Suicide is the leading cause of death for people incarcerated in jail in the United States, accounting for more than 30 percent of deaths in custody. And this number does not include the high incidence of nonsuicidal self-harm in jails. Although best practices for suicide prevention and response exist, the majority of jails in the United States (63 percent) do not conduct reviews following a jail suicide, and few institutionalized responses exist to respond to instances of self-harm.

In 2016, the Vera Institute of Justice (Vera) reported on the potential for addressing the problem of jail suicide and self-harm through review processes characterized by an all-stakeholder, nonblaming, and forward-looking examination of the error. These “sentinel event reviews” move away from a view of error as solely the product of individual negligence and instead encourage an institutionalized approach that identifies root causes and underlying system failures. Since then, Vera’s researchers have studied how four county jail systems review and respond to incidents of suicide and self-harm and the feasibility of integrating sentinel event reviews into those jails’ regular practices.

Creating the conditions for sentinel event reviews

Four key themes emerged in Vera’s analysis of the four jails as critical to the success of future sentinel event reviews: the model of health care delivery, the nature of collaboration and communication, the organizational culture, and the legal landscape.

Health care delivery model
An increasing number of jails contract with vendors to provide at least some health care services. Although the use of private vendors can create efficiencies in medical care, it can also introduce different systems of accountability, different training requirements, and different review processes.

Collaboration and communication
Strong collaboration and effective communication among staff are vital to create the conditions that prevent incidents of suicide and self-harm; they can also foster space for sentinel event reviews and corrective action when an event occurs. However, the necessary collaboration between corrections and health staff is sometimes challenging. Furthermore, line staff are generally not included in existing reviews, and there are few or no mechanisms for communicating the outcomes or plans for corrective action.

Organizational culture
Three aspects of organizational culture emerged as particularly relevant to creating the conditions for sentinel event reviews of jail suicide and self-harm.

› Staff described a culture of placing blame on individual people. Staff reported that they would be skeptical if they were invited or instructed to participate in such a review. Some staff, however, felt that this could be overcome through proactive leadership.
Many staff across the four jails characterized their colleagues and workplace as resistant to change. However, some staff were able to cite examples of corrective actions taken to prevent suicide and self-harm within their jails, and many of these corrective actions were direct outcomes of a formal review process.

For suicide prevention efforts to be effective, staff must feel confident they have the necessary knowledge and resources to identify and intervene in cases of potential suicide. Despite increasing attention to mental health training in corrections, Vera found that some staff still believe that not all instances of suicide in jails are preventable.

Encouragingly, the highest levels of leadership at each jail recognized how important their role is in fostering change and agreed that a proactive approach is critical to shifting attitudes, obtaining buy-in, and improving practice.

Legal landscape

The feasibility of conducting sentinel event reviews also depends on the complex legal landscape in each jurisdiction. Discussions about confidentiality (relating to the sharing of health information, public records requests, and discovery, for example) and calculations around risk and liability are likely heightened when thinking about incidents of suicide and self-harm. Regardless of these complexities, participants in Vera’s study concluded that engaging in sentinel event reviews would be an important means both to improve practices around suicide and self-harm prevention and to contain liability.

Some key recommendations

As part of a comprehensive suicide prevention program, Vera recommends that jails seeking to improve their responses to incidents of self-harm and suicide through a sentinel event review process should:

- actively demonstrate commitment to focusing on system weaknesses and addressing root causes, not individual errors;
- use trainings on mental health, suicide, and self-harm to develop staff capacity and overcome the belief that some suicides are not preventable;
- include stakeholders from all disciplines and levels in reviews;
- disseminate review findings and recommendations to all staff; and
- champion the value of a sentinel event review process as way to proactively avoid harm and contain liability.

Preventing and responding to incidents of suicide and self-harm must be urgent priorities for jails across the United States. There is emerging guidance around implementing sentinel event reviews in criminal justice settings. Jails that adopt sentinel event reviews will not only demonstrate leadership and commitment to advancing the field of suicide and self-harm prevention, but will also help instill a new culture in their facilities—one that promotes the safety and well-being of the people in their custody, as well as those who work there.