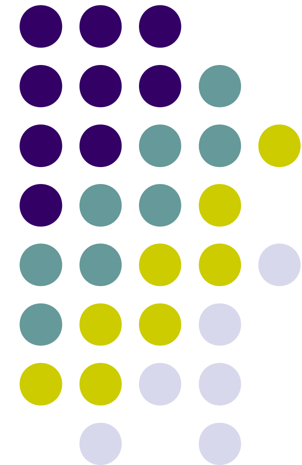
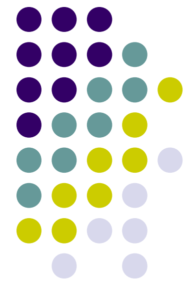
Suicide Prevention



Correctional Health Services
Maricopa County

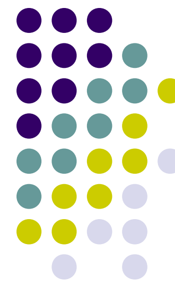
February 2010

Objectives



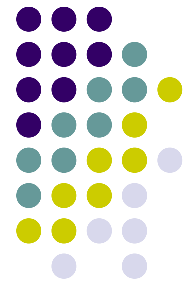
- Provide a definition of the “potentially suicidal patient”
- To identify risk factors for self harm, “at risk” populations, and dispel myths associated with suicidal behaviors To provide a general overview of effectiveness of intervention in the jails
- To identify elements of the CHS Suicide Prevention program, identify the Emergency Safety Response and Intervention for Imminent Suicide Risk
- To identify criteria for suicide levels and seclusion / restraint
- To discuss recognition and management of self injurious or manipulative behaviors
- To discuss differences in juveniles response to incarceration and suicidal behavior

The “Potentially Suicidal Patient”



- May be actively attempting to end their life
- May not be actively taking steps to end their life BUT are expressing suicidal statements or pre-occupation with death / dying
- May have a history of self destructive behaviors and / or previous suicide attempts
- May be detoxing off alcohol or street drugs

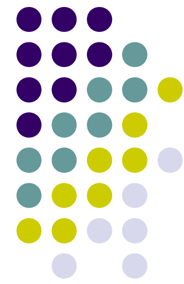
NCCHC Suicide Prevention Program J-G-05
Journal of Correctional Health Care 10/2009



The Benefits of Preventing Suicide

- Death by Suicide is preventable and significant public health problem
- Many Cultures and Religions consider suicide taboo
- Patient care focuses on compassionate recognition and response to human suffering
- Suicide has a multi-generational negative effect on families and communities
- Decreases stress of incarceration on patients

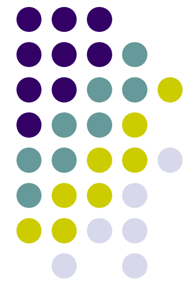
Early Suicide Prevention Activities



- Increases jail safety by decreasing:
  - Forcible cell extraction
  - Involuntary medication administration
  - Use of physical restraints
  - Staff injury
  - Number of patient transfers to hospital
  - Likelihood of future occurrence or epidemic
  - Health care costs

- Failure to meet patient needs results in maladaptive behaviors, upping the ante to increasing severity
- Decreases blaming across disciplines with overall reality of no improvement
- Decreases staff burnout and exposure to trauma similar to battlefield which increases burn out risk

Suicide Problem in Jail

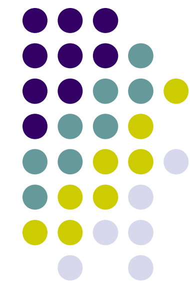


2006 Death Rates*

- 50.8%: illness
- 25.3%: suicide
- 5%: AIDS
- 7.9%: intoxication
- 5.1%: unknown
- 2.8%: accident
- 3.1% homicide

***Bureau of Justice August 2009**

Jail Inmate Deaths



US Dept of Justice Local Jail Inmate Deaths 2000 - 2006

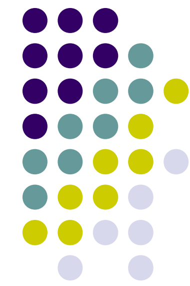
Percent

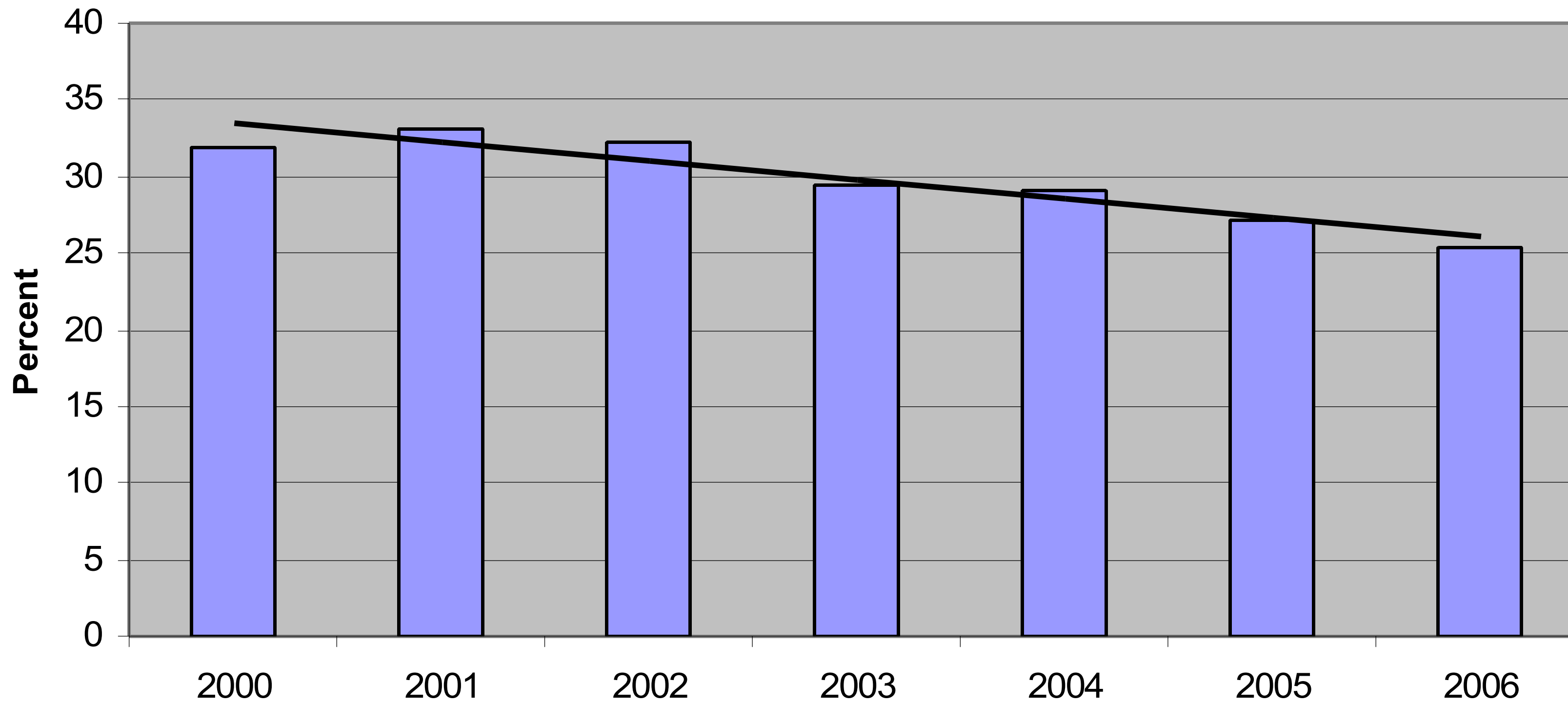
60
50
40
30
20
10
0

2000-2006
2000
2001
2002
2003
2004
2005
2006

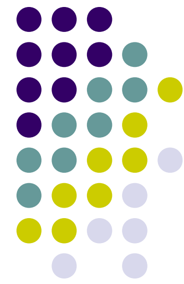
- Illness
- AIDS
- Suicide
- Drug/alcohol intoxication
- Accident
- Homicide
- Other/unknown

Jail Inmate Deaths from Suicide

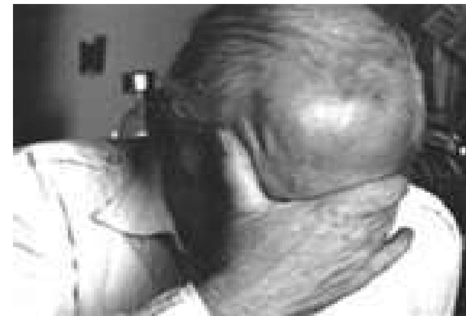




Population "At-Risk" for Suicide

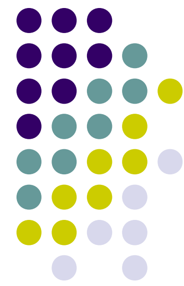


- Males 56% more likely
- White patients 6 times more likely than black and 3 times more likely than Hispanic
- Age:
  - Highest rate for all populations: juveniles under age 18 (suicide rate is more than twice that of adults age 55 and older)
  - Rate increases with age for adults
  - Highest rate for adults is age 55 and older
- Violent offenders: triple rate
  - Kidnapping: highest
  - Rape
  - Homicide



Department of Justice, August 2005

High Risk Periods

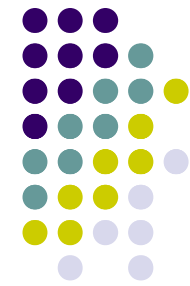


- Immediately upon admission
- Intoxication- 60% of those who died by suicide in jail were intoxicated (from JCHC Hayes/Rowan 1988)
- When placed in Segregation
  - Disciplinary Segregation
  - Administrative Segregation

- Following new legal problem
  - New Charges
  - Additional Sentences
  - Following Institutional hearings (denial of parole)
  - Fear of expectedly long sentence increases despair

Journal of Correctional Health Care 10/2009

High Risk Periods *(continued)*



- **After receiving bad news regarding self or family (serious illness, loss of loved one)**
- **After suffering humiliation or rejection (rape or threat of rape)**
- **Pending release after being held for a long period**
- **Being housed in isolation (World Health Org 2002)**
- **Patient in early stage of recovery from depression**
- **Juveniles have different high risk periods**

  (addressed later in this presentation)

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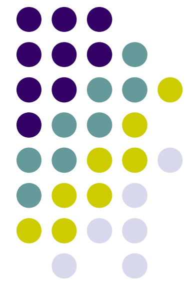
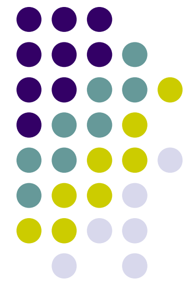
Myths / Facts



- Myth: People who make suicidal statements or threaten suicide don't commit suicide
- Fact: Most people who commit suicide have made either direct or indirect statements indicating their suicidal intentions
- Myth: Suicidal people are intent on dying
- Fact: Most suicidal people have mixed feelings about killing themselves. They're ambivalent about living, not intent on dying, they want to be saved.

Suicide Detention and Prevention in Jails 1999

Myths / Facts *(continued)*



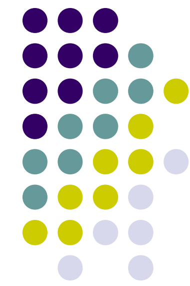
- Myth: Asking about and probing the patient about suicidal thoughts or actions will cause him to kill himself.
- Fact: You cannot make someone suicidal when you show interest in their welfare.

- Myth: All suicidal patients are mentally ill.
- Fact: They may be extremely unhappy, but not necessarily mentally ill.

- Myth: Patients who are really suicidal can be easily distinguished from those who are just being manipulative.
- Fact: Many Patients who have manipulative suicidal "gestures" to get attention may succeed in killing themselves accidentally.

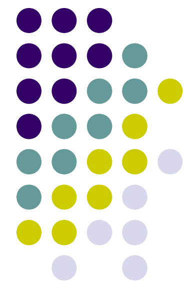
Suicide Detention and Prevention in Jails 1999

Suicide Methods



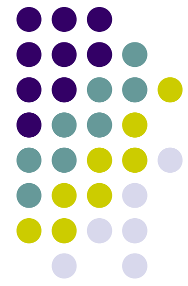
- **Hanging**
  - A leading cause of death by suicide is hanging from protrusions
    - Clothing, bedding, Ladmo bags, noose made from other materials
    - Hang from bed, showerhead, bars, sprinkler head, railing
- **Cutting**
  - Broom handle, cement, razor, pencil, paper clip, staple, metal pieces from pipes, bed, frame, screws, broken glass or plastic, id cards
- **Ingestion**
  - Medications (Rx or commissary or illicit), cleansers, pencils, paper clips, parts of mop, plastic
- **Puncture**
  - Stabbing (toothbrush or other sharps)
- **Suffocation**
  - Ladmo bag over head, sock in mouth

NCCHC Standard: Suicide Prevention Program



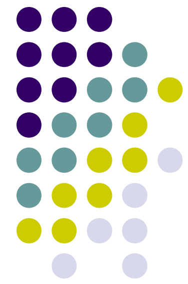
- National Commission on Correctional Health Care (NCCHC) Standard J-G-05
- Essential Standard
- “The facility has a program that identifies and responds to suicidal inmates.”

CHS Policy: Suicide Prevention Program J-G-05



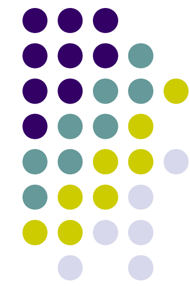
- Training
- Identification
- Referral
- Evaluation
- Treatment
- Housing
- Monitoring
- Communication
- Intervention
- Notification
- Documentation
- Review
- Critical Incident Debriefing

Training



- Initial Training at New Employee Orientation
- Annually
- Includes recognition and response to verbal and behavioral cues that indicate an patient's potential for suicide

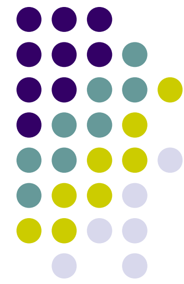
Identification



- Intake Receiving Screening: (D000)
  - Receiving Screening Questions
    - Thoughts of hurting self now?
    - History of suicidal attempts, hospitalizations?
    - Case Managed?
    - Family history of suicide attempts
    - Past treatment for mental illness
    - Observation of bizarre behavior
    - Medications

  - Positive response or no response prints automatically to psych intake office for mental health assessment & follow-up & immediate treatment if needed
  - Forward information / Communicate with outpatient mental health

Identification *(continued)*

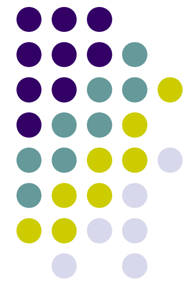


Receiving Screening Observation

- Assessment of suicide risk should not be viewed as a single event but an on-going process
- Bizarre Behavior
- Signs of self injurious behavior
- Unresponsive or unable to engage in conversation
- Arresting Officer provides information that arrestee demonstrated suicidal behavior or verbally indicated suicidal ideation
- Any situation that causes concern for safety of the arrestee

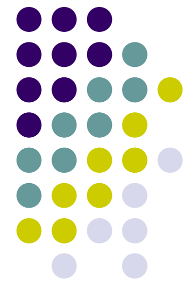
NCIA. 2007
CHS Suicide Prevention Procedure J-G-05-01

Identification *(continued)*



- The assessment process is continuous:
  - 14 day Mental Health Assessment
    - Assess mood, behavior, communication, support systems, treatment history, etc.
  - 14 day Physical Assessment
    - Victimization, sexual offenses, special education etc.
  - Patient Healthcare Request
  - Officer request (behavior, verbal, referral form, etc)
  - Staff request
  - Segregation Checks
  - CHS Liaison (family, courts, attorney, etc)
- All patients receiving mental health follow-up services are routinely assessed for suicidal behavior or thoughts of self harm.

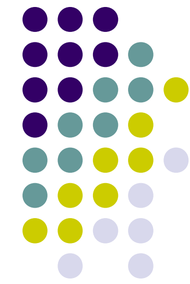
Referral



Any Patient identified as potentially suicidal or who has attempted suicide is assessed by clinic staff and referred to qualified Mental Health Staff or Mental Health Provider on-call.

CHS Suicide Prevention Procedure J-G-05-01

Evaluation

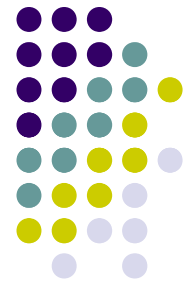


Clinic Staff or Mental Health Professional evaluates patient as soon as possible to determine:

- Level of suicide risk and intent
- Level of monitoring needed
- Patient's presenting behaviors and verbal responses
- Need for transfer to Mental Health Housing Unit (MHU)
- Need for emergency medication
- Need for Seclusion/Restraint to prevent immediate self harm
- Significant changes in patient condition
- Need for follow up appointments

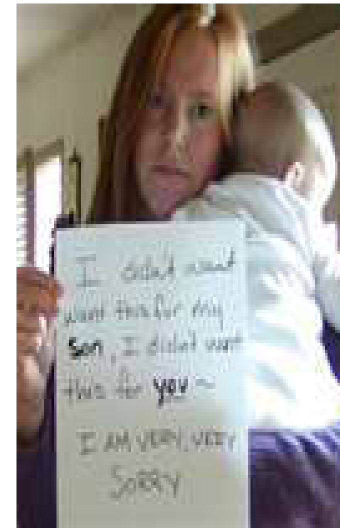
Journal of Correctional Health Care 10/2009
Suicide Prevention Program Procedure J-G-05-01
NCCHC Suicide Prevention Program Standard J-G-05

Evaluation *(continued)*

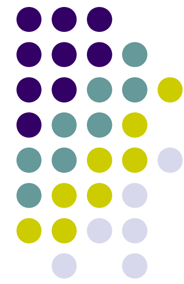


Suicide Assessment Badge: Risk Factors

- Feelings of guilt, shame, anxiety and hopelessness
- Talks about suicide while confined
- Serious mental illness / psych history
- New mother – Post natal blues
- Same sex rape or the threat of rape
- Bad news
- First time offender / crimes of passion
- First few hours of arrest
- Seriousness of charges
- Court/Sentencing Dates



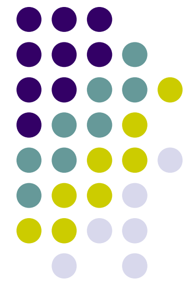
Evaluation *(continued)*



Suicide Assessment Badge: Observable Symptom

- Sadness and crying
- Withdrawal or silence
- Talk of death
- Suicide notes
- Sudden loss or gain in appetite
- Giving away possessions or saying “goodbye”
- Lethargy-slowing of movements
- Lack of caring

Suicide Detention and Prevention in Jails: Including Mental Impairments 1999

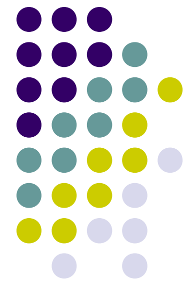


Evaluation *(continued)*

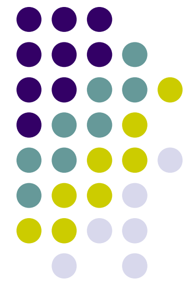
Suicide Assessment Badge: Quick Questions

- What is going on?
  - Is there a plan?
  - What is the plan?
- Current / past attempts or threats?
- Suicide history in family?
- Any recent losses?
  - Type of loss?
- Drugs / Alcohol?
  - Last use?

Talking Points



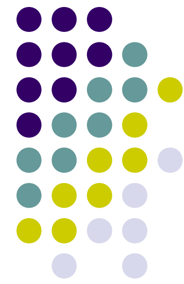
- Acknowledge their concern
- Ask them what helps:
  - Does medication help?
  - Are you able to trust yourself if you went back to your housing area?
- Don’t make false promises
  - Don’t break the rules
  - Don’t offer extra items
- Active listening



Talking points *(continued)*

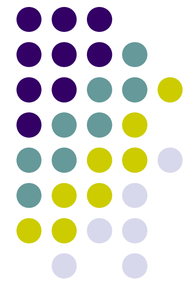
- DO NOT document "Contract for Safety"
- Instead Document (in quotes) patient response in progress notes.
  - For example: If the patient says "I'm not going to kill myself because I want to live for my kids", then document those words in the progress notes in quotes.

Talking points *(continued)*



- Assess if patient is able to engage in prevention plan:
  - Will you tell staff if you feel scared and suicidal? (ask for help)
  - Do you have someone you trust that you can talk to in your current housing unit?
  - Attempt to engage them in future directed planning (be cautious because future may look bleak and in that case the risk may be higher)

Self-Injurious Behaviors



- Definition: A direct behavior that causes minor to severe physical injury that is undertaken with or without suicidal intent and occurs in absence of psychosis or organic impairment
- Patients who engage in self-mutilation / self injury may not be directly suicidal, however may accidentally commit suicide through their self-injurious behavior.

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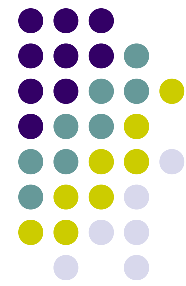
Examples of Self Injurious include:



- Suicide attempt
- Cutting skin
- Swallowing objects
- Burning skin
- Asphyxiation
- Inserting objects into body orifices
- Banging head or body part
- Amputation or destruction of body parts
- Life long injury / death due to secondary injury
- Threats of self harm as they indicate <u>potential</u> for self harm
- Jumping off top tier, bunk, or shower wall

Tormented guitarist Richey Edwards

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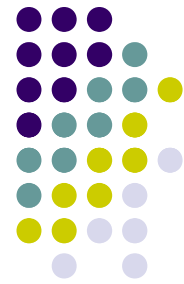
Evaluating Self Injurious Behaviors



Each episode of Self-injurious behavior is evaluated by clinical staff to determine:

- Severity of injury and immediate medical needs
- Immediate Mental Health needs
- Appropriate level of monitoring and staff supervision
- Where care should be rendered (jail clinic or hospital)
- Need for safe housing
- Need for suicide prevention garments
- Communications with MCSO regarding transportation and housing changes
- Frequency of follow-up after intensive supervision

NCCHC Suicide Prevention Program J-G-05
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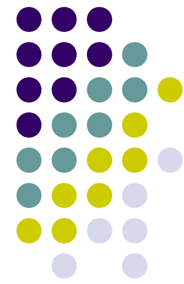
Why Do They Harm Themselves?



- Self Injurious Behaviors have complex multi-dimensional causes and vary with age, gender, ethnicity, and vulnerability to incarceration stress. Patients may use as:
  - Coping mechanism to relieve built up tension and anxiety ("The pain helps me")
  - Impulsive expression of anger, hostility, and self loathing
  - Non-verbal expression of emotional pain
  - Method to avoid more serious self destructive impulses
  - They are having difficulty coping with a controlling situation
- It has been found to have an addictive quality and frequently co-exists with drug and alcohol problems

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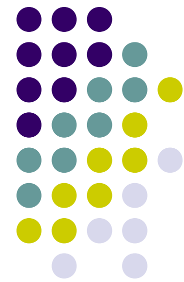
What if the Patient is Manipulative?



- Get past the labels! Assess and Treat each separate episode of self harm seriously
  - The belief that the patient is manipulating to control their environment may prevent a thorough assessment
  - Research shows many suicide victims engaged in manipulative, attention seeking behaviors or displayed problems with impulse control prior to death
  - Willingness to self mutilate or threaten suicide as a manipulative gesture demonstrates emotional imbalance
  - Absence of intent to die should not lead to conclusion that suicide is unlikely
- Suicide has occurred as an unintended consequence of self injury

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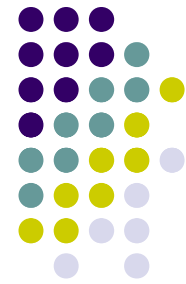
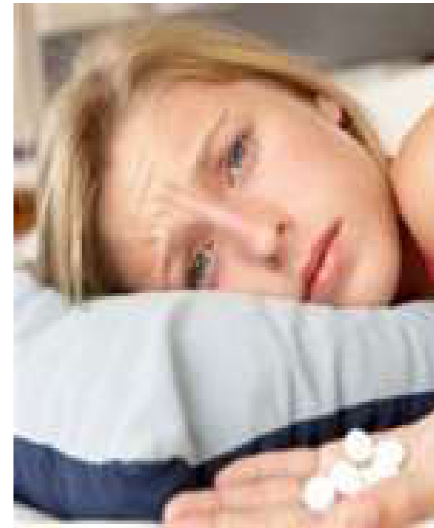


The Best Defense for Manipulative Behaviors

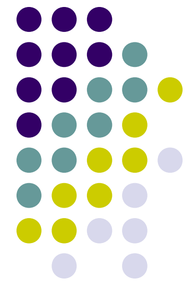
- Remove secondary gains
- Multi-disciplinary approach
- Respect and fairness
- Professionalism
- Follow the rules consistently
- Empathy with detachment
- Encourage coping and getting needs met in positive ways



Guiding Principles to Suicide Prevention in Correctional Facilities. National Center on Institutions and Alternatives. 2007.

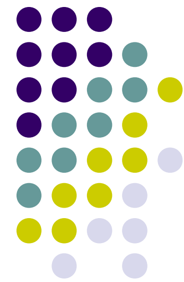
The Art of the Con: Avoiding Offender Manipulation. American Correctional Association. Lanham, Maryland. 2001.

Emergency Safety Response: for Imminent Risk



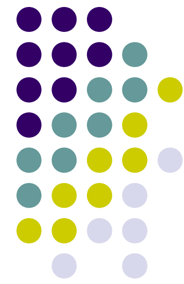
- Ensure Patient Safety Immediately
- Attempt for least restrictive intervention
- If patient is actively suicidal, emergency safety response may be required to intervene with life threatening behavior.
  - Safe Cell may be appropriate once clothing and items removed from patient access.
  - Restraint may be appropriate if patient attempting to gouge eyes out, chew at own flesh etc.
  - Suicide watch may be appropriate and requires transfer to Mental Health Housing Unit (MHU) (use safe cell till transfer occurs).

Evaluation



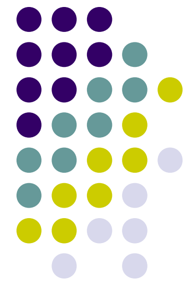
- Ensure patient safety
- Clinical (medical or mental health) staff will evaluate patient as soon as possible and notify Psychiatric Provider
- CHS Psychiatric Provider determines initiation and discontinuation of risk level
  - Level I: Restraint
  - Level II: Seclusion
  - Level III: Suicide Watch (inpatient areas only)

Treatment

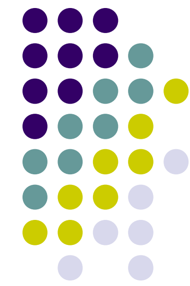


- Mental Health Staff
  - Special Needs Treatment Plan (SNTP) includes Goals for
    - Immediate stabilization &
    - Long term treatment
  - Signed by Mental Health Treatment Team and patient (may also be signed by family members of juveniles where possible)
  - Describes specific behavior, long term goals, short term objectives and therapeutic interventions.

Housing



- Transport to Mental Health Housing Unit (MHU) ASAP
  - Level I, II or III
  - Outpatient safe cell used for Level II (seclusion)
  - LBJ Outpatient; 4th Intake; Durango; Towers; Estrella
  - Used for Level II (Seclusion)
  - Padded cell with “china” toilet
- An order for “no single cell housing” may be written by Provider for additional precautions

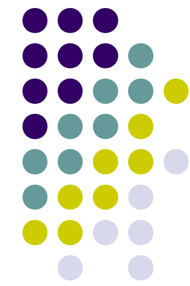


Orders

- Provider may order Suicide Levels I, II or III
  - Physician
  - Licensed psychologist
  - Physician assistant
  - Nurse practitioner

- Order may be obtained from provider by licensed staff (RN, LPN) via telephone
- Seclusion or Restraint (Levels I & II) limited to 6 hours in duration
  - Patient receives order to go in to restraints and there is a separate order to come out of restraints
  - May be renewed if behavior warrants

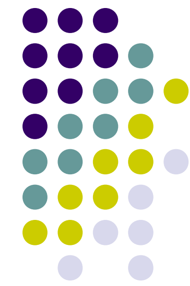
Monitoring: Level I



Level I: Restraint

- Last resort: LEAST RESTRICTIVE METHOD
- May be initiated by RN if Provider not on site
  - Order obtained within 1 hour
  - Restraint applied by trained detention staff
  - CHS staff do not intervene until patient restrained
- Restraint used only in intake area, infirmary and Mental Health Housing Units (MHU)
  - Leather restraints; allowed to wear clothing
  - Constant in-person monitoring by MCSO
  - Initial check by RN; 1 hour check after by Licensed Nurse
  - Removed as soon as able
  - Documented on flow sheet & clinic log

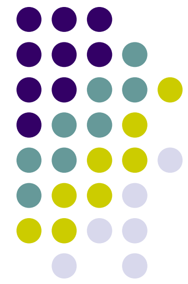
Monitoring: Level II



Level II: Seclusion

- Used as emergency safety method for patients exhibiting behaviors that are danger to self
- Clothing removed; placed in suicide smock or blanket
- No mattress or regular blankets, unless otherwise ordered by provider
- No books; magazines
- Monitored by MCSO every 15 minutes
- Vital signs at time of implementation & 12º hr x 24º then q 24º.
- Initial check by RN; 1 hour check thereafter by Licensed Nurse
- Removed from seclusion as soon as able
- Documented on flow sheet & clinic log

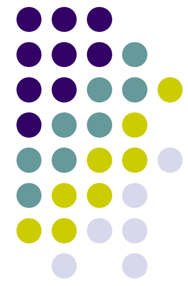
Monitoring: Level III



Level III: Suicide Watch (MHU / infirmary)

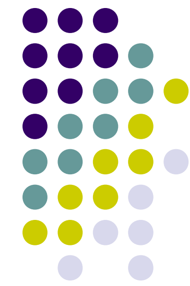
- Implemented when Patient has potential for danger to self and not actively demonstrating suicidal behavior
- Provider ordered; time limited
- Patient remains clothed; has mattress, bedding & regular diet
- Monitored by MCSO every 15 minutes
- RN assessment each shift & documented in progress notes
- RN notifies Provider immediately for increased risk
- Requires Provider order for discontinuation

Communication



- Clinical staff notifies MCSO when patient requires increased monitoring or transfer to another facility
- MCSO notifies CHS of concerns regarding patient behaviors that are perceived as high risk.

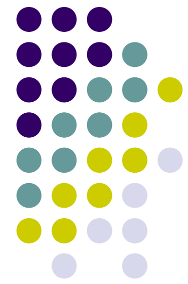
Intervention for Suicide attempt



- MCSO:
  - secures scene
  - rescues patient and
  - provides first aid measures as first responders
  - Initiates CPR
  - notifies CHS staff via Mandown Procedure

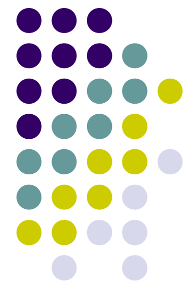
- CHS staff:
  - enters scene AFTER it has been secured by MCSO
  - continues with CPR and First Aid measures if indicated
  - advises MCSO to activate EMS if life threatening emergency
  - obtains orders from Provider, and
  - advises MCSO regarding monitoring and housing plans as indicated

Intervention for Inmate with Suicidal Verbalization



- MCSO
  - Stay with Patient
  - Notify CHS of verbalization (or behavior) of suicidal ideation
- CHS response
  - Assess Patient for severity of suicidal ideation
  - Notify Psychiatric Provider for orders
    - Implement orders ASAP

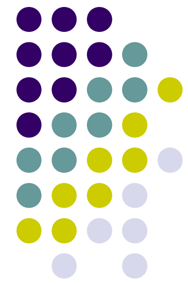
Notification



- Licensed Nurse contacts
  - On Call Psychiatric Provider
- Clinical staff contacts following for suicide attempts requiring ER run
  - Nurse Supervisor
  - Medical Director
  - Mental Health Director
  - Director of Nursing
  - Quality Management

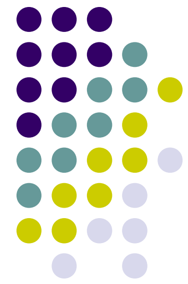
- MCSO notifies family if indicated

Documentation



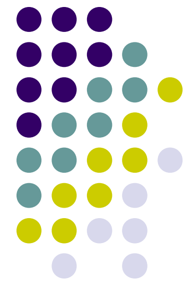
- Seclusion and Restraint Flow
  - Level I & II
- Email notification to MHU Supervisor, Medical Director and Mental Health Director for suicide attempts
- Progress Notes (SOAPE format)
  - Initial note of incident referring to flow sheet
  - Level III notes
  - Discontinuation note
  - Daily note for inpatient units on Level I & II
  - Provider assessment & treatment plan
- Order Sheet
  - Orders & treatment interventions

Reporting



- Seclusion & Restraint Log
  - Every event recorded on log
  - Reviewed by Nurse Supervisor regularly
  - Quality Management Review
    - Copy sent to QM department at the end of every calendar month
    - QM will maintain log for 3 years for each clinic
    - If no events in clinic, note “NONE” on the log and send to QM

Review / Debriefing



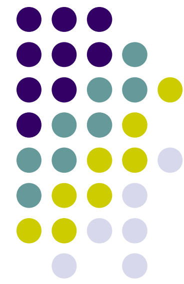
Review

CHS Quality Review Team coordinates a Critical Incident Review with mental health, medical, and administrative staff in the event of a suicide or serious suicide attempt.

Critical Incident Debriefing

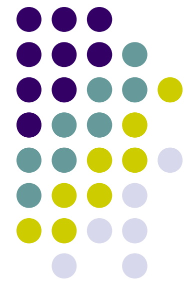
- Supervisor will assist staff in obtaining critical incident debriefing if indicated
- Mental Health Personnel will assess and provide critical incident debriefing for affected patients

Custody Ordered Restraint / Seclusion



- Initiated & discontinued by MCSO for security reasons
- RN assess patient
- RN review medical record to ensure no contraindications
  - If contraindicated, notify Detention Supervisor & if warranted Provider
- CHS monitor health status
  - Initial check by RN
  - 1 hour check thereafter by Licensed Nurse (circulation, ventilation, extremities, presentation, behavioral, verbal responses & readiness to be removed from restraint)
- CHS document on lavender Detention ordered restraint flow sheet; place in patient health record

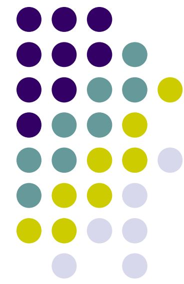
Remanded Juveniles



- It is recommended that all facilities take into consideration unique characteristics of adolescent suicide risk
- Adolescent suicide is a national tragedy and a public health problem
- Adolescent suicide rates have tripled since the 1950's
- Juveniles have a different response than adults to the stress of incarceration

National Strategy for Suicide Prevention. SAMHSA

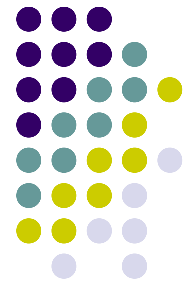
Differences In Juvenile Suicide Profiles



- Timing: Deaths are distributed evenly over the year
  - Few suicides in the first 24 hours
  - 71% occurred from 07:00-21:00 (daylight hours)
  - 50% from 18:00-24:00
  - 33% from 18:00-21:00
- Room Confinement: 50% of suicide victims are on timeout, segregation, quiet room, isolation due to failure to follow rules, inappropriate behavior, threats of physical abuse.
- History of Suicidal Behavior: 71% had a history of previous suicide attempts
- Common Profile: Suicide attempt followed by verbalizing suicidal ideation and/or threat, suicidal gesture, and self mutilation

Journal of Correctional Health Care. July 2009.

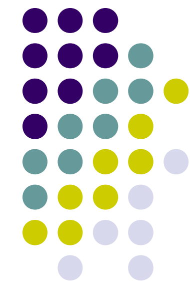
Helpful Points When Working With Adolescents



- Prior history of suicide attempts or related behaviors is strongly related to future risk
  - Check the patient's record for prior use of suicide precautions /mental health care during previous confinements
- Juveniles can become suicidal at any time so continuous assessment is critical to prevention
- Juveniles who need special precautions need frequent follow up and re-assessment
- Risk decreases with a multidisciplinary approach.
  - Communication of risk should include between arresting/transporting Officers, MCSO/medical staff, medical/mental health staff and the at-risk juvenile

Journal of Correctional Health. July 2009.

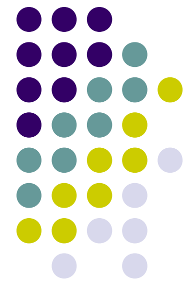
7 Protective Factors for Preventing Suicidal Behavior



- Effective application of clinical care for physical, mental, substance abuse disorders
- Easy access to clinical intervention and support for health seeking behaviors
- Restricted access to highly lethal methods
- Family and Community support
- Support from on-going medical and mental health relationships
- Learned skills from problem solving, conflict resolution, non-violent handling of disputes
- Cultural& Religious beliefs that discourage suicide and support self preservation

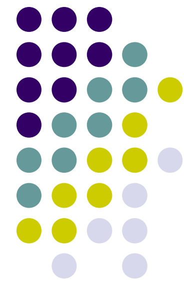
Journal of Correctional Health Care 10/2009

Forms

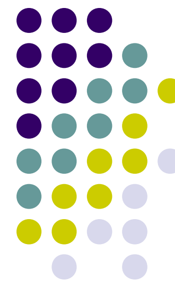


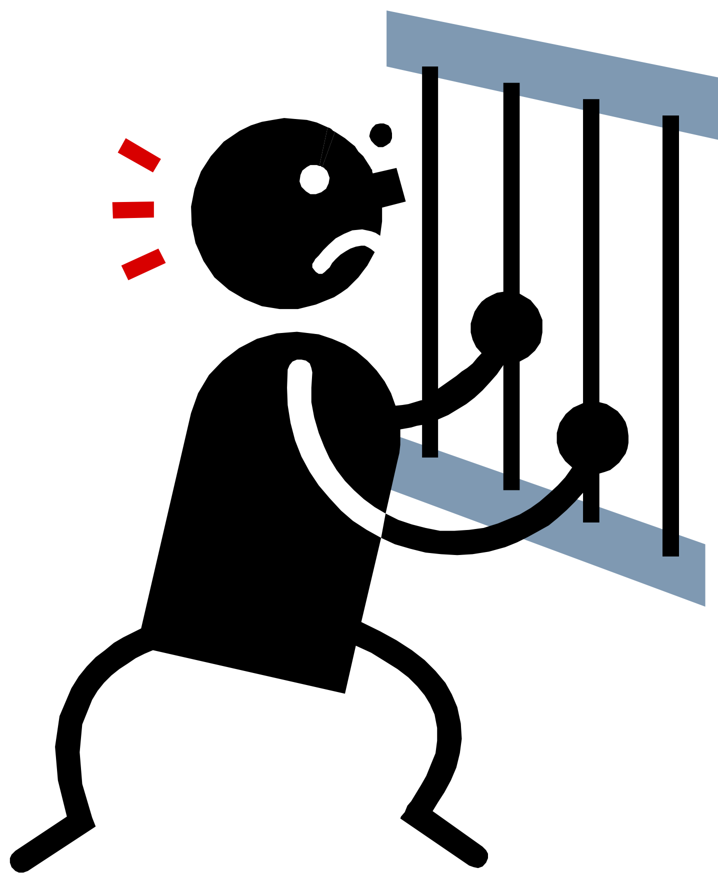
- Seclusion & Restraint Flow Sheet
- Seclusion & Restraint Log
- Seclusion & Restraint Detention Flow Sheet (Purple Form)
- Mandown Form

References



- CHS Policies and Procedures:
  - Suicide Prevention Program J-G-05
  - Restraint and Seclusion Use J-I-01-01 (A)
  - Use of Restraint and Seclusion in Correctional Facilities J-I-01 (A) and (B)
  - Emergency Response (Mandown) J-G-08-02
- Fagan, Cox, Helfnad & Aufderheide (2009). *Self-Injurious Behavior in Correctional Settings*. Journal of Correctional Health Care.
- Hayes, L. (2007). *Guiding Principles to Suicide Prevention in Correctional Facilities.* National Center on Institutions and Alternatives. Retrieved on 07/02/07 at http://www.ncianet.org/suicideprevention/publications/guidingprinciples.asp
- MSN Photo Search. Retrieved 01/27/10 at *www.Fotosearch.com*
- National Commission on Correctional Health Care (2009). *Position Statement: Prevention of Juvenile Suicide in Correctional Settings.* Vol. 15, Number 3.
- NCCHC Standards J-I-01 (A); J-I-01 (B)
- Substance Abuse and Mental Health Services Administration (SAMHSA). *National Strategy for Suicide Prevention.* Retrieved on 07/10/07 at http://mentalhealth.samhsa.gov/suicide prevention/young.asp.
- Texas Commission on Law Enforcement. (1999). *Suicide Detention and Prevention in Jails: Including Mental Impairments.* Course Number 3501 Revised.





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