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SUICIDE PREVENTION HANDBOOK

STATE OF CALIFORNIA
Governor George Deukmejian

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ACQUISITIONS

MESSAGE TO THE OFFICER

This handbook has been designed to help guide you in identifying and managing suicidal inmates.

It is not a substitute for formal mental health training or facility-specific procedures regarding the management of suicidal inmates. The handbook should be kept at your workpost. You should use it as a daily reference for information regarding inmates' behaviors, statements, or past experiences which may indicate suicidal risk. You may also use it to help you make decisions about how to interview inmates and how to manage inmates whom you believe may be suicidal.

Remember: You have the most direct daily contact with inmates. Using your skills in observation and knowledge of behavior can make the difference in preventing serious incidents and maintaining the stability of your facility.

SUICIDE: WHEN AND HOW

WHEN SUICIDES OCCUR

Suicides and suicide attempts are more likely to occur at certain times and during certain phases of the inmate's incarceration.

Critical Times

The most critical time is from 12 midnight until 8 A.M., as well as times of shift changes. These times are especially critical during weekends. During these times, the usual activities for inmates are not available and staffing is minimal.

Critical Periods

There are several critical periods during the inmate's incarceration:

1. **Time of Entry** - When entering the correctional facility, the inmate may experience fear, shock, disbelief and panic. These emotions may be more than the inmate can tolerate. In a study conducted by the National Center for Institutions and Alternatives (NCIA), it was found that: 27% of jail suicides took place within three hours of admission and 50% took place within the first 24 hours of incarceration.

2. **Legal Decisions** - Times when legal decisions are made (e.g., classification hearings, board hearings) intensify the inmate's sense of powerlessness and loss of control.

3. **Personal Problems** - Times of significant loss (e.g., death of close friend or relative, breakup of marriage or relationship, loss of job) reinforce the inmate's sense of isolation and hopelessness.

4. **Significant Dates** - Birthdays and anniversaries can sometimes highlight the inmate's loneliness and lack of belonging.

5. **Cluster Effect** - Suicides often follow other suicides or suicide attempts. These suicides may take place in the facility and may be reported in the media.

6. **After Visits** - It is important to observe for any change in an inmate's mood after visits. Inmates may experience feelings of guilt, depression or abandonment after a particularly emotional visit or lack of a visit.

HOW SUICIDES OCCUR

The NCIA study revealed that over 95% of suicides were completed by hanging. Most of these suicides involved an inmate's torn bedding. Clothing, other than shoe laces and belts, were also frequently used. Searches often emphasize removal of belts and shoe laces. This may be the reason that few suicides use this method. It is also important to realize that a person can die in 3 minutes by hanging himself or herself. The hanging does not need to take place from the top cell bar, but can be accomplished by attaching cloth to a lower bar or faucet and leaning forward.

Although hanging is the most frequent method of suicide, this does not imply that other methods are not attempted. Other methods include:

- cutting self with kitchen knife or pieces of sharp metal (e.g., can tops, ring from toothpaste tube)
- swallowing dangerous objects (e.g., silverware)
- jumping from the top of a tier
- overdosing on medication which has been hoarded
- provoking an officer or other inmate to infict bodily harm. This is a less obvious suicide attempt, but actions of this kind can be understood as ways to manipulate others into being the instrument of the inmate's death.

SIGNS OF SUICIDE

DEPRESSION

One of the most common indicators of suicide is **depression.** Approximately 70%-80% of all suicides are committed by depressed persons. Although depression is not the only cause of suicide, research has shown that people often kill themselves because they are depressed. This refers to a severe depression, not the sadness experienced when arrested and incarcerated.

People who are severely depressed might show some of the following signs:

* extreme sadness or crying
* apathy; loss of interest in all or almost all people and activities
* loss of appetite or weight
* unusually slow reactions; walking or completing tasks at an unusually slow speed as if they have no energy
* difficulty concentrating or thinking
* sleep disturbances
* emotional flatness: seems numb, non-reactive
* difficulty carrying out routine tasks: e.g., eating, dressing, etc.
* tension and agitation; inability to relax or sit still, pacing, hand wringing
* withdrawal; silent, uncommunicative; acting as if they are in their own world, as though you may as well not even be there
* pessimism; inappropriate pessimistic attitude about the future
* emotional outbursts; sudden expression of anger for no apparent reason
* feelings of hopelessness and helplessness

HOPELESSNESS

Officers should be particularly alert to this last indicator of depression - hopelessness. Hopelessness has been found to be a stronger indicator of suicidal intent than depression alone. A number of researchers state that the common emotion in the suicidal state is a "pervasive feeling of hopelessness/helplessness." The officer should be alert to indications that an inmate has given up - lost all hope for the future - and feels powerless to change his or her life.

OTHER SIGNS

In addition to depression, there are other warning signs of suicide that are important to note. They are important signs and symptoms that might include the potential for suicide.

Some of these signs are:

* prior suicide attempt (check for scars)
* talk of suicide (e.g., "I wish I was never born." "I have no future." "I don't enjoy anything anymore." "At times I wish I was dead.")
* joking about suicide
* intoxication
* recent critical loss (e.g., death of spouse, marital breakup, job loss)
* no sense of future or unrealistic sense of future (e.g., talks of getting out of prison unrealistically)
* excessive shame or guilt (possibly about crime committed)
* psychiatric history
* making final arrangements (giving away personal possessions, writing wills, etc.)
* very few close friends/family
* severe mood changes (e.g. person suddenly very happy and/or calm after appearing depressed; this may indicate a person's decision to commit suicide and his or her relief in making such a decision)
* overt psychoses (out of touch with reality)
* provocative behavior (i.e., goading others to harm himself or herself)

MYTHS AND MISCONCEPTIONS ABOUT SUICIDE

Many people hold mistaken beliefs about the nature of suicide and the way in which one should interact with a suicidal person. These beliefs often result in suicidal persons not being identified or given serious attention.

MYTH	FACT
People who talk about and threaten suicide don't commit suicide.	Most people who commit suicide have made suicide threats. Of any 10 persons who kill themslves, 8 have given definite warnings of their suicidal intentions.
Suicide happens suddenly and without warning.	The suicidal person gives many clues and warnings regarding suicidal intentions.
Suicidal people are intent on dying.	Most suicidal people have mixed feelings about killing themselves. They are ambivalent about living, and are not intent on dying.
People who attempt suicide have gotten it out of their system and won't attempt it again.	80 percent of persons who kill themselves have made at least one prior attempt.
You can't stop someone who is really intent on committing suicide.	Most suicidal persons want to be rescued.
If you discuss suicide, you will cause the inmate to have suicidal thoughts or actions.	You cannot make someone suicidal by showing your interest in his or her welfare through discussing the possibility of suicide.
All suicidal individuals are mentally ill.	Although the suicidal person is extremely unhappy, the person is not necessarily mentally ill.

SUBSTANCE ABUSE & SUICIDE

1. Sixty percent (60%) of the suicide victims in a major study were under the influence of alcohol and/or drugs at the time of their incarceration.

2. Of these victims, a full 90% committed suicide within the first 48 hours of confinement.

3. Almost 94% of those inmates committing suicide within the first 3 hours of incarceration were under the influence of alcohol and/or drugs at the time of arrest.

Given these factors, then, it is paramount to realize that when someone is high on drugs or alcohol, he or she is a very serious suicide risk. Key reasons for this are:

Intoxication
Persons under the influence of drugs and/or alcohol often do not think rationally. They are likely to become anxious or depressed, and much more prone to panic. Simultaneously, they become less inhibited, and are more likely to do things they wouldn't ordinarily do. Because of the combination of these effects they are likely to act in a more destructive and inappropriate way.

Shame/Fear
As the effect of the drug wears off, the full realization of the inmate's predicament becomes apparent. The inmate is so scared, depressed, or ashamed that suicide might seem to be the only way out.

Detoxification (Detox) or Sobering Up
The experience of coming off the drug and/or alcohol, especially if the person is addicted, may be so uncomfortable or painful that suicide may seem like the only relief available at the time.

Hallucinations and Delusions
Some drugs cause hallucinations or delusions (seeing or hearing things which are not there). As will be discussed shortly, this might cause people to act in a manner dangerous to themselves or others. Hallucinations and delusions can occur during intoxication or when the person is recovering from drugs or alcohol.

Masking Effect

Sometimes a person who is high on drugs or alcohol actually has other problems that are not evident when high. Only when the drug effects wear off do the real problems become clear. Sometimes people who are psychotic or very depressed will drink or take drugs as an escape from their problems. When the alcohol or drug wears off, you might then have a serious suicide risk because of the psychosis or depression that is revealed.

Signs of Intoxication

It is crucial that you be able to identify the signs of intoxication.

Some signs of alcohol or drug intoxication are:

- slurred speech
- vagueness
- confusion
- disorientation
- memory loss
- sensory-motor impairments
- redness or puffiness around face and neck (can be result of fluid retention, dilated capillaries or high blood pressure)
- mood change
- irritability
- euphoria (inappropriate happiness)
- depression
- aggressiveness (excessive, inappropriate)
- multiple bruises (due to accidents or impaired blood clotting)
- constricted pupils
- needle marks
- burns or discoloration of fingers (due to unawareness of falling asleep while smoking, loss of feeling in outer limbs, or from smoking "joints")

Alcohol Withdrawal

Alcohol withdrawal, which presents both serious medical and psychological problems, heightens the risk of suicide. One of the most frequent and difficult withdrawal situations is the person with D.T.'s (delirium tremens), sometimes called the "shakes", the "tremors", or the "rams". They usually occur 72-96 hours after the inmate has had his or her last drink.

With D.T.'s, the inmate becomes delirious, disoriented, and imagines terrifying things. The inmate may hear things, too. In addition, severe tremors of the tongue and hand or even the whole body occur. The inmate may have a high fever with convulsions, vomiting and severe sweating.

Delirium tremens is a very dangerous medical condition. If not responded to by hospitalization and/or medical treatment, it can be fatal. The inmate experiencing D.T.'s must be closely watched because sometimes, in trying to escape from the frightening delusions and/or hallucinations, the inmate may attempt suicide. Also note that an inmate can have delusions and hallucinations without having D.T.'s.

Issues to Remember About All Drugs

1. Determine if an inmate has a history of drug abuse. Type(s) of drugs taken, amount, frequency (how many times per week), last dose taken - all of these should be noted and reported to medical staff.

2. Today's drug abusers frequently combine a variety of substances, including alcohol. Identification, prediction of effects and appropriate intervention is difficult in such cases. **Alcohol intensifies the effect of most drugs.** Determine if alcohol-intoxicated inmates have taken any other substances.

MENTAL ILLNESS AND SUICIDE

The following are some signs of mental illness which are associated with suicide risk:

- severe, prolonged anxiety or state of panic
- abrupt changes in mood or behavior
- visual or auditory hallucinations
- severe paranoia
- delusions
- ideas of grandeur
- bodily ailments, disorientation, inmate's expressions make no sense
- prolonged or severe depression

Depression

Depression, for the most part, is a normal human experience. The question then becomes: When does depression cease to be a normal condition and become an abnormal clinical state? The intensity, severity, and duration of the depressive symptoms differentiate the "normal" depression from a clinical depression.

Characteristically, the onset of clinical depression is signaled by a depressed mood and/or loss of interest in usual activities. Symptoms may include:

- appetite, weight and sleep disturbances
- hyperactivity or lethargy
- anxiety, crying, slowed thinking
- suicidal tendencies and feelings of guilt
- worthlessness and hopelessness

Schizophrenic and/or Psychotic Disorders

When someone is suffering from this kind of disorder, there is a suicide risk because the inmate may not know what he or she is doing. Generally, this disorder lasts longer than 6 months and is characterized by a deterioration in the level of functioning in such areas as work, social relationships and self care. The symptoms are many and varied, though no single one is always present. A few of these symptoms are:

- hallucinations - seeing or hearing things that are not present
- delusions - false beliefs or ideas despite obvious evidence to the contrary
- thought disorders - manifested by disconnected speech, e.g., jumping from one topic to another for no reason, rambling in a nonsensical manner, or, in severe cases, incoherence

- loss of self-identity
- severe confusion or disorientation
- abnormal psychomotor activity, e.g., rocking, pacing, or immobility.

COMMUNICATION SKILLS

Good communication is the main tool of the correctional officer. However, good communication is often not so simple. There are always things happening above and below the surface. The officer is the sender of the message and the inmate is the receiver. The inmate communicates a response to you. Barriers to this communication may surface with the sender or the receiver or even within the environment in which the message is conveyed.

Additionally, the message that you send may be verbal or non-verbal. Often, we don't realize that we communicate in ways other than the content of our words.

Barriers

As an officer, you need to establish your role. This is best done with an open, respectful, non-judgmental attitude. By maintaining this attitude, it is likely you will establish better rapport which may lead to greater cooperation from the inmate. There are attitudes that can become barriers or roadblocks to effective communication. Let's look at some of these.

1. **Ordering, Commanding, Warning, Threatening**
   "You must...," "You have to...," "You will...," "If you don't, then..., "You better, or...,"
2. **Moralizing, Preaching, Judging**
   "You should...," "You ought to...," "It is your responsibility...," "You're wrong to be thinking that way...,"
3. **Name-calling, Ridicule**
   "Wimp," "Punk," "Well, Mr. Big Shot, now let's see you get out of this one...," "Hey dummy, what's the matter with you? Your mother never taught you how to speak...,?"
4. **Placating, Making light of**
   "Don't worry...," "You'll feel better...," "Things can't be that bad...," "Cheer up!"
5. **Sarcasm, Avoiding**
   "Let's talk about more pleasant things." "You were just borrowing that stolen money," "You really didn't do it, you were framed."

BRIDGES

In the correctional facility, we don't have much control over the environment of the inmate. We will focus on how we as senders may bridge communication by learning the following positive interaction techniques.

1. **Silence or Passive Listening** - often encourages the inmate to verbalize. Silence puts pressure on the inmate to send more. Time pressures may cause you to feel you can't wait out the inmate. In spite of these discomforts, you will find that silence is an effective bridge to communication.

2. **Simple Acknowledgement** - shows the inmate you want more communication. You can express this acknowledgement with responses like "Yes," "Uh-huh," "Mm - Mm," "I see."

3. **Restating** - rephrasing or mirroring back the inmate's message. For example: Inmate: I can't sleep, I stay awake all night. Officer: You're having difficulty sleeping?

4. **Offering General Leads** - encourages the inmate to continue. General leads are phrases such as "Go on" and "And then...,"

5. **Giving Broad Openings** - Ask the inmate to discuss something of what he or she is thinking. Statements like: "You look like you need to talk things over with someone...," "I'd like to hear about it...," "Tell me about it...," communicate that you want to hear what the inmate has to say. Broad openings may relieve the inmate's tension.

6. **Seeking Clarification and Probing for Specifics** - not only encourages the inmate to continue talking, but enables you to get more accurate information and better understanding of the inmate. To get clarification, ask "I'm not sure I understand. Could you explain? Can you tell me more?"

In conclusion, it is really important to remember that as you use these bridges, don't promise anything you can't deliver. Additionally, remember that positive attitudes such as respect, attentiveness, openness and acceptance increase the effectiveness of help.

THE SUICIDAL INMATE ON THE TIER

SIGNS OF SUICIDE

Emotional Indicators

Some examples of emotional indicators are:

- sadness
- crying
- hopelessness
- helplessness
- tension
- agitation
- emotional outburst
- emotional flatness
- self-doubt
- severe mood changes
- shame
- fear

Mood swings are an important indicator that may be misunderstood or entirely ignored. Depressed persons may commit suicide when their symptoms appear to be improving. You may wonder why this is so. A person who is depressed generally has very little energy - both physically and psychologically. Even though he or she may feel down, he or she may have little or no energy to do anything. As the depression lifts, the individual now has the energy and the determination to carry out a suicide plan. Also, once a person has decided on suicide, the person may feel a great sense of relief that he or she has found a way out. This sense of relief makes the person appear happier and more contented.

Behavioral Indicators

Some examples of behavioral indicators are:

- loss of appetite
- sleep problems
- unusually slow reactions
- social withdrawal
- difficulty carrying out routine tasks
- giving away possessions

Giving away possessions is one way a person makes final arrangements before his or her death. Other arrangements might include writing a will, trying to repair relationships, re-establishing old contacts, and, overall, trying to get things in order.

Verbal statements that you might hear in general conversation may also be valuable suicide indicators. When statements are direct suicide threats, the risk is obvious. But what about the person who jokes about suicide or makes subtle, indirect statements? When someone is joking about suicide, he or she is verbalizing that they **have** thoughts about suicide. They may be **expressing** these thoughts in a sarcastic or humorous way. But the point is - they have these thoughts. Indirect, subtle verbalizations might include: "I'm no good"; "I've got no future"; I'll never get out of here"; "I'll get out of here somehow" (when there is no realistic way).

Dangerous Times

Any personal loss represents a "dangerous time". It is important to be aware that the inmate may learn about the loss in different ways - "Dear John letter", lawyer's letter, being served with divorce papers, lawyer's visit, personal visit. It is obviously not possible to know all the events in an inmate's life, but if you are alert you are more likely to pick up information. Other times when an inmate may become suicidal are:

1. after the inmate or a significant other has developed a severe physical illness;
2. after any physical assault, particularly sexual;
3. after any threat of physical assault, particularly sexual;
4. during holidays;
5. pre and post sentencing
6. after visits

In addition, there have been several suicide attempts by inmates who are in protective custody. Being in protective custody can be an extremely isolating and stressful experience, increasing the likelihood of suicide.

SUICIDE PREVENTION TOOLS

Staying Alert

It is extremely important that the officer be alert and make observations at all times; on routine checks, before and after visitation, in the yard, during court appearances, etc. If you know the inmates on your tier, you will be more attuned to changes which might indicate suicide risk. Other inmates, as well as family and friends of the inmate, are also important sources of information.

You may obtain additional information which the inmate withheld. Another factor to be particularly alert to is - how is the inmate handling incarceration? Is the inmate:

- frightened of other inmates
- embarrassed
- depressed over lack of visits or absence of family support
- distressed about noise or lack of privacy
- affected by the change in diet?

Making Assessments

Once you have made observations, you must interpret them. Sometimes you may see indicators but not interpret them as signs of suicide risk. Often because of our attitudes and fears about suicide and managing the suicidal inmate, we don't see the obvious.

Communicating

We can't overstress the importance of communicating your observations and assessments. **Any** unusual occurrence should be noted in log books according to facility procedures and verbally relayed to the next shift. One officer's observation may begin to form a pattern when taken together with another officer's observation. Communicating observations of behavioral changes, such as loss of appetite or sleep disturbances, will help officers to distinguish a pattern of unusual behavior from an isolated incident.

Supervising

Once you have made an assessment of a suicide risk, supervision is your basic prevention tool. Carefully supervise the taking of medication. Don't minimize the importance of your supervision because your facility has structural safety devices. Precautions used to prevent suicide - barless windows and doors, tear-away sheets and blankets, and television monitors should not be considered substitutes for supervision and human interaction.

Making Interventions

There will be times when you'll want to, or even have to, make interventions. One aspect of intervention is making referrals to mental health or medical staff. Time is often of great importance. Don't wait to make your referral. Do it immediately, and carefully follow your facility's procedures. Another aspect of intervention will be done by you directly. As most suicidal wishes are temporary, your on-the-spot intervention may prevent a death. If you suspect the inmate is suicidal and medical or mental health staff are not immediately available, it is important to use your communication skills to ask clarifying questions. In general, it is best to incorporate clarifying questions into your regular interactions with inmates.

Clarifying Questions

1. How do you plan to take your life?
2. Where do you plan to take your life?
3. When do you plan to take your life?
4. Do you have the tools to do this?
5. If not, where do you plan to get them?

Remember, by discussing suicide with a potential victim, you will not give the inmate suicidal ideas. When the inmate has the opportunity to express feelings, the inmate is likely to have a sense of relief and discover a wish to live. Let him or her know you don't have the answers but you do want to help. Be direct and say something like this: "I don't have the answers, but if we keep talking maybe something will occur to one of us."

CRISIS SITUATION

One of the times when you **have to make intervention** is in the crisis situation in which a person is in the act of attempting suicide. This may be a last cry for help, rather than a firm commitment to die. You may still be able to prevent a suicide. "Build bridges" to this person and keep the following in mind:

- remain calm
- show interest
- keep inmate talking
- don't leave inmate alone
- don't rush or pressure the inmate to make a decision to abandon the plan
- offer alternatives
- get help

Just try your best. You may be too late to intervene but at least you will have tried. There may be times when, in spite of your intervention, an inmate will still take his or her life. Even if you have done your best in this situation and followed your facility's procedures, it is likely the suicide will be upsetting to you. Talking this over with someone close to you or even with a professional will be helpful.

MANIPULATION

Since ultimately we don't really know if someone is planning to kill oneself or if a manipulation will turn into a suicide, we must always take the necessary steps - increase supervision and make interventions.

Your preventive steps may not be what the inmate hoped to accomplish and may therefore discourage future manipulative attempts. In addition, making the decision about whether an inmate is manipulating should not be your responsibility. Communicate your concerns to medical or mental health staff and allow them to make an assessment.

MANAGEMENT STRATEGY SUMMARY

You Should Not:

1. Leave the inmate unattended.
2. Ignore the suicidal risk or threat. If you feel uncomfortable with the situation, get help. Don't just drop it!!
3. Minimize or invalidate the inmate's feelings (e.g., "Things really aren't that bad. You really don't want to kill yourself.")
4. Become angry, judgmental or threatening.
5. Encourage the inmate to feel guilty for feeling the way he or she does.
6. Challenge the inmate to make good on the threat or call the bluff by suggesting suicide.
7. Make promises you can't keep.
8. Humiliate, put down, or make fun of the inmate's actions.
9. Rely on structural safety devices.
10. Think the danger of suicide is over as soon as the inmate begins to cheer up.

You Should

1. Trust your own judgment. If you believe someone is in danger of suicide, act on your beliefs. Don't let others mislead you into ignoring suicidal signals.
2. Don't leave a suicidal inmate alone if you think there is an immediate danger. Stay with him or her until help arrives, or have someone else stay while you get help.
3. Maintain contact and conversation. Do not be reluctant to express your concerns about the inmate and be attentive to what the inmate is saying. Ask clarifying questions.
4. Listen patiently. Encourage the suicidal inmate to talk and express his or her feelings.
5. Make a verbal contract with the inmate in which he or she agrees not to hurt himself or herself until seen by a mental health professional.
6. Take all threats seriously.
7. Make referrals.

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