the hospital and absence of the two COs accompanying him created more stress for the COs covering the shift.

Engaging in multiple suicide attempts as well as several incidences of reporting attempts that were revealed to be false, Roy was proving to be a major management issue for both the COs and the mental health team. Roy was just one of several inmates with escalating self-harming and suicidal behaviors since the death of the suicidal inmate. In addition to suicidal behaviors, Roy was combative, faced additional time for punching a CO, was often non-compliant with treatment, and committed many rule violations related to substance use, fighting with other inmates, and possession of contraband items. Each time Roy faced disciplinary action or was moved to a more restrictive placement, he either made another attempt or claimed he had made an attempt.

Suicide Rates in Prison

As the number of beds in inpatient mental health facilities have declined – or in some communities disappeared – jails and prisons have become *de facto* centers for housing individuals with significant untreated mental health issues[1] and rates of suicide in correctional facilities, after a downward trend, have increased in the past few years. Statistics from the Bureau of Justice Statistics (BJS) indicate that the rate of suicides in US state prisons increased 30% from 2013 to 2014, after there had a been a 6% decrease in rates from 2012 to 2013.[2] In local jails in 2014, suicide was the leading cause of death, increasing 13% over 2013 rates, and was the largest number of jail suicides since reporting began in 2000.[3] Rates of mental illness are also higher in inmates in jails and prisons than in the general population, with 37% of prisoners and 44% of jail inmates reporting they had been diagnosed with a mental health disorder prior to incarceration. This rate is three times higher than the rate of mental health issues in the general population. Major depressive disorder was the most common disorder for both prisoners and jail inmates, with bipolar disorder, posttraumatic stress disorder, and anxiety disorders noted by 13 to 18 percent.[4]

The Challenge of Inmates with Mental Health Issues

Inmates like Roy create a dilemma for correctional facility staff. COs are wary of potential manipulative behaviors that may be used to "get out of jail," so to speak, and mental health professionals are pressed to identify risk and prevent attempts while not enabling manipulative or "secondary gain" behaviors. COs may be more skeptical of mental health issues and focused on managing and maintaining order in a facility, whereas mental health professionals are aware that some behaviors are beyond an inmate's control and may be exacerbated by the stress of incarceration.

A national study of suicide in correctional facilities revealed that most of the institutions that had experienced the death of an inmate by suicide subsequently created a written suicide prevention policy. However, it was less evident how comprehensive those policies were or how often they were being fully implemented.[5] Components of a comprehensive suicide prevention program in a correctional facility include training of all correctional staff, intake and ongoing assessment for suicide risk, means restriction, and suicide resistant housing, as well as procedures to facilitate communication amongst staff members regarding the status of the suicidal inmate.[6]

Though many facilities screen inmates upon intake, policies for addressing suicidality may focus on containment rather than treatment. For some facilities, inadvertently, the policies for managing a suicidal inmate may often be counter-productive – and in some cases punitive or demeaning. Suicidal inmates may feel pressured to deny being suicidal in order to be released back into the general population. Though many inmates may be screened for suicide, it may be more challenging to provide follow-up screening and assessment, or for a facility to have access to the resources to provide treatment for a suicidal inmate.

CAMS-care In Action

For the past three years, CAMS-care has trained mental health providers in a large state correctional organization to use CAMS with inmates in their mental health care systems. Implementation has revealed that CAMS provides a streamlined method to assess risk level, identify direct and indirect drivers of suicide, and collaboratively create a solid stabilization plan that inmates use with effective coping strategies to rely upon in the face of a suicidal crisis. The use of CAMS-care's assessment tool, the SSF-IV-R, helps clinicians and inmates move beyond the question *"Are you suicidal?"* to *"What are the factors (direct drivers) that make you want to end your life?"* and *"What treatments can be identified*

and implemented to target and treat those drivers so suicide is no longer the only coping strategy when those drivers are triggered?"

Getting at the Real Drivers

Clinicians who are new to CAMS in this system often report that when they use the SSF with inmates who experience both acute or chronic suicidality, they are surprised to discover that the direct and indirect drivers identified by the patient are different than what the clinicians had anticipated. For example, one clinician reported that she anticipated that an inmate serving a life sentence was likely suicidal due to despair over life imprisonment. However, when she completed CAMS-care's SSF with this inmate, he revealed that a direct driver was his shame about incarceration, since it prevented him from providing for and supporting his wife and children. A second direct driver was his grief at being separated from his wife. Though in despair about his life sentence, the sentence itself did not make him want to end his life. Instead, his sense of shame and guilt about the crime he had committed and the impact on his family is what made him suicidal. Ending his life would be a way to reduce the pain of the burden he felt he had created for his family and relieve himself of the emotional pain he felt about being separated from his wife.

In this case, the clinician's original assumption (that the inmate's direct driver of suicide was his life sentence) left her with limited options for treatment. What treatment can cure a life sentence? However, by using CAMS, she and the inmate were able to identify drivers of suicide that could be addressed by psychotherapy, and she was able to assist the inmate in developing a CAMS Stabilization Plan he could use when he began to feel suicidal in response to his sense of shame and grief.

What About Attention-Seekers and Malingerers in Prison?

Returning to Inmate Roy Jones, the issue with someone like Roy is trying to gauge whether his behaviors are primarily suicidal or primarily manipulative in order to make a determination regarding placement to either treatment or confinement. Roy's dramatic and risky self-injurious behaviors often occurred in response to disciplinary actions, changes in his housing, or a decline in his mental health functioning. In addition, inmates like Roy often have a history of suicide attempts prior to incarceration, making them at higher risk of completing suicide.

In fact, in the state correctional facility where CAMS-care provided training, some clinicians were initially skeptical about the benefit of using CAMS with this type of inmate, anticipating that the inmates would exaggerate their symptoms, making it difficult to accurately assess risk. For many clinicians, it was "safer" to send all inmates reporting suicidal ideation to the health center at the facility instead of returning them to the general population – even when, in their clinical judgment, the inmate was likely malingering.

Contrary to this assumption, for many inmates with this profile the use of CAMS revealed that inmates like Roy had direct and indirect drivers of suicide that had not been previously identified (i.e., disciplinary actions and changes in housing), and their main coping strategies when these drivers were triggered were self-harm and attempts at suicide. Clinicians reported that many of the inmates with primarily suicidal behaviors and secondary gain issues liked CAMS and reportedly found it helpful, particularly in identifying and using alternative coping strategies from their CAMS Stabilization Plan. Overall, Inmates with suicidal intent and attention-seeking behaviors, like Roy, found it a relief to engage in the CAMS framework.

In contrast, inmates who *were* malingering were very resistant to the use of CAMS and often refused to collaborate in the process, or openly admitted that they were using suicide to get their needs met.

As a result, clinicians reported feeling more confident regarding their assessment of risk as well as a positive experience using the SSF to identify direct and indirect drivers of suicide to help these inmates get out of the cycle of self-harm as a coping strategy or to get attention.

When Time is of the Essence

Clinicians in settings where they only meet with a suicidal inmate for one assessment session, or perhaps for one or two sessions before the inmate is due to be transferred, expressed an interest in using CAMS; however, they felt they could not since the CAMS-care Online Video demonstrates a 12-session protocol for using CAMS.

To accommodate clinicians in these short-term settings, a one-session model of CAMS was recommended and used successfully. In this model, clinicians were encouraged to collaborate with the inmate on completing an Initial Session SSF-IV-R, with an emphasis on creating a solid CAMS Stabilization Plan to start the inmate on the path of using alternative coping strategies. By identifying indirect and direct drivers of suicide in this one-session model and entering that information into the inmate's record, any clinician meeting with the inmate after discharge from the short-term setting would have access to the CAMS Treatment plan and likely be able to continue targeting and treating the inmate's drivers of suicide.

As more clinicians in this organization were trained in CAMS, the likelihood that an inmate could move from setting to setting and continue treatment in the CAMS framework increased, improving the odds that the risk level of suicide would decrease for the inmate.

In Summary

Despite some concerns that CAMS may be challenging to implement in a correctional setting, clinicians who have been trained in this setting over the past three years report that they prefer CAMS over other assessment tools, and inmates like the process of collaborating on the SSF. These clinicians now have more confidence in their suicide prevention efforts, and in some cases disruptive behaviors have decreased and suicidal inmates have reduced their suicidal behaviors.

CAMS may be a successful approach to managing suicidal inmates in both short-term and long-term settings, and clearly meets the criteria for an effective suicide prevention approach in a range of correctional facilities.

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5. Hayes, L.M. (2012). National study of jail suicides: 20 years later *Correct Health Care* Jul;18(3):233-45

6. Hayes, L. (2013). Suicide Prevention in Correctional Facilities: Reflections and Next Steps *International Journal of Law and Psychiatry* 36, 188–194

About Jennifer Crumlish Ph.D.

Dr. Jennifer Crumlish received her Ph.D. in clinical psychology at The Catholic University of America in 1996. She completed her pre-doctoral internship at St. Elizabeths in Washington, D.C., Her interest in research started while working in the Biological Psychiatry Branch in the NIMH at NIH during graduate school. She has taught courses in the graduate psychology program at Catholic University in psychopathology and diagnostic assessment and supervised students in the psychotherapy practicum. From 2006 until 2017, Dr. Crumlish was a consultant to the D.C. Department of Human Services Adult Protective Services division and conducted capacity evaluations of adults throughout the city. Dr. Crumlish is currently an examiner for the Superior Court of D.C. Probate Division and has presented at several conferences on elder abuse in Washington, D.C. Currently Dr. Crumlish is a partner in the Washington Psychological Center where she provides therapy to adolescents, adults and couples. In addition, she is the Assistant Director of the Suicide Prevention Lab at the Catholic University of America where she has been a consultant on several randomized controlled trials of CAMS. As a Senior Consultant with CAMS-care, LLC, Dr. Crumlish has provided training in CAMS to mental health providers at multiple military posts, a state correctional organization and local and state mental health suicide prevention organizations.

About CAMS-care

At CAMS-care, we offer suicide assessment and prevention training, consulting, and resources. For more information on CAMS, please contact us.