131512

INTERIM CURRICULUM

ON DETECTION AND PREVENTION

OF JAIL SUICIDE

Developed for Regional Seminars Conducted by Jail Suicide Prevention Information Task Force: National Center on Institutions and Alternatives, in cooperation with Juvenile and Criminal Justice International, Inc., with assistance from the National Sheriffs' Association

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Interim Curriculum developed by
Joseph R. Rowan, Executive Director
Juvenile and Criminal Justice International, Inc.
381 South Owasso Blvd.
Roseville, Minnesota 55113
(612) 481-9644

IV. DETECTION AND PREVENTION OF SUICIDE IN JAILS

Session Outline

I. Introduction

- A. Number One Cause of Death in Jails
- B. Session Objectives
- C. Trainer Notes
  1. Remember the Triad Training Method
     - a. the role of mental health services
     - b. the role of local correctional agencies
     - c. the role of law enforcement.
  2. List and discuss subject areas of trainer objectives on flip charts

II. Profile of National Study of Jail Suicides

III. Why Jail Environment is Conducive to Suicidal Behavior

IV. Pre-disposing Factors

V. High Risk Suicide Periods

VI. Signs/Symptoms of Potential Suicide

VII. Assessing Suicidal Risk/Special Aspects of Receiving Screening

VIII. Handling Potential Suicides

IX. Role of Correctional Officer/Jailer in Suicide Prevention

X. "Suicide-Proof" Architecture and Environment

Curriculum developed by Joseph R. Rowan, Executive Director, Juvenile and Criminal Justice International, Inc., for Virginia Department of Mental Health and Mental Retardation, 1986.

LESSON PLAN

COURSE TITLE:	MENTAL HEALTH EDUCATION FOR POLICE, JAIL AND MENTAL HEALTH PROFESSIONALS.
MODULE IV:	Detection and Prevention of Suicide In Jails
TIME FRAME:	THREE - FOUR HOURS
SPACE REQUIREMENTS:	Classroom style sufficient for all participants
INSTRUCTOR MATERIALS/ EQUIPMENT	1. Instructor's Manual 2. Overhead projector/transparencies 3. Chalk board or flip chart and stand 4. Chalk/marking pens, colored 5. Masking tape
TRAINEE MATERIALS:	Trainee's Manual, pads, pencils, pens
PARTICIPANT OBJECTIVES:	At he completion of this session trainees will be able to:

1. Explain the extent of the suicide problem nationally in jails/lockups
2. List at least three factors making the jail environment conducive to jail suicides
3. Describe at least four pre-disposing factors concerning potential suicides
4. Name at least four high risk suicide periods
5. List at least five characteristics of the typical jail/ lockup suicide victim
6. Identify at least five key warning signs and symptoms of potential suiciders
7. Identify at least five other signs/cues of possible suicide intention
8. Name at least five signs/symptoms of depression
9. List at least three signs of agitation
10. Cite two reasons why persons with delusions and hallucinations should be observed closely in jails
11. Outline at least four steps in assessing suicide risk
12. List at least five methods for successfully handling potential suiciders

LESSON PLAN

13. Identify at least four things to do if an inmate is about to commit suicide

14. Describe at least three aspects of the role of the jailer/lockup keeper in suicide prevention

15. Name at least five features of "suicide-proof" jail/lockup architecture/environment.

METHOD OF INSTRUCTION:

Lecture with group discussion, facilitated by the use of overhead transparencies and flip charts.

TRAINING ACTIVITIES	PRESENTATION GUIDE

LECTURE

I. INTRODUCTION

Transparency IV-1

A. Number One Cause of Death in Jails

Results of research done for a national article, a five-year state survey, and experience in the American Medical Association's Jail Project have established that suicide is the Number One cause of deaths in jails and lockups.1/

Many lawsuits have been filed and sizeable judgements rendered to relatives of jail suicide cases. Tightening of the drunk driving laws and the jailing of otherwise stable citizens, arrested and undergoing the trauma of jail experience for the first time appear to be producing a rash of suicides in local police lockups.

A reduction in suicides, however, is reported wherever officers have been properly trained to look for signs and symptoms of potential suicide.

SESSION OBJECTIVES
Transparency IV-2

B. (Please outline "Lesson Objectives" from lesson plan.)

Transparency IV-3

II. Profile of National Study of Jail Suicides

In 1981, the National Center on Institutions and Alternatives released its 1979 survey report on suicides in jails and lockups.2/ Following is the profile of those suiciders:

A. Twenty-two years of age

B. White (however in some urban areas, many are black or brown)

C. Male

D. Single

1/ Charlé, Suzanne, "Suicide in the Cellblocks," Corrections Magazine, August, 1981, pp. 6-16; Hudson, Page, M.D. and John Butts, M.D., "Jail and Prison Deaths: A Five-Year, Statewide Survey of 223 Deaths in Police Custody, North Carolina, 1972-76." Popular Government, Spring, 1979.

2/ Hayes, Lindsay M. and Barbara Kajdan, And Darkness Closes In . . . Alexandria, Virginia, 83 pp.

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency IV-3

II. Profile of National Study of Jail Suicides (con't)

E. Under influence of alcohol

F. First arrestee.

Following are additional characteristics of the 419 suicide cases:

A. Over half of suicides occur within first three hours

B. Over 60 percent are under the influence of alcohol

C. Seventy-four percent have been charged with non-violent crimes

D. Two-thirds occurred in isolation

E. Thirty-five percent are first offenders

F. Twenty-one percent have known mental illness; it is estimated that over half would be found to have a history of mental illness if police files had sought that information

G. Eleven percent have made prior attempts at suicide; again, if the police files had contained this missing information, the figure would be over 50 percent.

Transparency IV-4

III. Why Jail Environment is Conducive to Suicidal Behavior

Certain unique characteristics of the jail environment make it an ideal suicide-prone setting:

A. Authoritarian environment

Persons not used to being regimented can encounter traumatic difficulty in the jail setting.

B. No apparent control over the future

Following incarceration, many jail inmates experience feelings of helplessness.

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency IV-4

III. Why Jail Environment is Conducive to Suicdal Behavior (con't)

C. Isolation from family friends and community

For incarcerated individuals, support from family and friends may seem far away, especially with the restricted visiting privileges in many jails.

D. The shame of incarceration

Feelings of shame, inversely proportional to the gravity of the offense committed, frequently develop in those persons who have never been arrested before or who have a limited arrest history. As noted in the list of characteristics of the 1981 national study of suicides in jails, 74 percent were for non-violent crimes. It is not uncommon for jail suicides to be committed by inmates who have been arrested for traffic violations, disturbing the peace, or other minor offenses.

E. Dehumanizing Aspects of Incarceration

Confinement in even the best of jails is dehumanizing. Lack of privacy, associating with acting-out individuals, inability to make your own choices in the regulation of your life can all have a devastating effect.

Transparency IV-5

IV. Pre-Disposing Factors

In studying jail suicide deaths, the following pre-disposing factors are commonly found:

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 alcohol blood levels beyond the legal limit commit suicide while still intoxicated.

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency IV-5

IV. Pre-Disposing Factors (con't)

B. Recent loss of stabilizing resources:

1. Wife/loved one; for a juvenile this could be a peer who may be missed more than a parent

2. Job; or, expulsion from school

3. Home; or farm

4. Finances.

C. Severe guilt/shame over the offense

This may be disproportional to the offense.

D. Same-sex rape or threats 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.

E. Current mental illness

Persons who are depressed or suffer from delusions/hallucinations are prime subjects for suicide.

F. Poor health/terminal illness

While mainly a problem of the elderly, persons of all ages succumb to the depression of serious illness.

G. Any other unbearable situation(or combination of events which, a day or week later, when one of those situations no longer troubled, would not have invoked thoughts of suicide)

Each of us has our breaking point, although that point differs within each of us, according to time and situation.

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency IV-6

V. High Risk Suicide Periods

Experience has shown that there are certain high risk periods which correlate with certain steps or phases of the criminal justice process:

A. Initial time of confinement following arrest

This is the most crucial period, specifically the first three hours, based on the national 1981 survey referred to earlier.

B. When sobering up

Depression frequently sets in when the arrestee/inmate sobers up. Although alcohol is initially a stimulant, its effect is limited, and it soon becomes a depressant for many people, particularly those who drink because of problems.

C. Waiting for trial

The agony of the unknown and just plain waiting produce great anxiety and pressure on many people

D. Sentencing

The day of reckoning, particularly when awaiting or responding to a sentence just handed down, constitutes the breaking point for some inmates. Included in this group is the serious repeat offender who knows what kind of life to expect in prison and cannot bear the thought of returning.

E. Impending release

This phase catches many jail staff off guard because, like ordinary people, they consider that release from jail is something to look forward to. The problem is that, for a potential suicider, the stigma of facing family and friends and fellow workers upon release may be too great. Severe guilt/shame outweighs what ordinary people see as the positives.

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency IV-6

V. High Risk Suicide Periods (con't)

F. Bad news of any kind

Arresting officers, jailers and mental health workers should be aware of some crises which can greatly disturb an inmate. Some examples: "Dear John" letters; a restraining order by a wife prohibiting the husband's return home; getting that "pink slip"; notice of foreclosure on home or farm; a death notice; divorce proceedings.

Transparency IV-7

VI. Signs/Symptoms of Potential Suicide

Experience has shown that certain signs and symptoms often foretell of a possible suicide and, if detected, could often prevent a death. Following are some key warning signs of potential suicide:

A. Current depression or paranoia

B. Previous suicide attempts

C. History of mental illness

D. Under influence of alcohol/drugs

E. First-time arrestee/insignificant arrest

F. Committed heinous crime/one of passion

G. Expresses/evidences strong guilt/shame over offense

H. Previously imprisoned/facing more serious charges

I. Great concern over "What will happen to me?"

Transparency IV-8

Following are other signs or cues of possible suicide intentions:

A. Projects hopelessness or helplessness

B. Speaks unrealistically about getting out of jail

C. Has increasing difficulty relating to others

TRAINING ACTIVITIES	PRESENTATION GUIDE
Transparency IV-8	VI. <u>Signs/Symptoms of Potential Suicide</u> (con't) D. Does not effectively deal with present - preoccupied with past E. Talks about or threatens suicide F. Begins packing belongings G. Starts giving away possessions H. Behavior may change I. Noticeable agitation J. May act very calm once decision is made to kill self K. May try to hurt self.
Transparency IV-9	<u>Depression</u> is the single best indicator of potential suicide; following are common signs and symptoms of depression: A. Prevailing sadness and crying B. Withdrawal/silence C. Loss of appetite D. Weight loss E. Insomnia/awakening early F. Mood variations G. Tenseness H. Lethargy - slowing of movements I. Loss of self-esteem J. Loss of interest in appearance or activities K. Feelings of inability to go on L. Excessive self-blaming M. Guilt feelings.
Transparency IV-10	<u>Agitation</u> frequently precedes suicide; its symptoms are: A. High level of tension B. Anxiety

TRAINING ACTIVITIES		PRESENTATION GUIDE
Transparency IV-10	VI.	Signs/Symptoms of Potential Suicide (con't) C. Strong emotions: -- guilt -- rage -- wish for revenge D. Suicide may follow as means of relieving tension/pressure.
Transparency IV-11		Some jail inmates frequently suffer from delusions and hallucinations; such persons are prime candidates for suicide; voices may tell them to take their own lives. Or they may be overly aggressive and dangerous to others, driven by delusions or hallucinations.
Transparency IV-12	VII.	Assessing Suicidal Risk/Special Aspects of Receiving Screening Experience has clearly shown that properly trained correctional officers/jailers can effectively assess suicidal potential both at booking and while supervising inmates in the general inmate population. Many jails in the AMA Jail Project and its successor agencies reported significant reductions in suicide following the training of officers in awareness and implementation of sound procedures.
Transparency IV-13		Following are common how-to-assess factors: A. Try to gauge intensity of stress -- shame of arrest -- family problems -- job loss -- terminal illness B. Determine impulsiveness C. Look out for "mentals" D. Try to find out suicidal history E. Explore suicide plan if possible F. Assess resources available to help.

TRAINING ACTIVITIES | PRESENTATION GUIDE

Transparency IV-13

VII. Assessing Suicidal Risk/Special Aspects of Receiving Screening (con't)

Receiving Screening

Screening arrestees upon admission is considered the most important aspect of assessing potential suiciders. Following are observational and interview factors taken from the receiving screening form which pertains to screening.3/

"3. Appears to be under the influence of alcohol/drugs?

"4. Are there visible signs of alcohol and/or drug withdrawal?

"5. Does arrestee appear to be despondent/depressed?

"6. Appears to be irrational/mentally ill?

"15. Is this the first time . . . arrested?

"16. Have you ever tried to kill yourself or done serious harm to yourself?

"18. Have you had any previous mental or emotional problems?

"19. Were you ever hospitalized for any mental or emotional problem?

"22. Is there anything special that we should know about you for your welfare or protection?" (Although primarily intended to elicit information concerning gays, this question also may serve as a "red flag" to reveal thoughts of possible suicide.)

Disposition

Any clear "yes" answers to the above should alert staff to possible suicide potential. Generally, there will be several signs/symptoms upon which to make a disposition concerning supervision. Potential suiciders should be:

3/ See Appendix A for a sample of complete receiving screening form.

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency IV-13 VII. Assessing Suicidal Risk/Special Aspects of Receiving Screening (con't)

A. Placed in suicide-proof room under constant supervision, whether by staff, volunteers who are trained or selected, trained inmates who hold around-the-clock suicide watch from the outside of the cell; if none of these are possible,

B. Placed in room/cell with two or more selected, trained inmates who supplement staff supervision. This is a last alternative.

Transparency IV-14 VIII. Handling Potential Suiciders

Experience over the past several years has shown that certain approaches in handling inmates are successful in preventing suicides. The more common of these are:

A. Take all threats of suicide seriously

B. Take time to respond to inmate's talk about how bad he feels

C. Do not reject, condemn or criticize

D. Don't leave suicidal inmate in isolation

E. Try to enlist help of family or friends

F. When possible, quick referral to mental health

G. If tranquilizing medication is prescribed - be sure it is taken

H. Arrange for prompt medical treatment of all injuries.

If an inmate is about to commit suicide, the following approaches are recommended:

A. Do not do anything suddenly . . . stall for time

B. Approach with calm and concern

C. Offer your help . . . ask how you can help

D. Refrain from criticism, anger or sarcasm

E. Listen carefully without challenging

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency IV-14

VIII. Handling Potential Suiciders (con't)

F. Ask:
-- Why are you doing this now?
-- Do you really want to die?

G. If necessary, physically prevent inmate from harming self.

Transparency IV-15

IX. Role of the Correctional Officer/Jailer in Suicide Prevention

The single most important factor in jail suicide prevention is a well-trained correctional officer/jailer. Awareness training is the best description of what the officer needs. Following are basic factors stressing the role of the officer in suicide prevention:

A. BE AWARE of the symptoms ordinarily displayed by an inmate prior to a suicide attempt.

B. BE TUNED IN to the obvious and sometimes subtle signals which every inmate sends out.

C. DAILY CONTACT; by noticing any sudden behavioral changes you may be able to save a life.

D. BE SYMPATHETIC; don't be judgemental. You are responsible for their welfare, not judging moral character.

The mind-set of the correctional officer/jailer, which impacts jail suicides, is depicted in a monograph on the subject, "Non-Rejecting Staff Save Lives - 'Hard', Rejecting Staff can Foster Suicides"

> "It is commonly agreed by suicide experts that, if only one person cares or 'gives a damn,' a suicide will be prevented. If the booking/cell block officers are caring people and show this, some suicides will be prevented because of this positive attitude. Unintentionally neglecting a potential suicider when caught up in the rush of business, the same officer, although

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Transparency IV-15

IX. Role of the Correctional Officer/Jailer in Suicide Prevention (con't)

unaware, can be the means of a suicider being 'pushed over the edge.' The uncaring officer, in short, might be just 'the last straw.'"4/

E. DON'T GIVE UP: if inmate resists help, don't withdraw help and interest. Remain consistently sympathetic. It may be what saves a life.

Transparency IV-16

X. "Suicide-Proof" Architecture/Environment

Since architecture plays an important role in the prevention of jail suicides, following are certain aspects of the physical environment which should be addressed:

A. Rooms/cells should be devoid of fixtures to which a suicide noose can be affixed. This includes:

1. Exposed water sprinklers
2. Air grilles with openings wider than 3/16 inches
3. Wire mesh cages around lights with openings wider than 3/16 inches
4. Clothes hooks which are not collapsible with a few pounds of pressure
5. Shelves and beds with exposed angle support bars
6. Permanent shelves which are at right angles to the wall that do not have solid, triangular end support plates atop the shelf to prevent its supporting a noose
7. Bars which have not been covered on the inside, floor to ceiling, with security mesh/screen or security glazing

4/ Rowan, Joseph R., "Almost All Suicides in Jails and Lockups Can Be Prevented If . . ." a monograph on suicide prevention, Juvenile and Criminal Justice International, Inc., Roseville, Minnesota, 1985.

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency IV-16

X. "Suicide-Proof" Architecture/Environment (con't)

8. Electrical outlets (which inmates have used to electrocute themsleves, aided by the presence of a metal object and water)
9. Exposed utility pipes
10. Towel racks, either on walls or as part of a desk.

B. Doors which have only a small slit not only make it difficult for the officer to observe activities but also produce sensory deprivation for the inmate, leading to depression. The upper half of doors should be of glazing.

C. Obviously, shoe laces, belts and ties should be removed from inmates and placed with their property.

D. Television monitors can assist in providing supervision of those potential suiciders who are confined in a special observation room, but they are not considered a substitute for human supervision. Experience has proven that the staff monitoring TV become immune to what they see on the screen. Actual cases exist in which inmates have literally "died on camera" as well as other incidents in which the officer watched the inmate actually commit suicide but never came to his senses in time to save him through CPR. "TV camera hypnosis" is like "highway hypnosis", or the husband driving down the superhighway for hours, only to exlaim to his wife when he saw the wall map at the rest stop, "My gosh, when did we pass by those three towns?"

E. Taking away all clothes and providing tearaway clothing and blankets, or, its opposite, providing multi-stitched, non-tear clothing, should be considered superficial.

One woman hung herself by braiding a roll of toilet paper into a rope (alternating/overlapping the tear-spots).

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency IV-16 X. "Suicide-Proof" Architecture/Environment (con't)

Another inmate managed to stuff toilet paper into his nostrils and mouth, thus asphixiating himself.

Human interaction, in the form of good correctional officers/jailers who follow the Golden Rule (treat others as you want to be treated) and who have received "awareness" training in suicide prevention, is what is most needed to prevent suicides.5/

5/ The basic materials for this lesson were take from the manual on the Training of Jailers In Receiving Screening and Health Education, American Medical Association, in cooperation with the Department of Governmental Affairs, University of Wisconsin Extension, Madison, Wisconsin and The State Medical Society of Wisconsin, 1978, Unit V, pp. 32-37; and, Ibid.

SAMPLE RECEIVING SCREENING FORM FOR ARRESTEES HELD IN JAILS/LOCKUPS

Arrestee: Name/Number _____ Date _____ Time _____

Jailer's Name _____

Jailer's Visual Opinion:	(CHECK) Yes	No
1. Does arrestee have obvious pain or injury?	____	____
2. Is there obvious sign of infection?	____	____
3. Appears to be under the influence of alcohol/drugs?	____	____
4. Are there visible signs of alcohol and/or drug withdrawal?	____	____
5. Does arrestee appear to be despondent/depressed?	____	____
6. Appears to be irrational/mentally ill?	____	____
7. Appears to be mentally retarded?	____	____
8. Is arrestee small, frail/seemingly weak?	____	____
9. Appears to be gay/effeminate?	____	____
10. Appears to be naive/unsophisticated?	____	____
11. Is arrestee carrying medication?	____	____

Jailer-Arrestee Questionnaire	Yes	No	Refused
12. Presently taking any medication? If YES: For what? _____	___	___	___
13. Use alcohol? If YES: A. How often? _____ B. How much? _____ C. When drunk last? _____ D. When last drink? _____	___	___	___
14. Use any street drugs? If YES: A. Type(s)? _____ B. How often? _____ C. When high last? _____ D. When take last drugs? _____	___	___	___
15. Is this the first time you have ever been jailed?	___	___	___
16. Have you ever tried to kill yourself or done serious harm to yourself?	___	___	___
17. A. Do you have any serious medical or mental problems now? (If YES, check to right and specify problem under REMARKS.)	___	___	___
B. If YES, are you receiving any treatment? (If YES, check to right and specify under REMARKS.)	___	___	___
18. Have you had any previous mental or emotional problems?	___	___	___
19. Were you ever hospitalized for any mental or emotional problems?	___	___	___
20. If female,, are you pregnant? If YES, months? _____	___	___	___
21. Are you on any special diet? If YES, indicate under REMARKS.)	___	___	___
22. Is there anything special that we should know about you for your welfare or protection? (If YES, check to right and indicate below.)	___	___	___

REMARKS: _____

_____

_____

SAMPLE RECEIVING SCREENING FORM FOR ARRESTEES HELD IN JAILS/LOCKUPS

DISPOSITION/REFERRAL TO: (Please check applicable response(s): *

____General population

____Close supervision (potential same-sex rape victim)

____Emergency care (state where): _____

____Sick call

____Placed in one-person cell (#____) (for communicable disease cases).

____Placed in suicide-proof observation room/constant supervision (potential suiciders).

____Placed in two- or more-person cell (#__) under special/close observation (potential suiciders).

NOTE: All "YES" answers require action: See "Guidelines For Disposition".

* Each department/facility should modify the disposition checklist in accordance with its resources and procedures. The above depicts a model approach under recognized practices.

Original form developed in American Medical Association Jail Project, later revised by American Health Care Consultants, both of Chicago; this form revised by Juvenile and Criminal Justice International, Roseville, MN, 3/17/86.

SIGNS AND SYMPTOMS OF COMMON HEALTH PROBLEMS ENCOUNTERED BY ARRESTING OFFICERS AND JAILERS AND SAMPLE GUIDELINES FOR DISPOSITION INCLUDING RECEIVING SCREENING

1. OBVIOUS PAIN/INJURY (Trauma/Serious Illness)

Symptoms:
- a. Obvious pain
- b. Significant bleeding
- c. Untreated fracture(s)
- d. Profuse sweating
- e. Extreme breathing difficulty
- f. Significant vomiting and/or visible signs of trauma/serious illness

Disposition: Take to hospital (unless just minor vomiting or sweating associated with drug or alcohol use).

2. OBVIOUS SIGNS OF INFECTION (Possible Communicable Disease/Extreme Skin Condition)

Symptoms:
- a. Obvious fever
- b. Swollen lymph nodes
- c. Jaundice/yellow skin
- d. Chronic cough/phlegm
- e. Respiratory distress
- f. Uncontrolled vomiting
- g. Diarrhea/cramps
- h. Extreme weakness
- i. Evidence of infection which might spread to others and/or skin in extremely poor condition, e.g., rash, sores, spots, scabs.

Disposition:
- a. Isolate
- b. Take to hospital/Clinic

3, 13, 14. UNDER INFLUENCE - ALCOHOL/DRUGS

Symptoms: Appears to be under the influence of alcohol, barbiturates, heroin or any other drugs:
- a. Slurred speech
- b. Unsteady walk
- c. Confused/disoriented
- d. Dilated pupils
- e. Vomiting, sleepy or hyperactive
- f. Eyes "blood shot"/red

Disposition:
- a. Preferably, do not admit
- b. Refer to detoxification
- c. If subject must be admitted, seek medical clearance first,
- d. Keep under observation

Note: Vomiting is not uncommon for persons under the influence of alcohol/drugs and does not necessarily require a referral to hospital as for other conditions.

4. WITHDRAWAL

Symptoms: Visible signs of alcohol and/or drug withdrawal:
- a. Sweating
- b. Severe shaking
- c. Nausea/vomiting
- d. Pinpoint pupils
- e. Delirium
- f. Hallucinations
- g. Serious breathing difficulties or decreased level of consciousness

Disposition: Take to hospital or detox center

Sample Guidelines for Disposition

Receiving Screening

5. DESPONDENT (Potential Suicide)

Symptoms: a. Appears to be despondent
b. Intensely guilty or shame ridden/remorseful/self-condemning
c. Bereaved
d. Withdrawn

Disposition: a. Constant staff supervision
b. If totally suicide-proof observation room is unavailable, house with selected, trained inmates
c. Refer for mental health services

6. IRRATIONAL BEHAVIOR/MENTAL ILLNESS

Symptoms: Appears to be out of touch with reality:

a. Hearing voices
b. Hallucinating
c. Withdrawn/non-communicative
d. Displays some form of erratic behavior

Disposition: Follow Departmental/Agency General Order: "Handling Persons in Need of Mental Treatment"

7. MENTALLY RETARDED

Symptoms: a. Difficulty understanding questions/commands
b. Slowness in reacting/understanding
c. Short attention span
d. Weak/shortened memory
e. Language problems
f. Poor academic history

Disposition: a. Follow Departmental/Agency General Order: "Handling Mentally Retarded"
b. Refer to appropriate agency
c. If non-existent, exercise close supervision to assure non-victimization

8 - 10 POTENTIAL SAME-SEX RAPE VICTIM

Symptoms: a. Small b. Frail c. Appears weak
d. Naive/gay/effeminate e. Non-urban/non-ghetto

Disposition: a. Orient to jail culture b. Provide close supervision

11,12 MEDICATIONS

Disposition: Follow Departmental/Agency General Order: "Medications Administration"

13,14 UNDER INFLUENCE OF ALCOHOL/DRUGS (See Number 3)

Sample Guidelines for Disposition

Receiving Screening

15. FIRST ARREST

Disposition: A first arrestee, under the influence of alcohol/drugs should be considered a strong suicide risk, particularly if any of the symptoms outlined in #5 of the Screening Form are present. For disposition, follow Guideline in #5.

16. POTENTIAL SUICIDE

Disposition: Follow Guideline #5: "Despondent (Potential Suicide)"

17. SERIOUS MEDICAL PROBLEMS (For Mental Problems, See Disposition #6)

A. HEART CONDITION/ATTACK

Symptoms: Chest pain, pain radiating to arms/shoulders/neck/jaw, shortness of breath, nausea/indigestion, sweating, cold/clammy skin, very pale

Disposition: Take to hospital

B. ABDOMINAL PAIN

Symptoms: Severe pain/cramps, nausea/vomiting, difficult breathing pale, sweating, blood in vomitus

Disposition: Take to hospital

18,19. PREVIOUS MENTAL/EMOTIONAL PROBLEMS/HOSPITALIZATION

a. See Disposition #6 and make disposition on basis of current conditions
b. If previous despondency/depression/despair are reported, follow Guideline #5 for Suicide Prevention

20. PREGNANT

Disposition: a. Refuse admittance if near delivery date; or
b. Monitor closely, i.e., subject being within sight or sound at all times, with frequent visual checks.

21. SPECIAL DIET

Disposition: Alert health care personnel for followup.

22. SPECIAL WELFARE/PROTECTION PROBLEM

Symptoms: a. Subject may express opinion that s/he is gay or transsexual
b. A young, first arrestee who is small and apparently weak may be a target for same-sex attacks (see #8-10).

Disposition: a. Special housing and/or close supervision should be considered
b. Thorough orientation in risk avoidance upon admission

(Sample Form)

PRISONER MEDICAL CLEARANCE REPORT

NAME OF PRISONER_____

BROUGHT INTO JAIL BY_____

DATE_____ TIME_____

We have declined to accept the above-named prisoner into the jail, pending medical clearance, for the following reason(s):

_____
Signature of Jailer Date - Time

.....

NAME OF EXAMINING PHYSICIAN_____

DISPOSITION: (Check appropriate space)

____ I have examined the prisoner and find him/her acceptable for admission to the jail. I have no specific suggestions regarding care of this prisoner for the condition for which I have examined him/her.

____ I have examined the prisoner and find him/her acceptable for admission into the jail. I suggest treatment for the prisoner's condition as described below.

____ I have examined the prisoner and find him/her acceptable for admission to the jail providing the following conditions are met.

____ I have examined the prisoner and find him/her medically unacceptable for admission to the jail.

PHYSICIAN'S REMARKS:

_____ / / /
Signature of Physician Date Time Telephone Number

II. RECOGNITION AND MANAGEMENT OF MENTAL ILLNESS

Session Outline

I. Introduction

- A. A Serious National Problem
- B. Session Objectives

II. What is Mental Illness?

III. Signs and Symptoms of Mental Illnesses: Arrest and Jail Setting Considerations

IV. Medical Conditions with Mental Health-Appearing Symptoms

V. Guidelines for Referral

- A. Legal and Technical Aspects of Referrals
- B. Availability/Quality/Knowledge of Resources

VI. Effective Methods of managing mentally disturbed prisoners/inmates

- A. Dealing with the Disturbed Individual
- B. Special Observations/Housing Assignments

VII. Admission Receiving Screening

- A. What? When? By Whom?
- B. Values and Benefits
- C. How it Operates

Trainer Notes:

1. Please review the trainer guidelines for appropriate application of the training manual
2. Facilitate discussion to time lines established for this module
3. Flip charts should highlight subject matter in each trainee objective

LESSON PLAN

COURSE TITLE: MENTAL HEALTH EDUCATION FOR POLICE, JAIL, AND MENTAL HEALTH PROFESSIONALS

MODULE II: Recognition and Management of Mental Illness

TIME FRAME: 90 Minutes

SPACE REQUIREMENTS: Classroom style sufficient for all participants

INSTRUCTOR MATERIALS/ EQUIPMENT

1. Instructor's Manual
2. Overhead projector/transparencies
3. Chalk board or flip chart and stand
4. Chalk/marking pens, colored
5. Masking tape

TRAINEE MATERIALS: Trainee's Manual, pads, pencils, pens

TRAINEE OBJECTIVES: At the completion of this session trainees will be able to define mental illness.

1. List five signs/symptoms of mental illness common to jail inmates
2. Name at least five medical conditions which can produce signs/symptoms similar to those for mental illness
3. Outline at least four factors in handling inmates with chronic mental illnesses, regarding how they should be observed and housed
4. Outline at least five factors in handling inmates with acute mental illnesses regarding how they should be observed and housed
5. Describe at least five methods of effectively handling the disturbed arrestee/inmate
6. Name the factors or elements necessary to properly refer a case to a mental health agency, as outlined in Virginia laws
7. Outline the essential steps to follow in determining the availability of mental health services for arrested/incarcerated persons in respective communities
8. Define the purpose of mental health receiving screening

LESSON PLAN

9. List four problems easily overlooked without screening

10. Outline the basic elements of a successful receiving screening interview

11. Complete a health receiving screening form

METHOD OF INSTRUCTION: Lecture with group discussion, facilitated by the use of overhead transparencies, flip charts, and exercises.

TRAINING ACTIVITIES	PRESENTATION GUIDE

LECTURE
Transparency II-1

I. INTRODUCTION

A. A Serious National Problem

With the majority of states tightening their involuntary commitment procedure laws, based upon "dangerousness," jails have increasingly become substitute mental health facilities, usually without the resources to do the job properly.

Nationally, serious problems exist in the training of arresting officers, jailers and mental health workers in the recognition and handling of persons who are or appear to be mentally ill.

Working relationships among personnel working in these fields are not generally good.

Criminal justice personnel generally feel uncomfortable with the technical aspects of mental illness; mental health personnel often feel uncomfortable with the control factor involved in handling arrestees/inmates. The expression, "Nobody wants to work with the acting-out offender" is often heard.

The existence of this training package is evidence that the Commonwealth of Virginia is taking a national leadership role in resolving this serious problem.

SESSION OBJECTIVES
Transparency II-2

B. (Please outline "Lesson Objectives" from lesson plan.)

Transparency II-3

II. What is Mental Illness?

The Code of Virginia (Section 37.1-1) defines the mentally ill as: Any person afflicted with mental disease to such an extent that for his own welfare or the welfare of others, he requires care and treatment, provided that, for the purposes of Chapter 2 (Section 37.1-63 et. seg) of this title, the term "mentally ill" shall be deemed to include any person who is a drug addict or alcoholic. (Chapter 2 states that determinations, certifications, or orders of record related to the mentally ill are also applicable to the mentally retarded, alcoholic or drug addict.)

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency II-3

II. What is Mental Illness? (con't)

Mental illness is a common term used to describe a group of several distinct disorders which have a range of severity in terms of the symptoms associated with it. All of the disorders in this group have certain features in common. They are characterized by disturbances in behavior, thinking (cognition), and emotion (affect). These features or symptoms are observable and may appear in groups or clusters. Again, the symptoms can range from mild (hardly noticeable) to severe (usually noticeable to persons interacting with the person). The types of mental illness that will concern us primarily are those that result in severe symptoms and those we consider as a state of psychosis. Most important, in this setting, are those symptoms which indicate that the person may be of potential harm to him/herself or others. We are talking about schizophrenia and paranoia, which are cognitive disorders, and affective disorders such as mania and major depression. These symptoms may range from moderate to severe and are observable.

The critical issue for professionals in law enforcement and local corrections is the notation of observations on the prisoner's physical and mental condition and reporting those observations to persons responsible for the prisoner's care and custody. Please remember to make careful observations and report exactly what you see and hear. Do not diagnose or draw conclusions on the prisoner's condition.

Transparency II-4

III. Signs and Symptoms of Mental Illness: Jail Setting Consideration

There are a number of signs/symptoms which indicate mental or emotional distress. Many of these same signs are exhibited by normal individuals when undergoing stress. In the street and jail settings, mental illness is distinguished by extreme degree of emotions/behavior and their inappropriateness to a given situation. Behavior unusual for that particular individual could be a sign of distress or a worsening condition.1/

1/ Training of Jailers In Receiving Screening and Health Education, American Medical Association, in cooperation with the Department of Governmental Affairs, University of Wisconsin Extension, Madison, Wisconsin and the State Medical Society of Wisconsin, 1978, Unit V, pp. 25-28.

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency II-4

III. Signs and Symptoms of Mental Illness Common to Arrestees/Jail Inmates (con't)

The arresting officer and jailer are not expected to diagnose, i.e., correlate cause and effect. Depending upon the qualifications of the mental health worker, s/he also may be unable to diagnose.

Hence, the basic job is to observe common signs and symptoms and take action/report them to the proper source so as to aid later diagnosis and interim decision-making regarding handling.

The following signs and symptoms may indicate mental illness, if they are distinguished by extreme degree and inappropriateness to the situation. In addition, behavior which is unusual for that individual may indicate mental illness or a more severe state of it, as in the case of chronic mentally ill persons:

A. Fear
B. Anxiety
C. Withdrawal
D. Anger
E. Confusion
F. Depression/suicidal ideations
G. Mania (exaggerated gaiety, non-stop energy)
H. Delusions, i.e., thinks he is God/famous person
I. Hallucinations, i.e., hears voices, sees visions
J. Unusual/unreal physical symptoms
K. Feels people are plotting against him.

CAUTION Trainees: Report only what seen/heard; do not draw conclusions.

Transparency II-5

IV. Medical Conditions with Mental Health-Appearing Symptoms

The following medical conditions can produce signs/symptoms similar to those associated with mental illness. Some pertain to life-threatening conditions which, if diagnosed wrongly as mental illness, could mean loss of life. Hence, workers should report symptoms, not diagnose:

A. Diabetes
B. Severe infection
C. Head injury
D. Medication side effects
E. Alcohol and other drugs
F. High blood pressure
G. Epilepsy
H. Hardening of arteries 2/

2/ Ibid., pp. 30-31.

TRAINING ACTIVITIES PRESENTATION GUIDE

Transparency II-6

V. Availability/Knowledge of Resources

Ninety percent of the respondents to JCJI's 1985 survey of mental health services in Virginia said that programs existed in their communities for referral of mentally ill persons at the time of arrest. "Regular" referrals were made, according to 58 percent of the respondents; 20 percent said "frequently"; and another 22 percent said "occasionally." Overall, this is a positive response.

Reasons cited for non-referral were:

1. Lack of space for treatment of the mentally ill, cited by several respondents;

2. Lack of awareness of programs by criminal justice personnel was mentioned only three times;

3. Poor communications and understanding between agencies were cited six times. These appear to be the problems needing the most attention in this area.

VI. Effective Management of Arrestees/Inmates

Transparency II-7

A. Dealing with the Disturbed Individual

By following the "Do's and Don't's" of good discipline, effective management of disturbed persons will be a reality.

1. Fairness

Even when racial tensions were at their peak on America's streets, many inmates surveyed in jails and prisons said that fairness of officers mattered more to them than skin color. In fact, fairness in officers is ranked highest among all other attributes.

2. No favorites

When correctional officers have favorites among inmates, other inmates say it is not fair. Frequently the favorites picked are the sophisticated offenders.

3. Kept promises

Broken promises are lies to inmates and despised by fellow staff who must deal with the disgruntled inmate on a later shift.

Transparency II-7 VI. Effective Management of Arrestees/Inmates (con't)

4. Not power hungry

   This term, used to describe some correctional officers, is used by both other officers and inmates, but mainly by the former.

5. Admitted mistakes

   The officer who admits his mistakes is elevated, not lowered, in the eyes of others, although admitting mistakes seems to be one of the more difficult things for officers to do.

6. No Put-downs/non-condescending

   Secure, self-confident officers do not have to resort to put-downs; they treat fellow workers and inmates on an "eyeball-to-eyeball" basis.

7. No washing of dirty linen/no open criticism of staff

   A lot of problems in detention facilities center around these negative characteristics. They are insidious and devastating.

8. Answered questions

   Many officers don't/won't answer questions; or, when they do, frequently counter with "Why do you want to know?" or, "What business of yours is it?" Not to provide inmates with answers, whenever known, is a serious problem in many jails.

9. Asked, not always ordered to do things

10. Were consistent/used reasoning

11. Talked with us

    Contrarily, some officers (and jails) follow the policy (written or unwritten) of not getting involved with the inmates. Thus, they are guards, not correctional officers.

TRAINING ACTIVITIES PRESENTATION GUIDE

Transparency II-7 VI. Effective Management of Arrestees/Inmates (con't)

12. We looked up to them

Water runs downhill, but gravity for human beings is uphill. Inmates are generally looking for good role models, contrary to what they may appear to be doing by their behavior.

13. Were team workers

While this comment comes mainly from staff, many inmates are quick to pick out the "loner" or uncooperative member among staff personnel.

14. Self-confident, not arrogant

The self-confident officer sells what s/he can deliver; the arrogant person oversells and is usually the officer who doesn't think much of him/herself.

15. Were sincere and honest

16. Gave credit when credit was due

Most jail supervisors seem to be constantly looking for things that go wrong; most efforts of supervisors should instead be devoted to seeking out positives, an approach increasingly stressed in business and industry and patterned in part after Japanese industry. Officers, in turn, generally follow the practice of their superiors in dealing with inmates.

17. Knew how to accept criticism

This is a serious problem among jail staff, perhaps in part because the field, by its very nature, is a negative one, and the jails are often under the spotlight of public criticism.

18. They had open minds

Our crisis-oriented field direly needs adaptability and flexibility instead of rigidity and resistance to change, which appears to be a part of this problem.

TRAINING ACTIVITIES PRESENTATION GUIDE

Transparency II-7 VI. Effective Management of Arrestees/Inmates (con't)

19. Didn't keep threatening

Like many parents, some officers keep threatening, and inmates soon learn that a great deal of it is bluff; this produces poor respect and poor discipline.

20. Not "bent out of shape"

Inmates readily recognize those officers who come to work "bent out of shape" due to psychological/family problems, drinking and for other reasons. Respect where this exists is hard, if not impossible to earn.

21. No yelling or swearing

Some officers defend this on the grounds that "That's all the inmates know." However, such language means getting down to their level, not serving as that much needed positive role model.

22. They did more than was expected of them

The "average" officer generally will not make the top quarter of the rating list. As someone once said, "The two percent extra effort can make a 100-percent difference."

23. They were patient

It is felt that the patient officers are the secure officers who follow the Golden Rule.

24. Didn't give up easily

The officer who doesn't easily give up on an inmate may be the sole factor of change in that inmate's life. This characteristic conveys the feeling that "someone cares."

25. Didn't preach

Inmates generally resist/resent "preachy", judgemental officers, as do officers when supervisors follow that approach.

TRAINING ACTIVITIES | PRESENTATION GUIDE

Transparency II-7

VI. Effective Management of Arrestees/Inmates (con't)

26. They cared

This characteristic is frequently mentioned, in part because of the contrast found in those staff who "care" and those who put themselves first and others second, including agency, supervisors and fellow workers.3/

It cannot be over-emphasized that those good practices found in the 26 "Do's and Don't's of Good Custody/Discipline", if followed in managing general jail population inmates, will make the jailer an effective agent of change.

Transparency II-8

Special aspects to be followed by arresting officers/jailers and mental health workers in the handling of mentally ill persons are:

1. Try to calm individual and relieve anxiety by being calm, confident, firm, fair and reasonable yourself.

2. Explain:
   a. How you see problem
   b. What is being done
   c. What outcome will be.

3. Say that crisis is just temporary - things can be worked out.

4. Encourage arrestee/inmate to:
   a. Speak freely
   b. Express feelings
   c. Relate to you.

5. Remove from scene of crisis, when other persons are present and there may be psychological contagion.

3/ The basic material outlined in this lesson was adapted from "Curriculum on Professionalization of Correctional Officers/Jailers - with Emphasis on Suicide Prevention and Effecting Better Discipline/Custody," Juvenile and Criminal Justice International, Inc., Roseville, MN., 1984.

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency II-8

VI. Effective Management of Arrestees/Inmates (con't)

6. Avoid arguing

7. Help arrestee/inmate structure the experience so that:
   a. It is not so chaotic
   b. It does not appear unusual

8. Do NOT:
   a. Be sarcastic
   b. Lie
   c. Make promises that can't be kept.

Transparency II-9

B. Special Observation/Housing Assignments

1. Chronic (long-term) mentally ill inmates can be kept in the general jail population unless they are dangerous or need special observation.

2. Following are special aspects of supervising chronic mentally ill inmates/arrestees:
   a. Should be considered unpredictable;
   b. If diagnosed as being "dangerous," they should not be assigned to risk positions, such as in a kitchen, or serving as a trustee, where they can have access to toxic cleaning supplies, etc.
   c. There should be periodic, recorded visual checks made
   d. Their case should be verbally reviewed with relief staff at shift change
   e. Caution : Sudden changes demand attention.

Transparency II-10

3. Acute, seriously disturbed arrestees/inmates should be housed in a special unit:
   a. Located near control post or nursing station

TRAINING ACTIVITIES | PRESENTATION GUIDE

Transparency II-10

VI. Effective Management of Arrestees/Inmates (con't)

b. Under supervision of registered nurse

c. Mental health trained staff, including jailers, on duty 24 hours

d. All inmates are within sight or sound of a health trained staff person

e. Potential suiciders are under constant supervision

f. Rooms/cells are devoid of noose anchors

g. Upper half of doors are transparent

h. If all of aforementioned is not possible, house subject with selected, oriented/trained inmates.

VII. Admission Receiving Screening

Initial health screening upon admission is considered by many health care professionals as the most important aspect of the entire health care system.

Transparency II-11

A. What? When? By Whom?

1. What?

Receiving screening consists of three aspects:

a. Observation by the booking officer/jailer or, as in some jails, by health care personnel.

Discuss Form; Ask questions

Please refer to Appendix A, p. 1, for a sample receiving screening form outlining this aspect of the concept.

b. Jailer-Arrestee Questionnaire. This aspect consists of eleven questions cerning a variety of medical and mental health matters.

Discuss Form; Ask questions

Please refer to Appendix A, p. 2 for details.

c. Disposition Referral. This is an extremely important step because it documents what the booking officer or other screener observed/ascertained from the questions - a key factor in effective followup and lawsuit prevention.

TRAINING ACTIVITIES | PRESENTATION GUIDE

Transparency II-11 VII. Admission Receiving Screening (con't)

Discuss Form; Ask questions

Please refer to Appendix A, p. 3 for details of this process.

2. When?

Receiving screening should be conducted immediately upon arrival at the jail/holding facility. Deaths have taken place in holding pens/rooms/cells, waiting for receiving screening to be done the next morning when nursing and other registered/licensed professional staff come to work. Further, communicable diseases have been seriously spread because of the delay.

3. By Whom?

In the majority of jails, trained booking officers are known to do a creditable job of screening. The American Medical Association, representing the nation's physicians, strongly supported the concept of health-trained booking officers doing the screening.

In a few facilities, primarily large jails, receiving screening is done by EMTs and/or nurses.

Transparency II-12 B. Values and Benefits of Receiving Screening

The practice of receiving screening is formally about ten years old. It has many proven benefits:

1. Traumas, possible illnesses and infectious diseases are detected.

2. Possible drug/alcohol abuse/withdrawal can be assessed.

3. Early evaluation and treatment of chronic and acute mental illnesses can be effected.

4. Medications use is determined.

5. Legal liability protection; a number of lawsuits which were begun by inmates, were dropped after their attorneys reviewed the results of receiving screening.

TRAINING ACTIVITIES PRESENTATION GUIDE

VII. Admission Receiving Screening (con't)

Transparency II-13

C. How It Operates

1. Observation by the officer while s/he is booking:

   a. S/he notes behavior, speech, actions, attitudes and state of mind of the arrestee.

   b. Traumas/bruises, skin conditions/color are noted.

   c. Visible signs of drug/alcohol use and withdrawal are observed.

   d. Medications use is determined.

2. The questionnaire serves as a beginning, but screeners are encouraged to ask followup questions to elicit additional information.

   Experience in the AMA Jail Project has clearly shown that, when interviews with arrestees are properly conducted, over 90 percent of the responses will be truthful. What constitutes an effective interview?

   a. Explaining, as simply as possible, the rationale for what you're doing, as, "I'm going to ask you some questions which we ask all arrestees, because we are interested in your welfare," thus removing feelings of paranoia, or that s/he is being "picked on".

   b. Asking questions in a common-sense manner, as privately as the setting permits.

   c. Speaking in a normal, matter-of-fact tone of voice.

   d. Not being rushy, abrupt or sarcastic

   e. If not understood, repeat question slowly and clearly.

TRAINING ACTIVITIES PRESENTATION GUIDE

Transparency II-13 VII. Admission Receiving Screening (con't)

An effective interviewer impresses the arrestee that "somebody cares." After the trauma of arrest and incarceration, properly conducted receiving screening settles the inmate, relieving his tensions and anxieties. Jail administrators and officers who work where there are good receiving screening systems, testify to the positive effect on inmates and staff alike. The foundation of the process is the successful interview.

3. Refusal at admission/requiring medical clearance

While refusals at admission are not as common for suspected cases of mental illness as they are for medical traumas, they do occur and should be pursued when indicated:

"Prisoners who Seem Very Confused or Disoriented

Such a prisoner may be mentally ill, emotionally disturbed. Or he may be suffering from an adverse drug reaction. He may have recently suffered a severe head injury. Or he may be very ill. If a prisoner seems very confused, if he doesn't seem to know who he is or where he is or what is happening, have him professionally evaluated before you accept him. He may be just momentarily confused, or he may be in need of medical or psychiatric aid. It is not your job to diagnose his problem; it is your job to have him examined and evaluated before you admit him to your custody."4/

Following are other reasons why medical clearance should be sought prior to admitting an arrestee:

a. Prisoners who are unconscious

b. Prisoners with any significant external bleeding

c. Prisoners with any obvious fractures (broken bones)

d. Prisoners with any signs of head injury

TRAINING ACTIVITIES	PRESENTATION GUIDE

Transparency II-13 VII. Admission Receiving Screening (con't)

e. Prisoners who may have neck or spine injury

f. Prisoners with any other sort of severe injury

g. Prisoners who cannot walk under their own power

h. Prisoners displaying any signs or symptoms of possible internal bleeding

i. Prisoners with severe abdominal pain

j. Prisoners displaying signs of drug or alcohol abuse

k. Pregnant women in labor

l. Pregnant women with other serious problems

m. Prisoners who claim that they need certain types of medication but who do not have such medication with them. 4/

Exercise: 20 minutes
Process Receiving Screening Form and Medical Clearance Report

Directions

1. Ask all participants to count off.

2. Have odd numbered participants complete the receiving screening form on even numbered participants. Also, complete the disposition check list and the medical clearance report.

4/ Training of Jailers, op. cit., Unit II, pp. 1-14.

How Do You Pick Out the Suicider?

Booking officers should interview all arrestees **immediately** upon admission (receiving screening) using a form containing both a series of **observation** factors and **questions** concerning health and related matters. Booking officers can be quickly trained to do as good a job of screening as the more highly trained professionals. Asking all arrestees about any prior suicide attempts, prior emotional/mental problems and how they currently feel about themselves (particularly first-time arrestees, about **their offense)** will probably bring to the surface any existing suicide symptoms and verbal cues which can be vital in preventing suicides. Mental health experts support these practices as being sound.

Some verbal or symbolic cues to look for are expressions of:

1. Despair/hopelessness.
2. Poor self image/inadequacy.
3. Great concern over "What will happen to me?"

Non-Rejecting Staff Save Lives — "Hard", Rejecting Staff Can Foster Suicides

It is commonly agreed by suicide experts, that, if only one person cares or "gives a damn," a suicide will be prevented. If the booking/cell block officers are caring people and show this, some suicides will be prevented because of this positive attitude. Unintentionally neglecting a potential suicider when caught up in the rush of business, the same officer, although unaware, can be the means of a suicider being "pushed over the edge." The **uncaring** officer, in short, might be just "the last straw."

Lawsuit Areas

Failure to **train, supervise** and **direct** jail staff constitutes three of the "sins of management" which weigh heavily in lawsuits. This is particularly true when the issue is preventing deaths in jails. **Mandatory** training of jailers is **positively** regarded by the courts. The status of these factors determines "administrative intent," a major factor influencing court decisions.

What about the legal liability of the officer himself? Negligent performance by a jail officer, including failure to respond to what are considered obvious signs/symptoms of suicide, can make him legally liable.

Almost All Suicides in Jails and Lockups Can Be Prevented If . . .

URGENT

Read this **Before** You Build a New Jail — Both Single and Multiple-Cell Facilities Have Problems.

A Monograph on Suicide Prevention

by

JOSEPH R. ROWAN
Executive Director
Juvenile and Criminal Justice International, Inc.
381 South Owasso Blvd.
Roseville, Minnesota 55113
(612) 481-9644

SUICIDE, not **homicide,** is the Number One cause of death in jails and lockups!

In recent years suicides in lockups and jails, with accompanying **lawsuits,** have been increasing in alarming numbers. Why?

While there are various theories, one factor is **certain:** criminal justice experts did not anticipate and were unprepared for the fact that the drive toward implementing the "one-man-per-cell" concept would bring an **increase** in jail and lockup suicides.

Although the relatively new "one-man-per-cell" concept has its merits overall, without significant changes in practices and better architectural planning, the single cell approach, as born out by experience in the AMA Jail Project and elsewhere, is certainly not a problem-free panacea.

England, over many decades with the single-cell concept, had a large number of suicides. Then they were forced to go to multiple celling because of over-crowding, and they immediately noticed a dramatic **decrease** in the suicide rate. Most of their jails and prisons now use "communal" cells which house three or four inmates. The head of their prison/jail officers association recently reported that, while various groups keep pushing for a return of the one-man cells, the government is holding firm against it because of the lives which have been saved. He stressed that, "It is more humanitarian to use communal cells, since it is more natural for human beings to want to be together rather than being isolated."

With some single-cell jails in this country arranged along a narrow corridor, lacking not only the possibility for interaction with fellow cellmates but, more importantly, observation by the officer only when he passes the cell, it can be expected that suicides will be more prevalent.

In 1981 a national survey of jail and lockup suicides by the National Center on Institutions and Alternatives, Washington, DC, showed that two-thirds of jail suicides were committed by inmates in single-cell/isolation, where they were "placed for their own protection and/or surveillance" (a common entry in lockup and jail logs). It is believed that many of these suicides would never have occurred had jailers left them in holding cells or dormitory cell blocks in the presence of other inmates.

The exception to this, and much more preferable, would be for staff and/or volunteer supervision to be provided **constantly** in special observation rooms/cells, instead of checks every 15 to 30 minutes, which are totally inadequate for supervising potential suiciders.

It is only now becoming clear to us that during these many years multiple-bed cells/dormitories were in many instances responsible for **preventing** suicides. The criminal justice field's major and legitimate concerns in advocating one-man-per-cell were to prevent homosexual/same-sex attacks, assaults and homicides. But which of us knew that, in demanding one-man-per-cell, **more** lives would be lost than saved **unless we exercised extra precautions.**

This sad situation will become an even greater crisis if we rigidly insist on enforcing the "one-man-per-cell" standard/concept without amending or modifying its application, i.e., in **exceptional** cases, as a **last resort** for potential suiciders.

What Prevents Suicides?

A sufficient number of properly trained staff, receiving screening upon admission (supplemented by classification), constant supervision of potential suiciders and a "suicide-proof" environment constitute the greatest prevention factors. Can jails do it? Yes. There was a significant reduction in suicides and not one new successful lawsuit in over six years in the 177 jails accredited in the American Medical Association's Jail Project.

Some jails have 24-hour crisis/mental health workers who counsel with potential suiciders referred by officers. Other jails make referrals to local mental health agencies.

In 90 percent or more of the jails/lockups, however, the well trained (hopefully) caring jailer will be the only suicide prevention worker around. This is because about two-thirds of the jails have only one staff person, the jailer, on duty at any one time, and only a small percentage of all jails have access to mental health services. It has been demonstrated that such jailers can be trained to do an outstanding suicide prevention job. They can be quickly trained to recognize the symptoms of potential suicides and to be supportive persons in preventing them. This subject will be covered later.

In the jail dormitory, or multiple-cell setting, the other inmates help prevent suicides. Many incidents have been reported by sheriffs and jail superintendents in which other inmates have successfully discouraged (sometimes with physical force) the potential suicider from completing the act. Such help from inmates has far outnumbered those other instances in which the cell mate goaded another inmate into committing suicide or sat passively while the act was being carried out.

No one knows, moreover, how many suicides have been prevented by the sounds of a restless inmate during the night whose presence within hearing distance of the inmate may have been an inhibiting factor.

The decision on which model to follow must be made by the jail administrator and/or governing/financing bodies even **before** the jail is built. Some new, large urban jails now being planned intend to follow the dormitory model. But the same caution must be exercised here as in planning the single-cell jails: adequate, **properly trained staff,** receiving screening/classification and **constant** supervision are necessary for preventing serious, although different problems, i.e., homosexual/same-sex attacks, assaults and homicides.

While the number of jail homicides is **fewer** than that of suicides, the toll in lives ruined from same-sex attacks is heavy. Unlike the reports of suicides, which generally become known, same-sex attacks frequently remain unknown because of the code of silence. Although dormitories are "cheaper to build", responsible administrators have the obligation to fight for adequate staffing to protect lives as much as do single-cell jail administrators. Otherwise, lawsuits will be just as common in that model. It is obvious that these resources have not been adequately provided in the past; otherwise, there would not have been the strong drive for the "one-man-per-cell" standard.

The serious concern of JCJI is that the "getting-by-cheap" syndrome, so common in the criminal justice field, doesn't similarly plague single-cell jails and lockups. Having the upper half of the walls and doors of suicide watch rooms made of security glass for clear, constant observation by trained staff and also having the availability of mental health/crisis services may be expensive, but in the long run the lawsuit judgements would far exceed the cost of these preventive measures. Otherwise, without this planning in advance and **obtaining** adequate resources, we will not have saved more lives, and we won't be any farther ahead than before.

JCJI's much preferred approach, based on 43 years' experience of its Executive Director, including his six years' experience in directing the American Medical Association's Jail Project, is the one-man-per-cell concept, with screening upon admission by trained booking officers, proper classification and **constant** supervision of potential suiciders in suicide-proof cells. This approach, obviously, requires an adequate number of trained, non-rejecting staff.

Unfortunately, in about three-quarters of all jails, primarily those which are small, there is only **one** staff person on duty during the hours of most suicides, - at night. That **one staff person** must handle dispatching and all other duties, as well as being required to keep watch on inmates. Frequently, the cells are "out back", with no audio or visual monitoring. Even a staff person who is properly trained in detecting a potential suicider upon admission cannot always keep watch on all that goes on in such a lockup or jail.

No lockup or jail should be run by a single staff person who is trying to perform all duties. Hence, additional staffing should be vigorously pursued. Without it, the jail or lockup should try to obtain "on-

call" **volunteers,** persons who are oriented for the job.

Many jails use volunteers for a variety of purposes. Experience has shown that, if properly screened, oriented and supervised, they can be treated like staff in all aspects except pay.

But what to do until the volunteer arrives, or in the event one is not available? Jails/lockups should at this point consider using a selected inmate as a suicide-watch companion, as does the Federal Bureau of Prisons, which is set up in such a way that there is no possibility of physical contact. S/he can be stationed in an adjacent cell or in one across the hall or in front of the cell.

Those facilities which do not have the proper physical layout for the above, i.e., no sally port or catwalk, observation is not possible from another cell, or no perimeter security other than the cells, should consider another alternative.

It is at this time that consideration be given to placing the potential suicider in a multi-bed cell/dormitory with other selected inmates who can watch him, or at least whose presence in the same cell acts as an inhibitory force. Preferably, such inmates should be oriented for suicide "watch", as well as alerting jail staff of problems.

This approach has been successfully used in many public and private mental hospitals for many years without any legal problems. In fact, most jails with dormitories, where potential suicides were **not** removed and placed in isolation, have been unknowingly using this approach for years, not realizing that they were **saving lives** at the same time.

The matter of "multiple" celling under those circumstances (as a last resort) has been discussed with some of the best criminal justice legal scholars who are confident that the courts will **not** rule against administrators who, having pursued all other means, are trying to save lives.

All Newly Built Jails Are Not Suicide-Proof

Architects have not always been conscientious about possible suiciders in their designs for new jails. Exposed bars, wide-vent air intake and exhaust grilles or gratings and exposed water sprinklers are easily used to affix a noose. Architects have also been lax in not placing the control room officer in full view of the cells. Narrow slits for observation exist in some doors. One warden said he planned on removing the cell doors so his officers could see what was happening inside the cell. Still another warden said that the old cell doors with bars were better for observation. Wide security glass for clearer observation should exist, at least in the upper half of the doors.

The second floors in some modules unnecessarily project out so far that observation from the control rooms is partially cut off.

Many doors of infirmaries or sick bay rooms in new jails have been provided with only narrow vertical slits, either open or glassed in, on the premise that privacy is needed, whereas experience shows that dark rooms with little of an outside view produce depression, besides being very difficult to supervise.

Symptoms of Potential Suiciders

The most common profile of suiciders is:

1. First-time arrestee or insignificant history of prior arrests.
2. Age 20-25, single, male, white (although in some large urban jails they were black).
3. Arrested on a minor charge, frequently intoxication; hence, under the influence of alcohol.
4. Excessively depressed/ashamed/guilt ridden over the crime charged (which appears more serious than normal in their own minds).
5. Commits suicide within three hours of arrest, during hours of darkness.
6. No **documented**/known history of mental illness or previous suicide attempts.

COMMENTS: Many jurisdictions, instead of confining this type of arrestee, release him on his own recognizance and/or refer for detoxification, thus totally avoiding a potential jail suicide. If confined in jail/lockup, this type of arrestee is kept under **close,** "eye contact" supervision in the holding area or in special observation cells/rooms. When the individual becomes sober, it is common for him to feel depressed. Add to this the combined trauma of it being his first arrest, the experience of booking, confinement alone in a cell, strange odors, and strong guilt feelings/remorse over the offense. The result is a potential suicider.

Other, Less Common but Important Warning Signals are:

1. Prior suicide attempts.
2. Prior record of mental illness.
3. Persons who have committed heinous crimes.
4. Persons who have been in prison before, now face more serious charges and have a hopeless outlook on returning to prison.