



Suicide Prevention



Vermont Correctional Academy

Instructor's Manual

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Academy

71 Clement Rd
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December 15-18, 2008



Suicide Prevention

Agenda

Training for Trainers

December 15-18, 2008

Suicide Prevention Training For Trainers

December 15-18, 2008

Day One: December 15th

0830 Introductions and Welcome

- Course and Manual overview
- Participant introductions

0900 Ron Smith

- Suicide Prevention in VT Doc;
- Where we are at with future changes in Suicide prevention Directive

1130 Lunch

1230 Teaching Processes

- Understanding how to use your lesson plans
- Teaching Pointers

1600 Daily Evaluation Process

Suicide Prevention Training For Trainers

December 15-18, 2008

Day Two: December 16th

0830 Evaluation feed back

0900 Suicide Prevention LP Delivery

1130 Lunch

1230 Practice Delivery

- 2 Minute Drills

1600 Daily Evaluation Process

Suicide Prevention Training For Trainers

December 15-18, 2008

Day Three: December 17th

0830 Evaluation Feed Back

0900 Web Resources for Trainers

0930 Practice Delivery

1130 lunch

1230 Practice Delivery

- Role play Scenarios

1600 Daily Evaluation Process

Agenda For Four Day Suicide Prevention Training For Trainers

December 15-18, 2008

Day Four: December 18th

0830 Evaluation Feed Back

0900 Stipend Delivery

- Immediate Action Sets Scenarios
- INS performance Checklist
- SORF performance Checklist

1015 Practice Stipend Delivery

1130 lunch

1230 Discussion of issues in Training Suicide Prevention

1400 Action Plans

1515 Suicide trainers Email Alias

1530 Administering the Written Test

1600 Course Evaluation and Closing



Suicide Prevention

Student Materials

December 15-18, 2008

VERMONT CORRECTIONAL ACADEMY

SUICIDE PREVENTION

I. PERFORMANCE OBJECTIVES

By the end of this course, you should be able to:

- A) Recognize characteristics of prisons and jails that make them prone to suicide;
- B) List at least five signs and symptoms of a possibly suicidal inmate;
- C) Recognize times of increased suicide risk;
- D) Discuss events that can trigger a possible suicide;
- E) List the five steps to respond to an actively suicidal inmate;
- F) Review immediate action steps for responders intervening in a suicide attempt by hanging, cutting or overdosing/poisoning.
- G) Demonstrate use of the INS form by performing an INS interview; and
- H) Review the correct way to fill out a Special Observation Monitoring Sheet.

II. INTRODUCTION

Suicide prevention is a job of every corrections profession. Security, casework, administrative, and health care staffs must all work together to save lives. Suicides in corrections have a tremendous impact on staff, inmates, and our communities, so it is important to understand that we work with a population that is at high risk for suicide and self-harming behaviors. People from our communities that end up incarcerated in our facilities are people whose lives are in chaos. They may have addiction and/or psychological problems, depression, or feel some kind of disconnection from the community around them. Suicide for them is often seen as their only way out – a final solution for all their problems. It is a vital part of our job to try to help reconnect them back to their community, and to help them make meaningful changes in their lives. It is vital that we give them the opportunity to find the help they need.

Here are some important facts to know:¹

- A) Suicide was the ninth leading cause of death in the US (2000).
- B) Most suicidal people give definite warning signs of their intentions.
- C) Men are four times more likely to kill themselves than women, but three times more women than men attempt suicide.
- D) Throughout the US, 83 suicides occur each day or 1 suicide every 17 minutes.
- E) It is estimated there are at least 8 to 20 attempts for each death by suicide.

¹ Source: American Association of Suicidology, <http://www.suicidology.org>.

- F) People that are socially isolated are generally found to be at high risk of suicide.

Knowledge about suicide risk in our community is important. It allows us to be able to put into perspective the increased risk of suicide inside a correctional facility. Suicide is often the single most common cause of death in a correctional setting.

Nationwide suicide rates are 10.8 people per 100,000. Within correctional facilities and/or jails, the rate of suicide is 3-5 times higher than the general U.S. population. Jails that hold detained populations have higher rates of suicide than prison systems that just deal with sentenced long-term offenders. It is important to note that Vermont has a dual system housing with both detainees and sentenced offenders in the same facilities and often in the same units.

It is also important to note that a suicide in a corrections facility can have long term effects on its culture (i.e., cause high level of stress on staff and inmates that have to deal with the aftermath of an inmate suicide) and cause long term legal and political problems. Survivors of suicides (i.e., family and friends of a person that commits suicide) are also often at a higher risk of suicide as they deal with the grief of the loss of a loved one.

III. ELEMENTS OF A SUCCESSFUL SUICIDE PREVENTION PROGRAM

These eleven elements are seen as part of a successful correctional suicide prevention program:

A) Identification

The receiving screening form should contain observation and interview items related to the inmate's potential suicide risk

B) Training

All staff members who work with inmates should be trained to recognize verbal and behavioral cues that indicate potential suicide

C) Assessment

This should be conducted by a qualified mental health professional (QMHP), who formally determines the inmate's level of suicide risk.

D) Monitoring

The guidelines should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular documented supervision should be maintained.

E) Housing

A suicidal inmate should not be placed in isolation unless constant supervision can be maintained. If a sufficiently large staff is not available to provide constant supervision, the inmate should not be isolated. Rather, he/she should be housed with another resident or in a dormitory and checked every 10-15 minutes. The room should be as *suicide-proof* as possible.

F) Referral

The plan should specify the procedures for referring potentially suicidal inmates and attempted suicides to mental health care providers or facilities.

G) Communication

Procedures for communication between health care and correctional personnel regarding the status of the inmate should exist to provide clear and current information.

H) Intervention

The plan should address how to handle a suicide in progress, including how to cut down a hanging victim and other first-aid measures.

I) Notification

Procedures for notifying prison administrators, outside authorities, and family members of potential, attempted, or completed suicides should be in place.

J) Reporting

Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide.

K) Review

The plan should specify the procedures for the medical and administrative review if a suicide does occur.

We will concentrate on parts where Correctional officers play an important role.

IV. CHARACTERISTICS OF PRISON ENVIRONMENTS THAT MAKE THEM PRONE TO SUICIDE

The following are seven characteristics that make suicides in our institutions more likely:

A) Authoritarian environment

Persons unaccustomed to a regimented environment can encounter traumatic difficulty in a prison setting.

B) No apparent control over the future

Following incarceration, many inmates experience a feeling of helplessness and hopelessness. They feel powerless and overwhelmed.

C) Isolation from family, friends, and community

For incarcerated individuals, support from family and friends may seem far away, especially with restricted visiting and telephone privileges.

D) The shame of incarceration

Feelings of shame (often found in misdemeanants) are often inversely proportionate to the gravity of the offenses committed. Frequently, such feelings develop in those persons who have never been arrested before or who have a limited arrest history. In the NCIA national study of jail suicides, 75 percent of the victims were arrested for non-violent offenses.²

E) Dehumanizing aspects of incarceration

Viewed from the inmate's perspective, confinement in even the best of jails is dehumanizing. Lack of privacy, association with acting-out individuals, inability to make your own choices, and strange noises and odors can all have a devastating effect. Many facilities are old and overcrowding can create stress.

² Lindsay Hayes, "National study of jail suicides: Seven years later," *Psychiatric Quarterly*, Volume 60, #1, March 1989.

F) Fears

Fears, based on stereotypes of jails seen on television and in movies, and stories carried by various media, heighten anxieties on the part of some individuals about other inmates and sometimes, about staff.

G) Staff insensitivity to the arrest and incarceration phenomenon

Most, if not all persons working in the criminal justice field has never personally experienced the trauma of arrest and incarceration. Experience has shown that, in many instances, the longer people work in the criminal justice field, the more insensitive they can become to the emotional effects of arrest and incarceration. This is particularly true for the first time arrestee.

This is considered one of the factors, which influences suicides in jails and prisons. Staff often overlooks signs and symptoms because of their own insensitive attitudes and thinking.

V. SIGNS AND SYMPTOMS OF A POSSIBLY SUICIDAL INMATE

There are many signs and symptoms of a possibly suicidal inmate; the following is a list that a possible suicidal individual might display before attempting to try to take their own life.

A) Symptoms of current depression or paranoia;

Depression is the single best indicator of potential suicides. Approximately 70 to 80 percent of all suicides are committed by persons who are severely depressed.

B) Expresses or evidences a strong guilt or shame over offense;

C) Talk about or threatens suicide;

D) The person is under influence of alcohol/drugs;

E) Staff knowledge of previous suicide attempts or history of mental illness;

F) Severe agitation or aggressiveness;

G) Projects hopelessness or helplessness or no sense of future;

H) Expresses unusual or great concern over what will happen to them;

I) Noticeable mood and/or behavior changes;

J) Acts very calm once decision is made to kill self;

K) Speaks unrealistically about getting out of jail;

L) Has increased difficulty relating to others;

M) Does not effectively deal with present/preoccupied with past;

N) Begins packing belongings;

O) Starts giving away possessions;

- P) May try to hurt self;
- Q) Paranoid delusions or hallucinations;
- R) Feeling of inability to go on, hopelessness, or helplessness;
- S) Extreme sadness and crying;
- T) Withdrawal or silence;
- U) Loss or increase of appetite and/or weight;
- V) Pessimistic attitudes about the future;
- W) Insomnia or awakening early, or excessive sleeping;
- X) Mood and/or behavior variations;
- Y) Tenseness;
- Z) Lethargy (i.e., slowing of movements or non-reactive);
- AA) Loss of self-esteem;
- BB) Loss of interest in people, appearance, or activities;
- CC) Excessive self-blaming;
- DD) Strong guilt feelings;
- EE) Difficulty concentrating or thinking;
- FF) Agitation frequently precedes suicide;
- GG) High level of tension;
- HH) Extreme anxiety; and
- II) Strong emotions.
 - 1) Guilt
 - 2) Rage
 - 3) Wish for revenge

It is important that you pay attention to what a person is saying (both verbal and non-verbal), and to keep measuring it against what you know about the person. Communicate with Supervisors and health care about any concerns you have about an inmate's behavior.

VI. TIME PERIODS INMATES HAVE A HEIGHTENED SUICIDE RISK

The following list is of time periods during incarceration that we know an inmate is more likely to try to commit suicide. This means that we need to increase our vigilantes around these time periods.

- A) The first 24 hours of confinement;
- B) Intoxication/withdrawal;
- C) Waiting for trial;
- D) Sentencing;
- E) Impending release;
- F) Holidays or important anniversary of some kind;
- G) Darkness;
- H) Decreased staff supervision;
- I) Bad news of any kind; and
- J) The first 30 days after incarceration or movement into a new facility.

VII. EVENTS THAT MIGHT TRIGGER A POSSIBLE SUICIDE

It is also possible that an event could be the trigger of a suicide attempt. When we see these kinds of events happen we need to raise our awareness and pay attention.

A) Recent excessive drinking and/or use of drugs

In many instances, when intoxicated persons sober up, depression sets in. However, a number of persons with blood alcohol levels in excess of the legal limit commit suicide while still intoxicated. For some, even a small amount of alcohol or drugs can have a depressing effect, influencing suicidal behavior.

B) Recent loss of stabilizing resources

1) Any of the following can influence suicidal behavior:

- a) Loss of spouse/loved one. For juveniles this could be a peer who is missed more than a parent;
- b) Loss of Job, expulsion from school;
- c) Loss of home or farm; or
- d) Loss of finances.

C) Severe guilt or shame over the offense

While some inmates involved in serious crimes commit suicide, most that take their own lives are charged with minor offenses or civil violations. For most suicidal inmates, the guilt or shame may well be inversely proportionate to the seriousness of the offense. A person of high status in the community who commits shameful crimes (e.g., child molestation or sexual assault) may need close attention.

D) Same-sex rape or threat of

In interviews with inmates who were prevented from committing suicide, many of them said that they had been raped or strongly coerced for sexual favors.

E) Current mental illness

Persons who are depressed or suffering from delusions/hallucinations (e.g., have voices telling them what to do) are prime subjects for suicide.

F) Poor health or terminal illness

Any person suffering from serious illness (e.g., aids, cancer) can be at risk for suicide.

G) Approaching an emotional breaking point

Each individual has a breaking point where they can no longer deal with their stressors. This point can be influenced by the duration, time and situation of the stressors.

VIII. DEALING WITH INMATE SELF-INJURIOUS BEHAVIOR

When an inmate self-harms, or threatens to do so, the response that is most helpful to the inmate in the long run is to make him safe, apply an appropriate level of precaution, and bring the episode to a close promptly and without drama. It is very natural to want to bargain, comfort, or even just to watch, but all of these types of attention may just end up rewarding and reinforcing the self-injurious behavior. This makes the behavior more likely to happen again. Being neutral, brief, and unrewarding will take some getting used to, because it goes against some of our natural instincts, and a lot of our habits. But it will be worth it in the long run for us and for the inmates.

When an inmate is engaged in serious self harm communications between any staff and the inmate should be done in the most neutral manner that the situation permits, and should be as brief as possible.

- Security and medical staff will make the inmate safe, and attend to any injuries.
- During this process, there should be no bargaining with the person who is self-injuring (or threatening to) except if it is necessary to secure his immediate safety. For example, if an inmate is placed in a restraint chair, it is sensible to bargain that restraints can be removed if blades are given up.
- Talking to the inmate should not involve discussing comforts or rewards to be given if the inmate stops his behavior (exception above).
- Avoid pleading with the inmate not to harm himself. If he stops his behavior, he should be praised briefly.
- While the incident is on-going, avoid discussing the incident or the inmate in front of him, except as your duties require. In other words, say what you have to say to get the job done, but save other talk until later and when not in the presence of the inmate.
- Do not spend time talking to the inmate about what triggered his self harm. Just stop the behavior and tend to any injuries.

- When the incident is over, avoid the temptation to encourage him to do better, or tell him not to feel bad. Avoid the temptation to provide “a little something extra”, whether that is a privilege or a tender word.
- When the immediate incident is over, place the person on full suicide / self harm precautions. For some inmates this may not include having a blanket.
- If an individualized treatment plan is available on the unit, or to the shift supervisors, please follow it if at all possible.

Mental Health staff will speak with the inmate the following morning to review triggers, responses, and coping skills. Asking mental health to intervene during an incident or to speak with an inmate immediately afterwards is inappropriate both therapeutically and in terms of the security of personnel and inmates.

IX. INTERVENTION OF A POSSIBLY SUICIDAL INMATE

Intervention of a suicide is possible when staff is aware of the signs and symptoms, are vigilant during times of greatest risk, and we are paying attention to events that can trigger a suicides attempt. The earlier staff can identify at-risk inmates, the earlier we can apply the most suitable intervention and reduce the risk of losing a life.

These interventions may include:

- A) INS screening;
- B) Notification of Shift Supervisor, case work staff, and health care staff of observed behaviors;
- C) Special observation log;
- D) Counseling; and
- E) Suicide watches.

The earlier we can intervene and provide the inmate with care, the less likely we will have to resort to more drastic measures of restraint to keep the individual from trying to hurt themselves or others.

X. EMERGENCY INTERVENTIONS FOR AN ACTIVELY SUICIDAL INMATE

There are 5 key steps to intervening in an active suicide attempt. They are:

1. Report an active suicide immediately
2. Check the scene for safety
3. Administer immediate life saving actions
4. Secure the scene
5. Write your report

One: The call for help:

Give a 10/33 on your radio or phone if radio is not available, give the location of attempt, Type of suicide attempt, your need for medical assistance, and request any special equipment that you know you will need.

Two: In checking the scene you must:

- Check for a “set up”;
- Look for items that could be used as weapon (e.g., razor blade);
- Move all persons that are not actively giving life saving actions away from scene;
- Use universal precautions (e.g., gloves, goggles, CPR mask);

Three: In administering immediate life saving actions.

- You must start to take action to save the inmates life as soon as possible.
- Do not presume that an inmate is dead, appropriate life-saving measures will be initiated and continued until relieved by a qualified health care professional.
- Housing units will contain various emergency equipment, to include a first aid kit, pocket mask, face shield and rescue tool (to quickly cut through fibrous material.)
- You might have to use force to stop the inmate from doing harm to themselves.

Four: In securing the scene:

Secure site as soon as is possible after giving life sustaining actions. If the suicide is completed the incident scene will be treated as a crime scene until determined otherwise by AHS investigators or released by law enforcement authorities.

Five: Write your Report:

You are required to write an incident report as soon as possible about what you saw, heard, and did.

You will submit this report to your Shift Supervisor by the end of your shift before you leave to go home.

Here Are Suicide Prevention Immediate Action Steps For Security Staff On The Scene Of An Active Suicide Attempt:

For A Suicide Attempted by Hanging

1. Report the suicide attempt of the hanging inmate.
 - a. 10-33, Suicide by hanging, Location, Need Cut down tool, send Medical staff and bring an AED.
2. Check the scene for safety of self and others.
 - a. Take universal precautions, gloves, CPR mask, and any others as situation dictates.
3. If the scene is safe enter cell or area that the inmate is hanging.
4. Lift up on the body to release pressure from around the neck.
 - a. If unable to remove ligature continue to lift inmate until help arrives.
5. Cut Ligature and gently lower inmate to floor.
 - a. Be aware of possible neck injuries.
 - b. Treat the inmate as if they have a possible neck fracture or broken neck.
6. Check for vital signs.
 - a. If no pulse or breathing, start CPR and use the AED
 - b. Continue life saving actions until relieved or until unable to continue because exhaustion or a change in the scene that makes it unsafe for you to continue.
7. Secure scene after inmate is removed
8. Write and submit an incident report

For A Suicide Attempt by Cutting

1. Report the suicide attempt of the hanging inmate.
 - a. 10-33, Suicide Attempt Cutting, threatening to cut, or bleeding, Location, Type of sharp if known, send Medical staff and bring an AED.
2. Check the scene for safety of self and others.
 - a. Take universal precautions, gloves, CPR mask, and any others as situation dictates.

3. Try to communicate with the inmate.
 - a. Ascertain if the inmate is cooperative, combative or unconscious.
4. If cooperative ask inmate to place on the floor, or pass out of the cell the cutting instrument and to put direct pressure on their wound.
 - a. Remember that is they have one sharp; they might have another.
5. If combative, try to start a dialog with the inmate to distract them from cutting and to try to help them calm down.
 - a. Use force if necessary to protect self and others. Maintain a safe distance and wait for assistance to arrive.
 - b. Be aware that you might have to use force to stop them from cutting or hurting them self more.
 - c. When enough staff and equipment is available; staff will apply force to gain control of situation at the direction of the on scene supervisor if the inmate refuses to cooperate and/or they continue to try to harm them selves.
6. If the inmate is unconscious; try to ascertain if it is a set up.
 - a. If safe, secure sharp, check the inmate's vital signs and start giving aid by applying direct pressure to cuts.
 - b. If no pulse or breathing, start CPR and use the AED
 - c. Continue life saving actions until relieved or until unable to continue because exhaustion or a change in the scene that makes it unsafe for you to continue.
7. Secure scene after inmate is removed.
8. Write and submit an incident report.

For A Suicide Attempted by medication overdose or poisoning

1. Report the suicide attempt of the hanging inmate.
 - a. 10-33, Suicide Attempt Overdose or poisoning, Location, Type of medication or poison if known (this is important so the Control room officer can call the poison control center for instructions on first aid), send Medical staff and bring an AED.

2. Check the scene for safety of self and others.
 - a. Take universal precautions, gloves, CPR mask, and any others as situation dictates.
3. Try to communicate with the inmate.
 - a. Ascertain if the inmate is cooperative, combative or unconscious.
4. If cooperative ask the inmate what they have taken, how much and how long ago.
 - a. Remember that they might have more and could try to ingest them.
5. If combative, try to start a dialog with the inmate to distract them from hurting themselves and to try to help them calm down.
 - a. Use force if necessary to protect self and others. Maintain a safe distance and wait for assistance to arrive.
 - b. Be aware that you might have to use force to stop them from doing more harm to themselves.
 - c. When enough staff and equipment is available; staff will apply force to gain control of situation at the direction of the on scene supervisor if the inmate refuses to cooperate and/or they continue to try to harm them selves.
6. If the inmate is unconscious; try to ascertain if it is a set up.
 - a. If safe, secure medication or poison, check the inmate's vital signs and start giving aid as directed by medical.
 - b. If no pulse or breathing, start CPR and use the AED
 - c. Continue life saving actions until relieved or until unable to continue because exhaustion or a change in the scene that makes it unsafe for you to continue.
7. Secure scene after inmate is removed.
8. Write and submit an incident report.

XI. REPORTING SUICIDE/POSSIBLE SUICIDES

All active suicides will be called in as an emergency 10/33.

Any staff member that hears an inmate talking about suicide, has an inmate tell them that someone is considering suicide, or recognizes any of the signs and symptoms or triggering events that could lead to a possible suicide are required to report this information to the on-duty shift supervisor.

The shift supervisor will gather all important information about the inmate and pass it on to medical staff [so they conduct a suicide/mental health screening] and casework staff.

Staff must take all reports of a possible suicide seriously. Even an individual that is using self-mutilation to attempting to manipulate staff can often go too far and kill themselves.

Staff is required to report any suicidal behavior through their chain of command. Only mental healthcare providers can formally determine whether an individual is suicidal. Correctional officers are responsible for the safety of the inmates in their care.

XII. INITIAL NEEDS SURVEY (INS)

The INS is a screening tool used by the Vermont Department of Corrections to identify inmates that might have mental health issues or have the possibility of attempting suicide.

The INS is administered to all new intakes, transfers from another facility, or incapacitated persons held in protective custody.

Correctional officers involved in the booking process will solicit any relevant information from law enforcement and correctional field personnel which might suggest an admitting inmate's suicidal ideation or risk, and document these comments in the Initial Needs Survey (INS). This includes comments or statements made by the inmate prior to his/her arrival at the institution.

DOC Staff will administer and sign the Initial Needs Survey for all inmates entering a correctional facility at the time of their arrival.

- Staff should not rely exclusively on an inmate's denial that they are suicidal and/or have a history of mental illness and suicidal behavior.
- Previous Confinement in the facility must be recorded.
- Any behaviors or actions that are worrisome must be recorded and health services staff notified.

Upon completion of the INS forms (part 1 and 2) and/or the intake process, the booking officer will notify a qualified health care professional of every admission.

Booking officers will complete the intake screening process, including the INS form on all inmates prior to housing assignment, except under the following circumstances:

- The inmate refuses to comply with the process;
- The inmate is severely intoxicated or otherwise incapacitated;
- The inmate is violent or otherwise belligerent.

The Booking officer will complete all non-questionnaire sections of the inmates INS form and make a note on the form as to why the inmate was unable to answer the questionnaire section.

A continuing effort to complete the INS form must be made and documented at least every two hours until the inmate has been screened successfully.

For all inmates who scored an 8 or above and/or answered affirmatively on any asterisked item on the INS form, will be placed on suicide precautions and a Qualified Health Care Professional (QHCP) will develop an immediate individual safety plan.

This plan will include, but is not limited to:

- A level of observation and/or restraints to include;
 - Routine Observation
 - Close Observation
 - Constant Observation
- Housing, including the possible need for transfer to another correctional or mental health facility
- Frequency and duration of follow-up by mental health staff
- Any necessary property restrictions.

The Shift Supervisor will review and sign the INS forms for accuracy and completeness and consult with qualified health care and mental health professionals as needed to develop and implement the safety plan.

XIII SPECIAL OBSERVATION MONITORING SHEETS

Inmates that are identified as having some level of suicide risk will be placed on some level of monitoring.

- Routine Observation: For inmates, who acknowledge some degree of suicidal ideation, but deny any intent or plan and are deemed unlikely by qualified health care or mental health professional to self-injure.
 - Inmates under routine observation may remain in general population.
 - They are subject to checks and documentation per usual head count procedures.
 - Staff will give instructions to inmates under routine observation on how to access services on short notice if their suicidal ideation worsens.
- Close Observation: For Inmates who are not actively suicidal, but express suicidal ideation and/or have a recent prior history of self-destructive behavior.

- Inmates on close observation will be housed, to the extent possible, in the general population, mental health unit or a medical unit, located in rooms or cells proximate to staff.
- Correctional staff will observe inmates on close observation at staggered intervals not to exceed every 15 minutes.
- Correctional staff will document the inmate's behavior and general condition when the observation occurs, on a Special Observation Monitoring Sheet.
- Constant Observation: For Inmates who are actively suicidal or self-harming, either threatening or engaging in suicidal behavior. Staff will observe such inmates on a continuous, eye-contact basis, unless clinically contraindicated.
 - Inmates on constant observation may require placement in the infirmary, mental health unit or specialized housing as determined by the psychiatrist or advanced practice nurse.
 - Inmates on constant observation may require removal of certain clothing items, use of paper gowns, and/or other safety measures.
 - Correctional staff will document inmates on constant observation every 15 minutes.
 - Correctional staff will document the inmate's behavior and general condition when the observation occurs, on a Special Observation Monitoring Sheet.

Shift Supervisor's will review and sign each special observation monitoring sheet at the end of each shift.

XIV. SUPPLEMENTAL INFORMATION SOURCES

VT DOC Directive 362 Suicide Prevention.

American Association for Suicidology. www.suicidology.org.

Hayes, Lindsay M. *Prison Suicide: An Overview and Guide to Prevention*, National Center on Institutions and Alternatives (Mansfield, MA); National Institute of Corrections (Washington, DC), 1995.

Idem. *Technical Assistance Report on Suicide Prevention Practices within the Vermont Department of Corrections*, National Center on Institutions and Alternatives, April 11, 2005.

Marks, Michael and Philip McLaughlin. *Report into the Deaths of Seven Vermont Inmates and Related Issues*, Vermont Agency of Human Services (Waterbury, VT), 2004

National Center on Institutions and Alternatives (NCIA). <http://66.165.94.98/cjisl.cfm>

- Powell, Thomas A. and John C. Holt. *A Statistical Review of Incident Reports Documented as Attempted Suicides within the Vermont Department of Corrections During the Period Between January 1, 2003 and February 20, 2004.*
- Rowan, Joseph R., and Lindsay M. Hayes. *Training Curriculum on Suicide Detection and Prevention in Jails and Lockups.* National Center on Institutions and Alternatives (Mansfield, MA), 1995.
- World Health Organization. *Preventing suicide: A resource for prison officers* (WHO/MNH/MBD/00.5). Geneva: World Health Organization, Department of Mental Health, 2000d.



Suicide Prevention

Academy & Local
Lesson Plans

December 15-18, 2008

**AGENCY OF HUMAN SERVICES
VERMONT DEPARTMENT OF CORRECTIONS**

Lesson Plan

Course Title	Suicide Prevention
Lesson Title	Suicide prevention for new employees
Instructor (s)	
Prepared By	Ross T. Farnsworth
Date	December 8, 2008

<p>Time Frame: Total 7hr., 5 min. Suggested Schedule: Day: Times:</p>	<p>Target Population: Number of Participants:20-30 Space Requirements/Room Setup: Large class room</p>
<p>Performance Objectives: By the end of this Session participants will be able to:</p> <ul style="list-style-type: none"> • Recognize characteristics of prisons and jails that make them prone to suicide; • List at least five signs and symptoms of a possibly suicidal inmate; • Recognize times of increased suicide risk; • Discuss events that can trigger a possible suicide; • List the five steps to respond to an actively suicidal inmate; • Review immediate action steps for responders intervening in a suicide attempt by hanging, cutting or overdosing/poisoning • Demonstrate use of the INS form by performing an INS interview; and • Review the correct way to fill out a Special Observation Monitoring Sheet 	<p>Evaluation Procedures: (How will objectives be evaluated)</p> <p>Written test and class participation</p>

Methods/Techniques:	
Instructor Materials:	References:
Equipment and Supplies Needed:	<i>Video Player (VCR/DVD)</i>
<i>Flip Chart & Stands</i>	Type: VHS DVD Other
<i>Chalkboard</i>	<i>Videotape recorder with camera</i>
<i>Slide Projector</i>	TV (s) 23" 27" 33" <i>(Indicate size and quantity)</i>
<i>Screen</i>	<i>LCD Projector</i>
<i>Flip Chart Pad</i> <i>Number Needed</i>	<i>Laptop or Desktop Computer & cables</i>
<i>Felt-tip Markers</i> <i>Different Colors</i>	<i>Overhead Projector</i>
<i>Masking Tape (size 1/2")</i> <i>Rolls Needed</i>	
<i>Other Items:</i>	

Student Materials (Handouts)			
<i><u>Title</u></i>	<i><u># Needed</u></i>	<i><u>When Distributed</u></i>	<i><u>Comments</u></i>
<i>Copyright clearances will need to be obtained, unless otherwise indicated.</i>			

ANTICIPATORY SET

VT DEPT. OF CORRECTIONS



SUICIDE PREVENTION

Title Slide

Put up at the start of the class

Small Group Exercise

What we already know about Suicide Prevention

Need Flip chart paper, markers, and tape.

Break the Class into 3 or 4 small groups

Hand out a piece of flipchart paper and a marker to each group

Give each group a different question to work on.

- List what you believe are signs and symptoms of a possible suicidal inmate?
- When do you believe inmates are most likely to try to commit suicide?
- What are some characteristics of jails and prisons that make them prone to suicide?
- What kind of events do you believe could trigger a possible suicide?

Have each group brain storm a list.

Post lists on wall to refer to during training.

Compare what they know and believe to what is known about suicide and Prisons.

INSTRUCTIONAL INPUT

PERFORMANCE OBJECTIVES

By the end of this Training, Students will be able to:

- Recognize characteristics of prisons and jails that make them prone to suicide;
- List at least five signs and symptoms of a possibly suicidal inmate;
- Recognize times of increased suicide risk;
- Discuss events that can trigger a possible suicide;
- List the five steps to respond to an actively suicidal inmate;
- Review immediate action steps for responders intervening in a suicide attempt by hanging, cutting or overdosing/poisoning.
- Demonstrate use of the INS form by performing an INS interview; and
- Review the correct way to fill out a Special Observation Monitoring Sheet.

Cover performance objectives with class

Lecture Part 1

Instructors connection to suicide and prevention of suicide

Introduce yourself, your background, and any connections that you have with suicides in corrections and suicide prevention

Key points to cover

- Why suicide prevention is everyone's job in a correctional environment.
- Why and how suicides can have a tremendous impact on the staff, inmates, and our communities.
- That we work with a population that is a high risk for suicide.
- For some, suicide seems like their only way out.

Lecture Part 2

Suicide and the Correctional Professional

Preventing Suicide is a job of every corrections profession. we must all work together to save lives.

A Suicides in a corrections institution has a tremendous impact on staff, the inmates, and our communities. And it is important to understand that we work with a population that is at high risk for suicide and self-harming behaviors.

The People from our communities that end up incarcerated in our facilities are those whose lives are in chaos.

They may have addiction and/or psychological problems, may be dealing with depression, or feel some kind of disconnection from the community around them.

Suicide for them is often seen as their only way out – a final solution for all their problems.

So it becomes a vital part of our job to try to help them reconnect them back to their community.

To help them make meaningful changes in their lives.

Here Are Some Important Facts To Know:

- Suicide was the ninth leading cause of death in the US (2000).
- Most suicidal people give definite warning signs of their intentions.
- Men are four times more likely to kill themselves than women, but three times more women than men attempt suicide.
- Throughout the US, 83 suicides occur each day or 1 suicide every 17 minutes.
- It is estimated there are at least 8 to 20 attempts for each death by suicide.
- People that are socially isolated are generally found to be at high risk of suicide.
- Nationwide suicide rates are 10.8 people per 100,000.

[1] Source: American Association of Suicidology, <http://www.suicidology.org>.

Here are some important facts to know:

Review the above and add commentary

Knowledge about suicide risk in our community is important. It allows us to be able to put into perspective the increased risk of suicide inside a correctional facility. Suicide is often the single most common cause of death in a correctional setting.

Nationwide suicide rates are 10.8 people per 100,000. Within correctional facilities and/or jails, the rate of suicide is 3-5 times higher than the general U.S. population. Jails that hold detained populations have higher rates of suicide than prison systems that just deal with sentenced long-term offenders. It is important to note that Vermont has a dual system housing with both detainees and sentenced offenders in the same facilities and often in the same units.

It is also important to note that a suicide in a corrections facility can have long term effects on its culture (i.e., cause high level of stress on staff and inmates that have to deal with the aftermath of an inmate suicide) and cause long term legal and political problems. Survivors of suicides (i.e., family and friends of a person that commits suicide) are also often at a higher risk of suicide as they deal with the grief of the loss of a loved one.

Suicide

In the U.S. there are more than 80
deaths from suicide every day,
30,000 per year.

Play this intro video as a reinforce of your lecture

You must click on the video to make it work.

ELEMENTS OF A SUCCESSFUL SUICIDE PREVENTION PROGRAM

There are eleven elements seen as part of a successful correctional suicide prevention program.

So, Lets look into your Manual. You will find all eleven elements listed there.

Go back into your groups and on a flip chart list in order what your group believes are them most import elements to the lest important elements for a Correctional officer to pay attention to.

(give 5 minutes to work)

Have the groups post their work, and have a reporter from each group give their reasoning.

Have them work toward the Idea that all are vital to preventing suicides but that as correctional officers they have the ability to effect some elements more then others.

Let them work out what kind of impact they can have on suicide prevention.

Characteristics of Prison Environments that make them Prone to Suicide



Work to Connect their list with ours

Ask the question of why or how these characteristics are important or why they need to be acknowledged

Try to help them understand that these are environmental factors about corrections

“The following are seven characteristics that make suicides in our institutions more likely.”

“so lets ask the question; Why do you need to understand these characteristics?”

Authoritarian Environment

Persons not use to a regimented environment can encounter traumatic difficulty in a prison setting



Take time to explain what this looks like in corrections.

“Imagine going from a place where you generally make decisions on what you want to do and where you want to go and then suddenly finding yourself in a place where someone else makes all your decisions for you. You are in jail and they tell you when to eat and when to sleep. Someone is always giving you orders. What kind of feelings do you think this engenders? (get helplessness) Can you see how this might make a person more prone to suicide or self harm?”

No Apparent Control Over the Future

Many inmates experience a feeling of helplessness and hopelessness. They feel powerless and overwhelmed.



Take time to explain what this looks like in corrections.

As you can see, this feeling of helplessness can make an inmate feel like they have no control over what might happen in their future. The inmate might ask “I’m going to be here for years, how am I going to survive this? Do I want to?”

Isolation from Family, Friends, and Community



Support from family and friends may seem far away, especially with restricted visiting and telephone privileges.

Take time to explain what this looks like in corrections.

An inmate finds themselves in a cell with no way to see, call or touch family or friends. They are cut off from the community that use to support them through times of trouble. Even when they do get contact, it's restricted. An inmate will have to get strip searched to have a visit, their phone calls are recorded and they can only write so many letters a week. What if they can't write?

Ask yourself this question; Could I get through hard times and fear alone and with no apparent help? How could this make me feel?

The Shame of Incarceration



Feelings of shame (often found in misdemeanants) are often inversely proportionate to the gravity of the offenses committed.

Frequently, such feelings develop in those persons who have never been arrested before or who have a limited arrest history.

Take time to explain what this looks like in corrections.

What about shame? The inmate might say “I’ve never been in this kind of trouble before; “What will my friends and family think of me?” The inmate might say “They would be better off without me.”

If I was a person of some importance and I killed or sexually assaulted someone, how great a loss of stature might I feel? What kind of embarrassment could I feel?

It is important to realize that often the shame can come from what we think of as a small thing, but to the inmate that is incarcerated it could be huge.

Dehumanizing Aspects of Incarceration

Confinement in even the best of jails is dehumanizing.



Lack of privacy, association with acting-out individuals, inability to make your own choices, and strange noises and odors can all have a devastating effect.

Many facilities are old and overcrowding can create stress.

Take time to explain what this looks like in corrections.

What things about jails could be dehumanizing? Have you ever had to take your clothing off for someone to search you? Have you had to live in a small room with two or three other people for long periods of time? The inmate might say "I can't even go to the bathroom here without someone checking up on me." What kind of feelings would you have if you had to live like this for years?

Fears

Fears based on stereotypes of jails seen on television and in movies and stories carried by various media heighten anxieties on the part of some individuals.

The anxieties could be about other inmates and sometimes, about staff.



Take time to explain what this looks like in corrections.

Lets talk about fear. What kind of things might I be afraid of in Jail? (get assault, rape, other inmates stealing from me) Some of these fears may be real but some may be heightened by what I perceive jail is like from television or the movies. Think about your own fears. Now imagine a person in jail for the first time.

Staff Insensitivity to the Arrest and Incarceration Phenomenon

Think!

Do I care what happens to this person?

It's just another Inmate with all the same problems.

Take time to explain what this looks like in corrections.

Most, if not all persons working in the criminal justice field have never personally experienced the trauma of arrest and incarceration. Experience has shown that, in many instances, the longer people work in the criminal justice field, the more insensitive they can become to the emotional effects of arrest and incarceration. This is particularly true for the first time arrestee.

This is considered one of the factors, which influences suicides in jails and prisons. Staff often overlook signs and symptoms because of their own insensitive attitudes and thinking.

A officer might say "If I have to listen to one more inmate complain about why their life is so messed up I could just scream. These guys need to toughen up and deal with their problems like an adult."

Is there any problem with that kind of attitude?

Signs and symptoms of a possible suicide

- Current depression or paranoia
- Expresses or evidence of strong guilt or shame over offense
- Talks about or threatens suicide
- Under influence of alcohol/drugs
- Staff knowledge of previous suicide attempts or history of mental illness



Connect their list with ours

Don't just list, have the class describe what each of these signs and symptoms might look like

“There are many signs and symptoms of a possibly suicidal inmate; the following is a list that a possible suicidal individual might display before attempting to try to take their own life.”

Current depression or paranoia

Have class connect back to the mental health training.

Expresses or evidence of strong guilt or shame over offense

Ask the class what this might sound like?

Talks about or threatens suicide

Often a person will talk about or threaten suicide many times before he/she makes the actual attempt.

Under influence of alcohol/drugs

Ask the question; What kind of decision does a person make when under the influence of alcohol or drugs?

Staff knowledge of previous suicide attempts or history of mental illness

Often we know these guys, if they tried it in the past, they are likely to try it again in the future.

Signs and symptoms of a possible suicide

- Severe agitation or aggressiveness
- Projects hopelessness or helplessness or no sense of future
- Expresses unusual or great concern over what will happen to them
- Noticeable mood and/or behavior changes
- Acts very calm once decision is made to kill self



Connect their list with ours

Don't just list, have the class describe what each of these signs and symptoms might look like

Other signs might be:

Severe agitation or aggressiveness

Think of a time of frustration; a moment when you don't feel like you have any control. You rage against your helplessness until you can find a way through the situation. Sometimes the perceived solution is not what we would come up with if we were able to think clearly.

Projects hopelessness or helplessness or no sense of future

Often times a person who is suicidal will simply give up. There is no future and no reason to care what is going to happen later.

Expresses unusual or great concern over what will happen to them

Sometimes the person can't get over what happened to them and they will just obsess over a situation that they can not change or fix.

Noticeable mood and/or behavior changes

A suicidal person can have large swings in mood or behavior. They may seem calm at one moment and rage a moment later.

Acts very calm once decision is made to kill self.

One thing to be very aware of is that a suicidal person can become very calm once they have made the decision to kill themselves.

Signs and symptoms of a possible suicide

- Speaks unrealistically about getting out of jail
- Has increased difficulty relating to others
- Does not effectively deal with present/preoccupied with past
- Begins packing belongings
- Starts giving away possessions
- May try to hurt self
- Paranoid delusions or hallucinations



Connect their list with ours

Don't just list, have the class describe what each of these signs and symptoms might look like

Other signs might be:

Speaks unrealistically about getting out of jail

If the person is talking about leaving soon and there is no way that they are going any where, you need to be concerned.

Has increased difficulty relating to others

Sometimes a suicidal person is so rapped up in themselves that they have a hard time relating to others around them.

Does not effectively deal with present/preoccupied with past

Another sign is their inability to deal with present problems. Often they are stuck in the past.

Begins packing belongings

Sometimes the person starts to pack and clean up their space. They don't want to inconvenience others with taking care of their affairs.

Starts giving away possessions

A suicidal person may give away possessions. They are not going to need them where they think they are going.

May try to hurt self

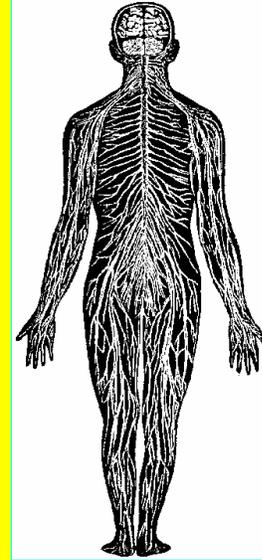
Sometimes a person will start their suicide attempt by building up to it. They may make practice cuts or try to hurt themselves in other ways, getting ready to work their nerve up to kill themselves.

Paranoid delusions or hallucinations

Sometimes a suicidal person hears or sees things that are not there. These delusions may convince them of the need to hurt themselves.

Depression is the single best indicator of potential suicides. Approximately 70 to 80% of all suicides are committed by persons who are severely depressed.

- Feeling of inability to go on, hopelessness, or helplessness
- Extreme sadness and crying
- Withdrawal or silence
- Loss or increase of appetite and/or weight
- Pessimistic attitudes about the future.
- Insomnia or awakening early, or excessive sleeping
- Mood and/or behavior variations



There is a strong connection between persons suffering from depression and suicidal behavior. Some of the signs of a suicidal person are also signs of possible depression and vice-versa.

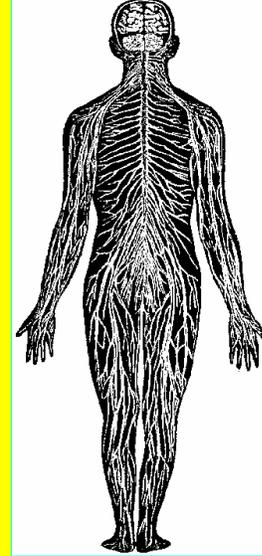
Review symptoms of depression. Connect back to mental health training.

Make the point that as correctional officers we must be aware the connection between depression and suicide.

“Signs of depress and signs of suicide idealization overlap”

Depression is the single best indicator of potential suicides. Approximately 70 to 80% of all suicides are committed by persons who are severely depressed.

- Tenseness
- Lethargy – slowing of movements or non-reactive
- Loss of self-esteem
- Loss of interest in people, appearance, or activities
- Excessive self-blaming
- Strong guilt feelings
- Difficulty concentrating or thinking



Continue from last slide

Agitation Frequently Precedes Suicide



- High level of tension
- Extreme anxiety
- Strong emotions
 - Guilt
 - Rage
 - Wish for revenge

This is important. Strong emotions and high levels of anxiety can often be a warning of a possible suicide attempt

Make the point that before a suicide attempt, we could see the person act out in frustration and rage.

When this behavior stops often we will see the person make an attempt

This is one reason that rapid changes in behavior are so important to pay attention to.

Times of Increased Suicide Risk



- The first 24 hours of confinement
- Intoxication/withdrawal
- Waiting for trial
- Sentencing
- Impending release
- Holidays or anniversaries
- Darkness
- Decreased staff supervision
- Bad news of any kind
- The first 30 days after incarceration or movement into a new facility

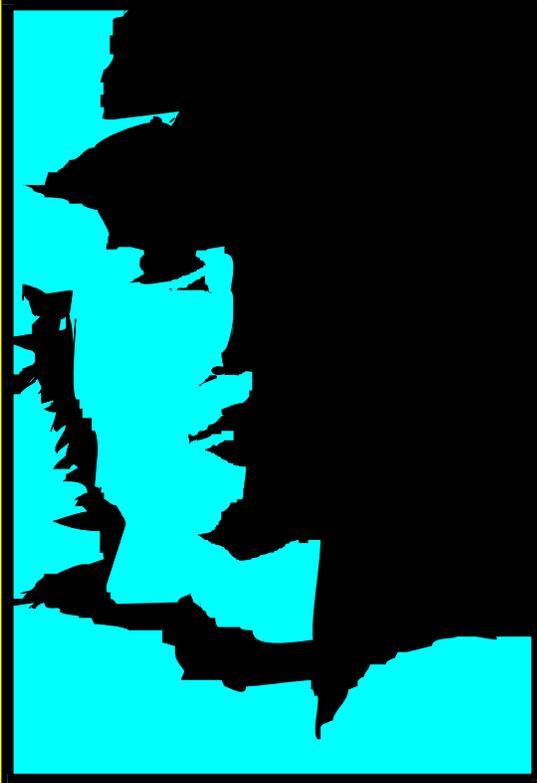
Connect their list with ours

“The following list is of time periods during incarceration that we know an inmate is more likely to try to commit suicide. This means that we need to increase our vigilantes around these time periods when we identify them.”

Ask class why each of these times is a risk

They need to understand that these are moments of risk. Make the point that we are aware of these high risk times and have to be vigilant to watch for possible suicide attempts.

Events that might Trigger a Possible Suicide



Connect their list with ours

It is also possible that an event could be the trigger of a suicide attempt. When we see these kinds of events happen we need to raise our awareness and pay attention.

Recent Excessive Drinking and/or Use of Drugs



I make great decisions when I have a couple of drinks.

Hic!

Give examples from your experience if possible

Ask what kind of feelings, moods and thoughts this event might cause that could lead to a suicide attempt.

- Recent excessive drinking and/or Use of drugs.
 - In many instances, when intoxicated persons sober up, depression sets in. However, a number of persons with blood alcohol levels in excess of the legal limit commit suicide while still intoxicated. For some, even a small amount of alcohol or drugs can have a depressing effect, influencing suicidal behavior.



Give examples from your experience if possible

Ask what kind of feelings, moods and thoughts this event might cause that could lead to a suicide attempt.

- Recent loss of stabilizing resources
 - Any of the following can influence suicidal behavior
 - Loss of Spouse/loved one (for juveniles this could be a peer who is missed more than a parent)
 - Job, expulsion from school
 - Loss of home or Farm
 - Loss of finances

Sever Guilt or Shame over the Offense



O' why did I do that!
I just don't deserve to live.

Give examples from your experience if possible

Ask what kind of feelings, moods and thoughts this event might cause that could lead to a suicide attempt.

- Severe guilt or shame over the offense

- While some inmates involved in serious crimes commit suicide, most that take their own lives are charged with minor offenses or civil violations. For most suicidal inmates, the guilt or shame may well be inversely proportionate to the seriousness of the offense. A person of high status in the community who commit shameful crimes (child molestation, or sexual assault) may need close attention

Same-Sex Rape or Threat of It

I would rather be dead
then to do that!!!!



Give examples from your experience if possible

Ask what kind of feelings, moods and thoughts this event might cause that could lead to a suicide attempt.

- Same-sex rape or threat of it
 - In interviews with inmates who were prevented from committing suicide, many of them said that they had been raped or leaned on heavily for sexual favors.

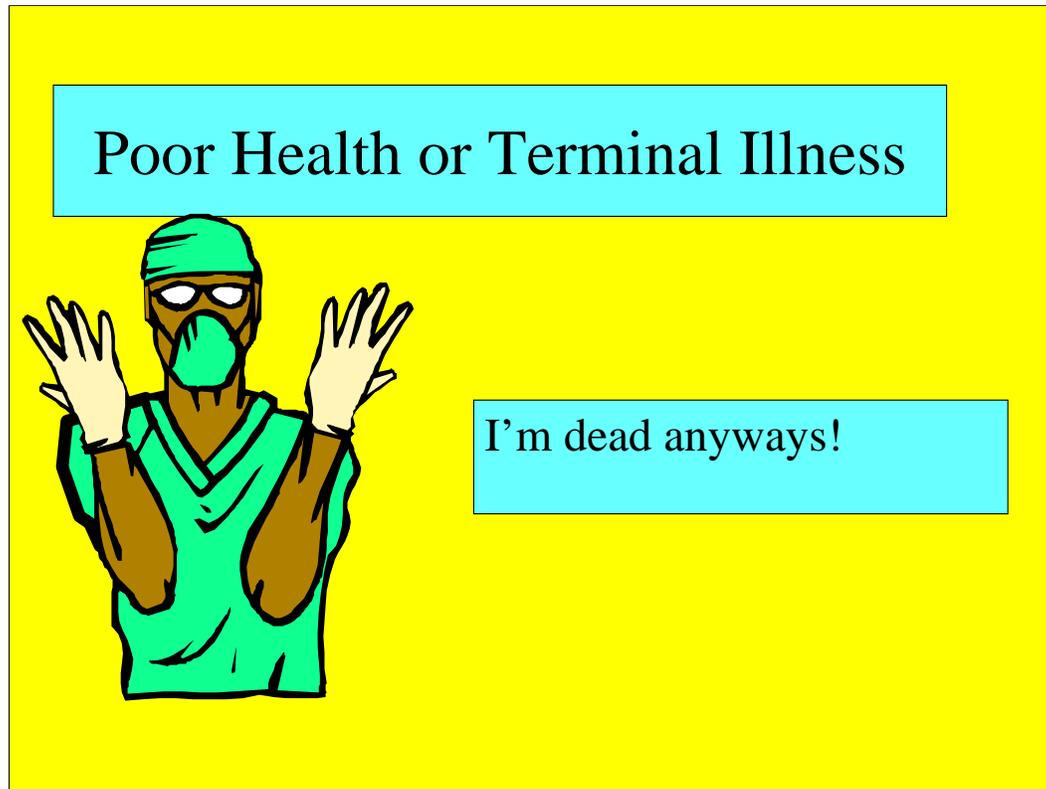


Give examples from your experience if possible

Ask what kind of feelings, moods and thoughts this event might cause that could lead to a suicide attempt.

- Current Mental Illness

- Persons who are depressed or suffering from delusions/hallucinations (have voices telling them what to do) are prime subjects for suicide



Give examples from your experience if possible

Ask what kind of feelings, moods and thoughts this event might cause that could lead to a suicide attempt.

- Poor health or terminal illness

- Any person suffering from serious illness (aids, cancer, etc) can be at risk for suicide

Approaching an emotional breaking point

I just can't do it anymore.

That was the last straw!!



Give examples from your experience if possible

Ask what kind of feelings, moods and thoughts this event might cause that could lead to a suicide attempt.

- Approaching an emotional breaking point

- Each of us has our own breaking point that we can no longer deal with stress. This point can be influenced by the duration, time and situation of the stress we are under.

DEALING WITH INMATE SELF-INJURIOUS BEHAVIOR

Lecture

So, when an inmate self-harms, or threatens to do so, the response that is most helpful to the inmate in the long run is to make him safe, apply an appropriate level of precaution, and bring the episode to a close promptly and without drama.

It is very natural to want to bargain, comfort, or even just to watch, but all of these types of attention may just end up rewarding and reinforcing the self-injurious behavior.

This makes the behavior more likely to happen again.

Being neutral, brief, and unrewarding will take some getting used to, because it goes against some of our natural instincts, and a lot of our habits.

But it will be worth it in the long run for us and for the inmates.

Check for understanding

DEALING WITH INMATE SELF- INJURIOUS BEHAVIOR

Looking at the section on DEALING WITH INMATE SELF-INJURIOUS BEHAVIOR in your Manual,

What kind of challenges as a correctional officer do you need to overcome to be effective in dealing with this behavior?

Let the class develop the discussion.

Make the point that you must always work from the level of a professional demeanor. That professionalism is a key to being successful at handling these difficult situation.

INTERVENTION OF A POSSIBLY SUICIDAL INMATE

- INS screening;
- Notification of Shift Supervisor, case work staff, and health care staff of observed behaviors;
- Special observation log;
- Counseling; and
- Suicide watches.

Intervention of a suicide is possible when you are aware of the signs and symptoms, are vigilant during times of greatest risk, and are paying attention to events that can trigger a suicides attempt.

The earlier staff can identify at-risk inmates, the earlier we can apply the most suitable intervention and reduce the risk of losing a life.

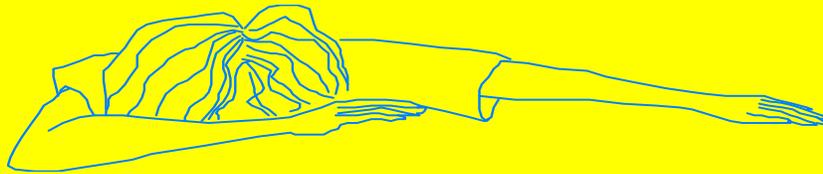
These interventions may include:

- INS screening;
- Notification of Shift Supervisor, case work staff, and health care staff of observed behaviors;
- Special observation log;
- Counseling; and
- Suicide watches.

The earlier you can intervene and provide the inmate with care, the less likely we will have to resort to more drastic measures of restraint to keep the individual from trying to hurt themselves or others.

5 Key Steps To Intervening In An Active Suicide Attempt

- 1. Report an active suicide immediately**
- 2. Check the scene for safety**
- 3. Administer immediate life saving actions**
- 4. Secure the scene**
- 5. Write your report**



There are 5 key steps to intervening in an active suicide attempt.

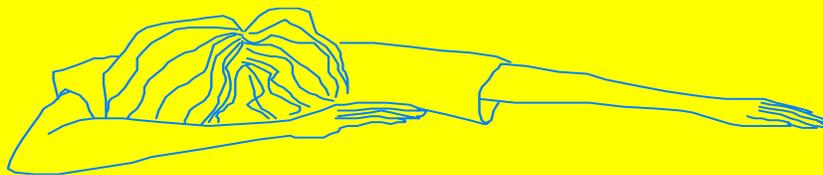
They are:

1. Report an active suicide immediately
2. Check the scene for safety
3. Administer immediate life saving actions
4. Secure the scene
5. Write your report

Now lets go into them in more detail.

5 Key Steps To Intervening In An Active Suicide Attempt

***One:* The call for help**



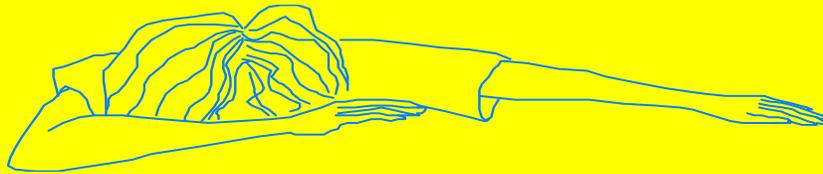
Talk about how this would work in the field sites as well as in the facilities

Give a 10/33 on your radio or phone if radio is not available,
give the location of attempt,
Type of suicide attempt,
your need for medical assistance,
and request any special equipment that you know you will need.

5 Key Steps To Intervening In An Active Suicide Attempt

***Two:* In checking the scene you must:**

- **Check for a “set up”;**
- **Look for items that could be used as weapon (e.g., razor blade);**
- **Move all persons that are not actively giving life saving actions away from scene;**
- **Use universal precautions (e.g., gloves, goggles, CPR mask);**



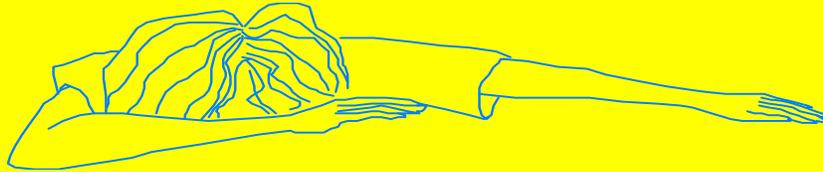
Talk about how this would work in the field sites as well as in the facilities

This is about staff safety. You must take all reasonable precautions to protect yourself and others from possible assault and blood borne pathogens.

5 Key Steps To Intervening In An Active Suicide Attempt

Three: In administering immediate life saving actions.

- You must start to take action to save the inmates life as soon as possible.
- Do not presume that an inmate is dead, appropriate life-saving measures will be initiated and continued until relieved by a qualified health care professional.
- Housing units will contain various emergency equipment, to include a first aid kit, pocket mask, face shield and rescue tool (to quickly cut through fibrous material.)
- You might have to use force to stop the inmate from doing harm to themselves.



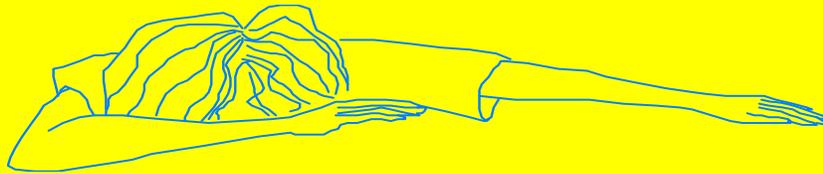
Talk about how this would work in the field sites as well as in the facilities

This will differ depending on the type of suicide attempt and how cooperative the inmate is to receiving help.

Show examples of Rescue equipment and demonstrate how you would use a cut down tool

5 Key Steps To Intervening In An Active Suicide Attempt

Four: Securing the scene:



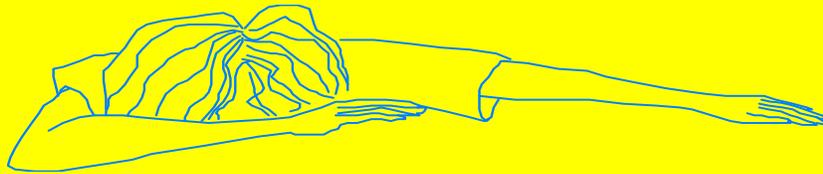
Talk about how this would work in the field sites as well as in the facilities

Secure site as soon as is possible after giving life sustaining actions.

If the suicide is completed the incident scene will be treated as a crime scene until determined otherwise by AHS investigators or released by law enforcement authorities.

5 Key Steps To Intervening In An Active Suicide Attempt

Five: Write your Report:



Talk about how this would work in the field sites as well as in the facilities

You are required to write an incident report as soon as possible about what you saw, heard, and did.

You will submit this report to your Shift Supervisor by the end of your shift before you leave to go home.

Staff Responsibility and Reporting Issues

- You must take all reports of possible suicide seriously.
- Self-mutilation to manipulate can go too far and inmates can kill themselves by accident.
- You are required to report any suicidal behavior to your chain of command.
- Only mental health providers can determine if an individual is suicidal or not.
- You are responsible to keep the inmates that are in your care safe.



All active suicides will be called in as an emergency 10/33.

If you hear an inmate talking about suicide, have an inmate tell you that someone is considering suicide, or you recognizes any of the signs and symptoms or triggering events that could lead to a possible suicide, you are required to report this information to the on-duty shift supervisor.

You must take all reports of a possible suicide seriously. Even an individual that is using self-mutilation to attempting to manipulate staff can often go too far and kill themselves.

So you are required to report any suicidal behavior through their chain of command.

It is only mental healthcare providers can formally determine whether an individual is suicidal or not.

But as Correctional officers are responsible for the safety of the inmates in your care.

Suicide Response Activity

Group activities

Break the class into 3 groups, using the immediate Actions steps for active suicides, have each group create and then act out a scenario where they demonstrate all key steps listed for, suicide attempted by Hanging, cutting and Poison/overdose. Give about 5 minutes for planning, give feed back on what they do right and what can be done better.

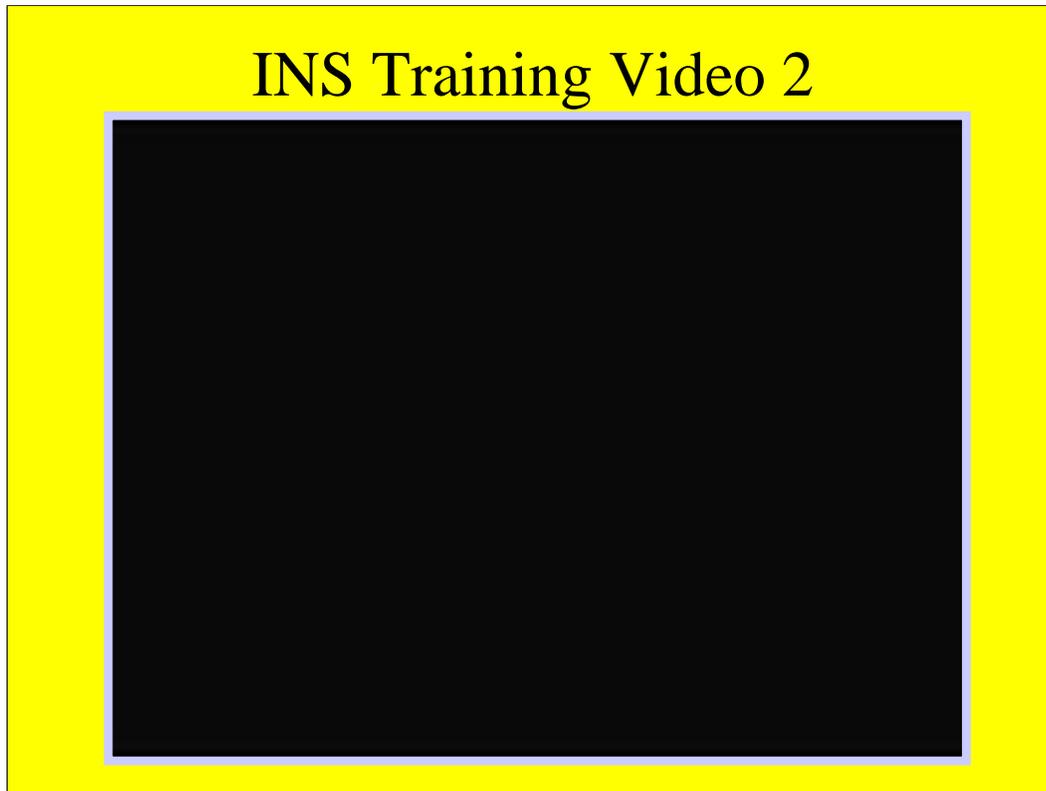
INS Training Video 1



Distribute INS Sheets to class

Explain how they are scored and then have the class follow the interview and score it.

Go over each question with the class. Talk about why they scored the questions as they did.



Repeat the process from the previous slide again

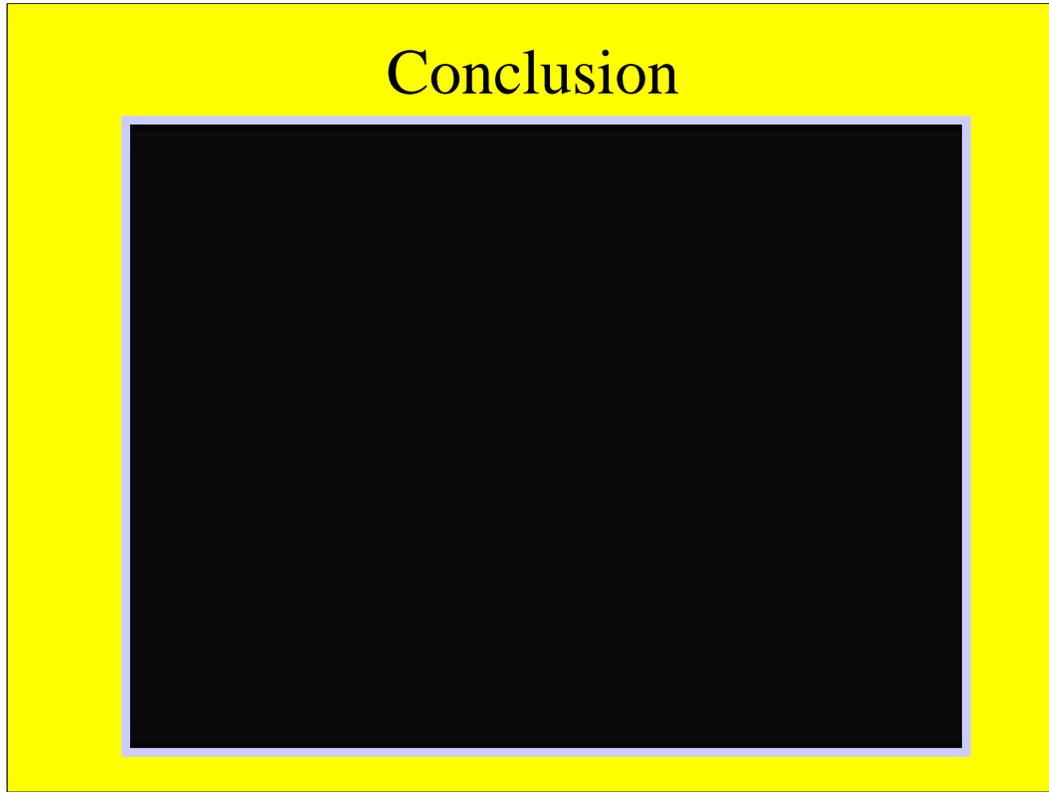
Special Observation Monitoring Sheets

Large Group activity

Have each participant find their copy of the Special Observation Monitoring sheet in their manual.

Have them fill one out as they follow along with you on the screen

CLOSURE EVALUATION



Make the point after playing this video that their attitude makes all the differences

Sources

Prison suicide: An overview and guide to prevention
US Department of Justice
National Institute of Corrections

Preventing Suicide: a resource for prison officers
Mental and Behavioral Disorders
Department of Mental Health
World Health Organization

Training Curriculum on suicide detection and prevention in jails and lockups
Joseph R. Rowan
Lindsay M Hayes

The web site : www.Suicidology.org
American Association for Suicidology

A statistical Review of incident Reports documented as attempted suicides within the Vermont department of Corrections during the period between January 1, 2003 and February 20, 2004
Thomas A. Powell, Ph.D.
John C. Holt, Ph.D.

The Web site: <http://66.165.94.98/>
National Center on Institutions and Alternatives (NCIA)

Investigative Report into the Deaths of seven Vermont inmates and related issues
Michael Marks, Esq.
Philip McLaughlin, Esq.

Show source material slide and tell where students can get more information on Suicide Prevention

**AGENCY OF HUMAN SERVICES
VERMONT DEPARTMENT OF CORRECTIONS**
Lesson Plan

Course Title	Suicide Prevention
Lesson Title	Suicide Stipend Delivery
Instructor (s)	
Prepared By	Ross T. Farnsworth
Date	December 8, 2008

<p>Time Frame: Total 2hr., 0 min. Suggested Schedule: Day: Times:</p>	<p>Target Population: Number of Participants: 12-20 Space Requirements/Room Setup: One room with video and flip charts. Tables in U or round</p>
<p>Performance Objectives: By the end of this Session participants will be able to:</p> <ul style="list-style-type: none">•Participate in a class discussion about Suicide prevention and intervention•Discuss the signs and symptoms, risk factors, time of increased risk, triggering events that staff have to be aware of•Develop a list of reasons corrections staff often has that leads to them becoming desensitized to the suicidal behaviors that inmates display•Discuss the impact of an inmate suicide on the Vermont department of corrections and to the culture of your local work site(s)•Review their local response plans for inmates attempting suicide by cutting, hanging or poison/overdose	<p>Evaluation Procedures: (How will objectives be evaluated)</p>

Methods/Techniques:	
Instructor Materials:	References:
Equipment and Supplies Needed:	X Video Player (VCR/DVD)
X Flip Chart & Stands	Type: VHS (DVD) Other
Chalkboard	Videotape recorder with camera
Slide Projector	TV (s) 23" 27" 33" (Indicate size and quantity)
Screen	X LCD Projector
X Flip Chart Pad Number Needed	Laptop or Desktop Computer & cables
Felt-tip Markers Different Colors	Overhead Projector
X Masking Tape (size 1/2") Rolls Needed	
Other Items:	

Student Materials (Handouts)			
Suicide in America			
Signs and symptoms handout			
<u>Title</u>	<u># Needed</u>	<u>When Distributed</u>	<u>Comments</u>
<i>Copyright clearances will need to be obtained, unless otherwise indicated.</i>			

ANTICIPATORY SET

VT DEPT. OF CORRECTIONS



SUICIDE PREVENTION

Title Slide

Trainer Introductions,

Include how you got involved with Suicide Preventions

Small Group Exercise

Are we desensitized to Suicidal Behaviors

Need Flip chart paper, markers, and tape.

Break the Class into 2 or 3 small groups

Hand out a piece of flipchart paper and a marker to each group

Have each group brain storm a list about;

Reasons that corrections staff become desensitized to the suicidal behaviors that an inmate may display.

Then have each group come up with strategies that can help staff maintain their awareness about suicide risk for inmates.

INSTRUCTIONAL INPUT

PERFORMANCE OBJECTIVES

By the end of this Training, Students will be able to,

- Participate in a class discussion about Suicide prevention and intervention.
- Discuss the signs and symptoms, risk factors, time of increased risk, triggering events that staff have to be aware of.
- Develop a list of reasons corrections staff often has that leads to them becoming desensitized to the suicidal behaviors that inmates display.
- Discuss the impact of an inmate suicide on the Vermont department of corrections and to the culture of your local work site(s).
- Review their local response plans for inmates attempting suicide by cutting, hanging or poison/overdose.

Cover performance objectives with class

Review of suicide risk

Hand out Signs and Symptoms

Hand out the signs and symptoms handout.

Review the hand out with the group.

Ask about some of the signs or risk factors they have observed working in correction.

Talk about any recent suicide attempts or situation that have happened recently at your work site.

Guided Practice

Video Activity

INS Review

Handout and Review the INS Sheet with the Class

Play the INS video and have the class score the sheets as they believe they should be answered.

Review the answers as a group.

Discuss why they answered as they did.

Lead a discussion about what signs or symptoms, triggering events, or times of risk they saw on the video

Ask the question, what can you do to reduce the risk of suicide that was shown in the video scenario.

Suicide Response Activity

Local response drill

Hand out the Immediate action steps list for Hanging, Cutting, and Poisoning/Overdoes. Have class review as a table top exercise their local response for each of these activities. Have available as their local cut down tools and an example of a Suicide response kit at their worksite.

Start slow and use these sheet to plan on full scale emergency drills with multiple players.

CLOSURE EVALUATION

Group leded Discussion

Important learning

End class by leading a discussion about what they thought was the most important thing they learned about suicide prevention during this training.

Then ask the question,

How will you bring what you learned back to the job?

Review Performance objectives

Handout Class Evaluation

Direct them to the online manual and test that they need to complete for certification.



Suicide Prevention

Tests

December 15-18, 2008

Suicide Prevention Test

1) True or False

All inmates that are possible suicide risks should be placed in restraints and put in an isolation cell to keep them from hurting themselves and others.

2) True or False

Inmates are at a greater risk of suicide for the first 30 days after they transfer to a new facility.

3) You need to secure the site of a suicide:

- a. As quickly as possible
- b. When the investigator arrives
- c. As soon as possible after giving life sustaining actions
- d. Once the body is removed

4) True or False

When staff is insensitive to the problems that an inmate is having with being arrested or incarcerated we increase the possibility of inmate suicide.

5) Name 3 characteristics about Jails and Prisons that make them prone to inmate suicides.

a. _____

b. _____

c. _____

6) True or False

Most suicides happen during the hours of daylight.

7) True or False

Force may be necessary to stop someone from committing suicide.

8) There are 5 steps to responding to a Suicide Attempt, name them.

a. _____

b. _____

c. _____

d. _____

e. _____

9) What must you do immediately after completing an INS interview if you check off any box that contains an *.

a. _____

10) What must you ask the transporting officer before he or she leaves in order to begin an INS Interview

a. _____

11) True or False

You must always wait for at least one other staff member to arrive before you can begin to perform life saving actions.

Suicide Prevention

Written Test

12) An INS is:

- a. A mental health screening
- b. A suicide screening
- c. Administered to all new intakes
- d. Administered to all transfers
- e. All of the above

13) Depression is the single best indicator of potential suicides. Approximately 70 to 80% of all suicides are committed by persons who are severely depressed. Please list 5 symptoms of depression.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

14) True or False

The inmate may act very calm once the decision to kill themselves has been made.

15) Jen's behavior has changed; she stays in her room all day and doesn't want to talk to anyone at all. She is:

- a. Acting out because she doesn't like jail
- b. Showing signs of possible depression
- c. Just afraid of the other inmates



Suicide Prevention

Stipend Handout

December 15-18, 2008

Suicide Prevention

Signs and symptoms of a possible suicide

- Current depression or paranoia
- Expresses or evidences of strong guilt or shame over offense
- Talk about or threatens suicide
- Under influence of alcohol/drugs
- Staff knowledge of previous suicide attempts or history of mental illness
- Severe agitation or aggressiveness
- Projects hopelessness or helplessness or no sense of future
- Expresses unusual or great concern over what will happen to them
- Noticeable mood and/or behavior changes
- Acts very calm once decision is made to kill self
- Speaks unrealistically about getting out of jail
- Has increased difficulty relating to others
- Does not effectively deal with present/preoccupied with past
- Begins packing belongings
- Starts giving away possessions
- May try to hurt self
- Paranoid delusions or hallucinations
- Depression is the single best indicator of potential suicides. Approximately 70 to 80% of all suicides are committed by persons who are severely depressed.
 - Felling of inability to go on, hopelessness, or helplessness
 - Extreme sadness and crying
 - With drawl or silence
 - Loss or increase of appetite and/or weight
 - Pessimistic attitudes about the future.
 - Insomnia or awakening early, or excessive sleeping
 - Mood and/or behavior variations
 - Tenseness
 - Lethargy – slowing of movements or non-reactive
 - Loss of self-esteem
 - Loss of interest in people, appearance, or activities
 - Excessive self-blaming
 - Strong guilt feelings
 - Difficulty concentrating or thinking
- Agitation frequently precedes suicide
 - High level of tension
 - Extreme anxiety
 - Strong emotions
 - Guilt
 - Rage
 - Wish for revenge

Suicide Prevention

Characteristics of the Prison Environment that make it prone to suicide

- Authoritarian environment
- No apparent control over the future
- Isolation from family, friends, and community
- The shame of incarceration
- Dehumanizing aspects of incarceration
- Fears
- Staff insensitivity to the arrest and incarceration phenomenon

Times of increased suicide Risk

- The first 24 hours of confinement
- Intoxication/withdrawal
- Waiting for trial
- Sentencing
- Impending release
- Holidays
- Darkness
- Decreased staff supervision
- Bad news of any kind
- The first 30 days after incarnation or movement into a new facility

Events that could trigger a possible suicide

- Recent excessive drinking and/or Use of drugs
- Recent loss of stabilizing resources
- Sever guild of shame over the offense
- Same-sex rape or threat of it
- Current Mental Illness
- Poor health or terminal illness
- Approaching an emotional breaking point



Suicide Prevention

Initial Needs Survey
Special Observation
Monitoring Sheets

December 15-18, 2008

INITIAL NEEDS SURVEY (INS)

Revised 11/05

Facility _____

Screening Officer (PRINT NAME) _____

DATE _____

Inmate Name _____

DOB _____

(SIGNATURE) _____

TIME _____

				Yes	No
1	Ask the transporting officer, "Do you believe the inmate may be a suicide risk?"			*	
2	"_____, is this your first arrest?"				
3	"Is there anyone who would visit you while you are held at this facility, post bail for you, or accept a collect call from you?"				
4	"Have you lost your job in the last six months?"	Y	N		
	"Has your marriage or relationship broken up in the last six months?"	Y	N		
	"Has a relative or close friend died in the last six months?"	Y	N		
5	"Do you have any serious money problems?"				
	"Do you have any serious problems with your spouse, girl/boyfriend, or members of your family?"				
	"Do you or anyone close to you have serious medical problems?"				
	"Do you fear losing your job?"				
6	"Has anyone in your family or anyone close to you ever committed suicide?"				
7	"Have you ever been admitted to a mental hospital?"				
	"Are you taking any medication for your nerves which was prescribed to you by a doctor?"				
	"Have you been to a mental health agency or a private counselor in the last six months?"				
8	"Have you ever gotten a DWI or DUI?"				
	"Have you ever received treatment or counseling for drug or alcohol problems?"				
	"Have drugs or alcohol ever caused problems for you such as losing your job, or fights with girl/boyfriend or spouse?"				
	"Has anyone ever been upset by or complained about your alcohol or drug use?"				
9	"Do you have any thoughts about hurting or killing yourself?"			*	
10	"Have you ever attempted to take your own life?"			*	
11	"Do you feel there is anything to look forward to?"				*
12	"Do you have any drugs in your system that were not prescribed by a doctor?"				
13	What is the inmate's BAC? _____ Is his/her BAC above .08%?			*	
14	Is the inmate showing signs of substance abuse or chemical withdrawal (e.g., slurring of speech, unstable gait, strong odor of alcohol, dazed look)?			*	
15	Does the inmate hold a position of respect in the community, or is the charge shocking in nature (e.g., raping a child)?			*	
16	Does the inmate show signs of depression (e.g., crying, "defeated" posture, blank or zombie-like look or repeated sighing)?			*	
17	Does the inmate appear overly anxious, afraid or is raging (e.g., hand wringing, profuse sweating, panting, excessive fidgeting or pacing)?				
18	Does the inmate appear to feel unusually embarrassed or ashamed (e.g., statements like, "I'll never be able to face my boss/family again")?				
19	Is the inmate behaving in a strange manner (e.g., not making sense; hearing, seeing or smelling things that aren't there; disorientation; or extreme withdrawal)?			*	

TOTAL # OF CHECKS IN NON-SHADED YES/NO COLUMNS

INS SCORING & ACTION SHEET (PART 2)

Screening Officer Action

1. For item #1, ask the transporting officer the question listed.
For items #2 through 12, ask the inmate the questions listed.
For items #13 through 19, record your observations.
2. For those items containing multiple questions, circle the appropriate "Y" or "N" for each question. Then, if the inmate responded "Y" to one or more of the items, make a check in the "Yes" box to the right.
3. Add the total number of check marks in the non-shaded Yes/No columns. Enter this figure below. If the total number is 8 or more, contact the Shift Supervisor.

TOTAL SCORE: _____
4. If you checked any of the non-shaded boxes which contained a *, notify the Shift Supervisor immediately. These are critical items for which immediate attention is warranted.
5. If the inmate's BAC is greater than .08%, notify the Shift Supervisor immediately.

Was the Shift Supervisor notified? Yes No

Comments: _____

Upon completion of this form, if there is no indication to contact the Shift Supervisor, please place this form in the designated space in the Booking Office.

Shift Supervisor Action

1. If you are notified by the Screening Officer, complete the following:

2. Supervision or observation instituted:

None _____ Minute Checks Constant Observation

Other (explain) _____

3. Others Notified:

Superintendent: _____

Assistant Superintendent: _____

Casework Supervisor: _____

Facility Nurse/Medical: _____

Mental Health Professional: _____

Shift Supervisor: _____
Print Name

Signature

Date: _____ Time: _____

SPECIAL OBSERVATION MONITORING SHEET

Inmate Name: _____

DOB: _____

Facility: _____

Date: _____

Type of Observation: Suicide Watch Mental Health Physical Health

Start Date:	Start Time:	Cell Location:	Discontinuation Date/Time:
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Observation Conditions	
	CLOSE OBSERVATION - Physical checks at staggered intervals not to exceed every 15 minutes (e.g.: 5, 10, or 12 minutes)
	CONSTANT OBSERVATION – Continuous uninterrupted observation
	Special Accommodations:

Code for Inmate Behavior and Staff Interventions	
A. Quiet	E. Eating
B. Sleeping	F. Threatening Behavior
C. Agitated Behavior	G. Out of Cell Activities
D. Destructive Behavior	H. Other

Time	Codes	Correctional Officer	Time	Codes	Correctional Officer	Time	Codes	Correctional Officer

Shift Supervisor's Signature: _____ Date: _____ Time: _____



Suicide Prevention

Immediate Action Steps

INS Performance

Checklist

December 15-18, 2008

Security Staff's

Suicide Prevention Immediate Action Steps for:

A Suicide Attempted by Hanging

1. Report the suicide attempt of the hanging inmate.
 - a. 10-33, Suicide by hanging, Location, Need Cut down tool, send Medical staff and bring an AED.
2. Check the scene for safety of self and others.
 - a. Take universal precautions, gloves, CPR mask, and any others as situation dictates.
3. If the scene is safe enter cell or area that the inmate is hanging.
4. Lift up on the body to release pressure from around the neck.
 - a. If unable to remove ligature continue to lift inmate until help arrives.
5. Cut Ligature and gently lower inmate to floor.
 - a. Be aware of possible neck injuries.
 - b. Treat the inmate as if they have a possible neck fracture or broken neck.
6. Check for vital signs.
 - a. If no pulse or breathing, start CPR and use the AED
 - b. Continue life saving actions until relieved or until unable to continue because exhaustion or a change in the scene that makes it unsafe for you to continue.
7. Secure scene after inmate is removed
8. Write and submit an incident report

Security Staff's

Suicide Prevention Immediate Action Steps for: *A Suicide Attempt by Cutting*

1. Report the suicide attempt of the hanging inmate.
 - a. 10-33, Suicide Attempt Cutting, threatening to cut, or bleeding, Location, Type of sharp if known, send Medical staff and bring an AED.
2. Check the scene for safety of self and others.
 - a. Take universal precautions, gloves, CPR mask, and any others as situation dictates.
3. Try to communicate with the inmate.
 - a. Ascertain if the inmate is cooperative, combative or unconscious.
4. If cooperative ask inmate to place on the floor, or pass out of the cell the cutting instrument and to put direct pressure on their wound.
 - a. Remember that is they have one sharp; they might have another.
5. If combative, try to start a dialog with the inmate to distract them from cutting and to try to help them calm down.
 - a. Use force if necessary to protect self and others. Maintain a safe distance and wait for assistance to arrive.
 - b. Be aware that you might have to use force to stop them from cutting or hurting them self more.
 - c. When enough staff and equipment is available; staff will apply force to gain control of situation at the direction of the on scene supervisor if the inmate refuses to cooperate and/or they continue to try to harm them selves.
6. If the inmate is unconscious; try to ascertain if it is a set up.
 - a. If safe, secure sharp, check the inmate's vital signs and start giving aid by applying direct pressure to cuts.
 - b. If no pulse or breathing, start CPR and use the AED
 - c. Continue life saving actions until relieved or until unable to continue because exhaustion or a change in the scene that makes it unsafe for you to continue.
7. Secure scene after inmate is removed.
8. Write and submit an incident report.

Security Staff's

Suicide Prevention Immediate Action Steps for:

Suicide Attempted by medication overdose or poisoning

1. Report the suicide attempt of the hanging inmate.
 - a. 10-33, Suicide Attempt Overdose or poisoning, Location, Type of medication or poison if known (this is important so the Control room officer can call the poison control center for instructions on first aid), send Medical staff and bring an AED.
2. Check the scene for safety of self and others.
 - a. Take universal precautions, gloves, CPR mask, and any others as situation dictates.
3. Try to communicate with the inmate.
 - a. Ascertain if the inmate is cooperative, combative or unconscious.
4. If cooperative ask the inmate what they have taken, how much and how long ago.
 - a. Remember that they might have more and could try to ingest them.
5. If combative, try to start a dialog with the inmate to distract them from hurting themselves and to try to help them calm down.
 - a. Use force if necessary to protect self and others. Maintain a safe distance and wait for assistance to arrive.
 - b. Be aware that you might have to use force to stop them from doing more harm to themselves.
 - c. When enough staff and equipment is available; staff will apply force to gain control of situation at the direction of the on scene supervisor if the inmate refuses to cooperate and/or they continue to try to harm them selves.
6. If the inmate is unconscious; try to ascertain if it is a set up.
 - a. If safe, secure medication or poison, check the inmate's vital signs and start giving aid as directed by medical.
 - b. If no pulse or breathing, start CPR and use the AED
 - c. Continue life saving actions until relieved or until unable to continue because exhaustion or a change in the scene that makes it unsafe for you to continue.
7. Secure scene after inmate is removed.
8. Write and submit an incident report.



FTO Module Performance Checklist

Chapter: Prepare Written Reports **Module Title:** Special Observation Monitoring Sheet

Trainee: _____

FTO: _____

PERFORMANCE OBJECTIVE: Following Demonstration by the designated Field Trainer, the trainee will be able to:

Demonstrate filling out 3 Special Observation Monitoring Sheets following the steps listed below.

STEPS:

1. When you assume a work post that has inmates on special observation monitoring for Suicide prevention, you will review all current special observation monitoring sheets to make sure they are filled out correctly and that you know who each individual is. You must do this before the officer you are reliving may hand over and be relieved from the post.
2. When ordered to, you will start a new special observation monitoring sheet or continue one already started that has run out of space.
3. Starting at the top left corner, print the inmate's name, next you will print the inmate's date of birth at the line mark DOB. In the line marked facility put the abbreviation for your work site. The line marked date is for the current date.
4. Next check if the check is for suicide watch, mental health, or physical health
5. The next line has start date and start time. This is the date and time that the inmate was first put on checks. This date is carried over on each continuation of this inmates monitoring.
6. Next print the inmate's cell location
7. The last space is for the date and time that the observations are discontinued. This line is always the late thing that is filled on this sheet.
8. Next check what type of Observation it is, (Constant or Close) and print any special accommodations that this inmate needs.
9. The next line is for the officer's observations:
 - a. Annotate the time the Inmate was checked (using 24 hour time)
 - b. annotate behavior code, (A-H)
 - c. And sign your name and print your initials is your signature is hard to read.
10. Have CFSS/ACFSS sign, date & time Observation sheet prior to the end of their shift.

Reads/Reviews Task Document	FTO Explains & Demonstrates	Trainee Explains as FTO Demonstrates	Trainee Explains & Demonstrates	Trainee Practices	Trainee Performs Successfully (Proficiency Test Completed)
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***I certify that proficiency was demonstrated by the above trainee
Concerning this task on _____ (date)***

X **FTO**

X **Trainee**



Suicide Prevention

Suicide Information

December 15-18, 2008



Facts about Suicide and Depression

FACTS ABOUT SUICIDE

In 2002, suicide was the eleventh leading cause of death in the U.S., claiming 31,655 lives. Suicide rates among youth (ages 15-24) have increased more than 200% in the last fifty years. The suicide rate is highest for the elderly (ages 65+) than for any other age group.

Four times more men than women complete suicide, but three times more women than men attempt suicide.

Suicide occurs across all ethnic, economic, social and age boundaries.

Many suicides are preventable. Most suicidal people desperately want to live; they are just unable to see alternatives to their problems. Most suicidal people give definite warning signals of their suicidal intentions, but those in close contact are often unaware of the significance of these warnings or unsure what to do about them.

Talking about suicide does not cause someone to become suicidal.

Surviving family members not only suffer the loss of a loved one to suicide, but are also themselves at higher risk for suicide and emotional problems.

WHAT IS DEPRESSION?

Major Depressive Disorder (MDD) is the most prevalent mental health disorder. In the U.S., the lifetime risk for MDD is 16.6% according to a recent study (Kessler et al., 2005). According to the National Institute of Mental Health (NIMH), 9.5-% or 18.8 million American adults suffer from a depressive illness in any given year.

The symptoms of depression (listed below) interfere with one's ability to function in all areas of life (work, family, sleep, etc).

Common symptoms of depression, reoccurring almost every day for a period of two weeks or more:

- Depressed mood (e.g. feeling sad or empty)
- Lack of interest in previously enjoyable activities
- Significant weight loss or gain, or decrease or increase in appetite
- Insomnia or hypersomnia
- Agitation, restlessness, irritability
- Fatigue or loss of energy
- Feelings of worthlessness, hopelessness, guilt
- Inability to think or concentrate, or indecisiveness
- Recurrent thoughts of death, recurrent suicidal ideation, suicide attempt or plan for completing suicide

A family history of depression (e.g., a parent) increases the chances (11-fold) that a child in that family will also have depression.

The treatment of depression is effective 60 to 80% of the time. However, according to the World Health Organization (WHO), less than 25% of individuals with depression receive adequate treatment.

Depression often is accompanied by co-morbid (co-occurring) mental disorders (such as alcohol or substance abuse) and, if left untreated, can lead to higher rates of recurrent episodes and higher rates of suicide.

THE LINK BETWEEN DEPRESSION AND SUICIDE

Suicide is the major life-threatening complication of depression.

Major Depressive Disorder (MDD) is the psychiatric diagnosis most commonly associated with completed suicide. Lifetime risk of suicide among patients with untreated MDD is nearly 20% (Gotlib & Hammen, 2002).

About 2/3 of people who complete suicide are depressed at the time of their deaths.

In a study conducted in Finland, of 71 individuals who completed suicide and who had Major Depressive Disorder, only 45% were receiving treatment at the time of death and only a third of these were taking antidepressants (Isometsa et al., 1994).

About 7 out of every 100 men and 1 out of every 100 women who have been diagnosed with depression at some time in their lifetime will go on to complete suicide.

The risk of suicide in people with Major Depressive Disorder is about 20 times that of the general population.

Individuals who have had multiple episodes of depression are at greater risk for suicide than those who have had one episode.

People who have a dependence on alcohol or drugs in addition to being depressed are at greater risk for suicide.

Individuals who are depressed and exhibit the following symptoms are at particular risk for suicide:

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – as if there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, inability to sleep or sleeping all the time
- Dramatic mood changes
- Expressing no reason for living; no sense of purpose in life

TREATMENT

The most commonly used treatments for depression are:

- Pharmacology (i.e. antidepressants)
- Psychotherapy
- Electroconvulsive Therapy (ECT)

The best treatment for depression is the combination of antidepressants and psychotherapy. A meta-analysis of 16 studies (Pampallona et al., 2004) demonstrated the advantages of combined treatment versus pharmaceutical treatment alone. One hypothesis is that therapy increases adherence to the antidepressant treatment.

Treatments are effective 60 to 80% of the time. The Collaborative Depression Study indicates that after a first episode, 70% recovered within 5 years (National Institute of Mental Health).

In summary...

- ❖ Risk benefit ratio clearly resides on the side of treatment as opposed to no treatment for depression.
- ❖ The best treatment is combined pharmacology and psychotherapy.
- ❖ Most suicides in individuals with Major Depressive Disorder are among those who do not receive treatment.
- ❖ We still know too little about those who don't improve despite adequate treatment.
- ❖ More clinical research is needed.

ANTIDEPRESSANTS and SUICIDE RISK

In short-term studies, there has been some evidence that children and adolescents taking antidepressants exhibit a risk of increased suicidal ideation and/or suicidal behaviors (suicidality). Given this, the concern is that antidepressants could potentially lead to completed suicides.

The U.S. Food and Drug Administration (FDA) analyzed 24 trials that included over 4400 patients and concluded that the risk of suicidality in children and adolescents who were prescribed antidepressants was 4%, twice the placebo risk of 2% (www.fda.gov).

As with any new prescription in children and adolescents, careful monitoring of symptoms and side-effects should be observed by an adult. Any changes in symptomatology should be reported to the prescribing physician.

More research is required to determine if antidepressants are related to suicidality in children, adolescents and adults.

FDA 'BLACK BOX' WARNINGS

The Food and Drug Administration (FDA) is now requiring manufacturers of antidepressants to add a 'black box' warning label describing the potential risks of suicidality and the need for close monitoring of anyone prescribed this type of pharmacotherapy.

As well, the FDA developed a Patient Medication Guide (MedGuide), a user-friendly guide intended to educate patients and their caregivers about their prescription.

A joint meeting of the Psychopharmacologic Drugs Advisory Committee and the Pediatric Drugs Advisory Committee in September 2004 analyzed the short-term placebo-controlled trials of nine antidepressant drugs. The results demonstrated "a greater risk of suicidality during the first few months of treatment of those receiving antidepressants, the average risk of such events on drug was 4%, twice the placebo risk of 2%. No suicides occurred in these trials" (www.fda.gov). Based on these findings, the FDA issued the following warnings (the 'black box' warnings) regarding antidepressants:

- Antidepressants increase the risk of suicidal thinking and behavior (suicidality) in children and adolescents with MDD (Major Depressive Disorder) and other psychiatric disorders.
- Anyone considering the use of an antidepressant in a child or adolescent for any clinical use must balance the risk of increased suicidality with the clinical need.
- Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.
- Families and caregivers should be advised to closely observe the patient and to communicate with the prescriber.

All patients being treated with antidepressants should be closely monitored for any changes in symptoms especially at the beginning of treatment or when the dose is adjusted up or down.

For more information on the FDA warnings, please visit their website (<http://www.fda.gov>).

BE AWARE OF FEELINGS, THOUGHTS, AND BEHAVIORS

Nearly everyone at some time in his or her life thinks about suicide. Most everyone decides to live because they come to realize that the crisis they are experiencing is temporary, but death is not. On the other hand, people in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control. Frequently, they:

Can't stop the pain

If you experience any of these feelings, get help!

Can't think clearly

Can't make decisions

If you know someone who exhibits these feelings, offer help!

Can't see any way out

Can't sleep, eat, or work

Can't get out of the depression

Can't make the sadness go away

Can't see the possibility of change

Can't see themselves as worthwhile

Can't get someone's attention

Can't seem to get control

TALK TO SOMEONE -- YOU ARE NOT ALONE. CONTACT:

- A community mental health agency
- A school counselor or psychologist
- A suicide prevention/crisis intervention center
- A private therapist
- A family physician
- A religious/spiritual leader

American Association of Suicidology

The goal of the American Association of Suicidology (AAS) is to understand and prevent suicide. AAS promotes research, public awareness programs, education, and training for professionals, survivors, and all interested persons. AAS serves as a national clearinghouse for information on suicide. AAS has many resources and publications, which are available to its membership and the general public. For membership information, please contact:

*American Association for Suicidology
5221 Wisconsin Avenue
Second Floor
Washington, D.C. 20015
Phone: (202) 237-2280
Fax: (202) 237-2282
Website: www.suicidology.org*

References:

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Websites:

- National Institute of Mental Health (<http://www.nimh.nih.gov/>)
U.S. Food & Drug Administration (<http://www.fda.gov/>)



The Suicide Information and Education Centre (SIEC) is a computer-assisted resource library containing print and audiovisual materials on suicide, suicidal behaviours, and suicide bereavement.

The Suicide Prevention Training Programs (SPTP) provide skill training that increases caregiver competence and confidence while improving community collaboration. SPTP delivers a variety of workshops, including ASIST, a 2-day suicide intervention workshop.

For more information, you can contact us at:

SIEC/SPTP
201, 1615 - 10 Ave. SW
Calgary AB T3C 0J7
Canada

Phone: 403-245-3900
Fax: 403-245-0299
E-mail:
siec@suicideinfo.ca
sptp@suicideinfo.ca

Visit our website:
<http://www.suicideinfo.ca>

Hello,

In this PDF, we provide two versions of the "Suicide Helpcard". You can use these resources as you wish.

You can download "Helping Someone Who May be Suicidal" and use it as a photocopy master. You may want to use this page as a handout for events such as school presentations or public awareness meetings.

You can also download the "Suicide Helpcard". We suggest either:

- Printing this page at a slightly reduced scale to ensure the Helpcard will fit on a 8.5" x 11" sheet, or
- Photocopying at a slightly reduced scale.

You may also want to:

- Stamp your agency name or community crisis line number on the back.
- Photocopy the Helpcard on paper which is a little bit heavier than regular bond.

We hope you will find these resources helpful.

Suicide Information and Education Centre (SIEC)
Suicide Prevention Training Programs (SPTP)

Suicide Affects All of Us. Let's Talk About It.



The Suicide Information and Education Centre (SIEC) is a computer-assisted resource library containing print and audiovisual materials on suicide.

You can find additional suggestions for helping someone you are concerned about at:

<http://www.suicideinfo.ca/support/concerned.htm>

For lists of Canadian, American, and international crisis services, go to:

<http://www.suicideinfo.ca/support/index.htm>

For more information about our prevention resources or ASIST, a 2-day suicide intervention workshop offered by the Suicide Prevention Training Programs (SPTP), please contact us at:

SIEC/SPTP
201, 1615 - 10 Avenue S.W.
Calgary AB T3C 0J7

Phone: (403) 245-3900
Fax: (403) 245-0299
E-Mail: siec@suicideinfo.ca

Visit our website at:
<http://www.suicideinfo.ca>

HELPING SOMEONE WHO MAY BE SUICIDAL

If someone you know:

- threatens suicide
- talks about wanting to die
- shows changes in behaviour, appearance or mood
- abuses drugs and/or alcohol
- deliberately injures themselves
- appears depressed, sad, withdrawn...

You can help:

- stay calm and listen
- let the person talk about their feelings
- be accepting; do not judge
- ask if the person is having suicidal thoughts
- take all threats of suicide seriously
- do not swear secrecy - tell someone

Get help: You can not do it alone

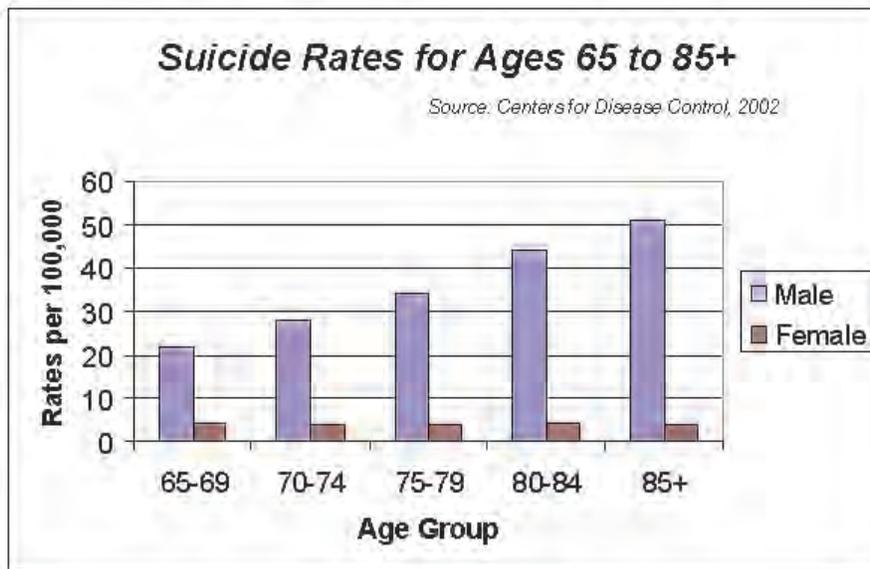
Contact your:

- family, friends, relatives
- clergy, teachers, counsellors
- family doctor
- local or national crisis lines
- mental health services
- hospital emergency department



Elderly¹ Suicide Fact Sheet

- The elderly made up 12.3% of the population; they accounted for almost 17.5% of all suicides.
- The rate of suicide for the elderly for 2002 was 15.6 per 100,000.
- There was one elderly suicide every 95 minutes. There were about 15 elderly suicides each day, resulting in 5,548 suicides in 2002 among those 65 and older.
- Elderly white men were at the highest risk with a rate of approximately 35 suicides per 100,000 each year.
- White men over the age of 85, who are “old-old”, were at the greatest risk of all age-gender-race groups. In 2002, the suicide rate for these men was 51.1 per 100,000. That was 4.6 times the current rate for all ages (11.0 per 100,000).
- 85% of elderly suicides were male; the number of male suicides in late life was 5.5 times greater than for female suicides.



¹ In this fact sheet, elderly refers to persons over the age of 65. Unless otherwise specified, information presented refers to the latest available data (i.e., 2002 data).

- The rate of suicide for women declined after age 60 (after peaking in middle adulthood, ages 45-49).
- The suicide rate for the elderly reached a peak in 1987 at 21.8 per 100,000 people. Since 1987, the rate of elderly suicides has declined 28% (down to 15.6 in 2002). This is the largest decline in suicide rates among the elderly since the 1930's.
- Although older adults attempt suicide less often than those in other age groups, they have a higher completion rate. For all ages combined, there is an estimated 1 suicide for every 25 attempts. Among the young (15-24 years) there is an estimated 1 suicide for every 100-200 attempts. Over the age of 65, there is one estimated suicide for every 4 attempts.
- In 2002, suicide rates ranged from 13.5 per 100,000 among persons aged 65 to 74, to 17.7 per 100,000 persons aged 75 to 84.
- Firearms were the most common means (72%) used for completing suicide among the elderly. Men (79%) use firearms more than twice as often as women (33%).
- Alcohol or substance abuse plays a diminishing role in later life suicides compared to younger suicides.
- One of the leading causes of suicide among the elderly is depression, often undiagnosed and/or untreated.
- The act of completing suicide is rarely preceded by only one cause or one reason. In the elderly, common risk factors include:
 - The recent death of a loved one;
 - Physical illness, uncontrollable pain or the fear of a prolonged illness;
 - Perceived poor health;
 - Social isolation and loneliness;
 - Major changes in social roles (e.g. retirement).

Sources

The information for this fact sheet was gathered from the National Center for Injury Prevention and Control (NCIPC) website (<http://www.cdc.gov/ncipc/wisqars/default.htm>) run by the Center for Disease Control and Prevention (CDC).

American Association of Suicidology

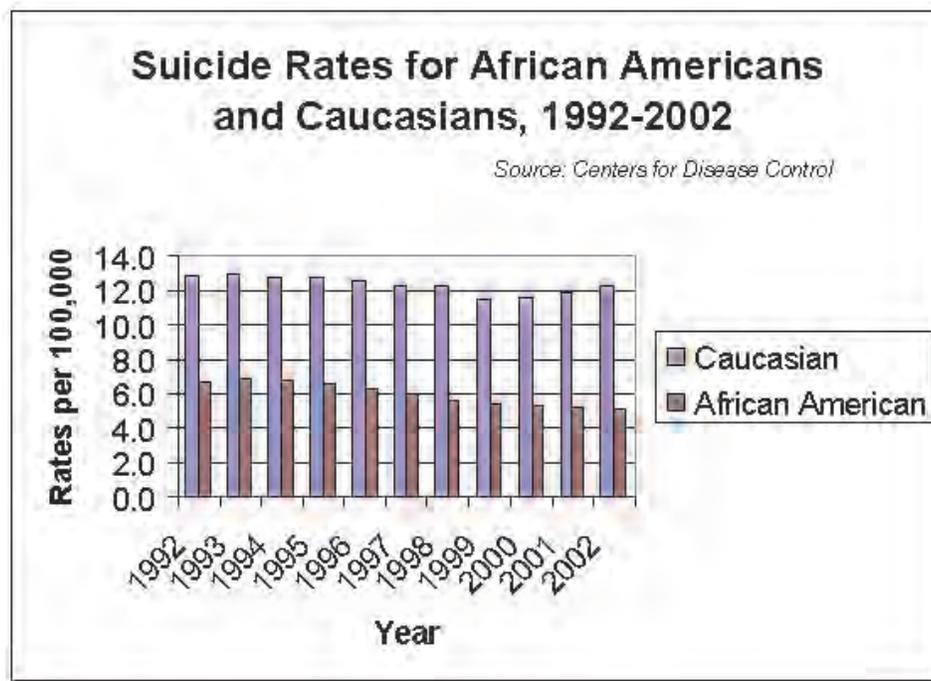
The goal of the American Association of Suicidology (AAS) is to understand and prevent suicide. AAS promotes research, public awareness programs, education, and training for professionals, survivors, and all interested persons. AAS serves as a national clearinghouse for information on suicide. AAS has many resources and publications, which are available to its membership and the general public. For membership information, please contact:

*American Association of Suicidology
5221 Wisconsin Avenue, N. W.
Washington, DC 20015
(202) 237-2280 (202) 237-2282 (Fax)
Email: info@suicidology.org
Website: www.suicidology.org*



African American Suicide Fact Sheet¹

- In 2002, 1,939 African Americans completed suicide in the U.S. Of these, 1,633 (84%) were males (rate of 9.1 per 100,000). The suicide rate for females was 1.6 per 100,000.
- In 2002, there were only 306 African American female suicides. The ratio of African American male to female was 5.34 to 1. The suicide rate among African American females was the lowest of all racial/gender groups.
- As with all racial groups, African American females were more likely than males to attempt suicide and African American males were more likely to complete suicide.
- From 1993 to 2002, the rate of suicide for African Americans (all ages) showed a small but steady decline (from 6.9 in 1993 to 5.2 in 2002). For Caucasians, the rate declined until 1999 (from 13.0 in 1993 to 11.5 in 2009), and then increased slightly since 2000 (see graph below).



- Suicide was the third leading cause of death among African American youth, after homicides and accidents. The suicide rate for young African American youth was 6.5 per 100,000 (n = 403).
- For African American youth², the rate of male suicide (11.3 per 100,000) was 6.6 times higher than that of females (1.7 per 100,000).

In this fact sheet, unless otherwise specified, the information presented refers to the latest available data (i.e., 2002 data).

² The term 'youth' refers to individuals 15 to 24 years of age.

December 7, 2004

- African American youth suicide rates were generally low until the beginning of the 1980's when rates started to increase radically. Between 1981 and 1994, the rate increased 78%. Since then, the rate has decreased 43%, from 11.48 in 1994 to 6.5 in 2002.
- Although Caucasian youth are twice as likely as African American youth to complete suicide, the rate of suicide grew faster in this time period among African American youth than among Caucasian youth.
- From 1981-1994, the suicide rate increased 83% for 15-24 year old African American males and 10% for African American females. Since 1994, the rates for males have decreased 45%.
- Males accounted for 86.5% of African American elderly (65 and older) suicides.
- Firearms were the predominant method of suicide among African Americans regardless of gender and age; among 15 to 24 year olds, 63% of all suicides were by firearm, among 24 to 35 year olds, 54% of all suicides were by firearm, and among those 65 and older, 74% of all suicides were by firearm.

Proportion of African American Suicides by Firearm, 2002

	Both genders	Males	Females
All ages	55%	59%	38%
15-24	63%	67%	40%
25-34	54%	58%	36%
65 and older	74%	79%	38%

Things We Can Do to Help:

- Help remove the stigma and myths that suicide contradicts gender and cultural role expectations:
 - Religious stigma of suicide as the “unforgivable sin”;
 - African American men are macho and do not take their own lives;
 - African American women are always strong and resilient and never crack under pressure.
- Remove barriers to treatment.
- Improve access to mental health treatment.
- Remove stigma associated with mental health treatment.
- Increase awareness in cultural differences in the expression of suicidal behaviors:
 - African American are less likely to use drugs during a suicide crisis;
 - Behavioral component of depression in African Americans is more pronounced;
 - Some African Americans express little suicide intent or depressive symptoms during suicidal crises;
- Develop liaisons with the faith community.
- Recognize warning signs and help a friend or family member get professional help.

Warning Signs of a Suicidal Person:

A suicidal person may:

- Threaten to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself;
- Look for ways to kill him/herself by seeking access to firearms, pills or other means;
- Talk or write about death, dying or suicide when these actions are out of the ordinary for that person;
- Express a sense of hopelessness;
- Experience rage, uncontrolled anger, and seek revenge

- Act reckless or engage in risky behavior and activities, seemingly without thinking;
- Feel trapped, that there's no way out;
- Increase alcohol or drug use;
- Withdraw from friends, family and society;
- Feel anxious, agitated, and experience an increase or decrease in the amount of sleep;• Experience dramatic mood changes;
- Feel that there is no reason to live, that live no longer has a sense of purpose.

If you or someone you know is suicidal,
please contact a mental health professional
or call 1-800-273-TALK (8255).

For More Information:

American Association of Suicidology

www.suicidology.org

National Organization for People for Color Against Suicide

www.nopcas.com

National Center for Injury Prevention and Control

www.cdc.gov/ncipc/wisqars

Sources

The information for this fact sheet was gathered from the National Center for Injury Prevention and Control (NCIPC) website (www.cdc.gov/ncipc/wisqars/default.htm) run by the Center for Disease Control and Prevention (CDC), the National Institute of Mental Health website (www.nimh.nih.gov/) as well as the National Organization for People of Color Against Suicide (NOPCAS) website (www.nopcas.com).

American Association of Suicidology

The goal of the American Association of Suicidology (AAS) is to understand and prevent suicide. AAS promotes research, public awareness programs, education, and training for professional, survivors, and all interested persons. AAS serves as a national clearinghouse for information on suicide. AAS has many resources and publications, which are available to its membership and the general public. For membership information, please contact:

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Website: www.suicidology.org

U.S.A. SUICIDE: 2002 OFFICIAL FINAL DATA

	Number	Per Day	Rate	% of Deaths	Group (Number of Sui.)	Rate
Nation	31,655	86.7	11.0	1.3	White Male (22,328)	19.9
Males	25,409	69.6	17.9	2.1	White Female (5,382)	4.8
Females	6,246	17.1	4.3	0.5	Nonwhite Male (2,344)	9.2
Whites	28,731	78.7	12.2	1.4	Nonwhite Female (568)	2.0
Nonwhites	2,924	8.0	5.5	0.9	Black Male (1,627)	9.1
Blacks	1,939	5.3	5.1	0.7	Black Female (330)	1.5
Elderly (65+ yrs.)	5,548	15.2	15.6	0.3	Hispanic (1850)	5.0
Young (15-24 yrs.)	4,010	11.0	9.9	12.1		

Completions: *Suicide rate increased slightly in both 2002 and 2001 after declines for six consecutive years and a steady 2000 rate.*

- Average of 1 person every 16.6 minutes killed themselves.
- Average of 1 old person every 1 hour 34.7 minutes killed themselves.
- Average of 1 young person every 2 hours 11 minutes killed themselves. (If the 264 suicides below age 15 are included, 1 young person every 2 hours 3 minutes)
- 11th ranking cause of death in U.S. — 3rd for young

Cause	Number	Rate	Ages	Number	Rate
All Causes	33,046	81.4	10-14	260	1.2
1-Accidents	15,412	38.0	15-19	1513	7.4
2-Homicide	5,219	12.9	20-24	2497	12.2
3-Suicide	4,010	9.9			

- 4.1 male deaths by suicide for each female death by suicide.
- Suicide ranks 11th as a cause of death; homicide ranks 14th.

Attempts: (figures are estimates; no official U.S. national data are compiled)

- 790,000 annual attempts in U.S. (using 25:1 ratio)
- 25 attempts for every death by suicide for nation. 100-200:1 for young; 4:1 for elderly.
- 5 million living Americans (estimate) have attempted to kill themselves.
- 3 female attempts for each male attempt.

Survivors: (i.e., family members and friends of a loved one who died by suicide)

- *Each suicide intimately affects at least 6 other people.* (Estimate- Shneidman, 1969, *On the Nature of Suicide*)
- Based on the over 745,000 suicides from 1978 through 2002, estimated that the number of survivors of suicides in the U.S. is 4.47 million (1 of every 64 Americans in 2002); number grew by nearly 190,000 in 2002.
- If there is a suicide every 16.6 minutes, then there are 6 new survivors every 16.6 minutes as well.

Suicide Methods:

Suicide Methods	Number	Rate	Percent of Total
Firearm suicides	17,108	5.9	54.0%
Suffocation/Hanging	6,462	2.2	20.4%
Falls	740	0.3	2.3%
Drowning	368	0.1	1.2%
Poisoning	5,486	1.9	17.3%
Cut/pierce	566	0.2	1.8%
Fire/flame	150	0.1	0.5%
All but Firearms	14,547	5.1	46.0%

Old made up 12.3% of 2002 population but represented 17.5% of the suicides.

Young were 14.1% of 2002 population and comprised 12.7% of the suicides.

U.S.A. Suicide Rates 1993-2002

(Rates per 100,000 population)

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
<u>Age</u>										
5-14	0.9	0.9	0.9	0.8	0.8	0.8	0.6	0.8	0.7	0.6
15-24	13.5	13.8	13.3	12.0	11.4	11.1	10.3	10.4	9.9	9.9
25-34	15.1	15.4	15.4	14.5	14.3	13.8	13.5	12.8	12.8	12.6
35-44	15.1	15.3	15.2	15.5	15.3	15.4	14.4	14.6	14.7	15.3
45-54	14.5	14.4	14.6	14.9	14.7	14.8	14.2	14.6	15.2	15.7
55-64	14.6	13.4	13.3	13.7	13.5	13.1	12.4	12.3	13.1	13.6
65-74	16.3	15.3	15.8	15.0	14.4	14.1	13.6	12.6	13.3	13.5
75-84	22.3	21.3	20.7	20.0	19.3	19.7	18.3	17.7	17.4	17.7
85+	22.8	23.0	21.6	20.2	20.8	21.0	19.2	19.4	17.5	18.0
65+	19.0	18.1	18.1	17.3	16.8	16.9	15.9	15.3	15.3	15.6
Total	12.1	12.0	11.9	11.6	11.4	11.3	10.7	10.7	10.8	11.0
<u>Gender</u>										
Men	19.9	19.8	19.8	19.3	18.7	18.6	17.6	17.5	17.6	17.9
Women	4.6	4.5	4.4	4.4	4.4	4.4	4.1	4.1	4.1	4.3
<u>Race</u>										
White	13.1	12.9	12.9	12.7	12.4	12.4	11.7	11.7	11.9	12.2
Nonwh	7.1	7.2	6.9	6.7	6.5	6.2	6.0	5.9	5.6	5.5
Black	7.0	7.0	6.7	6.5	6.2	5.7	5.6	5.6	5.3	5.1

15 Leading Causes of Death in the U.S.A., 2002

(total of 2,443,387 deaths; 847.3 rate)

Rank	Cause of Death	Rate	Deaths
	Total	847.3	2,443,387
1	Diseases of heart (heart disease)	241.7	696,947
2	Malignant neoplasms (cancer)	193.2	557,271
3	Cerebrovascular diseases (stroke)	56.4	162,672
4	Chronic lower respiratory diseases	43.3	124,816
5	Accidents (unintentional injuries)	37.0	106,742
6	Diabetes mellitus (diabetes)	25.4	73,249
7	Influenza & pneumonia	22.8	65,681
8	Alzheimer's disease	20.4	58,866
9	Nephritis, nephrosis (kidney disease)	14.2	40,974
10	Septicemia	11.7	33,865
11	Suicide [Intentional Self-Harm]	11.0	31,655
12	Chronic liver disease and cirrhosis	9.5	27,257
13	Homicide [Assault]	7.0	20,261
14	Essential hypertension and renal disease	6.1	17,638
15	Pneumonitis due to solids and liquids	6.1	17,593
	All other causes (Residual)	141.5	407,900

Official data source: Kochanek, K. D., Murphy, S. L., Anderson, R. N., & Scott, C. (2004). Deaths: Final data for 2002. National Vital Statistics Reports, 53 (5). Hyattsville, MD: National Center for Health Statistics. DHHS Publication No. (PHS) 2005-1120.

Population figures source: Table I, p. 108, of the National Center for Health Statistics (Kochanek et al., 2004) publication above.

$$\text{suicide rate} = \frac{\text{number of suicides by group}}{\text{population of group}} \times 100,000$$

Suicide Data Page: 2002
16 October 2004

Prepared for AAS by John L. McIntosh, Ph.D.

Rate, Number, and Ranking of Suicide for Each U.S.A. State*, 2002

<u>Rank-State ('00 rank)</u>	<u>Rate</u>	<u>Number</u>	<u>Region [Abbreviation]</u>	<u>Rate</u>	<u>Number</u>
01 Wyoming (04)	21.1	105	Mountain [M]	16.9	3,216
02 Alaska (06)	20.5	132	East South Central [ESC]	12.6	2,175
03 Montana (02)	20.2	184	South Atlantic [SA]	11.8	6,330
04 Nevada (03)	19.5	423	West North Central [WNC]	11.5	2,235
05 New Mexico (01)	18.8	349	West South Central [WSC]	11.4	3,688
06 Arizona (10T)	16.2	886	Nation	11.0	31,655
07 Colorado (05)	16.1	727	East North Central [ENC]	10.7	4,763
08 West Virginia (07T)	15.3	276	Pacific [P]	10.3	4,809
09 Idaho (07T)	15.1	202	New England [NE]	8.3	1,172
10 Vermont (26T)	14.9	92	Middle Atlantic [MA]	7.8	3,122
11 Oregon (10T)	14.7	518			
12 Utah (13T)	14.7	340			
13 North Dakota (20T)	14.4	91			
14 Oklahoma (09)	14.3	501			
15 Florida (13T)	14.0	2,338			
16 Arkansas (12)	13.9	377			
17 Tennessee (20T)	13.4	778			
18 Washington (24)	13.4	811			
19 Kentucky (22)	13.2	540			
20 Maine (19)	12.8	166			
21 Kansas (36)	12.7	345			
22 South Dakota (15)	12.4	94			
23 Missouri (18)	12.2	693			
24 Indiana (26T)	12.1	743			
25 Mississippi (28T)	11.9	343			
25 North Carolina (23)	11.9	986			
27 Nebraska (35)	11.6	201			
28 Alabama (28T)	11.5	514			
28 Wisconsin (25)	11.5	627			
30 Ohio (37)	11.3	1,287			
31 Louisiana (34)	11.1	499			
United States	11.0	31,655			
32 Michigan (38)	11.0	1,106			
32 Virginia (31T)	11.0	799			
34 Pennsylvania (39T)	10.9	1,341			
35 Iowa (39T)	10.7	314			
35 South Carolina (28T)	10.7	440			
37 Georgia (31T)	10.6	909			
37 Texas (39T)	10.6	2,311			
39 New Hampshire (17)	10.4	132			
40 Minnesota (42)	9.9	497			
41 Hawaii (31T)	9.6	120			
42 California (46T)	9.2	3,228			
42 Delaware (16)	9.2	74			
44 Illinois (43)	9.1	1,145			
45 Maryland (44)	8.7	477			
46 Rhode Island (45)	8.0	86			
47 Connecticut (46T)	7.5	260			
48 Massachusetts (50)	6.8	436			
49 New Jersey (49)	6.4	553			
49 New York (51)	6.4	1,228			
51 District of Columbia (48)	5.4	31			

Source: Kochanek, K. D., Murphy, S. L., Anderson, R. N., & Scott, C. (2004). Deaths: Final data for 2002. National Vital Statistics Reports, 53 (5). Hyattsville, MD: National Center for Health Statistics. DHHS Publication No. (PHS) 2005-1120. (p. 92, Table 29) [data are by place of residence] [Suicide = ICD-10 Codes X60-X84, Y87.0]

Note: All rates are per 100,000 population.

* Including the District of Columbia.

Suicide State Data Page: 2002
26 September 2004

Prepared by John L. McIntosh, Ph.D. for

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Fax: (202) 237-2282

“to understand and prevent suicide as a means of promoting human well-being”

Visit the AAS website at: www.suicidology.org

For other suicide data, and an archive of state data, visit the website below and click on the “Recent Suicide Statistics” link:
<http://mypage.iusb.edu/~jmcintos/>



Caution: Annual fluctuations in state levels combined with often relatively small populations can make these data highly variable. The use of several years' data is preferable to conclusions based on single years alone.



Youth¹ Suicide Fact Sheet

- Suicide ranks as the third leading cause of death for young people (ages 15-19 and 15-24); only accidents and homicides occur more frequently.
- Whereas suicides account for 1.3% of all deaths in the U.S. annually, they comprise 12.3% of all deaths among 15-24 year olds.
- Each year, there are approximately 10 suicides for every 100,000 youth.
- Approximately 11 young people between the ages of 15-24 die every day by suicide.
- Within every 2 hours and 15 minutes, a person under the age of 25 completes suicide.
- In 2001, 30,622 people completed suicide. Of these, 3971 were completed by people between the ages of 15 and 24.
- Suicide rates, for 15-24 year olds, have more than doubled since the 1950's, and remained largely stable at these higher levels between the late 1970's and the mid 1990's. They have declined 25.6% since 1995.
- In the past 60 years, the suicide rate has quadrupled for males 15 to 24 years old, and has doubled for females of the same age (CDC, 2002).
- Suicide rates for those 15-19 years old increased 11% between 1980 and 1997. Since the peak in 1994 with 11.1 suicides per 100,000, there has been a 25.1% decrease. Currently, the rate is 8.2 per 100,000.
- Males between the ages of 20 and 24 were 6.6 times more likely than females to complete suicide 2001. Males between 15 and 19 were 4.8 times more likely than females to complete suicide (2001 data).

	Males	Females	Both genders
Ages 15 to 19	12.9	2.7	7.95
Ages 20 to 24	20.5	3.1	11.97

- The male to female ratio of completed suicides was 5: 1 among 15-19 year olds and 6.9: 1 among 20-24 year olds (2000 data).
- Firearms remain the most commonly used suicide method among youth, regardless of race or gender, nearly accounting for almost three of five (57%) completed suicides.

¹In this fact sheet, youth refers to the age groups of 15 to 19 and 20 to 24. Unless otherwise specified, information presented refers to the latest available data (i.e., 2001).

19 March 2004

- Research has shown that the access to and the availability of firearms is a significant factor in the increase of youth suicide. Guns in the home are deadly to its occupants!
- Among 15-19 year old black males, rates (since 1980) have increased 80% (2001 data). The rate for black males ages 15-19 is currently 7.3 per 100,000. For the age group 20 to 24, the rate is 19.4.
- For every completed suicide by youth, it is estimated that 100 to 200 attempts are made. In grades 9 through 12, 8.8% of students attempted suicide in the previous 12 months (6.2% male and 12.2% female). These numbers decrease from grades 9 (10.7%) to 12 (5.5%). A prior suicide attempt is an important risk factor for an eventual completion.

Suicide Among Children

- Suicide rates for those between the ages of 10-14 increased 99% between 1980 and 1997. This age group has shown a small decline in the past two years. For 2001, the rate is 1.5 per 100,000.
- Although their rates are lower than for whites, black youth (ages 10-14) showed the largest increase in suicide rates between 1980 and 1995 (233%). The rate for black males ages 10-14 was 1.7 per 100,000 (2001 data).
- In the 10 to 14 age group, white youths (ranked 3rd leading cause of death) were far more likely to complete suicide than black youths (ranked 7th leading cause of death). White males between 10 and 14 years of age were three times more likely to complete suicide than females of the same age.
- In 2001, there were 272 suicides in the U.S among children ages 10 to 14.

Other factors

- Research has shown that most adolescent suicides occur after school hours and in the teen's home.
- Although rates vary somewhat by geographic location, within a typical high school classroom, it is likely that three students (one boy and two girls) have made a suicide attempt in the past year.
- The typical profile of an adolescent nonfatal suicide attempter is a female who ingests pills, while the profile of the typical completer suicide is a male who dies from a gunshot wound.
- Not all adolescent attempters may admit their intent. Therefore, any deliberate self-harming behaviors should be considered serious and in need of further evaluation.
- *Most* adolescent suicide attempts are precipitated by interpersonal conflicts. The intent of the behavior appears to be to effect change in the behaviors or attitudes of others.
- Repeat attempters (those making more than one nonlethal attempt) generally use their behavior as a means of coping with stress and tend to exhibit more chronic symptomology, poorer coping histories, and a higher presence of suicidal and substance abusive behaviors in their family histories.
- Many teenagers may display one or more of the problems or "signs" detailed below. The following list describes some potential factors of risk for suicide among youth. If observed, a professional evaluation is strongly recommended:

Presence of a psychiatric disorder (e.g., depression, drug or alcohol, behavior disorders, conduct disorder [e.g., runs away or has been incarcerated]).

The expression/communication of thoughts of suicide, death, dying or the afterlife (in a context of sadness, boredom, hopelessness or negative feelings).

Impulsive and aggressive behavior; frequent expressions of rage.

Increasing use of alcohol or drugs.

Exposure to another's suicidal behavior.

Recent severe stressor (e.g., difficulties in dealing with sexual orientation; unplanned pregnancy, significant real or anticipated loss, etc.).

Family instability; significant family conflict.

Sources

The information for this portion of the fact sheet was gathered from the National Vital Statistics Reports on the National Center for Health Statistics website (<http://www.cdc.gov/nchs/Default.htm>) run by the Center for Disease Control and Prevention and from the National Mental Health Association website (<http://www.nmha.org/>).

Suicide Among College Students

- In 1998, suicide was the second leading cause of death in college-age students (20 to 24 year olds).
- It is estimated that there are more than 1,000 suicides on college campuses per year.
- One in 12 college students have made a suicide plan.
- In 2000, the American College Health Association surveyed 16,000 college students from 28 college campuses.
 - 9.5% of students had seriously contemplated suicide.
 - 1.5% have made a suicide attempt.
 - In the twelve month period prior to the survey, half of the sample reported feeling very sad, one third reported feeling hopeless and 22% reported feeling so depressed as to not be able to function.
 - Of the 16,000 students surveyed, only 6.2% of males and 12.8% of females reported a diagnosis of depression. Therefore, there are a large number of students who are not receiving adequate treatment and/or who remain undiagnosed.
- Of the students who had seriously considered suicide, 94.8% reported feeling so sad to the point of not functioning at least once in the past year, and 94.4% reported feelings of hopelessness.
- Two groups of students might be at higher risk for suicide:
 - Students with a pre-existing (before college) mental health condition, and
 - Students who develop a mental health condition while in college.Within these groups, students who are male, Asian and Hispanic, under the age of 21 are more likely to experience suicide ideation and attempts.
- Reasons attributed to the appearance or increase of symptoms/disorders:
 - New and unfamiliar environment;
 - Academic and social pressures;
 - Feelings of failure or decreased performance;
 - Alienation;
 - Family history of mental illness;
 - Lack adequate coping skills;
 - Difficulties adjusting to new demands and different work loads.
- Risk factors for suicide in college students include depression, sadness, hopelessness, and stress.

- As with the general population, depression plays a large role in suicide. “Ten percent of college students have been diagnosed with depression” (NMHA, 2001). “The vast majority of young adults aged 18 and older who are diagnosed with depression do not receive appropriate or even any treatment at all”.

Sources

The information for this portion of the fact sheet was gathered from *Safeguarding your Students Against Suicide - Expanding the Safety Net: Proceedings from an Expert panel on Vulnerability, Depressive Symptoms, and Suicidal Behavior on College Campuses*, a report by NMHA and The Jed Foundation (2002).

American Association of Suicidology

The goal of the American Association of Suicidology (AAS) is to understand and prevent suicide. AAS promotes research, public awareness programs, education, and training for professionals, survivors, and all interested persons. AAS serves as a national clearinghouse for information on suicide. AAS has many resources and publications, which are available to its membership and the general public. For membership information, please contact:

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Website: www.suicidology.org



Warning Signs

Key Messages

Are you or someone you love at risk of suicide? Get the facts and take appropriate action.

Get help immediately by contacting a mental health professional or calling 1-800-273-8255 for a referral should you witness, hear, or see anyone exhibiting any one or more of the following:

- Someone threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself.
- Someone looking for ways to kill him/herself by seeking access to firearms, available pills, or other means.
- Someone talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person.

Seek help as soon as possible by contacting a mental health professional or calling 1-800-273-8255 for a referral should you witness, hear, or see someone you know exhibiting any one or more of the following:

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking

- Feeling trapped – like there’s no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood changes
- No reason for living; no sense of purpose in life

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Survivors of Suicide Fact Sheet

A survivor of suicide is a family member or friend of a person who died by suicide.

Some Facts...

Survivors of suicide represent “the largest mental health casualties related to suicide” (Edwin Shneidman, Ph.D., AAS Founding President).

There are currently almost 31,000 suicides annually in the USA. It is estimated that for every suicide there are at least 6 survivors. Some suicidologists believe this to be a very conservative estimate.

Based on this estimate, approximately 5 million American became survivors of suicide in the last 25 years.

About Suicidal Grief

The loss of a loved one by suicide is often shocking, painful and unexpected. The grief that ensues can be intense, complex, and long term. Grief work is an extremely individual and unique process; each person will experience it in their own way and at their own pace.

Grief does not follow a linear path. Furthermore, grief doesn't always move in a forward direction.

There is no time frame for grief. Survivors should not expect that their lives will return to their prior state. Survivors aim to adjust to life without their loved one.

Common emotions experienced in grief are:

Shock	Denial	Pain
Guilt	Anger	Shame
Dispair	Disbelief	Hopelessness
Stress	Sadness	Numbness
Rejection	Loneliness	Abandonment
Confusion	Self-blame	Anxiety
Helplessness	Depression	

These feelings are normal reactions and the expression of them is a natural part of grieving. At first, and periodically during the following days/months of grieving, survivors may feel overwhelmed by their emotions. It is important to take things one day at a time.

Crying is the expression of sadness; it is therefore a natural reaction after the loss of a loved one.

Survivors often struggle with the reasons why the suicide occurred and whether they could have done something to prevent the suicide or help their loved one. Feelings of guilt typically ensue if the survivor believes their loved one's suicide could have been prevented.

At times, especially if the loved one had a mental disorder, the survivor may experience relief.

There is a stigma attached to suicide, partly due to the misunderstanding surrounding it. As such, family members and friends of the survivor may not know what to say or how and when to provide assistance. They may rely on the survivor's initiative to talk about the loved one or to ask for help.

Shame or embarrassment might prevent the survivor from reaching out for help. Stigma, ignorance and uncertainty might prevent family and friends from giving the necessary support and understanding. Ongoing support remains important to maintain family and friendship relations during the grieving process.

Survivors sometimes feel that others are blaming them for the suicide. Survivors may feel the need to deny what happened or hide their feelings. This will most likely exacerbate and complicate the grieving process.

When the time is right, survivors will begin to enjoy life again. Healing does occur.

Many survivors find that the best help comes from attending a support group for survivors of suicide where they can openly share their own story and their feelings with fellow survivors without pressure or fear of judgment and shame. Support groups can be a helpful source of guidance and understanding as well as a support in the healing process.

Children as Survivors

It is a myth that children don't grieve. Children may experience the same range of feelings as do adults; the expression of that grief might be different as children have fewer tools for communicating their feelings.

Children are especially vulnerable to feelings of guilt and abandonment. It is important for them to know that the death was not their fault and that someone is there to take care of them.

Secrecy about the suicide in the hopes of protecting children may cause further complications. Explain the situation and answer children's questions honestly and with age-appropriate responses.

American Association of Suicidology

The American Association of Suicidology (AAS) offers a variety of resources and programs to survivors in an attempt to lessen the pain as they travel their special path of grief. These include:

- Survivors of Suicide Kit: an information kit consisting of fact sheets, a bibliography and sample literature.
- *Survivors of Suicide: Coping with the Suicide of a Loved One* booklet and *A Handbook for Survivors of Suicide*.
- *Surviving Suicide*, a quarterly newsletter for survivors and survivor support groups.
- "Healing After Suicide", an annual conference held every April, for and about survivors.
- Suicide Prevention and Survivors of Suicide Resource Catalog: a listing of books, pamphlets, etc. which can be ordered from AAS. Includes resources for children and those who care for them.
- Directory of Survivors of Suicide Support Groups – print version available for purchase and an online version available at www.suicidology.org.
- Guidelines for Survivors of Suicide Support Groups: a how-to booklet on starting a support group.

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Additional Resources

- American Foundation for Suicide Prevention (AFSP) (www.afsp.org).
- Survivors of Suicide (www.survivorsofsuicide.com).
- The Link National Resource Center (www.thelink.org).



AMERICAN ASSOCIATION OF SUICIDOLOGY

Dedicated to the Understanding and Prevention of Suicide

Understanding and Helping the Suicidal Individual

BE AWARE OF THE WARNING SIGNS

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- Increased alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood changes
- No reason for living; no sense of purpose in life

BE AWARE OF THE FACTS

1. Suicide is preventable. Most suicidal individuals desperately want to live; they are just unable to see alternatives to their problems.
2. Most suicidal individuals give definite warnings of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them.
3. Talking about suicide does not cause someone to be suicidal.
4. Approximately 32,000 Americans kill themselves every year. The number of suicide attempts is much greater and often results in serious injury.
5. Suicide is the third leading cause of death among young people ages 15-24, and it is the eighth leading cause of death among all persons.
6. Youth (15-24) suicide rates increased more than 200% from the 1950's to the late 1970's. Following the late 1970's, the rates for youth suicide have remained stable.

7. The suicide rate is higher among the elderly (over 65) than any other age group.
8. Four times as many men kill themselves as compared to women, yet three times as many women attempt suicide as compared to men.
9. Suicide cuts across all age, economic, social, and ethnic boundaries.
10. Firearms are currently the most utilized method of suicide by essentially all groups (male, female, young, old, white, non-white).
11. Surviving family members not only suffer the trauma of losing a loved one to suicide, and may themselves be at higher risk for suicide and emotional problems.

WAYS TO BE HELPFUL TO SOMEONE WHO IS THREATENING SUICIDE

1. Be aware. Learn the warning signs.
2. Get involved. Become available. Show interest and support.
3. Ask if he/she is thinking about suicide.
4. Be direct. Talk openly and freely about suicide.
5. Be willing to listen. Allow for expression of feelings. Accept the feelings.
6. Be non-judgmental. Don't debate whether suicide is right or wrong, or feelings are good or bad. Don't lecture on the value of life.
7. Don't dare him/her to do it.
8. Don't give advice by making decisions for someone else to tell them to behave differently.
9. Don't ask 'why'. This encourages defensiveness.
10. Offer empathy, not sympathy.
11. Don't act shocked. This creates distance.
12. Don't be sworn to secrecy. Seek support.
13. Offer hope that alternatives are available, do not offer glib reassurance; it only proves you don't understand.
14. Take action! Remove means! Get help from individuals or agencies specializing in crisis intervention and suicide prevention.

BE AWARE OF FEELINGS, THOUGHTS, AND BEHAVIORS

Nearly everyone at some time in his or her life thinks about suicide. Most everyone decides to live because they come to realize that the crisis is temporary, but death is not. On the other hand, people in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control. Frequently, they:

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat or work
- Can't get out of the depression
- Can't make the sadness of away
- Can't see the possibility of change
- Can't see themselves as worthwhile
- Can't get someone's attention
- Can't see to get control

TALK TO SOMEONE – YOU ARE NOT ALONE

CONTACT:

- A community mental health agency
- A school counselor or psychologist
- A suicide prevention/crisis intervention center
- A private therapist
- A family physician
- A religious/spiritual leader

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