LESSON PLAN **SUICIDE PREVENTION**

- Signs of Suicide Risks/Supervision of Inmates
- Types of Suicide Intervention/Counseling Techniques
- Suicide Precautions

TIME FRAME 1 Hour (Recommended)

PURPOSE To increase staff knowledge about the factors related to inmate suicides and to raise awareness concerning the fundamental care and custody responsibilities of all staff. To provide basic information, skills, and techniques for recognizing, responding, follow-up and monitoring inmates in time of crisis. Meets ACA and BOP requirement.

OBJECTIVES

- Identify common myths and accurate information about suicide
- List high risk groups, settings, and locations for suicide in your institution
- Identify risk factors and warning signs which may identify a potential suicide attempt
- State the four basic responses of a staff member who believes an inmate is at risk of suicide
- Describe the location of the suicide watch room(s) at your institution and what staff should/should not do when assigned to work a suicide watch post

STUDENT MATERIALS None Noted

INSTRUCTOR MATERIALS

- Lesson Plan
- PowerPoint Presentation

REFERENCES

- PS 5324.08, Suicide Prevention Program
- PS 5324.07, SENTRY Psychology Alert Function
- American Correctional Association (ACA) Standard 4-4373, Suicide Prevention and Intervention
- Inmate Suicide Roster, 2018
- Summary of Inmate Suicides, 2018
- Suicide Myths and Facts. Centre for Suicide Prevention.
- Why is Suicide Prevention Education Important? Centre for Suicide Prevention. www.suicideinfo.ca
- We Educate for Life. Centre for Suicide Prevention.

RECOMMENDED INSTRUCTORS	Psychology Department Staff
CONTACT	Learning and Career Development Branch (LCDB) Curriculum Development at BOP-HRM/Curriculum~
SPECIAL NOTES	**Local Modification:** The portion, "Our High Risk Inmates" on Page 17 requires modification at the local institution. Please enter the photo and the requested information on PowerPoint slide #29. Add the number of slides needed. Be prepared to review local inmates (if any) from the Inmate Suicide Roster, 2018, and the Summary of Suicides, 2018. **Special Note:** **Curriculum will be updated and resent for the statistical data at the end of Fiscal Year 2018. This includes Page 4 and 5 of the lesson plan and Slides 3, 4, 5, and 6 of the PowerPoint presentation. Updated information will also be added regarding inmate deaths by suicide beginning on Slide 33.**

I. INTRODUCTION

Slide 1 – Suicide Prevention (Header Slide)

Note: Introduce self and topic.

II. OBJECTIVES

Slide 2 - Objectives

At the end of the lesson, participants should be able to:

- Identify common myths and accurate information about suicide.
- List high risk groups and locations for suicide in their institution.
- Identify risk factors and warning signs which may identify a potential suicide attempt.
- State the four basic responses of a staff member who believes an inmate is at risk of suicide.
- Describe the location of the suicide watch room(s) at their institution and what staff should/should not do when assigned to work a suicide watch post.

As you know, everyone in the Bureau of Prisons, regardless of their specific job description, must first function as a correctional worker, ensuring the security of the institution. We all also have an equal responsibility to ensure that each inmate receives adequate and timely care for their physical, spiritual and emotional needs. During this session, we will discuss a number of facts and procedures that each of you as correctional workers should know about managing offenders.

We will be talking about a number of situations where you must critically weigh the care needs of the inmate with the custody needs of the institution. One of the most important situations of this kind is in preventing suicides.

This training session will assist you in recognizing the important signs indicative of potential suicidal behavior. It will acquaint you with a number of facts about inmates who have committed suicide in federal prisons, and help you identify high risk groups of inmates. It will also provide you with critical information about how best to respond during a suicide crisis situation.

It is important that you openly express your concerns to psychology or medical staff about inmates who are experiencing troubles. It is also very important to remember that psychology or medical staff do not see inmates as regularly as other staff, and therefore, may not be as aware of changes in their behavior or how various courses of treatment are affecting the inmate.

It is also very important that all employees, regardless of job specialty, feel empowered to inform the appropriate staff if inmates are not receiving treatment or are obviously deteriorating even if they are receiving treatment.

This is not to say you should be trying to diagnose inmates or should dispute or debate the merits of treatment decisions made by the professional staff. However, in many cases you are with the inmates most of the day and are probably better able to see problems or changes than a health care professional who may only see the inmate for a relatively shorter period of time.

Your responsibility to ensure an inmate is receiving appropriate care does not stop simply because you have referred him or her to another staff member, or because the inmate is receiving treatment. If you are actively involved with that inmate on a regular basis and you have good, supportable reasons to feel that a particular course of action does not seem to be working, you should express those concerns to appropriate supervisors.

III. COMMON MYTHS AND FACTS ABOUT SUICIDE

Slide 3 – Inmate Suicides in 2018

Note: Numbers should be entered in this section at the end of Fiscal Year 2018.

Slide 4 – Inmate Suicides in 2018

- There were 28 inmate suicides in Fical Year 2018.
- The rate of inmate suicides was 15 per 100,000.
- This is significantly higher than last year's rate and most similar to 1995.
- Inmates who died by suicide reflect traditional BOP high risk groups.

Slide 5 – Trends in 2018

- 11 % of suicides were by inmates in pre-trial status, compared to 17% in 2017 and 19% in 2016.
- 43% of inmates who died by suicide were in the first 36 months of their incarceration compared to 35% in 2017.
- 50% of suicides were by inmates in single cell status. Similar to the 57% in 2017.
- 46% of suicides occurred in restrictive housing as compared to 52% in 2016.

Slide 6 – Trends in 2018

- 4% of inmates who died by suicide did so by exsanguination.
- 39% of inmate deaths by suicide involved inmates with a conviction or charge for a sex offense, a significant increase over 26% in 2017.

- No suicides occurred at a private contract facility.
- 79% of inmates who died had a history of mental health problems.

Overall, our rates continue to track changes in the community and in the decade from 2000 – 2009, the average rate was just below 10/100,000. In FY2010, our rate of 5/100,000 was as low as it has ever been; the rate for FY2012 was 13/100,000, which represents 29 suicides and the rate for FY2013 was 6/100,000. The rate for FY2014 was 10/100,000. This tracks with higher years such as 2000, 2001, 2008, 2009 and 2012. The Bureau's rate remains well below the average rate of 20.2/100,000 for men in the community.

Unfortunately, it is difficult to know exactly why the rates have declined over the last 40 years or why they spike and decline for any given year. Part of the decline has to be attributed to the Suicide Prevention Program, and particularly to staff who have learned to recognize and refer inmates before they make attempts. Rather than focusing on a particular year, it is useful to monitor trends.

Knowing how often suicide occurs can be helpful because it can make us more sensitive to the issue. It is also important to know where and with whom the risk is greatest.

Slide 7-8 – Video – Suicide Myths and Facts

Note: The video has no sound. It is the responsibility of the instructor to read the myths and facts aloud to the audience, if desired. Depending upon the view of the audience, it may not be necessary to read aloud.

Note: Play video by clicking reel. Video will play automatically if in presentation mode. The content of the video are below:

Myth: Talking about suicide can cause suicide.
Fact: Talking about suicide does not cause people to think about killing themselves.

Myth: People who are suicidal want to die.
Fact: People who are suicidal do not want to die, they want the pain of living to end.

Myth: Teens die by suicide most often.
Fact: Middle-aged men, ages 40-60, die by suicide more than any other group.

Myth: Suicide rates are highest around Christmas.
Fact: The rate of suicide is fairly consistent throughout the year and slightly peaks in early spring.

Myth: Suicide occurs without any warning.
Fact: Learning to identify the warning signs of someone who is suicidal can prevent harm.

Myth: Suicide prevention should be left to professionals.
Fact: Anyone can learn how to intervene with someone at risk of suicide.,

Myth: People who are suicidal cannot be stopped.
Fact: Thoughts of suicide can exist for limited amounts of time, but have the abilitiy to re-occur.

Myth: Not talking about suicide means we are not liable.
Fact: Not discussing suicide does not protect against liability, nor will it prevent a suicide.

Note: End of video. Continue with the lesson.

For much of history suicide has been considered shameful or sinful. The stigma associated with suicide is slowly lifting and suicide is more commonly being viewed as a behavior associated with mental illness and emotional pain. However, many myths about suicidal behavior and its causes remain. It is important to base our decisions about suicide on the facts. Here are additional common misperceptions and facts about suicide.

- **"If a person decides to commit suicide, he or she will find a way regardless of what we do."** Suicidal impulses are often brief. Most suicidal people have mixed feelings about dying. The methods available to commit suicide can influence the occurrence and outcome of suicidal acts.
- **"Asking a person about suicide might give them the idea."** Asking about suicidal thoughts will not result in a suicide. Showing concern will likely assist the inmate. Open dialogue will assist in identifying problems and attaining help.
- **"Inmates who threaten to kill themselves don't really want to die."** Individuals who threaten suicide are at higher risk. Suicidal intent can change quickly. The lethality of self-harm acts can be misjudged. Accidental death can occur.
- **"If we ask about suicide and the inmate denies it, we've done our part."** There are many ways individuals may communicate suicidal intent. If individuals could always know and communicate their own risk, there would be no risk. Psychologists in the Bureau of Prisons (BOP) are trained to examine all the risk factors and make informed recommendations.

IV. HIGH SUICIDE RISK INMATES AND LOCATIONS

Slide 9 – Which Inmates Are At Risk? (Header Slide)

A. At Risk Groups

Note: Discuss the groups of inmates that have the highest risk of suicide in the BOP. If the institution has any inmates in high risk groups, it is important to personalize this data to the institution.

Over the years, we have identified only four groups of federal inmates that appear to be at higher risk for suicide than the general inmate population.

Slide 10 – At-Risk Groups

The four groups are:

1. Pre-trial Inmates

Pretrial inmates are at a higher risk for suicide. Several factors can contribute to the stress level of these inmates. For example, withdrawal symptoms from the use of drugs or alcohol, fear of a long sentence, sudden loss of freedom, and/or shame and embarrassment.

2. Mentally Ill Inmates

The second high risk group is mentally ill inmates. Sixty-eight percent (68%) of the inmates who died by suicide had a history of or present mental illness.

3. Inmates in Restrictive Housing and Secure Mental Health Housing Units

The third high risk group is inmates in the Special Housing Unit (SHU) who have protective custody/separation concerns. Historically, one third of all suicides occur in SHU. Many of those have been in protective custody (PC), and the majority of them killed themselves within the first 72 hours in SHU. Other restrictive housing environments include the Special Management Units (SMUs), mental health seclusion, the Administrative Maximum Security Facility (ADX), and Secure Treatment Programs.

4. Sex Offenders

Although it is a recent trend, sex offenders are also an easily identified group of inmates that have an increased suicide risk. Their risk is highest at the beginning of their sentence or at the time of a transfer. They made up **forty-one percent** (41%) of those inmates who completed suicide during fiscal year 2014. These inmates are considered to be at higher risk due to the stigma associated with their charges, many receive lengthy sentences, and many end up in SHU after requesting protective custody.

B. High Risk Settings

Slide 11 – At-Risk Settings

Note: Discuss the location and methods of suicides, generally in the BOP. Be specific about the locations in your institution which are potential high risk locations.

1. Restrictive Housing

A common location for suicides is a lock down unit, typically in the SHU, SMU, or a psychiatric seclusion unit in the ADX.

2. Single Cells

Within all units, single cell status raises the risk of inmate suicide more than any other factor. It is important to minimize the use of single cells when possible, especially for inmates who have other risk factors present such as mental illness or sex offender status.

With this in mind, double cell all inmates unless there is a compelling reason not to do so. It reduces isolation, reduces privacy, and provides rescue opportunity. Place at-risk inmates in higher visibility cells and finally, reduce or eliminate the presence of tie-off points.

3. Private Spaces

There has, however, been a recent trend of more suicides occurring in the general population, so it is important for staff to be vigilant in all areas. Of those that occurred in the general population, most occurred in the inmate's cell. The remainder occurred in common inmate areas such as showers, mop closets, stairs, etc. where the inmate could gain privacy. With that in mind, important prevention measures include frequent rounds, not allowing inmates to cover windows, and establishing professional and meaningful relationships.

Note: At this point, ask for questions regarding the material or about responsibilities in dealing with suicidal inmates.

To summarize, a disproportionate number of inmate suicides occurred in some type of restrictive housing or while in a single cell. This finding is consistent with most research findings on prison suicides and indicates why high risk inmates should not be placed in isolation without a higher than normal level of monitoring.

C. Methods

Slide 12 – Methods

In the Bureau, inmates also use the most lethal means available to them. Unquestionably, hanging represents the most frequently chosen and most potentially lethal method of suicide available to federal inmates' intent on committing suicide. It is important to know that an inmate can commit suicide by hanging without actually hanging. Death in most cases occurs because the blood supply in the neck is stopped from reaching the brain. This can happen if an inmate is standing or even sitting. Loss of consciousness may happen within seven (7) seconds. Although death takes significantly longer, from this point on, the inmate is no longer able to save him or herself.

As long as a noose can be tightened enough to stop the blood flow, and it does not take much, the inmate will slowly lose consciousness; brain cells will begin to stop functioning, and the inmate will eventually die. Significant brain damage can begin to occur in 4 to 5 minutes.

This is important because even minor attempts or gestures can result in death simply because it is much easier than many people might think to die in this manner.

A new trend in prison has been overdose. Because of this, the use of "pill line" is a recommendation for some high risk inmates.

Finally, staff access to firearms in Residential Reentry Centers (RRCs) also increases risk of death.

V. RISK FACTORS AND WARNING SIGNS OF A POTENTIAL SUICIDE ATTEMPT

Slide 13 – What is Suicide Risk? (Header Slide)

We must stay alert and in touch with the inmates under our supervision and be observant to detect any behavioral changes that might suggest the possibility of suicide. Next, we will discuss risk factors and warning signs that may assist you in identifying inmates at risk for suicide as you work with them throughout the day.

A. Risk Factors

Slide 14 – Risk Factors

Note: Discuss risk factors. Ask questions as appropriate.

Risk factors are empirically derived from population studies. They tend to be longstanding, unchangeable and predispose individuals to suicidal behavior. Risk factors cannot determine the risk level of a particular individual.

SAD PERSONS is a mnemonic device to help staff remember risk factors for suicide.

- **Sex -** 73% of US suicides are committed by white males. Men are nearly four (4) times as likely to die by suicide as are women. 60% of these suicides are by gunshot.
- **Age -** Suicide is the third leading cause of death for males between 15-24. Individuals over the age of 65 are also at significant risk.
- **Depression -** 30 – 40% of people who die by suicide are diagnosed with depression.
- **Previous Attempt -** Approximately 15% of individuals who have attempted suicide will eventually complete suicide. Individuals who have made a life threatening attempt are at greater risk. A recent attempt followed by remorse that the attempt was not successful, is a warning sign.
- **Ethanol Abuse -** Alcohol has been consumed by 15-25 % of those who complete suicide and 55% of individuals who attempt suicide. Alcoholics are an especially high risk group in that 15% of them die by suicide or 270/100,000.
- **Rational Thought Loss –** Rational thought loss may refer to psychosis- schizophrenia and depression with psychotic features.
- **Social Support Lacking –** This includes limited social support or the recent loss of important support.
- **No Spouse** – No spouse refers to inmates who are separated, divorced, or widowed. Single individuals are at greater risk.
- **Sickness** – Individuals diagnosed with life threatening illnesses are at increased risk. Medical illness plays a role in 25% of completed suicides and this percentage rises with age.

There are some risk factors specific to inmates that are of special importance. Some indications that stress factors such as legal problems, sentence length and inmate-related conflicts were related to increased suicide.

Stress factors include:

- ongoing legal problems.
- history of past suicide attempt in custody.
- lengthy sentences.
- existence of mental disorder or history of psychiatric treatment.
- having charges related to a sex offense.

Slide 15 – Adverse Childhood Experiences (ACEs) – Building a Vulnerability

The adverse childhood experiences (ACE) study is a retrospective cohort study of 17,337 adult HMO members from San Diego who attended a primary care clinic between 1995-1997. Increasing number of ACE's are associated with illness, death, and poor quality of life. ACEs are emotional, physical, sexual abuse, battered mother, household substance abuse, mental illness in household, parental separation/divorce, and/or incarcerated household members.

Experiencing adverse childhood experiences such as emotional, physical, sexual abuse; household substance abuse; mental illness in the household, etc., is associated with illness, death and poor quality of life. As the number of ACEs increase so does the risk for suicide. This reinforces the complex nature of the development of a vulnerability to suicide. Our interactions are most effective when they focus on reinforcing individual strengths and facilitating resilience.

Slide 16 – The Perfect Storm

This is a pictorial representation of factors coming together which result in suicidal behaviors and attempts.

Every individual has specific vulnerabilities. This is why it is so important to have a professional relationship with and understand inmates. Examples could be poor coping resources, susceptibility to anxiety, an inability to occupy themselves, not being future oriented, isolated from family, impulsivity, or any number of other concerns.

The prison setting is an environmental factor that impacts inmates. These include things such as uncertainty and fear, potential victimization by other inmates, isolation, poor facilities and breakdown of relationships.

We all experience situational triggers that cause us to resort to old habits or in some cases to give up. These may include any of the identified factors on the slide. By communicating and interacting with staff and inmates we can frequently obtain this information. Unfortunately, these are often seen as just a part of life in prison. How we assist and model dealing with these things can be the difference between the inmate who resorts to suicide or one who resorts to a healthier coping skill.

Slide 17-18 – Video (1 minute 40 seconds) – Why is Suicide Prevention Important?

Note: Play video by clicking reel. Video will play automatically if in presentation mode. After video, ask audience for other reasons and/or examples of why suicide prevention is important.

B. Warning Signs

Slide 19 – Warning Signs

A warning sign is a behavior exhibited by some individuals who are considering suicide.

There are a number of warning signs that can be observed in inmates who may be suicidal. It is important, however, to caution against relying on these behaviors because some inmates who commit suicide do not show any evidence of this behavior, at least to staff, prior to their death. So, while behavior is important to be aware of, a number of other factors such as prior attempts, mood, housing status and mental health history must also be considered at the same time.

Warning signs are changeable and point to a current suicidal crisis. They suggest near-term (hours to a few days) risk. Examples include:

- withdrawal from friends
- suspiciousness
- saying "good-bye"
- giving away property
- hoarding medications
- signs of depression

Some of these behaviors are also associated with other special needs inmates who have severe mental health problems.

If inmates begin to show some of these behaviors, although they may not seem suicidal, it is important to contact psychology or medical staff and refer the inmate for evaluation.

1. Inmate-Specific Warning Signs

There are some warning signs specific to inmates that we are more likely to see in a correctional setting. Just as before, it is important to refer inmates exhibiting any of these behaviors to Psychology Services.

Knowing common symptoms or behaviors of suicidal inmates helps us recognize a potentially suicidal inmate.

By combining this information with what we know about their history, their current life stress, and the extent to which they are similar to high-risk inmates who have committed suicide, we are much more likely to be able to identify and refer those inmates who may be at significant risk for suicide.

If an inmate has been referred and the professional staff is aware of their behavior, it is still important to maintain some regular contact with that inmate to determine if the behavior is responding satisfactorily to treatment.

If unusual behaviors persist, or get worse, do not hesitate to contact the appropriate staff again to voice your concerns. Some of these behaviors include the following:

- A suicidal threat anytime
- Rehearsal behaviors observed by staff
- Trying to obtain a single cell
- Hoarding medication

As mentioned earlier in the session, your responsibility to provide adequate care for inmates does not stop because the inmate was referred to someone else.

VI. STAFF RESPONSES

Slide 20 – How Should Staff Respond to the Risk of Inmate Suicide? (Header Slide)

Note: Ask the question. Encourage discussion.

Let's assume an inmate fits the pattern we have just described, and their behavior suggests to us the potential for suicide.

How should we respond? What precautions should we take?

A. Staff Responsibilities

Slide 21 – Four Staff Responsibilities

There are four staff responsibilities when dealing with suicide. They include the following:

- ***Recognize warning signs*** that tell us inmates may be experiencing problems.
- ***Communicate concern and empathy*** to the behavior and take appropriate actions.
- ***Respond correctly*** to those problems.
- ***Follow-up and monitor*** inmates who have been identified and treated.

B. Basic Staff Responses

Slide 22-23 – Video – We Educate for Life

Note: Play video by clicking reel. Video will play automatically if in presentation mode. Upon completion, ask participants for feedback to the question.

What are some of the ways to respond to suicidal behavior?

Slide 24 – Four Basic Responses

There are four basic ways to respond to suicidal behavior. They are:

- Listen and hear.
- Take thoughts and feelings seriously.
- Support and affirm.
- Refer the inmate to the Psychologist, medical professional, shift supervisor, or Lieutenant.

The first three responses are good practices to follow in any situation and using them will improve your communication skills and be beneficial whether an inmate is suicidal, mentally ill, or simply wants to talk.

If an inmate talks about suicidal feelings, however, it is important to give your undivided attention and not to dispute, ignore, or ridicule their claim that they are feeling suicidal.

We should not try to minimize the inmate's statements about thinking of suicide by telling them not to worry so much, or that many people think of suicide.

Your response to these initial statements or behaviors is very important because it is often the first time that staff becomes aware of the potentially suicidal inmates. Once you have identified an inmate as suicidal, it is critical that you respond in a manner that is appropriate, adequate, and timely.

C. Reducing the Risk of Suicide

Slide 25 – What Works?

The risk of suicide can be reduced. These are some of the ways:

- Inmate participation in psychotherapy for as few as four sessions.
- Staff interactions characterized by caring and hope.
- Ensuring that relationships with inmates are genuine.
- Training in basic skills (i.e., how to communicate, manage intense feelings, etc.).
- Investing in meaningful roles (i.e., renewed identities such as parent, employee, etc.)

Slide 26 – What Else Can You Do?

Suicide prevention can be effective. Use the SENTRY assignment of PsycAlert and the Psychology Advisory List in TRUSCOPE to stay up to date on those inmates who may be at risk.

Also,

- Foster hope.
- Help the person remember times they did not feel suicidal.
- Foster a belief that times are temporary and things can improve.
- Help the person experience successes.
- Limit access to means (i.e., weapons, medications, etc.).

VIII. SUICIDE WATCH ROOM

Slide 27 – Suicide Watch Rooms and Procedures

After you have referred the inmate, a psychologist or medical professional will evaluate their suicide risk using many of the same signs and concepts we have just discussed. If the inmate is viewed as an acute suicide risk, a Suicide Watch will be initiated.

Note: State the identified location of suicide watches and the time frame for checking on the inmate. Discuss what staff should and should not do.

A Suicide Watch can last several hours to several days depending on the inmate's intent to harm him or herself.

A. Suicide Watch Post

1. Inmate Observers

Slide 28 – Inmate Observers

In the BOP, inmate observers may be used to help watch a potentially suicidal inmate. These inmates will be selected and trained by the Psychology Services staff and will rotate in shifts for as long as the inmate is on formal Suicide Watch.

Inmate observers are not trained to be therapists or to provide any type of treatment, but rather, they are only used to observe the potentially suicidal inmate and to immediately inform staff if the suicidal inmate's actions are inappropriate.

While it is fine for them to talk to the inmate and provide companionship, they are never to be placed in the cell with the suicidal inmate and they should not be allowed to step outside their very limited role in dealing with the suicidal inmate.

Note: Indicate whether or not your institution uses inmate observers.

In our institution, we do (do not) use inmate observers.

In many cases, whether the institution uses the inmate observer program or not, staff may also be called upon to function on a Suicide Watch. In those cases, you must read the post orders and should ask the psychologist any questions you may have.

Note: Discuss the specifics of what staff should and should not do when they are assigned to work a Suicide Watch.

2. Inmate Companions

Slide 29 – Inmate Companions

Inmate Companions are used at many institutions and complement the services that staff provide. Given their different overall role in the institution, when working as a companion, adjustments need to be made.

The use of inmate companions must be explicitly approved by the Warden.

Inmate companions may only work a maximum of four (4) hours in any 24-hour period. This helps them to remain alert and requires that this job assignment is shared amongst a number of inmates.

When inmate companions are working, they will have a means to summon help. Frequently, this is a direct line to the Control Center who can alert staff in case of an emergency situation.

Behavioral observations of the inmate on watch will be made in a Suicide Watch log book. Staff will use this record as a means of assessing the inmate on watch.

Prior to working as an inmate suicide companion, inmates will undergo initial training, then receive it on a regular basis thereafter. An important element of this training will be to recognize signs of stress or agitation.

3. Staff Roles

Slide 30 – Staff Roles

1. Your role is simply to be available AT ALL TIMES providing DIRECT OBSERVATION of the inmate.

2. During your time and on watch, your ONLY responsibility is to watch that identified inmate and to summon help if the inmate makes a suicide attempt.

3. Consequently, you should NEVER become involved in any other activity, either voluntarily or by direct order, that does not permit you to observe the inmate at all times.

4. While you are not responsible for the actions of the inmate, you are responsible for observing and responding appropriately to those actions. You cannot fulfill that responsibility if you are not observing the inmate at all times.

5. Policy clearly states that NO ONE except the Suicide Prevention Program Coordinator or designee has the authority to terminate a suicide watch once it has begun.

6. Even when inmate observers are working, you are still responsible for making hourly rounds.

Following suicide watch, an inmate may be transferred to a medical referral center, or more typically, returned to general population or other pre-watch status.

Often, other inmates may have heard that the inmate was placed on a suicide watch and respond in an unfavorable manner that creates more problems and concerns for the inmate.

When an inmate returns to the general population, we should attempt to be supportive and to help the inmate retain as much dignity as possible. Staff should not share information about an inmate's emotional problems with other inmates nor express the same type of negative reactions they are receiving from other inmates.

The risk of suicide is not over simply because the inmate has been removed from Suicide Watch and returned to population.

4. Local High Risk Inmates

Slide 31 – Our High Risk Inmates (Header Slide)

Slide 32 – Name, Register Number (Our High Risk Inmates)

Note: This slide requires modification at the local institution. Please enter the photo and the requested information. Copy the slide as many times as necessary to accommodate all high risk inmates at the local level. Review additional local inmates of particular concern.

VIII. SUICIDES OF FY2018

We will now apply knowledge of suicides to actual cases.

Slide 33 – Examples of Inmate Deaths by Suicide FY 2018 (Header Slide)

In order to assist you in applying the information in this presentation, we will review some of the inmate suicides that occurred in Fiscal Year 2018. As we discuss the cases, please focus on listening for risk factors and warning signs.

Note: The presenter should review at least 2-5 of the suicides from the Inmate Suicide Roster FY18. These should be selected based on similarities between the case and the institution in which the presentation is being offered, with the goal of identifying relevant risk factors and warning signs.

Slides 34-37 – FY2018 Inmate Death by Suicide

Note: Present information on each of the selected cases. After overview, ask participants to identify risk factors.

IX. REVIEW OF OBJECTIVES

Slide 38 – Review of Objectives

Now that we have completed the lesson, participants should be able to:

- Identify common myths and accurate information about suicide.
- List high risk groups and locations for suicide in their institution.
- Identify risk factors and warning signs which may identify a potential suicide attempt.
- State the four basic responses of a staff member who believes an inmate is at risk of suicide.
- Describe the location of the suicide watch room(s) at their institution and what staff should/should not do when assigned to work a suicide watch post.

X. SUMMARY

Slide 39 – Summary

Note: Conduct a summary of the important points.

As stated earlier, it is as much our responsibility to provide care and treatment for an inmate's basic physical and emotional needs as it is to maintain them in custody.

Like the role of custody, the role of providing care does not fall to only a few. If we remain observant and remember many of the topics discussed in this section, we will not only be fulfilling our basic correctional responsibilities, but we may be a significant force in preserving a life that may have been otherwise lost.

In conclusion, each of us has four responsibilities where suicidal inmates are concerned. Those responsibilities are that we must:

- be able to recognize the warning signs that tell us inmates may be considering suicide.
- consider the inner world of these inmates and communicate concern and empathy.
- be able to respond correctly to the behavior and take the appropriate precautions.

- follow-up on and monitor inmates who have been identified and referred.

Thank you for your attention and participation today. Just as your input has helped me in this presentation, the Bureau's continued success with the Suicide Prevention Program depends on your daily participation and involvement.

Note: Ask for any final questions. Encourage discussion.

Slide 40 – Thank You

Thank you.