

Criminal Justice

Response

**To people with mental illness
Arrested or incarcerated in Tennessee**

**Module 5
Suicide Intervention**

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Module Five: Methods and Procedures, Suicide intervention

Length of Presentation: 1 hour

Handouts and Materials:

Handout 5-1, Suicide, the Problem

Handout 5-2, Myths and Facts of Suicide

Handout 5-3, Suicide: Signs and Symptoms

Handout 5-4, Suicide Assessment: Law Enforcement

Handout 5-5, Suicide Assessment: Corrections

Handout 5-6, Intervention: Suicide Counseling

Handout 5-7, Suicide Prevention in Correctional Facilities

Handout 5-8, Response: Suicide Assessment and Intervention

Objectives

- Understand suicide;
- Identify signs and symptoms of suicidal intent;
- Identify risk factors for suicide, especially in criminal justice situations;
- Learn methods for assessing suicidal intent;
- Learn procedures for suicide intervention in law enforcement and correctional settings.

[Instructor note: Optional discussions are included throughout the discussion section. Use examples and concerns voiced by trainees to emphasize points in the handouts. Particularly apt situations can be substituted for or added to scenarios in the “Response” exercise with permission from the trainee. Use the experience and expertise of the group to work through the scenarios to an appropriate and practical approach.]

[Participants may bring up traumatic experience with suicide intervention. Allow group discussion and feedback with the trainee’s permission, but be sensitive to verbal and non-verbal reluctance to discuss the situation publicly. If necessary, set aside time to discuss the situation with the individual after the training session. If you have concerns, refer the trainee for further counseling.]

DISCUSSION

Suicide Intervention

Law enforcement, corrections and probation officers will encounter suicidal individuals in the course of their work. The purpose of this section is to give a basic understanding of suicide, to identify signs of suicidal intent, to identify and reduce risk factors in criminal justice settings, and to learn methods for assessing and intervening to prevent suicide.

Optional Discussion:

[Time limit, 5 minutes.]

- How many here have dealt with suicidal individuals in your work?
- What are your main questions and concerns regarding your role in suicide intervention?

The Problem of Suicide

Suicide is a complex behavior usually caused by a combination of factors. Research shows that almost all people who kill themselves have a diagnosable mental or substance abuse disorder or both, and that the majority have depressive illness. Studies indicate that the most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of depression and other psychiatric illnesses.

[Instructor: Review Handout 5-1, Suicide, the Problem.]

The Surgeon General's 1999 *Call to Action to Prevent Suicide* recommends a national strategy including:

- Promote public awareness of suicide as a preventable national problem;
- Increased resources to alleviate distress leading to suicide, including crisis lines, mental health and substance abuse services and support groups;
- Increase training of all mental health, health and human service professionals (including law enforcement and corrections) concerning suicide risk assessment, treatment, management and after care regimens;
- Increased monitoring and reporting of suicides and evaluation of suicide prevention programs.

The Tennessee Suicide Prevention Network *[see handout for contact information]* is part of that national strategy. The Network offers a number of services including:

- A statewide suicide hotline that is available 24/7;
- A web site with information on suicide and suicide prevention;
- Suicide prevention training conducted across the state with multiple stakeholder groups, using consistent, effective programs.

Suicide prevention and intervention are often hampered by commonly held misconceptions. Handout 5-2, *Myths and Facts of Suicide*, describes the most common myths, and the facts.

[Instructor: Refer to Handout 5-2, Myths and Facts of Suicide. Only review handout if class is inexperienced with suicide.]

Most people are severely depressed at the time of a suicide attempt. The first section of Handout 5-3 shows signs of depression associated with suicide.

[Instructor: Review first section of Handout 5-3, Suicide: signs and symptoms.]

Studies indicate that suicide is nine times as common among correctional inmates as in the general population¹. The remainder of Handout 5-3 lists signs and risk factors in the correctional environment.

[Instructor: Review remainder of Handout 5-3.]

Jail Environment Risk Factors (Adapted from L.M. Hayes, Jail Suicide/ Mental Health Update, Fall 2000)

The experience of being arrested and jailed can traumatize an individual who has little or no criminal background, especially if the person has severe mental illness, is young, is pregnant, is withdrawing from intoxication, or is a public figure. Law enforcement and corrections personnel who respond sensitively to those individuals can alleviate the emotional trauma that can lead to suicidal behavior. The last section of Handout 5-3 lists some correctional risk factors.

Authoritarian environment: Inmates who are not used to regimentation may be traumatized by the correctional environment, especially if they have delusions, hallucinations or symptoms of severe depression. Mounting stress levels combined with inadequate coping skills increase the likelihood of suicidal behavior.

Fear of what the future holds: Following incarceration, many jail inmates feel powerless over their future. They may have a sense of impending doom about the legal process. Feeling helpless and hopeless increases the suicide risk.

Fears: Stereotypes of jails from the media may heighten anxiety about other inmates and the staff. Individuals who are prone to paranoia or anxiety may be more vulnerable to suicidal behavior induced by terror.

Social isolation: Inmates may feel cut off from family, friends especially with restricted telephone and visiting privileges. Inability to obtain support and encouragement increases risk of suicide.

Shame: Feelings of shame are common in misdemeanants. Often, those charged with minor crimes feel more ashamed than those charged with more serious offenses. Inmates with little or no criminal history also feel more shame. Humiliation is a common factor in suicide.

¹ Hayes L., Rowan, R. (1988) National Study of Jail Suicides: Seven Years Later, Alexandria, VA. National Center on Institutions and Alternatives. National Institute of Corrections, U.S. Department of Justice.

Dehumanizing aspects of Incarceration: From the inmate's perspective, confinement, even in the best of jails, is dehumanizing. Lack of privacy, association with poorly behaved individuals, lack of opportunity to make choices, strange noises and odors, and overcrowding can all have a devastating effect.

Officer insensitivity to arrest and incarceration: Most professionals working in the criminal justice environment have never personally experienced the trauma of arrest and incarceration. Experience has shown that, in many instances, the longer people work in the criminal justice field, the more insensitive they can become to the emotional effects of arrest and incarceration, particularly for the first-time offender.

Optional Discussion:

[Time limit, 5 minutes.]

- How many here have dealt with individuals who seemed traumatized by arrest or incarceration?
- How did those individuals behave?
- What did you and other officers do that either improved or worsened the situation?
- If you or others did something that made the situation worse, what would you do differently?

Suicide Assessment

Suicide Assessment: Law Enforcement

Law enforcement is commonly called to the scene of an attempted or completed suicide. Officers may refer individuals who have attempted suicide to crisis intervention or mental health services, but as the first officials to arrive, their observation of signs, symptoms, and the physical environment to are essential to begin the assessment and intervention process.

[Instructor: Review Handout 5-4, Suicide Assessment: Law Enforcement.]

Individuals arrested for crimes may also pose an increased risk of suicide. Often those with the least criminal history arrested for minor offenses are at greater risk of becoming suicidal. Another high-risk group are arrestees with psychotic disorders who may hear voices telling them to kill themselves.

To detect possible suicidal intent law enforcement officers must observe the individual's behavior:

- During arrest;
- During transport to the jail;
- At booking/intake.

Law enforcement officers should alert booking and/or correctional staff when there is a suspicion of suicidality. Many officers help prevent jail suicides by transmitting observations and information indicating danger of self-harm. On the other hand, some have been named in lawsuits for failing "duty of care," or for deliberate indifference.

Suicide Assessment in Correctional Facilities

Intake screening should occur immediately after a new inmate arrives at the jail, and should assess risk of suicide or self-harm. Screening should be conducted by trained booking or corrections officers, or by medical personnel. Failure to conduct an immediate screening increases the chance that an inmate will kill or harm himself or herself. The facility will probably be subject to a lawsuit if there is an accidental inmate death.

The following are some pointers for effective intake interviewing:

- Explain the purpose of the intake interview to the inmate, especially if the inmate has no previous experience with incarceration or appears frightened, withdrawn or aggressive.
- Use the screening questionnaire as a beginning. Follow-up on any verbal or behavioral responses that suggest the inmate may intend self-harm.
- Ask questions in a straightforward manner speaking in a quiet, matter-of-fact tone. Do not use an abrupt, confrontive tone. You will not get truthful responses and may increase the risk of suicide.
- If the inmate does not understand you, repeat the question.
- Use as private a setting as possible.

If there is any indication of suicidality or mental illness, the inmate should be referred for a more thorough mental health assessment and should be closely monitored.

Warning

More than 50% of all jail suicides occur within the **first 24 hours** of arrival at the jail.

[Instructor: Review Handout 5-5, Suicide Assessment: Corrections.]

Suicide Attempts vs. Manipulation

It is common for officers to view suicide attempts as manipulative behavior. Studies show that self-mutilation should be taken seriously, because an eventual completed suicide is likely if the individual is not monitored (Liebling, 1996). While not all suicide attempts are self-mutilation, it is not useful to try to distinguish self-injury from manipulation. It is more useful to ask, "Why is this person trying to injure himself or herself?" (Danto and Lester, 1993).

Suicide Counseling

[Instructor: If you only have law enforcement trainees or corrections trainees, use the appropriate discussion script. The handout is the same. If you have both in the audience review the handout during the law enforcement section of the script, but then proceed to corrections.]

Law Enforcement: Suicide Counseling

Once an assessment has been done, whatever the level of risk, law enforcement officers should begin the suicide counseling process. The objective is to assist the individual to resolve desperate, all-or-nothing thinking and consider healthy alternatives.

If the individual is has not committed a crime, the guidelines are as follows:

- **Low risk of self-harm:** Individual can be counseled and released if suicidal ideation was resolved. The chosen method of self harm may need to be confiscated or neutralized. Contact information for local mental health treatment providers should be supplied to the individual;
- **Moderate risk:** Individual should be transported or referred to a mental health agency after initial suicide counseling. Chosen method of self-harm should be confiscated or neutralized and other suicide precautions should be activated;
- **High risk:** Individual should be escorted to an emergency room or psychiatric inpatient facility. Chosen method of self-harm should be confiscated or neutralized and other suicide precautions should be activated. Due to liability concerns, the individual may need to be restrained;

Individuals who are under arrest should be monitored closely at all times during arrest, transport and booking if there is risk of self-harm. This not only keeps the individual safe, but also affords an opportunity to counsel the individual and gather information that is needed by correctional officers.

Whether the individual has committed a crime or not, the officer that asks about self-harm and demonstrates caring attention can save a life. It may not be appropriate for the officer to follow the counseling process through to the action planning stage, but initial steps should be taken to minimize the risk of self-harm in the immediate future.

[Instructor: Review Handout 5-6, Suicide Counseling.]

Suicide Counseling In Correctional Facilities

The inmate who presents an increased risk of suicide should be placed on suicide watch and counseled by mental health or medical personnel. However, correctional security officers may spend much more time around the inmate and will be in a position to notice signals from the inmate that distress is increasing and self-harm is a possibility. As with law enforcement, it may not be appropriate for the officer to follow the counseling process through to the action planning stage, but initial steps should be taken to minimize the risk of self-harm in the immediate future.

[Instructor: Review Handout 5-6, Suicide Counseling if you haven't already done so.]

Managing Suicidal Individuals In Correctional Facilities

In general, correctional security officers are more involved in managing suicidal inmates than suicide counseling. Handout 5-7 describes principles and procedures for maintaining the safety of suicidal inmates while reducing risk of suicide attempts. Individuals at risk of self-harm must be monitored **at all times** and must be treated with care to reduce traumatizing factors in the correctional environment.

[Instructor: Review Handout 5-7: Suicide Management in Correctional Facilities.]

Suicide Proofing

Increased suicide risk is a fact of life in incarceration. Correctional administrators and staff that take an ongoing, proactive approach to suicide proofing will reduce the chances of having to make drastic changes after the fact. In addition to thorough, systematic screening at intake, there are a few relatively simple, inexpensive approaches to correctional suicide prevention.

- Training of security and medical personnel, initial and on-going;
- Specific physical plant changes;
- Policy and procedure changes;
- “Last resort” approach to use of restraints and forced medication;
- Morbidity and mortality review procedures, critical incident debriefing;
- Good communication between inmates and staff.

[Instructor: Review Handout 5-8, Suicide Prevention in Correctional Facilities.]

Response Exercise:

[Instructor: Particularly apt situations voiced by trainees in discussions can be substituted for scenarios in the “Response” exercise with permission from the trainee. Use the experience and expertise of the group to work through the scenarios to an appropriate and practical approach.]

*[Instructor: Proceed through exercise on Handout 5-9, **Response:** Suicide Assessment and Intervention.*

Option 1: Work through scenarios as a group.]

Option 2: Divide the class into small groups (up to 6 trainees) assigned to work through two or more scenarios. Facilitate a whole-group discussion to share what small groups developed.

Write responses on flip chart or marker board.]

References

Hayes, L.M. (2000) Suicide Despite Denial: When Actions speak louder than words, Jail Suicide/ Mental Health Update, Fall, (10) 1, 1 – 6.

Hayes, L. (1997) From Chaos to Calm: One Jail’s Struggle with Suicide Prevention. Behavioral Science and the Law, 15, 399-413.

Levitt, G. (2000) Practical Suicide Prevention, *Corrections Today*, December, 110-117.

Texas Commission on Law Enforcement; (2000); *Suicide Detection and Prevention in Jails*. # 3501(Revised).

Handout 5-1

Suicide, the Problem

Suicide is a complex behavior usually caused by a combination of factors. Research shows that almost all people who kill themselves have a diagnosable mental or substance abuse disorder or both, and that the majority have depressive illness. Studies indicate that the most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of depression and other psychiatric illnesses.

- Suicide was the eighth leading cause of death for all Americans (up from ninth in 1996) and the third leading cause of death for young people aged 15-24.
- Suicide took the lives of 30,903 Americans in 1996 (10.8 per 100,000 population). Suicides in that year accounted for only 1% of all deaths, compared with 32% from heart disease, 23% from cancer, and 7% from stroke, the top three causes of death in the U.S.
- More people die of suicide than from homicide. In 1996, there were three suicides in the U.S. for every two homicides committed.
- Up to 80% of all suicides are completed by people who are severely depressed.
- The highest suicide rates were for white men over 85, who had a rate of 65 per 100,000 individuals. However, suicide was not the leading cause of death for this age group.
- Males are four times more likely to die of suicide than are females. However, females are more likely to attempt suicide than are males.
- In 1996, white males accounted for 73% of all suicides. Together, white males and white females accounted for more than 90% of all suicides in the United States. However, during the period from 1979-1992, suicide rates for Native Americans were about 1.5 times the rates for the general population. There were a disproportionate number of suicides among young male Native Americans during this period, as males 15-24 accounted for 64% of all suicides by Native Americans.
- Nearly 3 of every 5 suicides in 1996 (59%) were committed with a firearm, while 79% of all firearm suicides are committed by white men.
- There are an estimated 16 attempted suicides for each completed suicide. The ratio is lower in women and youth and higher in men and the elderly. Suicide attempts are expressions of extreme distress that need to be addressed, and not just a harmless bid for attention. A suicidal person should not be left alone and needs immediate mental health treatment.

From: *The Surgeon General's Call To Action to Prevent Suicide, 1999*, <http://www.surgeongeneral.gov/library/calltoaction/fact1.htm>

In Tennessee: Statewide Suicide Hotline, (800) SUICIDE (784-2433)

For more information on suicide prevention: Tennessee Suicide Prevention Network
<http://www.state.tn.us/mental/suicidePrev/suicide.html>

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Handout 5-2

Myths and Facts of Suicide

- 1) **Myth:** Once someone decides on suicide, he or she cannot be stopped.
Fact: Most suicidal people have mixed feelings. Most do not want death; they want to end the pain: physical and psychological. They may be miserable, but they wish to be saved.
- 2) **Myth:** Most suicides are caused by one sudden traumatic event.
Fact: Most people communicate warning signs of how they are reacting to events that are drawing them toward suicide. There are often a number of opportunities to assist the individual.
- 3) **Myth:** Talking about suicide gives people the idea.
Fact: Asking someone about their suicidal feelings may actually make them feel relieved that someone finally recognizes their emotional pain.
- 4) **Myth:** People who talk about suicide never actually do it.
Fact: Almost everyone who has attempted suicide has given some warning or clue. When someone talks about committing suicide, he or she may be giving a warning that should not be ignored by others who hear such comments.
- 5) **Myth:** Suicide occurs without warning.
Fact: Research has consistently shown that at least two thirds of all suicide victims, including adolescents, communicate their intent some time before death.
- 6) **Myth:** The suicidal act is a well-thought-out expression of an attempt to cope with serious personal problems.
Fact: Most people are irrational at the time of a suicidal crisis. They have very strong mixed feelings. They want to live, but are overwhelmed with despair, anxiety and hopelessness. They cannot see any other solution.
- 7) **Myth:** People who have tried suicide and did not succeed are less likely to try it again because they have gotten it out of their system.
Fact: Eighty percent of those people who die by suicide have made at least one previous attempt.
- 8) **Myth:** Inmates who are really suicidal can be distinguished from those who hurt themselves just to be manipulative.
Fact: Manipulative goals in self-injury are not useful in distinguishing more lethal attempts from less lethal attempts.
- 9) **Myth:** There is a "typical" type of person who commits suicide.
Fact: The potential for suicide exists in all of us. There is no typical type of suicidal person.

Handout 5-3

Suicide: Signs and Symptoms

Most people are severely depressed at the time of a suicide attempt. Narrow, all-or-nothing thinking leads them to view suicide as the solution to an intolerable situation. Assessment and counseling can assist suicidal individuals to pursue healthier approaches to problems.

Depressive symptoms

- Expression of an inability to go on (hopelessness, helplessness);
- Extreme sadness, crying;
- Withdrawal, silence;
- Marked changes in appetite and/or weight;
- Changes in sleep: insomnia or over-sleeping;
- No sense of the future, or hopeless attitude toward the future;
- Marked mood changes;
- Tenseness, agitation, aggression;
- Lethargy, slowed movements;
- Loss of self-esteem;
- Self-blaming, strong guilt feelings about offense;
- Loss of interest in people, appearance, activities;
- Difficulty concentrating.

Other signs of suicidality

- Talking about, threatening suicide;
- Intoxication, alcohol/drug withdrawal;
- Previous suicide attempts, history of mental illness;
- Paranoid delusions or hallucinations;
- Does not deal with the present, is preoccupied with the past;
- Poor health or terminal illness;
- Increased difficulty relating to others;
- Engaging in non-lethal self-injury.

In correctional facilities:

- Speaking unrealistically about getting out of jail or “being free”;
- Begins packing or giving belongings away when release is not imminent.

Risk factors in criminal justice settings

Suicide rates in correctional facilities are nine times greater than in the general population.

- Arrestee with little or insignificant criminal history;
- Previous imprisonment and facing new serious charges and long prison term;
- Previous painful alcohol/drug withdrawal, unwilling to go through it again;
- Juvenile, whether or not waived to adult court;
- High status in the community;
- Prior suicide by close friend or family member;
- Recent suicide attempt by another inmate (copycat syndrome);
- Harsh, condemning, rejecting attitudes of officers, e.g. “We’ll give you the rope...”
- Same sex rape, or threat of it.

Risk influences in jail environments:

- Authoritarian environment;
- No apparent control over the future, fear of legal process;
- Isolation from family, friends and community;
- Shame about incarceration;
- Dehumanizing aspects of incarceration;
- Fears of inmates and staff;
- Officer insensitivity to inmates’ experience of arrest and incarceration.

Source: Hayes, L.M. (2000) Suicide Despite Denial: When Actions speak louder than words, Jail Suicide/ Mental Health Update, Fall, (10) 1, 1 – 6.

Handout 5-4 Suicide Assessment: Law Enforcement

Situation	Questions
Attempt has occurred.	Suicide paraphernalia evident? Is individual bleeding? Is individual conscious? What are the vital signs?
	Is anyone else present? If so... Did they see what happened? If not.... How soon after the even did they arrive? Exactly what did they see/hear /when they arrived?
	If conscious ask: Have you already attempted to kill or harm yourself? What did you do? When did you do it? Response time is critical. Seconds might count.
Attempt has not yet occurred.	
Assess immediate risk:	Observe: Physical signs of depression? Slowed movements; Slowed verbal response; Unkempt appearance; Untidy living place.
	Ask: Have you thought about harming or killing yourself? Affirmative answer or perceived evasiveness = higher risk.
	Ask: Have you thought about how you would do it? More lethal methods = higher risk.
	Have you thought about when you would do it? The more immediate/specific time frame = higher risk.
	What have you done already to prepare to harm yourself? More available methods = higher suicide risk Confiscate weapons, sharp object, medications, other means to suicide
Assess prior behavior:	Have you tried to harm yourself before? How many times? How did you do it? More lethal methods = higher risk What happened?
Assess social support:	Are you feeling alone with these thoughts of suicide? Who have you turned to for help? What happened? Who else has helped you in the past? Fewer, more distant persons = higher risk
Assess behavioral cues:	Combative, challenging toward law enforcement: "suicide by cop" Depressed, withdrawn, expresses hopelessness, helplessness, Expresses no sense of future: "I won't be here." If incarcerated, speaks unrealistically about release. Packs/gives away belongings.
Assess other risk factors:	Recent loss of family member, close friend; family history of suicide; loss of: job, financial security, relationship, pet; history of mental illness; public humiliation: especially for public figures; pregnant inmates; inmates needing psychiatric medications, who do not have them.

Handout 5-5 Suicide Assessment: Corrections

Intake:	If there is ANY doubt about suicide, refer the inmate for mental health assessment.
Information about arrest:	Does the arresting and/or transporting officer have any information to indicate that the inmate is a medical, mental health or suicide risk now? If yes, explain.
Prior/collateral information:	<ul style="list-style-type: none"> ○ Was the inmate a medical, mental health or suicide risk during any prior contact and/or confinement within this facility? If yes, explain. ○ Does the inmate display symptoms of depression, aggression or intoxication that increase suicide risk? If so, what? ○ Is there any notification/documentation from sending agency to indicate possible suicide risk? If so, what? ○ Is there any information from relatives or friends that might indicate suicide risk? ○ Is the inmate in treatment through a mental health agency? ○ If so, request signed consent to release information from inmate; ○ Contact agency to notify of incarceration and obtain diagnosis, medication list, history of danger to self or others.
Intake questions:	<ul style="list-style-type: none"> ○ Have you ever attempted suicide? If yes, when, why and how? ○ Have you ever considered suicide? If yes, when and why? ○ Are you now, or have you ever been treated for mental health or emotional problems? If yes, when and where? ○ Have you recently experienced a significant loss, such as a relationship, death of a family member or close friend, or job loss? If yes, explain. ○ Has a family member or close friend ever attempted or committed suicide? If yes, explain. ○ Do you feel there is nothing to look forward to in the near future? If yes, explain. ○ Are you thinking of hurting or killing yourself? If yes, explain.
<p>Answers will not necessarily indicate that the individual is suicidal, but the screener should always refer the inmate for assessment if self-harm is suggested by:</p> <ul style="list-style-type: none"> ○ Verbal responses; ○ Behavior; ○ Demeanor; ○ Background; ○ Scars from previous suicide attempts; ○ Bruises, skin condition and color; ○ visible signs of intoxication, drug withdrawal. 	
Observation in jail:	
High risk periods:	<p>More than 50% of jail suicides occur in the First 24 Hours; Many within the first 3 hours. Other high-risk periods:</p> <ul style="list-style-type: none"> ○ Darkness; ○ Times of decreased staff supervision; ○ When an inmate first starts taking psychiatric medication; ○ When bad news is received; ○ Holidays; ○ During sentencing; ○ As release date nears.

Handout 5-6

Intervention: Suicide Counseling

The first officer at the scene of a suicide attempt should use basic suicide counseling techniques to calm the individual and begin exploration of healthy alternatives to suicide. The role of an officer is to administer “emotional first aid”. Suicidal individuals should be referred or escorted to professional services at the earliest opportunity.

Steps in suicide counseling:

Engage the individual

- Show compassion. Your calm, caring, confident, firm demeanor provides a model. It will encourage trust and will help the individual calm down and begin thinking rationally.
 - Paraphrase implied feelings then invite the individual to discuss them:
“You seem desperate to relieve the pain you are feeling. Tell me how it feels.”
 - Encourage the person to talk about what is happening from his/her point of view.
 - Do not show condemnation or shock.
- Convey that suicidal thoughts are normal part of severe depression. Allows individual to feel less guilty and isolated.

Ask direct questions about suicide

- If the individual has not already spoken of it, ask directly about suicidal intent or attempt:
“It sounds like you were planning to kill yourself. Is that true?”
“How were you planning to do it?” (The more specific, immediate and lethal the higher the risk)
- Keep asking questions until you and the individual understand events and feelings in the recent past that led to this point.
- Stay in the here and now, in the recent past and immediate future.
Do not dwell on early childhood or the distant future.
- Keep the focus on the individual, not family, spouse, etc.
- Focus on the individual’s ambivalence about suicide.
“You want to die, but I think another part of you wants to live. Tell me about that part.”
- Begin problem solving only AFTER feelings have been identified and you understand the person’s situation.

Redirect the individual away from the act toward alternatives.

- “What else could you do right now to make yourself feel better?”
- If emergency procedures have been initiated, explain how you see the situation, what is being done, and the intended outcome.
- Help the individual realize that the crisis is just temporary and things can work out.
- Assure the individual that help is available.

Help the individual develop an action plan

- The plan should be specific: what, where, when, who, how?
- The plan should be achievable: a modest plan that can be carried out will encourage the person. An ambitious plan that does not work is dangerous.
- The person should commit to the plan. Get the person to repeat the agreement out loud.
 - A voiced commitment is more likely to be kept.
- Plan for crisis support. Plan what the person will do if desperate, suicidal feelings return. The plan can include other inmates, staff, contacting clergy, family, etc.
- Suicide-proof the environment: Remove all hazards, particularly those that were used in previous suicide attempts.

Handout 5-7

Suicide Management in Correctional Facilities

Individuals at risk of self-harm must be monitored **at all times**, with more intensive monitoring during high-risk periods. At the same time, inmates on suicide watch should be treated with care to reduce further trauma. The following procedures will reduce risk of inmate self-harm or suicide:

- Officers who have regular, fair, non-judgmental communication with inmates will be more likely to spot verbal and behavioral cues as an inmate prepares a suicide or self-harm attempt:
 - Inmate is withdrawn, does not respond to greetings or questions;
 - Inmate who has been withdrawn is suddenly cheerful or relieved (indicating that a decision to suicide has been made);
 - Inmate hides something as officer approaches;
 - May have secured means of suicide including bedding, braided toilet paper, wadded toilet paper used for suffocation, sharp object to be used in laceration, pills for overdose.
 - Search inmate and inspect cell thoroughly for evidence of suicide preparation. Remove all possible means.
 - Inmate is packing belongings or giving them away;
 - Other inmates notify officer that inmate is up to something or has said something that raises concerns about suicide;
 - Inmate speaks unrealistically about “release” or “Soon I won’t be here.”
- Procedures for medication administration should include “watch and swallow” techniques and secure storage of disposal of syringes and instruments.
- When inmate is on suicide watch, frequent contact with correctional officers is essential: at least every 15 minutes at staggered intervals, round the clock. Adopt a caring approach to minimize the sense of isolation that increases suicide risk.
- Monitoring by on-call suicide watch personnel may be necessary in high-risk situations. Specially trained security officers, nursing assistants or psychiatric technicians have been used effectively in county jails.
- Removal of clothing and bedding may be necessary. Use of paper garments or suicide proof garments is another option, but suicide garments are not hazard-free, and should not be considered a substitute for close monitoring.
- Use of transitional cells in full view of the security office is a better option than relying on video cameras and monitors.
 - Transitional cells, or suicide watch cells should be free of protrusions, large bore grates and other hazards that can be used in hanging.
 - Plastic bunks are available to reduce possibility of the bed frame being used.
 - Resources used to establish transitional cells can be considered insurance against considerable financial outlay that will be necessary if the jail is sued after an inmate suicide.

Handout 5-8 Suicide Prevention in Correctional Facilities

Increased risk of inmate suicide is a fact of life in correctional facilities. A proactive approach will save lives and will reduce the chance of being forced to make drastic changes after the fact. In addition to thorough and consistent screening at intake, there are a few relatively simple, inexpensive approaches to correctional suicide prevention.

Common Means of Suicide	Suicide Proofing
Hanging: 93.5% of correctional suicides <ul style="list-style-type: none"> ○ Using bedding 47.9% ○ Using clothing 33.7% 	<ul style="list-style-type: none"> ○ Paper garments Can still be shredded & used for suffocation, or Braided and used for hanging. ○ Suicide blankets (must be dated, replaced every 6 months) ○ Plastic bunks
Overdose 1.2%	<ul style="list-style-type: none"> ○ Perform watch and swallow techniques; ○ Periodic observation of staff during medication administration.
Lacerations 1.2%	<ul style="list-style-type: none"> ○ Secure disposal procedures to track and dispose of razors and other sharp instruments. ○ Periodic observation of staff procedures during inmate shaving;
Other methods	<ul style="list-style-type: none"> ○ Determine facility weak spots: review incident reports to list means and ways previously used in suicide attempts.

Facility tour: Necessary even in new facilities
Use multi-disciplinary team: include security and mental health staff. Examine facility for potential means of suicide. Include medical/mental health units. Put yourself in the shoes of a desperate inmate.
Look for potentially lethal items: vents with large bore grating, light fixtures that can be bent, open railings, window bars, bunk supports, shower heads, protruding objects, accessible electrical or telephone cords.
Look for poorly visible areas: stairwells, shower stalls, dark corners, sections of cells not visible through door.
Survey inmates: about their observations about the institution's vulnerabilities toward suicide
Remove hazardous conditions: Commit resources and change policies.

Observation cameras: Limitations and solutions
Limitations: <ul style="list-style-type: none"> ○ TV monitor must be watched constantly. Staff in the security office are usually answering the phone, responding to radio messages, observing other activities, completing paperwork; ○ Poor picture quality: rooms not well lit, pictures may be grainy, distorted; ○ Blind spots: Areas of the facility may not be within camera range; difficult to install cameras into existing structures without leaving exposed wiring.
Solutions: <ul style="list-style-type: none"> ○ Place inmate under constant observation. Hire trained on-call nursing assistants or psych techs; ○ Build transition cells that are in full view of the security tower. Equip with plastic bunks.

Policies and procedures:
See examples in: National Commission on Correctional Health Care: <i>Standards for Health Services</i> . Compare with federal, state and local mandates. Review annually. Make sure medical and security policies are coordinated and consistent.
Should be detailed, objective and easy to understand.
Regular staff training to ensure familiarity.
Topics:
Emergency psychiatric interventions: Include triage system, expected staff responses and outcomes. Train medical and security officers to respond to psychiatric crises.
Suicide prevention and response:
<ul style="list-style-type: none"> ○ Must have round the clock observation/intervention plan for suicidal inmate. ○ Double bunking with a responsible peer inmate; ○ Consultation with mental health specialist; ○ Transfer to local hospital if necessary. ○ Risk levels with required response.
Forced medications: Should be used only
<ul style="list-style-type: none"> ○ After other measures have been tried unsuccessfully, AND ○ If the psychiatrist or other qualified psychiatric professional determines that the inmate meets criteria for involuntary administration of medication.
Restraint and seclusion procedures: May be overly restrictive and traumatic for the individual. Must be written with the inmate's constitutional rights in mind. Very detailed and objective, concrete decisions and procedures. Staff accountability measures should be included. Use only as last resort. Document procedure with videotape.

Morbidity and mortality review/ Critical incident debriefing
When inmate completes suicide, analyze events leading up to suicide.
Identify mistakes, to assist in procedure performance improvement.
Develop plan for improvement.
Common issues: response time, disorganized medical intervention, paramedics or crisis team having difficulty entering the facility, failed communication between inmate and staff before the event.
Medical and security staff should participate.
Debriefing should address trauma in staff and inmates (to prevent "copy cat" syndrome).
Report suicide to the appropriate authority.

Source: Levitt, G. (2000) Practical Suicide Prevention, *Corrections Today*, December, 110-117.

Handout 5-8
Suicide Prevention in Correctional Facilities

Handout 5-9

Response: Suicide Assessment and Intervention

Scenario 1: A 22-year-old woman calls 911 to report that she has taken an overdose of her medication. When law enforcement officers arrive she is still conscious, but is slumped in the corner of her living room and gives minimal verbal responses. Her speech is slurred.

- What steps do you take to assess level of risk?
- What steps do you take to assist the woman?

Scenario 2: A 35-year-old male, employed as a teacher at the local elementary school, is arrested for sexual assault on a 10 year-old girl. The man has no previous criminal record. During transport to the booking facility he appears withdrawn and murmurs, "There is no point in going on."

- What steps do you take to maintain the safety of the individual?
- What steps do you take to assess level of suicidality?

Scenario 3: A 25-year-old male inmate is discovered hanging from a grate in his cell. He is still breathing, but his skin is blue.

- What steps do you take to maintain safety?
- What steps do you take to assist the individual after the initial crisis has been resolved?

Scenario 4: Workers in an office building call to report that a man is poised on the fifth floor of a parking ramp across the street. When law enforcement officers arrive, the man is shouting angrily at the air and waving a length of metal pipe to ward off onlookers.

- What steps do you take to maintain safety of the individual, law enforcement personnel and onlookers?
- After getting the individual back from the ledge, what steps do you take to further assist the individual?

Scenario 5: A 32-year-old female inmate, diagnosed with schizoaffective disorder and borderline personality disorder, is discovered in her cell having slashed her wrists with a piece of plastic soda bottle. She is bleeding profusely, but is still conscious.

- What steps do you take to maintain the safety of the individual?
- What steps do you take to assess the suicidality of the individual?
- What steps do you take to maintain safety of other inmates?

Scenario 6: After a serious suicide attempt, your sheriff orders a thorough inspection of the correctional facility to remove hazards. Your county is in a budget crisis and the jail has a number of unfilled security officer positions.

- What steps would you take to inspect the facility? Who would be involved?
- What potentially hazardous conditions and items might you look for in the facility?
- What steps can you take to make the facility safer, given budget constraints?

Scenario 7: A 21-year-old male has been placed on your probation caseload. He is a client of the local mental health center where he has been treated for schizophrenia prior to 6 months of incarceration in the jail. He reports that he was refused services when he went to the mental health center yesterday because he does not have TennCare yet. The voices are saying bad things to him.

- What steps would you take to assess his level of suicidality?
- What steps would you take to maintain the safety of the individual in the community?