Insights into Suicidal Behavior in the Jail Setting

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Agenda

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- Suicide Prevention and Intervention
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Introduction

- Suicide is the second leading cause of death in jails and the third leading cause in prisons.
- Suicides in jails occur at a rate of 43 per 100,000 inmates (NBJS 2013)
- Suicide Prevention Training is a critical factor in reducing suicide
Introduction

- The most effective way to diffuse local and universal obstacles in Suicide Prevention begins with “ATTITUDE.”

- Proper “ATTITUDE” refers to the philosophy that even one completed suicide is unacceptable in our facility.
Proper Attitude is important...

The Orange County California Detention Center houses an ADP of over 5000 inmates. It has had “0” completed suicides in the past 10 years. (NCIA, 2008)

*The Orange County jail commander has this to say about the importance of attitude:

“ When you begin to use excuses to justify a bad outcome, whether it be low staffing levels, inadequate funding, physical plan concerns, etc.-Issues we struggle with each day-you lack the philosophy...that even one death is not acceptable. If you are going to tolerate a few deaths then you already lost the battle.”
Statistics

- Every 18 minutes someone dies by suicide.
- Every 43 seconds someone attempts suicide. *(figures on attempts are estimates only: there is no official US national data compiled for attempts)* -
- More people die by suicide than homicide.
- Women attempt suicide more than men. Yet men **complete** the act of suicide more than women.
- 73% of completed suicide victims had a history of psychiatric treatment. *(Knoll, 2009)*
- More people die by suicide than automobile accident.
Myths about Suicide

- Once someone is suicidal, he or she will be suicidal forever.

- If a person tries to kill themselves once they are less likely to try again.
Myths about Suicide

- People who are suicidal clearly want to die.

- It is a bad idea to ask people if they are suicidal. Talking about suicide might give them the idea that they should kill themselves.
Myths about Suicide

- If a depressed or suicidal person feels better it usually means that the problem has passed.

- People who talk about killing themselves will never do it. Those who kill themselves don’t normally talk about it. They just go ahead and do it.
Myths about Suicide

- Cutters and people that constantly cut or burn themselves do not really want to die and therefore they are not a real risk for suicide. They just want attention and are trying to manipulate.
Suicide in the Corrections / Jail Setting

- Suicide research in corrections has independently examined jail and prison populations.

- Beginning with a landmark study in 1981 and confirmed by a follow-up study in 1986, researchers discovered an alarming suicide rate in jails throughout the country.
Suicide in the Corrections /Jail Setting

From 2009 to 2013, the suicide rate increased 23% from 35 per 100,000 jail inmates to 43 per 100,000 (appendix table 4).

• Suicide was the leading cause of death in local jails in 2013 (34% of all jail deaths) and has been the leading cause of death in local jails each year since 2000.

• Suicides in local jails increased 9%, from 300 suicides in 2012 to 327 in 2013.
Suicide in the Corrections / Jail Setting

- Research revealed a consistent profile for jail suicide victims: young, white, single, first-time arrested, intoxicated, substance abuse history, hanging by bedding or clothing, isolated without supervision in jail housing, and death within the first 24 hours.
Facts about Suicides in Jails

- 75% of victims are detained on non-violent charges
- 60% of victims are intoxicated at the time of confinement
- 51% of suicides occur within 24 hours of confinement, 29% occur within the first 3 hours
- 2 out of 3 victims are in isolation at the time of suicide
- 94% of suicides are by hanging – most victims use their clothing opposed to bedding
Pre-disposing Factors of Suicidal Behavior

- Recent excessive drinking or drug use
- Loss of stabilizing factors such as spouse, job or home
- Severe guilt or shame over offense
- Same-sex rape or threat of it
- Current mental illness
- Poor health or terminal illness
- Approaching an emotional breaking point
Characteristics that make Jail Environments Conducive to Suicidal Behavior

- Authoritarian environment
- No apparent control over the future, including fear and uncertainty over legal process
- Isolation from family, friends and community
- Fears
- Shame of incarceration
- Dehumanizing
- Staff insensitivity
High-Risk Suicide Periods-Jails

- The first 24 hours of confinement
- Intoxication and withdrawal
- Waiting for trial
- Sentencing
- Impending release
- Holidays
- Darkness
- Decreased staff supervision
- Bad news of any kind
High Risk Suicide Periods-Prisons

- Realization of losses
- Isolation
- Sentencing
- Impending release
- Holidays
- Darkness
- Decreased staff supervision
- Bad news of any kind
Verbal signs of suicide

- “I wish I were dead”.
- “The world would be a better place without me”.
- “I just can’t take it anymore”.
- “I don’t want to be a problem to anyone anymore”.
- “I will be getting out of here soon”
- “My problems are over”
Behavioral signs of suicide

- Sudden change in behavior (i.e. Calm serene after a period of sadness).
- Giving away personal items.
- Writing good-bye notes, long letters.
- Packing up personal items or taking down personal photos of family members or children.
- Reduced eye contact and overall communication with staff and others.
Changes in daily activities

● Poor hygiene,

● Social withdrawal (not taking part in activities he or she normally enjoyed or initiated). Avoiding contact with others.

● Sleep disturbances,

● Sleeping most of each day

● Excessive weight gain or loss
Emotional Cues for Suicide

- Hopelessness,
- Helplessness,
- Confusion,
- Irritability
Other Signs and Symptoms of Suicidal Behavior

- DEPRESSION is the single best *emotional* indicator of potential suicides
- Crying
- Moping or isolating when ordinarily active
- Reclusive when ordinarily interactive
- Speaking unrealistically about getting out of jail or prison
- Paranoid delusions or hallucinations
- History of previous attempts and other self-injurious behavior.
Motives for Suicide

- We cannot always understand the motive for suicide.
- It is not our job to try and predict suicide based on motive possibilities alone.
- What we may see as a temporary setback or a relatively small issue may be a reason for suicide to another person.
- It is dangerous to make a decision to remove someone from suicide precaution or not place them on suicide precaution because we do not see what we consider a “real” motive in play.
Stressors

Possible precipitating factors in both jails and prison suicide

- **Conflicts with Institutional Environment** (i.e.: undesired housing unit, work assignment, and/or disciplinary
- **Interpersonal Conflicts** (i.e.: separation from, loss of family/friends, physical or sexual assault
- **Legal Process**: denied bail, additional charges, parole denial, sentencing greater than expected.
Suicide Prevention

- Any staff member should be able to put an inmate on a suicide watch.

- The primary objective of the suicide prevention intervention strategy is patient safety.

- The ultimate goal is to have the patient assume responsibility for their own safety.
Suicide Prevention

AVOID ISOLATION WITHOUT SUPERVISION

• Whether the Suicidal inmates are housed in the general population, mental health unit or infirmary, he or she should be located close to staff.

• All staff members need to be aware of where potentially suicidal inmates are housed.

• Cells should be suicide-resistant.

• Removal of clothing should be avoided whenever possible.

• Suicide gowns are appropriate. The inmate should not be kept naked.
Suicide Prevention

- If an officer recognizes potential suicide in a detainee or inmate then steps are to be taken immediately.

- Once identified, they should remain in direct site.
Levels of Supervision

- **Continuous Observation**: This is the highest level of supervision. Preferable for suicide precaution.

- **Close Observation**: Also referred to as “Psychiatric Observation” in some facilities. This is a less intensive level of supervision to be used for non-suicidal patients.
**Continuous Observation** – patient is constantly observed by any trained staff member, correctional, medical or other. This watch is generally used for patients who present as acutely suicidal and who are at imminent risk of engaging in self-injurious behavior. A continuous watch should also be considered when there is a question of imminent risk and the clinical picture is unclear. Recent, serious suicide attempts (e.g. attempted hangings, wrist slashing, etc.) may also warrant this watch.
Suicide Prevention - Levels of Supervision

- Mental health professionals should evaluate patients daily while on Continuous Observation/Suicide Watch, then follow them with periodic evaluations as long as appropriate once removed from this precaution.

- Once the patient is released from Continuous Observation the patients status should be downgraded to Close Observation. Patients downgraded to Close Observation from Continuous Observation/Suicide Precaution should be considered for razor restriction.
Levels of Supervision

- **Close Observation** – Patient is checked and observed every 15 minutes or more. This watch requires that the patient remain in full view of a correctional staff member or medical staff when the check is done. This observation will be documented on the appropriate form by either trained security, medical or other staff randomly and at least every 15 minutes on an irregular schedule. Documentation will include the patient’s current observation level and meaningful action oriented statements that reflect the patient’s actions while under observation, i.e. standing, sitting, resting, eating.
Case Studies

• The cases of John P., Marie H. and John D.
Case Study #1  John P.

- Background:
  
  John P. was a 19 year old college freshman at the University of North Carolina Charlotte. One evening in 1997 he left an off campus party intoxicated and walking with an open container of beer. As he proceeded back to campus and his dormitory he was stopped by local authorities. It was reported that when he was stopped by the police he was not cooperative and became verbally belligerent. The officers decided to take him to jail central and book him on public intoxication charges as well as a violation of the open container ordinance.
The case of John P. continued;

- John P. arrived in booking at approximately 1:00am. He was not medically screened due to his inability to focus on the questions being asked. However, several officers did feel a need to try and “scare him straight”. John was told that he would be booked and sent into general population where he would wait for “trial and maybe even go to prison”. The reality of the situation was that he would be sent into video court within 5 hours and given a ticket that he could have paid or entered a drug and alcohol program that would prevent anything from going on his record.
After the brief “scared straight session” John P. was witnessed sobbing. He was then placed in an isolation room known as the “Drunk Tank”. John P. was the only detainee in the Drunk Tank at that time. He was placed there to sleep it off until video court. John had **not** been informed about video court and the reality of his minor charges prior to entering the drunk tank.
What happened to John P.?

- At approximately 5:00am John P. was found dead in the isolation room. He had hanged himself with his own shirt from a protruding pipe on the wall. He was pronounced dead at the scene.
The aftermath of John P.’s death

- A family lost their only son in the prime of his life.
- Public outcry for answers grew intense.
- Several officers were suspended
- One officer was fired
- One officer resigned
- A complete investigation ensued resulting in the revamping of the system wide policies and procedures.
- It became necessary to start a mental health program where one did not exist prior.
- A 7 digit out of court settlement was paid to the family.
The Significance of John P.’s Profile

- As stated earlier there is a definite profile to the average completed or attempted jail suicide: young, white, first time arrested, intoxicated, hanging by bedding or clothing, isolated without supervision and event occurs within first 24 hours.

- John P.’s profile: Age 19, white, intoxicated, first time arrested, isolated without supervision, died within 4 hours of entry into facility. Hanged himself with his shirt.
Case Study #2  Marie H.

- In 1997 Marie was a 19 year old, white female that had been arrested 6 times. All of her arrest were for heroin possession and prostitution. Marie was on probation for her last conviction when she was re-arrested for failing a drug test at the probation office.

- Marie entered the facility reporting a $100 per day intravenous heroin habit. Marie had used heroin daily for the past 3 months. She had not had any heroin in 2 days prior to entry. She also reported she had been an addict since age 13. All of this she freely reported at intake.
The case of Marie P. Continued;

- After intake screening Marie was placed on withdrawal monitoring. She denied all suicidal ideation, plan or intent.

- As part of her withdrawal procedure she was prescribed valium twice per day for 5 days and placed in an observation room within the infirmary. She was being monitored by a deputy that was sitting outside of her cell about 10 feet away.

- She was given a “boat” on the floor to sleep on with a mattress for fear she would fall out of the bed and hurt herself during her withdrawal process. She was in a regular uniform.
Case#2 continued:

- On day 2 Marie began to experience symptoms of withdrawal. She began to vomit and have diarrhea, along with tremors and sweating.
- On day 3 Marie began presenting signs of psychosis. She had episodes throughout the day where she was not oriented to time, person, place and appeared to be responding to internal stimuli. She became verbally aggressive and highly irritated.
A change in status?...

- According to protocol Marie was receiving 15 minute checks by the deputy that was seated 10 feet away outside of her cell. The cell was a glass front cell.
- On day four Marie was more agitated and phoned her mother asking her to go talk to the judge for her. It was observed that she was yelling at her mom to, “get me out of here!” At 11:00 am she asked for her Valium and asked when lunch would be served. At 11:35 her lunch was served, but the nurse failed to give her Valium that morning as prescribed.
Marie was found dead by hanging at 12:05pm
The Post-Mortem findings...

- Because she was classified as a withdrawal patient she was not checked for suicidal ideation. As though a patient cannot be experiencing both.
- The deputy did the security checks at the same time every hour. The checks were not random or staggered. This time he was 3 to 4 minutes later than usual.
- The deputy was emotionally and psychologically shaken by the event and resigned.
- Marie’s mother settled out of court for a sum of money in the very high 6 figures.
- For one year prior to this event it was suggested to command staff that plexi-glass cover the window bars in those cells. After Marie, they were.
Case Study #3
John D.

- This case demonstrates the importance of taking the “boy who cried wolf serious”.

- As stated earlier it is a myth to think that those persons that cut themselves are not really a danger to themselves. Many wrongly trust that these persons just want attention or are trying to manipulate. In this case we will see how such a person could still lose their life and we will still be held responsible.
Case Study 2 – "The Behavioral Problem"...

John D.

- 24 year old Caucasian male enters the jail on charges of statutory rape on 6/30/04
- John D. is seen by mental health staff upon intake due to significant scarring on arms, but he denies any current risk issues, and is sent to an observation unit.
- After 7 days of psychiatric observation in the infirmary he is released to general population.
John D. – A pattern emerges

- By 9/14/04, John D. has cut himself 5 times, and threatened to cut at least 3 times. He also has removed his sutures two times.

- Staff notices a pattern to John D’s cutting – it always occurs on either Tuesday or Wednesday.
John D’s History comes to light

• John D’s records from prison arrive, and reveal a pattern of cutting or threatening suicide on the days that “store” is delivered. Apparently, he routinely had borrowed from others and on the day he was to repay, he would cut and be sent to a new unit after a period in the infirmary on a precaution.

• At the facility in this case study store is delivered to inmates on Tuesday night/Wednesday mornings.
John D. continued...

- John D. is refused by the state psychiatric hospital twice after cutting himself, they refuse him based on their knowledge of him and his history in their facility.
- John D. begins to systematically manipulate inexperienced medical staff and security staff while on safety precaution in medical, convincing them to bring him unauthorized items.
- He is labeled a manipulator and is not taken seriously or considered a real threat to himself.
John D. and weapons of opportunity

John D. used a variety of unusual instruments to inflict harm to self and others including:

- Strap of restraint chair – cut easily through scar tissue on his arm
- Small pieces of porcelain from toilet/sink
- Small pieces of tile pulled up from shower stall
- Metal brace used to mount table to cell wall used to saw open arm
- Used teeth to cut into arm/bite self
- Slid restraint bed across room (while restrained) to gain access to metal bed frame in cell
- Broke apart a bookshelf in the hospital to use pieces to assault staff and cut self
Weapons of Opportunity

- Example of shower stall where tile was easily removed
John D’s Manipulation

- John D’s signature M.O. is to use a tourniquet above his wound to control bleeding.
- John D. then directs blood under door and around room to add for dramatic effect.
- On his last attempt, John D accidentally drops tourniquet, consequently loses too much blood. At which time he loses consciousness.
- It should be noted that John D. was on razor restriction at the time of this event. However, his environment was not inspected thoroughly.
John D’s Last Attempt
John D’s extreme blood loss almost claims his life
The aftermath of John D.’s attempt

- It was found that the deputy that allowed John to use that shower was a new recruit in training left alone to cover another deputy's lunch. He had no training yet in suicide potential and there was no pass-on to him in regards to John D.

- Jail and medical staff note the potential for John D’s attempts to become more lethal.

- A joint safety plan is developed in cooperation with jail command staff, RRT, and the medical and mental health staff.

- Jail Command Staff and State Psychiatric Hospital Administrators strike a bargain to allow direct access to hospital as needed.
The attention seeker

- In cases like John D. It can be easy to let our guard down. Many times frequent cutters are not taken seriously, like the boy who cried wolf too many times. However, as seen in John D. this does not mean they cannot become lethal in their behavior.

- Take all threats seriously...no matter the perceived motive!
Beware of Overlapping Motives

- 5% of inmates with self-injurious behaviors commit suicide within nine years.

- Parasuicidal (self-injurious) behavior is the single best predictor of death by suicide.

- In a 2002 study of self-harm behavior in incarcerated women; Non-suicidal self-harm and suicide attempts did not differ in their motives. (Brown, M.Z., Comtois, K.A., Linehan, M. (2002))
Collaboration is Paramount

Medical

Security  ↔  Mental Health
Collaboration = Teamwork = Safety

- Suicidal inmates require repeated safety interventions over time
- Safety interventions require collaboration among security, medical, and mental health teams
- Adverse outcomes are more likely when teams are not collaborating
Intervention

- All staff should be trained in standard first aid, CPR and AED.
- All housing units should have an emergency response bag with gloves, a breathing device or shield and a rescue tool for cutting
- All staff should know the location of the AED.
- NEVER assume the victim is dead.
- Initiate life-saving measures as soon as the scene is secure.
Self-Care for the First Responders

- Acknowledging the emotional and physical impact of trauma scenes.
- Dealing with stress
- Debriefing
- Preventing Burn-Out
- Understanding Post Traumatic Stress Disorder
- Seeking Professional Consultation
- Creating a support system
Screening Form for Suicide and Medical/Mental/Developmental Impairments

Question #1
Serious injury/hospitalization in last 90 days?

Question #2
Currently taking any prescription medications?

*Serious (life changing) injuries, operations, and/or illnesses can lower the threshold for suicidal/self harm thoughts. Some side effects for certain medications can be depression or suicidal thoughts.*
Screening Form for Suicide and Medical/Mental/Developmental Impairments

- Question #3
- Any disability/chronic illness (diabetes, hypertension, etc.)

If the answer to this question is yes then we need to know more information such as... What treatment have you received? Where were you treated? When were you treated? What was the name of the provider? When were you first diagnosed?
Screening Form for Suicide and Medical/Mental/Developmental Impairments

- **Question #4**
  Appears to be under the influence of alcohol or drugs.

As we discussed earlier in the program, intoxication is part of the profile for a jail suicide attempt. In the case study of John P. we witnessed how intoxication along with age and being arrested for the first time all played a role in John P.’s suicide. Intoxicated persons should never be isolated without supervision. They should at the very least be monitored for any withdrawal symptoms.
Question # 5

Have you had problems with drugs or alcohol?

The answer to this question speaks to the person’s coping skills and overall physical health. It is also understood that many people faced with withdrawal from a drug or alcohol may contemplate suicide. Substance abuse is a contributing factor to suicidal ideation.
Screening Form for Suicide and Medical/Mental/Developmental Impairments

- Question #6
  Do you think you will have withdrawal symptoms from stopping the use of medications or other substances (including alcohol or drugs) while you are in jail?

Suicidal behavior can be prevalent during withdrawal and the risk of suicide may increase after opiate and benzodiazepine detox/withdrawals.

*If yes, Notify Medical or Supervisor Immediately*
• Question # 7
Have you ever had a traumatic brain injury, concussion, or loss of consciousness?

Traumatic brain injury and other types of closed and open head injuries can cause major changes in the patients ability to cope with stress. These injuries may also manifest with psychiatric presentations such as Major Depression and Psychosis.

*If yes, Notify Medical or Supervisor Immediately
Section II

- Initial Staff Observation of patient;

Is the inmate unable to answer questions? If yes, note why, notify supervisor and place on Suicide Watch until completed.

A non answer is still an answer when it comes to suicide prevention. Whether it be a conscious choice by the inmate or patient or they are impaired we must error on the side of safety.
Section II

Question 1a

Does the arresting/transporting officer believe or has the officer received information that inmate may be at risk of suicide?

If so then immediate precautions should be taken until the officers information can be processed with the inmate.

**IF YES, NOTIFY SUPERVISOR, MAGISTRATE, AND MENTAL HEALTH IMMEDIATELY**
Screening Form for Suicide and Medical/Mental/Developmental Impairments

- Section II
- Question 1b

Are you thinking of killing or injuring yourself today? If so how?

It is best to ask this question in a very concrete manner. Remember it is a myth to think that asking a person about suicide will induce suicidal behavior. In fact it may just have the opposite effect.

**IF YES, NOTIFY SUPERVISOR, MAGISTRATE, AND MENTAL HEALTH IMMEDIATELY**
Screening Form for Suicide and Medical/Mental/Developmental Impairments

- Section II
- Question 1c

Have you ever attempted suicide? If so, when and how?

Remember the greatest “behavioral” predictor of suicidal behavior is past suicidal behavior. The more recent the last serious attempt the higher the level of potential for another attempt. The past method of attempt will also provide insight into the current potential.

*IF YES, NOTIFY SUPERVISOR, MAGISTRATE, AND MENTAL HEALTH IMMEDIATELY*
Screening Form for Suicide and Medical/Mental/Developmental Impairments

- Section II
- Question #1d

Are you feeling hopeless or have nothing to look forward to?

**Helplessness and Hopelessness** are two emotional symptoms of suicide potential. These two emotions reflect a severe form of a clinical depressive episode that could turn lethal. Listen for expressions like, “it does not matter what happens to me” …” There is no help for me...” etc. IF YES, NOTIFY SUPERVISOR, MAGISTRATE, AND MENTAL HEALTH IMMEDIATELY
Screening Form for Suicide and Medical/Mental/Developmental Impairments

- Section III
- *IF YES to 2-12 BELOW, NOTIFY SUPERVISOR AND MAGISTRATE.*
  Notify Mental Health when warranted
- Question #2
  Do you hear any noises or voices other people don’t seem to hear?  
  
  *We are looking for signs of symptoms of psychosis. Persons experiencing psychosis may be paranoid and could be responding to internal stimuli.*
Screening Form for Suicide and Medical/Mental/Developmental Impairments

Section III, Question #3

- Do you currently believe that someone can control your mind or that other people can know your thoughts or read your mind?

- Again this is a question designed to determine the presence of any form of psychosis. Auditory Command Hallucinations or Delusions of thought insertion or retrieval can increase the possibility of self-harm behavior.
Screening Form for Suicide and Medical/Mental/Developmental Impairments

- Section III, Question # 4
  Prior to arrest, did you feel down, depressed, or have little interest or pleasure in doing things?

This question is looking for signs and symptoms of Major Depressive Disorder that the patient may have been suffering prior to arrest. If so, then the arrest may exacerbate those symptoms and lead to self-harm ideation.
Section III, Question #5
Do you have nightmares, flashbacks or repeated thoughts or feelings related to PTSD or something terrible from your past?

Research indicates that there is a correlation between many types of trauma and suicidal behaviors. For example, there is evidence that traumatic events such as childhood abuse may increase a person's suicide risk. A history of military, and/or sexual trauma also increases the risk for suicide and intentional self-harm.
Screening Form for Suicide and Medical/Mental/Developmental Impairments

- Section III, Question #6
  
  Are you worried someone might hurt or kill you? If female, ask if they fear someone close to them.

  This question relates to trauma and traumatizing relationships prior to arrest. Fear can be a catalyst for suicide. Many times a traumatizing relationship was also the catalyst for the arrest.
Section III, Question #7
Are you extremely worried you will lose your job, position, spouse, significant other, custody of your children due to arrest?

Remember we are trying to understand the whole picture. We know he or she is getting locked up, but that may just be the tip of the iceberg. The severity of the stress they are experiencing is an indicator of that person’s suicidal potential. Of course it also depends on their support system if any and their coping skills as well.
Screening Form for Suicide and Medical/Mental/Developmental Impairments

Section III, Question # 8
Have you ever received services for emotional or mental health problems?

If the answer to this question is yes then we need to know more information such as...was there a diagnosis? Where were you treated? When were you treated? What was the name of the provider? Though this may not demand a suicide precaution it does require possible psychiatric observation and follow-up.
Section III, Question # 9
Have you been in a hospital for emotional/mental health in the last year?

While question #8 asked about treatment this question ask in particular about “in-patient” treatment. A history of in-patient treatment may connote a more serious history of psychiatric illness. Again we need details, when, where, etc.
Screening Form for Suicide and Medical/Mental/Developmental Impairments

- Section III, Question # 10

  If yes to 8 or 9, do you know your diagnosis? If no, put “Does not know” in comments.

  The comment section of this form is very important. It is imperative to understand that this screening is a conversation and the more information we can retrieve from this conversation the more likely we can keep this person safe. Push the patient to give as much detail as possible.
Section III, Question # 11

In school, were you ever told by teachers that you had difficulty learning?

An arrestee with a learning disability or a borderline intellect or lower may be at risk due to their possible inability to understand the nuance of what is going on around them as well as those with a lower intellect may experience stress in a more dramatic way.
Screening Form for Suicide and Medical/Mental/Developmental Impairments

- Section III, Question #12
  Have you lost / gained a lot of weight in the last few weeks without trying (at least 5lbs.)?

Weight gain or loss is part of the criteria for the diagnosis of Major Depressive Disorder. This could be significant for a mood disorder or even substance use. Both are possible contributing presentations for Suicide potential.
Screening Form for Suicide and Medical/Mental/Developmental Impairments

- Section IV (If yes to questions 13-16 Below, notify a supervisor, magistrate, and mental health immediately)

Question #13
Does inmate show signs of depression (sadness, irritability, emotional flatness)?

Questions 13-16 are not questions for the patient, but for the screener. These are observations. #13 is looking for signs of depression or a compromised coping ability.
Section IV, Question #14
Does inmate display any unusual behavior, or act or talk strange (cannot focus attention, hearing or seeing things that are not there)?

Looking for observable signs of psychosis or compromised cognitive functioning. Under extreme stress these patients may turn to self harm behavior to end their pain or try and change their environment.
Screening Form for Suicide and Medical/Mental/Developmental Impairments

Section IV, Question #15
Is the inmate incoherent, disoriented or showing signs of mental illness?

As with question #14 you are continuing to look for specific signs of mental illness. This question is more focused on those patients that are presenting the most acute forms of mental illness.
Section IV, Question #16
Inmate has visible signs of recent self-harm (cuts or ligature marks)?

As stated before the number one “behavioral” predictor for self harm behavior is past self-harm behavior. Especially if it is recent or pervasive.
A word about a popular liability. This is an actual advertisement:

- In cases where the mental illness involved is depression, the result of official intervention can be suicide in a jail cell or other institutional setting. If you have lost a loved one to suicide in an institutional setting as a result of untreated or misdiagnosed depression or other mental illness, contact the Cleveland wrongful death attorneys at Freidman, Domiano & Smith. We know how to investigate and prove cases of official negligence resulting in jail suicide or other self-destructive behavior...
More of the advertisement:

...Where lapses in official responsibility result in death by suicide, the authorities or their mental health professionals can be held liable.

Our lawyers know how to investigate and prove liability due to negligence in cases involving preventable suicide in a variety of settings—not only in jails and prisons. END of ADD.

*Remember our lack of diligence, cooperation and communication will cost, most importantly –lives- but besides lives, it can ruin careers and cost a tremendous amount of money.*
A Successful Suicide Prevention Program

- Good communication between corrections, medical and mental health
- Awareness of prior risk being a strong indicator to future risk
- Do not rely exclusively on direct statements. “Actions speak louder than words.”
- Trust your own judgment if you have a concern about any inmate.
A Successful Suicide Prevention Program

• Create more interaction between inmates, correctional, medical and mental health staff while in “special housing units.”

• Avoid creating barriers that discourage inmates from accessing mental health services.

• Placing an inmate on Suicide Precaution Status should never be a punitive action. If it is punishment then it will not be an effective intervention. Inmates will then be hesitant to report thoughts of depression etc.
A Successful Suicide Prevention Program

- Determining whether an inmate is manipulative or suicidal is not your responsibility.
- Refer – Observe – Document
- Take all threats seriously.
Obstacles to a successful suicide prevention program

- Maladaptive attitudes: such as...
  “There is no way to prevent suicides unless you have someone sitting watching the inmate all the time”

  “We did not consider him suicidal, he was manipulative and went too far this time”

  “If someone really wants to die, you can’t stop them”

  “Due to their spontaneous nature jail suicides are extremely difficult to predict.”

(“Avoiding Obstacles to Prevention”, L. Hayes NCIA, 2007)
Conclusion

- Commit to the philosophy that “Even one death is not acceptable.”

- Those of you who have been working in an institution when a suicide occurs are well aware that the suicide has an impact on the “survivors”.

- While it is clear that not all suicides can be prevented, health care professionals and correctional officers must be proactive in attempting to identify inmates at risk and then providing appropriate interventions.
Where to Get More Information

- American Association of Suicidology
- National Center on Institutions and Alternatives, Inc. (Lindsay Hayes M.S. Editor)
- Department of Public Welfare (Office of Mental Health and Substance Abuse Services)
- Befrienders International
- National Vital Statistics Report
- SPAN USA
- National Bureau of Justice Statistics
- Correctional Mental Health Report (James Knoll, M.D.)