SUICIDE PREVENTION

In Juvenile Facilities

January 1982

Department of the Youth Authority

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Region IV—Division of Field Services

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INTRODUCTION

SUICIDE PREVENTION IN JUVENILE FACILITIES

Death must inevitably be a lonely experience, and nowhere more lonely than in custody. Isolated from family, friends, and most of the compensations for the hardships of life, locked in a small room, inhibited by fear, depression, and guilt, people often think about taking that solitary final trip from which there is no return. Choosing the total isolation of death, they attempt to hang or cut themselves. If their loneliness and isolation can be broken by the contact, concern, and caring of another human being, the final step towards death might not be taken.

This is paraphrased from a publication by an organization called *Lifeline,* a volunteer group which works with inmates in Boston, Mass.; and describes the basic purpose of this publication.

Suicide prevention in any institutional setting is a humanitarian effort, as well as a self-protection measure. A suicide or attempted suicide within such a facility, besides being a tragic event, has definite legal ramifications. An increasing number of wrongful death suits initiated by concerned third parties has been experienced by jails and detention facilities, both adult and juvenile, throughout the Country.

There exists a pressing need to develop a profile of the individual who is likely to commit suicide, as identification of suicide-prone persons is the crux of an effective suicide prevention program. Also, the determination of environmental factors which both directly and indirectly contribute to suicidal behavior is essential. This should be followed by the development and implementation of specific operational procedures designed to respond to attempted suicides and/or to prevent their recurrence. Finally, facility staff should be trained in recognizing suicide-prone individuals and in dealing with them in humane and effective ways.

County-administered facilities for juvenile offenders in California have done a good job over the years in suicide prevention programming. As far as is known, all such facilities have programs in effect. They vary in nature and sophistication, based upon such factors as design and structural features, staffing, location, and access to medical/psychiatric care and other resources. According to a recent report by a suicide prevention committee convened by the Los Angeles County Probation Department, there were only 15 suicides in the past five years in both county and Youth Authority facilities; and Los Angeles County has experienced only four in their history of operating such facilities. Furthermore, revised juvenile hall standards adopted in 1978 require that any death of a minor be reported to the Youth Authority (15 Cal Adm Code 4308); and in all cases, inspections resulting from these reports have concluded that facilities appeared to be in compliance with minimum standards at the time of the occurrences.

The fact remains, however, that suicide is the second leading cause of death among youth. It is generally held that such acts occur out of feelings of isolation, humiliation, parental deprivation, depression, and a lack of self-worth. These feelings are much more likely to be prevalent among youth held

in juvenile facilities. This is documented by a study conducted by the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, which concluded that the incidence of suicide among detained youth was higher than that of the general population. This has *not* been the case in California, however.

The purpose of this publication is to provide counties with some information with which to assess and compare procedures already in place, in terms of completeness and adequacy. It is presented in four major categories—identification, procedural factors, structural factors, and training of personnel. It should not be considered a model, although it does represent something of a composite of current thinking among correctional practitioners and sample county procedures and training plans.

Persons who are in any way involved in the arrest, intake, reception, and supervision and care of minors in detention and treatment facilities comprise a cadre of concerned individuals to whom this information may be of value. The material is designed to provide a resource for training of such persons and as a reference in establishing and implementing appropriate procedures. Some points and concepts may be repeated, due to the extent of the material drawn upon in preparing this publication. In some instances, repetition may be a good measure for added emphasis. When it is not, we ask that you bear with us in hopes that the total information presented here will be useful to the reader, resulting in better understanding and improved procedures.

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THE SUICIDE PHENOMENON

The rate of childhood suicide is increasing rapidly. Also on the sharp statistical rise are teenage and child pregnancy, teen and child prostitution and pornography, venereal disease, truancy, illiteracy, criminality, and teen and child drug addiction and alcoholism. By far the most terrible aspect of the flight from childhood is suicide and there are no indications that the rate of youthful suicide, drug abuse, and alcoholism will decrease. Teenage suicide is on the increase, with 5,000 suicides by young people every year. Suicide among 14 to 24 year olds has risen by nearly 300% in twenty years. It has risen so sharply that it has reached epidemic proportions. Every day 13 more young people take their own lives. According to estimates, 57 American children attempt suicide every hour.

Suicide is now the second leading cause of death among young people, having risen from fifth place five years ago. Accidents rank first among teens. Mental health professionals, however, often list accidental deaths among teens as hidden suicide statistics; for this reason they count suicide as the Number One—not Number Two—cause of death among young people. Suicide among the young is assumed to be significantly under-reported. Between 1968 and 1976, 800 deaths among children 10 to 14 years of age were of "undetermined" causes. This, coupled with the strong psychological denial in families of kids who commit suicide, suggests actual rates may be a lot higher than reported rates.

SUICIDE—OCTOBER 1975 by: Tom Frazier

The following is a paper entitled "Suicide—October 1975" by Tom Frazier. Mr. Frazier has a Masters Degree in Social Work and worked several years for the Departments of Corrections and Youth Authority. He was a Treatment Team Supervisor at the O.H. Close School for Boys in Stockton and was a forerunner in the application of the Transactional Analysis (TA) treatment modality in YA institutional programs. He has done extensive training within YA institutions and parole programs. He has left the Department and more recently has acted as a consultant specializing in TA and team building.

His 1975 paper on "Suicide" is included only for the purpose of providing the reader some historical and philosophical perspective as well as background information about the problem of suicide. Any opinions or conclusions expressed in the paper are Mr. Frazier's and do not necessarily reflect those of the Department of the Youth Authority or the Chief Probation Officers of California.

At least 20,000 men, women and children commit suicide every year in the United States. Suicide is the tenth leading cause of death. In the Pacific Coast States, suicide is higher than the U.S. average, and in California it is the sixth or seventh leading cause of death. For every suicide there are eight to ten attempts. Suicides among whites is 11 per 100,000 of population, and among non-whites, it is only 5.5. The number of adolescent suicides is low in relation to the total number of suicides but the risk is very high (it is the third ranking cause of death). The number of suicide attempts and suicides among adolescents have gone up fairly dramatically.

In over half of all suicide deaths there is a history of previous, spontaneous suicidal communications ("I'm gonna shoot myself"). Seventy-five percent of suicides have seen a doctor, for one reason or another, within six months of their death, and 95% are said to have some kind of psychiatric illness. Only about 10% of those who attempt suicide and do not kill themselves actually commit suicide successfully at some later date. There are some high risk populations in the area of suicides, namely, college students, alcoholics, mental patients, the aged, and, to a greater degree than previously thought, the young. As said above in 1970–1972, the suicide rate for the 15 to 24 year age group was almost doubled as compared with the average for that age group during the prior 25 years.

The literature describes three broad categories of suicidal behavior; a) completed suicides, b) attempted suicides, and c) suicidal ideas. Among those making suicidal attempts there are two groups: A) The larger group making gestures and telling that they are in a crisis; this group has a relatively good prognosis for survival. B) There is a smaller group of people who make more lethal and yet less communicative suicide attempts and they have a very high mortality rate.

By far, the most frequent way of committing suicide is to take in solids (pills), liquids and gases. The second means are firearms and explosives, followed by hangings and strangulations, then jumping; after that, cutting and piercing instruments and finally drowning. The above preferences come from a report *Suicide in California,* 1960–1970 by Nancy H. Allen. With women, the first means of solids, liquids and gases tends to be more popular, whereas men by far prefer firearms and explosives. The means of hangings and strangulations between men and women is about even.

Historical and Theoretical Considerations

Mankind, generally, has been philosophically and practically opposed to suicides; however, there are some well-known exceptions such as the harakiri, permissible among the Japanese nobility class when the individual has encountered failure, or the Indian woman who throws herself on the funeral pyre after her husband's death. The early Christian church was very much opposed to suicide, saying that the person is no better than a murderer; in fact, the early English word used was "self-murdere" or "self-homicide." The church said that the truly good man will bear all the suffering, and the soldier of Christ will not desert his post. As early as the fourth century the punishment for suicide was "no Christian burial or commemoration." The present day Catholic Church regards suicide as a mortal sin. In our society, generally, there is still a stigma attached on the survivors as well as to the deceased that is not associated with any other mode of death.

In the last 30–40 years, suicide has been looked on as a disease which starts early in childhood; and, that the person really cannot help it. Some professionals have believed that there is no situation in the human suffering or experience which warrants suicide. In the past five to ten years, however, some of these beliefs have been changed. We are coming to the view that

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life and death are no longer a dichotomy but are on a continuum. In fact, the way a person chooses to die reflects his physical and mental lifestyle. Some also feel more and more strongly that the person committing suicide is fully responsible for what he does and that blaming his suicide on an unhappy childhood is counter-productive.

In the history of suicide we have talked mostly about overt acts such as hanging or shooting oneself; however, there are many related hidden behaviors which can bring about a slow and sometimes not so slow death of the individual. These are: 1) use of drugs, alcohol, sniffing material, 2) overeating, 3) accident proneness, 4) a contagious suicide during war or during a panic, 5) a slow suicide through bodily dysfunctions such as refusing to take needed treatment or developing stomach ulcers and colitis.

Legal Considerations

The early English regarded suicide as a felony; this was gradually softened. In the U.S. history there have been a few states where suicide was considered a crime, but the same laws and interpretations conceded that it may not be punished as it was by the early church. Insurance companies have suicide clauses but they are seldom enforced unless it is shown that the insured contemplated suicide when he took out a policy.

Does the person then have a moral right to take his life? Some suicide prevention workers would say "Yes," and this goes along with an earlier statement that the person attempting or committing suicide is fully responsible for taking these acts even though he may have a mental illness. Most people, however, say that the suicidal person does not have the right to take others with him (bomb on plane, car accident, murder-suicide husband and wife, etc.). California does not have a law against suicide but it is against the law to aid or abet someone in committing suicide. In many correctional settings an attempted suicide or a successful suicide requires a disciplinary report. It is perhaps the correctional setting's intent to control behavior to deter people from harming themselves, and to stop manipulation through suicidal attempts.

Most professionals have a quasi-legal obligation (for instance, the physician's Hippocratic oath) to preserve life where at all possible.

Diagnosis

Suicide is an attempt to resolve *intra*personal or *inter*personal struggles, or the individual just wants to be done with the struggle. It is a definite crisis where the individual rejects himself and others in the society. In terms of transactional analysis, it is the stance called "I am not ok and you're not ok." Again, in transactional analysis terms, the individual is obeying messages that he got or felt early in his childhood; messages, which more often than not, were given secretly rather than openly, usually by his mother and father. Here are some of the signals or messages: "don't be, don't be you, don't grow up, don't take responsibility, don't do for you, don't live." And the early decisions based on these secret messages are: "I'll show you even if it kills me." "I'll get you even if it kills me." "If things get bad enough, I'll kill myself."

There is a general diagnostic picture of suicidal individuals.

1. They have a strong ambivalence or mixed feeling between wanting to live, on one hand, and wanting to die on the other.
2. There is a good bit of magical thinking which often rules out or denies objective computer-type information.
3. As a person is thinking less clearly, there is a definite loss of alternatives for action.
4. There are all types of verbal, body posture and behavioral signals. For instance, in a group discussion the individual may show a limp body, a sad voice, tears in his eyes, rigid avoidance of someone who is dead, divorced or separated, and there may be bizarre, erratic, or impulsive behavior which has not been the pattern of the individual.
5. Because the suicidal person often harbors a great deal of anger and despair, homicide and suicide are often next door neighbors in the diagnostic scheme.

The National Association for Mental Health lists four categories of suicidal or potentially suicidal persons.

1. The person who has already inflicted injuries and the process is completed.
2. The person has been intercepted in the process of carrying out suicidal acts.
3. The person has been diagnosed as depressed but has not manifested suicidal intent.
4. The person has not been diagnosed or evaluated as suicidal but from his behavior and from observation, can be identified as contemplating suicide.

Farberow and Shneidman distinguish between three types of suicidal gestures.

1. Those who really want to die.
2. Those leaving survival to chance.
3. Those who definitely are expecting to be saved.

Again, looking at the diagnostic picture, at the various signals that suicidal persons give, R. S. Mintz lists several kinds of suicidal communications.

1. There is a desire to die, "I wish I were dead."
2. "I would be better off dead."
3. "The family would be better off if I were dead."
4. "I'm gonna kill myself."
5. "I can't go on any longer."
6. There are communications or references to methods of committing suicide. For instance, the person will ask, "Does drowning hurt?" or "Can swallowing glass kill you?" "How do you donate your eye or kidney after you die?"
7. Then there are the dire prediction-type statements, "I won't be around when you get back."
8. Especially older people want to die before their spouse or "go" together. For instance, they might say "I'll be gone before my wife."

9. Some suicide-prone people state rather bluntly, "I'm not afraid to die."
10. Another communication occurs when the suicidal person starts putting his or her affairs in order.
11. There are references to burial or graves or cemeteries.
12. There are threats; "If she doesn't marry me, I'll kill myself."

All of these communications may be very direct and easily detectable, but others are very hard to recognize and it takes a skilled therapist, a keen observer to detect these underlying messages.

R. S. Mintz also lists several motivations for suicidal acts.

1. His hostility against a lost loved person. In the area of mourning, this often plays a strong role.
2. There is an aggressive impulse turned on the self, "I'm so mad at myself I could kill myself."
3. There is a wish to retaliate to spite the other person and to punish him or her by inducing guilt.
4. Suicidal motivation may be an effort to force affection.
5. There may be an effort to achieve atonement and to relieve guilt.
6. There may be an effort to destroy intolerable feelings within the self, particularly hostility, guilt, self-punishment.
7. Some people commit suicide because they have fantasies around rebirth or reincarnation. This may be true with certain religious sects or also with people who are mentally very disturbed. Sometimes these two overlap.
8. There is a desire to merge with the dead or a lost loved one.
9. There is the desire to escape from the real or the anticipated physical or mental pain, or deformity, loss of self-esteem, etc.
10. There may also be a counter-phobic response to the fear of death, which was mentioned earlier in the statement of, "I'm not afraid to die."

In the correctional institution setting, suicidal gestures or fantasies are frequently triggered off by such events as the following: A "Dear John" letter, pressure for sex or rations from peers, lack of communication, an adverse case conference decision, physical or mental deprivation such as movies, canteen, the loss of a friend, the death of a relative. Finally, it is generally felt that the suicidal person does not have a unitary single purpose death wish. He is ambivalent; he wants to die and to live, to kill himself and be saved. Although he has a right to kill himself, being that he is part of our society, we have the right and responsibility to help him discover other options and particularly that part of him which wants to live. This then leads to therapy with suicidal persons.

Therapy—The Right to Live

Each suicidal person has the right to die and the right to live. As helpers, because of our deep concern for others and our professional duty, we support the person's interest to live, be it ever so small. We can assume this interest is there because, after all, he has not killed himself. Since suicidal persons are generally in a critical state only a short time, and since most of them also want to live, working with these people can be a hopeful and successful process (statistics point out that only one in ten who ever made an attempt, killed themselves later). It is during those first crucial and precious moments when relief is given that the person can be helped to make short-term and even long-term solutions to live.

There are some *principles* which can be applied in helping the suicidal person.

1. We accept the fact that each person has the right to his own feelings.
2. We accept his limitations.
3. We find his strength.
4. We place responsibility on the person as early as possible.
5. We accept our own limitations as helpers.

There are three major areas of procedures or techniques.

1. The helper is very *active*.
2. He operates with considerable *authority*, and
3. There is an *involvement* of others in the helping process.

Steps in the Helping Process

1. Handle physical problems or threats.
   a. Always helpful to take someone along, especially if you don't know the person.
   b. Medical intervention is usually first.
   c. Remove dangerous weapons or lethal pills.
2. Size up the whole situation.
   a. Gather information from:
      1. Files
      2. People
      3. Clues in grooming
      4. Clothing
      5. Body posture
      6. Previous history of suicide attempts
   b. Look around the room.
3. Establish relationship.
   a. Privacy
   b. Ask permission to "May I (we) come in?" (He's invited to take interest off of himself for a minute, then he has to make his first decision and take some responsibility).
   c. Sit, stand, crouch in a helpful position, always preserving his space, his self-determination.
   d. Tell him why you are here. (Go right to the subject of suicide and his behavior. This is another way of placing responsibility on his shoulders. "I heard you cut yourself," "Try to hang yourself," "You called?", etc.)
4. Focus on problem.
   a. Clarify, assess it.
   b. Ask him to tell you what he did, especially immediately prior to the

attempt. (Put responsibility on his shoulders).
   c. Accept his mixed feelings but support his will to live from the very beginning.
5. Help with thinking and decision making.
   a. Offer basic information and education.
   b. Help him with greater number of choices than he has now.
   c. Help him look at the immediate problem and solution and do the same with long range solutions
   d. Trust him to take responsibility, take a hopeful stance.
   e. Talk about next steps and make them concrete.
6. Create a bridge between now and next steps.
   a. Ask him what he is feeling, what he wants.
   b. Make definite appointments for two hours from now, tomorrow morning, with self or others.
   c. Give him your card, name, telephone number, on a slip of paper so he can contact you.
   d. It is always helpful to the person who is first on the scene as a helper to make at least one definite, concrete follow-up activity with the person.
7. Contracts (These can come at any time along the helping continuum).
   a. Ask him: "Do you want to see me again, or talk to me again?" Or, "May I see you again?" Or even, "I will see you again tomorrow morning," all depending on the person's willingness to take responsibility on himself.
   b. "I will work with you."
      (1) By far the most will respond favorably to a. and b.
   c. Then say something like: "I will work with you if you promise not to kill or hurt yourself anymore."
   d. Ask him what he will do instead, and again focus on his responsibilities, on the hopeful aspects of his life and on some very concrete, obtainable solutions.
   e. Counteract the secret messages, or injunctions, mentioned earlier, with "Don't kill yourself." Or, "I want you to live." Help him make new decisions on the basis of this encouragement.
8. Next steps after the interview. (One of the biggest shortcomings in suicide prevention is the lack of a planned systematic follow-up).
   a. Inform others:
      (1) Doctor
      (2) Nurse
      (3) Regular counsel
      (4) Parents
      (5) Person in charge of the living unit, etc.
   b. Actively involve others.

Other aspects of therapy: Anywhere between one and eight, the helper can delve deeply into personal feelings and feeling decisions through intensive counseling; and this may include TA and Gestalt work in intimate combination. Following are three examples when these two methods may be used:

1. One young man slashed himself because he wanted to join his mother in the grave where she had just been placed a week before.
2. Another swallowed two razor blades after an angry visit with his father.
3. Another ate a half a bottle of tranquilizers after receiving a "Dear John" letter from his girl.

In these instances, one would put the mother, the father or the girlfriend opposite the young man and later have him be that other person. We can ask the person what *he* wants to do that is so difficult to do and as we discuss his search, we can increase hope, find new solutions, and above all, encourage him to stop punishing himself.

The correctional setting has some special considerations with people who are suicidal. Here we must take special safety precautions because, as was mentioned above, the line between suicide and homicide is often very fine. In the correctional setting, the residents often have a very low opinion of themselves and they go so far as to commit suicide to influence others to help them get their way. As counselors, we then help them find these solutions without suicidal manipulations. If the person is isolated from the group or from his friends, we help him reconnect with these individuals. Because of these manipulations, it is very tempting for staff to use their "Critical Parent" (in TA language) making statements like, "Why don't you do it right next time?", or one staff saying to the other, "That kid is a pain in the neck; next time I'm gonna give him a knife so he can cut himself good." On the other hand, there are many staff who use their "Nuturing Parent" very heavily, and they become over-solicitous, over-helpful. The isolation room in the correctional setting has often played an important role either prior to the suicidal attempt or after it. People who are in isolation rooms for long periods of time often get depressed, bored, and desperate. In order to create some kind of excitement, they start cutting on themselves because there is simply nothing else to do. Many people who have attempted suicide in the open dormitory or in their living quarters have ended up in isolation for long periods of time because the staff want to make sure that they quit this behavior. In either case, one should carefully consider a decision to isolate upset people to any great extent. At the time of crisis in a democracy, people need to be close to each other and helpful to each other rather than be isolated from each other.

In the free world, as well as in the correctional scene, sometimes the counselor has to decide whether or not to hospitalize the person. If the counselor simply does not trust the person to call when he's upset or before making another attempt on his life, he should feel free to recommend hospitalization. In the hospital there is not only less danger that the person will harm himself, but he may need to be temporarily away from socially dangerous relationships, from "sick" friendships or from a hostile dependency on his living unit. Hospitalization should be as brief as possible so that a new dependency does not develop and so that the person can be helped to take responsibility for himself as early as possible.

Counselors Have Feelings Too

The most important treatment tool in suicide prevention is the counselor's feeling of autonomy, enthusiasm, common sense, liking for people without controlling them, and an ability to get close. The choice of therapy technique is not so important as long as it provides an orderly process that suits the counselor's interest and strength. As in any therapy, in working with suicidal people the counselor must be able to take a close look at himself, particularly at a time of crisis. "What are my feelings about 'cry babies' that slash their wrists?" "How will I handle the death of a close friend or relative?" "Do I have a need to take over when someone is down?" "Do I feel guilty or perhaps relieved when my suicidal patient finally kills himself?" "In working with suicidal patients, do I get very anxious each time, or have I become hardened?" "Am I glad when at least it didn't happen on my shift or when I was on duty?" "Do I feel normal grief when a person I've been working with finally kills himself?" "Do I sometimes have tears of joy when the person breaks out of his self-punishing bind and decides to live?"

Most suicide work involves brief therapy and crisis intervention techniques. It is at this time that the counselors' feelings come to the fore or are challenged more critically than in much other therapy. Suicidal prevention may be very draining. It deals with very intimate, personal questions about living and dying. Many counselees work towards the counselor's rejection so that suicide becomes justifiable. And many counselors fall into the trap of being sarcastic, impatient, angry, or not caring. Some counselors feel guilt or relief when the person "finally kills himself." Others carry a good deal of blame, extra responsibility and feeling of inadequacy within them. The counselor who withdraws behind his professional role or behind psychological jargon and does not show his own feelings will not be effective in this kind of work.

As an illustration: At the Los Angeles Suicide Prevention Center, failure to experience anxiety while working with suicidal persons disqualifies the therapist. As the desperate person is allowed to experience pain and hope, fear and trust, apathy and decision-making, he is helped to exercise his right to live.

IDENTIFICATION OF SUICIDE PRONE YOUTH

The first rule of a suicide prevention program is that any threat or other indication should be taken seriously. Also of major importance is the training of intake, child care, and supervisory staff to develop their capability to recognize actions, behaviors, and information which might suggest even the possibility of a suicide ideation. Another consideration is in the development and implementation of a communications system that provides reasonable guarantees that critical information can and will be available to and shared by all personnel.

Some general characteristics and commonalities of suicide acts by youth in juvenile facilities are as follows:

—It will most likely happen when a person is alone.
—It is more likely to happen during the first day of confinement.
—It is more likely to happen at night, or at times during the day when supervision is minimal.
—It is much more likely to be a male.
—It is more likely to be a person of the White race.
—It is much more likely to be accomplished by hanging.
—It is very likely that the person's case history will reveal prior attempts, or at least threats or other suicidal ideation.
—It is likely that there is a significant history of involvement with drugs and/or alcohol.
—It is much more likely to occur in a detention rather than a treatment facility.
—If the act doesn't follow closely after intake, it is probable that it will follow some significant event; i.e., interview, visit, court appearance, peer conflict, letter, rejection and/or deprivation, etc.

Signs of Depression and Potential Suicide Risk

sad, withdrawn
lack of interest in activities previously enjoyed
apathy and fatigue
pessimistic, irritable
loss of appetite and weight
loss of sexual interest
sleep disturbance—insomnia, sometimes early waking, nightmares
difficulty in making conversation and carrying out routine tasks
sense of futility
indecisiveness
feeling worthless
loss of religious faith
feelings of guilt and self-blame
preoccupation with illness, real or imaginary
financial worries
drug or alcohol dependence
preoccupation with, or talk about suicide
a definite plan for committing suicide
suicidal impulses
previous suicide attempts
social isolation
recent loss
unsympathetic relatives, feeling that "nobody cares"
tidying up affairs, giving away possessions
suicides in the family or among close friends
fear of losing control, going crazy, harming self or others
feelings of helplessness
low-energy
anxiety
stress

If a person seems depressed, do not be afraid to *ask* "Do you feel badly enough to harm yourself?" It can be a great relief to them if you bring up the subject and let them talk freely about suicidal thoughts, feelings, impulses, plans, or fantasies. Talking about it to someone who accepts them, without showing shock or disapproval, may clear the air and reduce the tension. Nearly everyone can be helped to overcome almost any kind of situation which might destroy their self-confidence, if they have someone who will listen to them, take them seriously, and show that they care about them. One should be cautious, however, not to give the appearance of in any way approving of suicide as an alternative. Also, depending upon the individual, it may be appropriate to be confrontive and critical of the person for thinking and/or verbalizing such thoughts.

The person who commits suicide may see it as the *only* choice. Your role will be to help them to see that they can choose to live. If you can help them to understand that, hopefully they will choose to live rather than to kill themselves.

There are many reasons why someone is suicidal, usually having to do with what they are thinking and feeling. For instance:

1. They may feel very guilty about a real or imagined act (murder, assault, rape, or other violent crime).
2. They may blame themselves for that act.
3. They may feel very down or depressed—may not be able to sleep or eat, and have feelings that they are suffering too much, can't stand it any more, and must get relief from all that suffering.
4. They may think a great deal about suicide.
5. They may have experienced actual, imagined, or delusional loss of any of the following:
   Family member or other loved one.
   Love of an important person whom they feel they need.
   Fear of a long loss of freedom or a long punishment (sentence).
   Don't love or respect themselves any more because they got involved in a homosexual act.
   Money and/or property—with the belief that life is not worthwhile without them.
   The importance of and the kind of role they have with their family.
6. Concern about religion, divine judgment, sin, morality.

7. Fear of ill health, injuries, diseases, "bugs", handicaps.

A person may express suicidal feelings in many ways. For example:

- They may say they want to commit suicide.
- They may make a statement such as the following:
  "I wish I were never born."
  "I'm a failure."
  "I'm no good, rotten, evil—my family and the world would be better off if I were gone."
  "My life has no meaning—I'm going nowhere."
  "There is no future."
  "I'm never going to get out."
- They may have a wish to reunite with someone who is dead who they loved. They think it would be a happy reunion. They may think of this if the person just died or if it is the anniversary of that person's death.

What you can notice that may tell you someone is suicidal

1. They tell you.
2. They are unable to sleep, especially if they wake at 3 or 4 in the morning and brood.
3. Their physical appearance—they don't care any more how they look—don't shave, fix their hair, wash, change clothes, etc.
4. They put things in order—pack things up when you *know* they aren't going anywhere.
5. They give away to someone else something they value very much.
6. They have more and more problems getting along with people.
7. They have never been arrested before; this is the first time in jail.
8. They change: they stay in the cell all the time, when they used to get out and talk, or they get into fights.
9. They have a history of trying to kill themselves.
10. They cry without apparent cause.
11. They keep hurting themselves, banging fists, cutting, etc.
12. They have a history of being in mental hospitals.

Mental Status Interview

A mental status interview is designed to evaluate the present state of psychological functioning by an individual. No single outline would serve for all cases, but the material included in the appendix (page 69) should provide some insights into what kinds of questions to ask and what responses to look for.

The preceding material was included in order to provide some insight into the potentially suicidal individual, and to aid in developing the knowledge and skill needed to determine with some degree of certainty who those individuals are. One must be extremely cautious, however, not to be lulled into a false sense of security. Apparent improvement in the suicide-prone person's mental outlook may be the calm before the storm. Be alert! Be aware! Listen, observe and care!

SUICIDE PREVENTION STRATEGY

PROCEDURAL FACTORS

Each juvenile facility should establish and maintain a suicide prevention program. Procedures should be categorized into the components of intake, security, surveillance, intervention/follow-up care, communications, and training. The following material is intended to provide a suggested framework within which a suicide prevention program may be designed, but by no means should be considered all inclusive. It must be remembered that situations vary substantially based upon such factors as structural features, staffing, access to medical/psychiatric care and other resources.

A. INTAKE

All incoming detainees should have a preliminary screening for suicidal/self-destructive potential as soon after arrival as possible. Screening should be based upon all available information such as the following:

1. Information on arrest reports.
2. Physical observation of wounds that may be a result of past self-destructive behavior.
3. Any available past records; i.e., institutional case files.
4. Any other information available; i.e., medical records.
5. Any statements made by the detainee indicating a proneness toward suicide or self-destructive behavior.

In addition to the above factors, continuing screening activities might include:

—Interviews with the detainee and recording of statements, facts, or situations which may call for a classification as a suicidal/self destructive prone individual.
—Observations of the detainee's abnormal behavior with a specific recording of the nature of that behavior.
—Actual recording of statements, behaviors, and any other significant information, including the time and date of occurrences.
—Describing detainee's interaction with staff and other detainees.

If any of the above indicators result in a suspicion that possible suicidal/self-destructive behavior patterns are in evidence, the following measures should be considered:

1. The detainee should be placed in as safe and secure a setting as possible.
2. Appropriate support staff (i.e., administrative, supervisorial, and medical/psychological/psychiatric) should be notified immediately.
3. All staff should be placed on alert to implement and maintain suicide prevention procedures.

B. SECURITY

Security means a safe and secure environment which may be used for the placement of any detainee acting out or demonstrating the potential for suicidal/self-destructive behavior, and includes specific staff procedures for handling such persons. Physical areas for temporarily housing such persons would be the following:

1. An area adjacent to or within close proximity of a control center or staff duty station, whereby the person at risk can be continuously observed and supervised.
2. A multiple room or dormitory area where other detainees are present and are not themselves viewed as being prone to suicidal/self-destructive behavior. The area should be accessible to supervising staff who maintain sight and sound contact, and detainees should *not* be given the responsibility for the behavior of others.
3. An individual room designated to physically isolate detainees who are acting out or demonstrating suicidal/self-destructive behavior. It should be structurally designed to eliminate all devices which might aid in inflicting physical damage; e.g., exposed or protruding light fixtures, window bars, towel racks, interior hinges, drawers, and bed frames which can be disassembled or any other item which can be removed from the structure. (These rooms should be set aside for short-term emergency usage.)

Policies and procedures should be known, understood, and adhered to by all staff and cover but not necessarily be limited to the following:

—Surveillance procedures which are consistent with overall institution, staff, and detainee security should be established and followed.
—When a detainee is placed in a secure room, procedures should include skin searches upon entrance to (and again with movement from and back into) the room.
—Humane but effective physical restraints such as handcuffs or headgear should be used to prevent self-injury, but should be removed as soon as it is safe to do so.
—Only clothing which cannot be used to self-inflict injury or death should be used; and bedding, eating implements or any other instruments that can cause harm should be withheld as long as is necessary.
—Medical or psychological staff should be available and on continuous alert during the time a detainee is at risk.

C. SURVEILLANCE

Surveillance means a monitoring/supervisorial system established to maintain maximum observation in a setting which is safe and secure for potential or acting out suicidal/self-destructive detainees, and should consist of the following:

1. The ability to maintain as high a degree of direct sight and sound contact as possible. Video and audio equipment should be considered an adjunct to and not meant to supplant surveillance. In addition to determining physical well being, direct personal contact and observation demonstrates care and concern by staff.
2. Physical checks should occur within periods of 10–15 minutes (at irregular intervals), and all checks should be noted on a log designated

for surveillance of suicidal/self-destructive individuals. Notations should also include observations of emotional and physical behavior (examples: food consumption; physical movement; lethargic, depressive, and/or agitated behavior).

D. INTERVENTION/FOLLOW-UP CARE

Treatment of suicidal/self-destructive prone detainees falls into two major categories: crisis intervention and general intervention. Crisis intervention means immediate procedures applied when an individual has physically attempted suicide or self-mutilation, or made verbal threats of suicide or self destructive behavior. General intervention means the handling of cases as the result of obtaining information or observing behavior which gives an indication that a detainee is prone to acting out as a suicidal/self-destructive individual.

1. **Crisis Intervention:** In the event of a suicide attempt, self-mutilation or verbal threats, the following should be made immediately available:
   a. Medical attention, including:
      —Emergency first aid services, including CPR, to be applied by facility personnel.
      —Medical care by a qualified physician. In those cases where transportation to a pre-arranged medical and/or emergency facility is required, procedures should be in place and rigidly followed.
   b. Thorough skin searches for detection of possible instruments of self-destruction; e.g., eating utensils, wire, combs, razor blade, medication, etc.
   c. Placement in a safe and secure environment, as previously described.
   d. Continuous monitoring/surveillance, as previously described.
   e. Interview by qualified and trained personnel.

   Clinical release should be by the Superintendent or designee, and based upon information including but not limited to a casework evaluation, personal observations, medical diagnosis and prognosis, and security factors. Recommendations for continued care in the period following crisis should be made available to and followed by designated staff.

2. **Follow-up Care:**
   a. Any detainee who has been identified as a suicidal/self-destructive risk by a medical person, psychologist/psychiatrist, or intake or other staff shall be placed in a situation wherein they are under close observation and procedures exist to carry out preventive activities.
   b. Facility staff should be trained to provide counseling directed toward reducing or eliminating the risk of suicidal/self-destructive behavior.
   c. Whenever possible, the etiology (causes) of the behavior should be determined.

   d. All significant counseling contacts and observations should be recorded in the detainee's file for facility staffs' continuous review with provisions to provide current information on a regular basis.
   e. Staff should be alert to and log any significant event which might precipitate further crisis, such as but not limited to the following:
      —interviews by DPOs, attorneys, law enforcement, public defenders, etc.
      —mail content, or lack of mail.
      —nature of visits, or lack of them.
      —rejection by family.
      —court hearings.
      —pressure in group living situations.

   Termination of follow-up care should be in accordance with the general conditions set down for release from the crisis intervention treatment program.

E. COMMUNICATIONS

Communications means a system that is established to inform living unit staff and other responsible personnel in writing of past classifications and current information on any detainee who is thought to be suicidal/self-destructive prone, whether it is potential or the detainee is involved in a crisis situation in the institution. Communications should be utilized as an aid in preventing or intervening in any suicidal/self-destructive attempt. The system should include but not be limited to the following:

1. Information resulting from screening during the initial detention period, as previously described.
2. Case history.
3. Casework summaries.
4. Recommendations for special handling.
5. All documents relative to suicide.

This information should be reviewed by all responsible facility staff. Some communication devices for staff use are as follows:

1. A special incident and/or suicide log to report the current situation—whether a detainee is passively or actively involved in suicidal/self-destructive behavior. Each staff member should be responsible for reporting observations and behavioral notations in the log.
2. Individual records (files) within the facility should also be available for up-dating information regarding suicidal/self-destructive behavior.
3. A system by which recommended treatment or special handling techniques can be made available.
4. All room and security checks should be logged/documented with specific date, time, and the initials of the staff making the entry.

Whenever possible, responsible staff should have access to directly related medical records and correspondence which does not fall under the category of privileged communications.

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TRAINING

Training resources should be provided to all staff—line, supervisory, support—who are responsible for the care and supervision of minors in juvenile facilities. The training should be designed to equip staff with the knowledge and skill to identify minors at risk. In addition to knowledge about symptomology, dynamics, etiology, etc., staff must possess good interviewing and listening skills. It is also imperative that staff be effective in the special handling required by the suicidal and self-injurious minor, thus counseling skills take on added importance.

Experts in civil liability for institutions and institutional personnel contend that such liability can be largely neutralized by the existence of effective written procedures and implementation and proper practice of those procedures. This includes the knowledge and skill factors required by staff to properly carry out the procedures and to respond immediately and appropriately to emergency situations.

Training should be optimized as a method to assist living unit and other responsible staff to prevent or treat suicidal/self-destructive behavior.

The training should include, but not be limited to, the following:

1. Identification of the suicide prone person.
2. Basic elements of suicide prevention.
3. A general overview of suicide prevention, detection, and treatment.
4. Crisis intervention, which includes institutional procedures and staff responsibilities and delineates general responsibility and reporting criteria.
5. Counseling and casework intervention skills.
6. First aid.
7. Use of physical restraints.
8. Use of suicide prevention procedures on the living unit.

Materials should also be made available to all staff in an effort to increase information resources. Each facility should consider maintaining the following:

1. Written materials on suicide prevention including texts, case studies and other information as available.
2. Suicide prevention program models in other facilities.
3. Mental health strategies relating to prevention techniques.
4. Consultation reports, including assessments of suicide prevention and/or training needs in institutions.

Included in the appendix are samples of local procedures, both county and Youth Authority facilities, and training plan formats.

STRUCTURAL FACTORS

There are several precautionary measures which may be taken in order to reduce the physical/structural capability for suicide attempts in juvenile facilities. One of these is the use of multiple or dormitory sleeping rooms, as it is widely known that a suicide is far less likely to occur when the individual is in the company of others. Another measure consists of the setting aside of

individual holding and sleeping rooms which are designed to minimize the opportunity for suicide attempts. In developing such specialized rooms, it must be emphasized that no protrusions should extend from the ceiling, walls, or floor. Following are some specifics for consideration:

Electrical

1. Light fixtures should be recessed, with properly secured lenses that will prevent their removal or access to light bulb and electrical wiring. When a recessed fixture is not practical, a vandal-proof fixture should be used.
2. All junction boxes and abandoned switch boxes should be permanently sealed to prevent access to electrical wiring.
3. All electrical control switches shall be located outside the room.
4. No exposed conduits shall be utilized inside the room.

Plumbing

1. Water closets and all piping should be removed from room. If toileting is required inside the room, the bell end of the waste drain pipe should be screened with ½" round steel rods fastened in a manner that makes them an integral part of the waste drain.
2. Lavatories and all piping should be removed from the room and all wall protrusions sealed permanently.
3. All towel racks, wash cloth racks, and toilet tissue racks should be removed from the room.
4. No exposed plumbing lines should be utilized in the suicide prevention room. The flush-o-meter should be located outside the room and piped under the floor and enter the waste drain between the round rod screen and the trap.

Windows

1. All windows should be screened, utilizing stainless steel screening of appropriate gauge and mesh to prevent access to glassed windows and eliminate the hazard of tying any items between the mesh openings.
2. Screen frames should be heavy gauge metal and fastened in a manner so they cannot be removed from inside the room.

Bed

1. If 24-hour occupancy is required, the bed frame should be removed and a mattress only provided for sleeping.

Doors

1. No door hardware, such as door handles and door closers, should be installed on the interior side of the door.
2. Observation panels should be wire glass of sufficient strength to eliminate breakage hazard. This glass should be mounted in a heavy metal frame with metal stops fastened with tamper-proof screws.

SUICIDE PREVENTION STRATEGY

Heating, Air Conditioning and Ventilation

1. All heating, air conditioning, and ventilation grills and registers should be constructed of sufficient gauged metal to eliminate the risk of removing any section. These grills and registers should be fastened with tamper-proof screws or welded.
2. Openings in all grills and registers should not be large enough to allow any items to be tied between them.

If cell padding is necessary, one should consult with the State Fire Marshal's office in order to determine if the cell padding meets the Fire Marshal's flame spread and toxic fumes codes.

The use of specialized (protective) holding and sleeping rooms should be limited to the degree that is absolutely necessary. Such facilities are usually lonely, stark and meagerly furnished and their very design, and the immediate environment they offer can conceivably add to and exacerbate the feelings and circumstances which bring about the threat of suicide. Frequent but irregular contacts should be made and counseling should be provided. Specially trained mental health personnel should be available. There should be provision for frequent supervisory and administrative review of isolation procedures. Affected youth should be integrated back in to the group living situation as soon as possible.

In considering the practice of companionship, or so-called "buddy systems", great care should be exercised. Minors in detention should not be placed in a position where they are held in any way responsible for the physical and/or emotional safety of another youth. The very nature of the detention criteria in the Welfare and Institutions Code would tend to render most detained youths as themselves unfit for the care and supervision of another. Multiple sleeping areas do provide facility managers with the capability for companionship by the suicidal youngster with other youths, in selected and appropriate cases. Another practice, though rarely used, is that of sleeping suicidal minors in direct view of custody personnel; i.e., in an open area such as a hallway or dayroom immediately adjacent to a duty station. This is an acceptable practice when more than one staff person is on duty in the unit or if emergency back-up assistance is immediately available.

It must be remembered, however, that structural precautions are only a part of a suicide prevention program; and they are effective only if the other components are in evidence. We must first be able to identify the suicide-prone youth and have the training, skills, and procedures necessary to deal with them.

APPENDIX

The material in the appendix includes sample procedures from Monterey County Juvenile Hall and the Department of the Youth Authority's Ventura School and training plans from Los Angeles County Probation and the Modesto Regional Criminal Justice Training Center. Also included is a "Mental Status Interview" extracted from material prepared by the Los Angeles County Sheriff's Department.

This material is presented as examples of what specified agencies have developed for their use and is unique to their programs. Procedures developed by individual counties/facilities may vary depending upon such factors as size, structure, resources, access to emergency assistance, etc.

We are grateful to the aforementioned agencies for granting permission to reprint their material in this publication.

APPENDIX

MONTEREY COUNTY JUVENILE HALL
EMERGENCY PROCEDURES
SUICIDAL AND EMOTIONAL PROBLEMS

ASSESSMENT OF DETAINEE'S EMOTIONAL CONDITION

The behavior and emotional stability of Detainees is a source of concern for Juvenile Hall employees. The Assessment Guide is designed to aid personnel directly involved with Detainees in assessing the potential for emotional instability of harmful behavior in a particular Detainee.

Violent behavior directed within an individual or towards staff is sometimes a serious problem complicating the incarceration of Detainees. Usually, violence results from emotional disability. There may be antecedent causes such as drug abuse or intoxication, a seizure disorder due to brain damage, antisocial attitudes due to unfortunate childhood deprivations such as abandonment, neglect, physical abuse or sexual seduction, as well as attitudes shaped by uncorrected deficits in the cultures and subcultures of our society. However, the behavior and emotional status of an individual represents the final summation of the above factors plus those which are purely psychological. Thus, behavior and feelings can be comprehended as the consequence of the action of specific contributing factors rather than as the result of vague and mysterious influences emanating exclusively from chemical abnormalities or disordered brain functioning.

People can be understood; however, it takes time and hard work to gather data. Sharing observations with others increases the possibility of accurate conclusions and simultaneously reduces conflict between staff members centering about differing theories of what is the meaning of a particular Detainee's behavior.

Group staff discussion is imperative when the group behavior of Detainees takes precedence over their individual problems. Similarly, when a Detainee distorts the facts of a situation, consultation between staff members, only one of whom may be adequately informed, is necessary if the Detainee's distortions and staff's counter-distortions are to be reduced or resolved. Sometimes the individual with the needed facts is not a member of the Juvenile Hall staff. He/she may be a physician, probation officer, psychiatrist, psychologist, social worker, nurse, law enforcement officer or a member of some other agency.

Any statements or behavior suggestive of impulses towards harmful behavior should always be taken seriously. No one can predict behavior; however, the chances of accurate prediction increase when data-gathering is an ongoing process. This takes time, so that individuals with the needed information may be contacted, when possible. In addition, with the passage of time, staff does become better acquainted with a Detainee and staff's understanding can be added to information derived from other sources.

The Assessment Guide is designed to aid Juvenile Hall staff in making some estimate of the degree of emotional instability and possibilities of harmful behavior in Detainees that are unfamiliar to staff. This is a general and rough guide to the areas in which data about Detainees is collectable.

The order in which the categories are listed is not intended to indicate a hierarchy of importance. The estimated degree of "risk" of emotional instability in a Detainee should encompass, in addition to the Detainee's past history, an evaluation of the circumstances surrounding the detention and of the current overall situation in the Juvenile Hall, and on the unit to which the Detainee will be assigned.

RISK OBSERVATION (WATCH)

In order to provide adequate care for Detainees at Juvenile Hall, it is essential to obtain and have as much information as possible about them each time detained as well as during detention. This information may be obtained from several sources which include the Detainees themselves, his/her parents, probation counselors, probation officers, physicians, psychiatrists, psychologists, social workers, other Detainees and others. When information is received, a written follow-up memo is to be requested for the record. Information may indicate that a Detainee's personal situation requires a level of observation beyond which is normally provided.

Level of room observation normally provided will be a physical check of every room and observe (eye contact) the condition of the Detainees at irregular intervals of not longer than twenty (20) minutes throughout their stay in their room during any shift.

The levels of observation listed below are designed to acquaint counselors with the needs of new or risk Detainees and to provide each Detainee with the level of required observation.

Juvenile Hall staff, physicians, psychiatrists, psychologists, and nursing staff may place a Detainee on the appropriate observation from information obtained from the various sources and from an evaluation of the Detainee's behavior.

However, Detainees shall not be removed from the appropriate observation without the approval of the Juvenile Hall Superintendent or the nursing staff, psychologist, psychiatrist, physician and the Juvenile Hall Superintendent.

INTAKE OBSERVATION:

All individuals admitted to the Juvenile Hall shall be placed on Intake Observation for a minimum of forty-eight hours. This observation period shall be noted on the Adjustment Summary Report. During this period of observation, staff is to closely observe the Detainee's behavior and attempt to get to know the Detainee, his/her feelings, attitude and general orientation. During this period, the Detainee should be allowed to attend school and participate in all activities unless his/her behavior indicates otherwise. Any deviation from normal behavioral expectations such as withdrawing, speaking of suicide, attempting suicide, depression or acting out behavior shall be noted in the unit log and the Detainee's chron file as well as the Adjustment Summary Report. Incident reports shall be written where appropriate.

The Detainee shall be removed from this observation status after forty-

eight hours if there are no apparent problems. Where problems are apparent, appropriate action shall be taken which may include placing the Detainee on a different observation status, a special or limited program referring the Detainee to one of the following:

1. Medical
2. Psychologist
3. Psychiatrist
4. Hospital

Room checks are to be made every ten minutes of the Detainee while in his/her room at irregular intervals throughout their stay in their room during any shift for the first forty-eight hours.

SPECIAL OBSERVATION:

Where information or a Detainee's behavior indicates that his/her care requires observation beyond that which is normally provided, the Detainee shall be placed on Special Observation. Behavior such as statements, some acting out behaviors, behavior considered to be bizarre or depression are reasons that a Detainee may be placed on Special Observation.

The reasons that a Detainee is placed on Special Observation shall be noted in the unit log, observation log and in the Detainee's chron file. Where appropriate, an incident report shall be written.

Detainees on Special Observation may attend school and participate in other activities where appropriate. Detainees may not be removed from Special Observation without proper approval of the appropriate individual.

Detainees on Special Observation shall be provided with a stable roommate when it is advised by the counselor in charge as far as is possible. While on Special Observation, Detainees shall not be allowed to participate in work details outside the unit such as being a member of the dish washing crew, assisting in the laundry, cleaning, assisting in the kitchen or assisting in janitorial work. These Detainees shall not participate in work Details where sharp objects or cleaning fluids and chemicals are used.

When placed on Special Observation, a physical check will be made of the individual by observing (eye contact) his/her condition at irregular intervals of not longer than five (5) minutes throughout their stay in their room during any shift.

Individuals on this status shall be scheduled for an appointment with the psychologist for an evaluation as soon as possible.

CLOSE AND HISTORY OBSERVATIONS

When a Detainee is determined to be an acute suicide risk as determined by his or her behavior, information obtained from any source should so designate. Reasons for this status shall be noted in the unit and observation logs as well as in the Detainee's chron file. Where appropriate, an incident report shall be written. Monterey County Juvenile Hall Suicidal and Emotional Problems procedures shall be adhered to by all staff.

Each Detainee placed on Close or History observation status shall be

referred to the nurse and to the psychologist or in their absence taken to Hatividad Medical Center for observation screening. A stable roommate shall be provided to a Detainee on Close or History observation status as far as it is possible or practical. Detainees on this status shall not participate in work details in or off the unit. Detainees on Close or History observation shall not be removed from this status without the proper approval of the appropriate authorized individual.

When placed on Close or History observation status, a physical check shall be made of the individual by observing (eye contact) his/her condition at irregular intervals of no longer than three (3) to five (5) minutes depending upon the situation throughout their stay in their room during any shift.

CLOSE OBSERVATION:

Is designed to signal those cases where Detainees are actively attempting suicide or have attempted such acts in the last six months. Detainees in this status shall not attend school. Staff shall design a special close observation program for these Detainees that shall provide more time out of their rooms in order that they may have maximum contact with staff and others, so that the risk of their being successful in their suicidal attempts is minimized.

HISTORY OBSERVATION:

Is established to accommodate those cases where Detainees have in the more distant past, here in Juvenile Hall or elsewhere, attempted or threatened suicide or who were suspected of being suicidal and where evaluation of their potential for suicide has not been thoroughly evaluated. Detainees on this status shall be allowed to attend school where appropriate.

MEDICAL OBSERVATION:

At times, a Detainee's medical condition requires a level of observation beyond which is usually provided and will be determined depending upon the situation. Such conditions may include epilepsy, asthma, chronic diseases or conditions associated with drug use or injury.

The nurse shall provide the unit with information concerning the Detainee's medical condition, type of observation required and any limits placed on the Detainee's participation in activities. The information shall be noted in the Unit Medical Log and in the Detainee's chron file.

Detainees on Medical Observation shall not be removed from this status without the approval of the nurse or the attending physician by written memo.

MANAGING SUICIDAL AND POTENTIALLY SUICIDAL DETAINEES

Juvenile Hall has in its population from time to time, Detainees who are suicidal or potentially suicidal. It is Juvenile Hall policy that every possible precaution will be taken to prevent Detainees from committing suicide.

APPENDIX

To maintain consistency regarding the managing of suicide risk Detainees, the following procedures are to serve Juvenile Hall staff as guidelines:

1. Any information received about a Detainee that would indicate that the Detainee is a potential suicide risk is to be relayed to the unit on which the Detainee is as well as requesting when possible a written memo.
2. The senior staff member having knowledge is responsible for implementing the procedure for potentially suicidal Detainees.
3. Information regarding a potentially suicidal Detainee is usually received from the following sources: Juvenile Hall staff (counselors, service, teachers), medical staff, probation officers, arresting officers, parents, other Detainees or anyone having knowledge of the minor's potential for suicide.
4. Juvenile Hall staff shall work on the premise that a suicidal Detainee is a danger to him/her self until proven otherwise.
5. The following precautions shall be used on all units for Close and History Observations:

- The Detainee shall be given immediate intensive counseling. Additional counseling shall be given as conditions indicate.
- The Detainee shall be moved to a room as close to the unit office as possible and when possible, placed with a stable roommate.
- Whenever a Detainee is awake and in his/her room, he or she shall be observed (eye contact) at intervals of no more than three (3) to five (5) minutes depending upon the situation and spoken with at intervals of no more than fifteen (15) to thirty (30) minutes.
- Whenever a Detainee is asleep, then he or she shall be observed (eye contact) at intervals of no more than three (3) to five (5) minutes depending upon the situation.
- Room searches shall be made frequently during each shift as needed and at least once each day prior to bed with all harmful or potentially harmful objects removed. The room shall be stripped if necessary.
- The Detainee shall be searched each time he/she goes into his or her room and shoes shall remain in the hallway by the door.
- The Detainee is to be encouraged to stay out of his/her room as much as possible and to participate in programmed activities.
- Detainees shall not be allowed to participate in any craft projects without approval of the counselor in charge.
- Detainees shall not be allowed to participate in any craft projects without approval of the counselor in charge.
- The individual shall be evaluated continually to determine changes in status or whether special precautions need to be taken.
- School teachers shall be provided with the name of Detainees on Observation status, attending school daily.
- Counselor in charge shall assign a counselor from the Detainee's unit to discuss the Observation status with the minor's probation or parole officer at least once each week and shall encourage that officer to visit the minor at least once each week making a comment in the Detainee's chron file when the contact was made and when the minor was visited.

- Detainees shall not be removed from Observation status without directions by the proper authorized individual.

ASSESSMENT GUIDE

I. PERSONAL PSYCHOLOGICAL FACTORS

Consider the following: History of emotional or mental problems, history of psychiatric treatment or medication, use or abuse of illicit drugs (including alcohol), previous suicidal or assaultive behavior. Consider the Detainee's present emotional and mental condition—just before and during admission to Juvenile Hall.

II. PERSONAL MEDICAL FACTORS

Consider the following: History of chronic or serious illness; use of prescribed medications and their effect, if any, on mood and behavior; physical deformities or deviations such as obesity, burn scars, etc.; history of past surgeries and hospitalizations or upcoming medical procedures.

III. FAMILY CIRCUMSTANCES

Consider the following: Marital discord, separation, divorce, especially recently; serious medical illness, death from illness or suicide; emotional or mental disorders in family members; attitudes of Detainee towards family and vice-versa, i.e., severe longing to be with family, or depression, feelings of being rejected or not wanted; wants to kill or hurt family members or wishes never to return to the family.

IV. CULTURAL

Consider intense identifications with specific ethnic groups, radical political groups; religious or ideological beliefs which might affect the Detainee's thinking and behavior in a way which requires special consideration by the staff.

V. JUVENILE HALL CONDITIONS

Consider such factors as recent increase in total population, lowered morale on a unit, effect of vacations, illness or double shifts on the remainder of the staff, unusual conditions inside or outside the Juvenile Hall affecting the staff, i.e., wage and contract negotiations, reductions in available money.

VI. AVAILABILITY OF MENTAL HEALTH, MEDICAL, PSYCHIATRIC AND NURSING CONSULTATION, INCLUDING CLERGY STAFF

Is consultation indicated on emergency basis or in the near future?

VII. PROBATION DEPARTMENT

Are there problems or questions which can be resolved only by Probation Department members?

VIII. LAW ENFORCEMENT AGENCIES

Do the agencies have pertinent information regarding the apprehension and detention of a ward which might relate to his/her emotional condition/state?

ADJUSTMENT SUMMARY

The Adjustment Summary Report has been designed to facilitate the accessibility of information on a returning Detainee's previous adjustment at Juvenile Hall. Through the use of the Adjustment Summary Report, counseling staff will have immediate information regarding returning Detainees as well as information about those Detainees who are with us for several weeks or even days.

When a Detainee receives a permanent release or is transferred to another unit, it will be the responsibility of the lead counselor to complete the required Adjustment Summary Report during that shift and place it in the Detainee's chron file.

It shall be required that the counselor on duty, when the Detainee arrives, to complete the portion on the intake sheet under Unit Notations-Attitude and that the counselor shall sign the sheet.

The Adjustment Summary Report is as follows:

MONTEREY COUNTY JUVENILE HALL

ADJUSTMENT SUMMARY REPORT

DATE_____

DETAINEE'S NAME: _____ STAFF MEMBER _____
UNIT _____
LENGTH OF DETENTION _____

I. UNIT ADJUSTMENT

ON INTAKE: (relaxed) (cooperative) (incooperative) (nervous) (depressed) (frightened).
COMMENTS: _____

II. ATTITUDE TOWARD STAFF:

(rejecting) (accepting) OF AUTHORITY
COOPERATIVE (with) (without) URGING
(communicative) (uncommunicative)
COMMENTS: _____

III. ADJUSTMENT TO GROUP:

Maturity level in relation (high) (low) (average)
Involved in racial conflicts (yes) (no)
Influence on group (positive) (negative) (none)
In relation to group (leader) (follower) (instigator)
Gets along best with (few) (most) (a loner)
Participates in activities (enthusiastic) (with urging) (seldom)
Performs work assignments (well) (with supervision) (average)
Follows directions (well) (fairly well) (poorly)
Behavior at co-ed activities (good) (bad)
School adjustment (good) (with problems)
COMMENTS: _____

IV. EMOTIONAL STABILITY:

Appears (normal) (depressed) (restless)
Angers easily (yes) (no)
Suicide gestures (yes) (no)
Behavior unpredictable (yes) (no)
Acting out behavior (never) (frequently) (occasionally)
Sexual problems (yes) (no) (unknown)
COMMENTS: _____

V. ATTITUDE TOWARD VISITORS:

Relation with probation or parole (good) (bad) (unknown)
Frequency of visitors (regular) (rare) (occasionally)
Feelings toward visitors (welcome) (doesn't care) (hostile)
Ever any instances of contraband (yes) (no)
After visits (upset) (happy) (unaffected)
COMMENTS: _____

VI. SPECIAL PROGRAMS:

(medical) (security) (school) (behavior) (etc.) EXPLAIN:

VII. DESCRIBE ANY CHANGE DURING DETENTION:

APPENDIX

Department of the Youth Authority
VENTURA SCHOOL

SUICIDE PREVENTION PROGRAM

I. INTAKE

A. All incoming students have files screened by the Classification Committee within first 24 hours of arrival. At that time, the Classification Committee will also do a preliminary screening for suicidal potential. If there is a history of suicide or suicide attempts in the immediate family members or significant others, the Chief Medical Officer or staff psychiatrist will be immediately informed. A short memo (VS Form 367.1) will be routed as well as a telephone call to the Chief Medical Officer or staff psychiatrist. A copy of VS Form 367.1 will go to the Parole Agent/Casework Specialist of the assigned living unit (for filing in team file). Parole Agent/Casework Specialist will also immediately interview student and complete VS Form 367.3—Suicide Prevention Interview, and route.

B. Within three working days after a new student arrives on the living unit, the PA/CS is to do a *thorough* reading of the file. The VS Form 367.2—File Review, is to be completed and routed on all students. If the file indicates history of suicide behavior or talk or if there is a history of suicide attempts in the immediate family members or significant others, (not already reported), the Chief Medical Officer or staff psychiatrist will be immediately informed. A short memo, VS 367.1 will be routed as well as a telephone call to Chief Medical Officer or staff psychiatrist. The PA/CS will also immediately interview student and complete VS Form 367.3, Suicide Prevention Interview.

II. TREATMENT

A. Any student assessed as suicide potential by the Chief Medical Officer or staff psychiatrist will be followed in treatment by the psychiatrist. A short form (VS Form 231)—Psychiatric Contact Note, will be routed through the Parole Agent III to the PAC/CS. (Original in field file and copy to PA/CS for inclusion in team file).

B. Staff on living unit will include any assessed suicide potential as a goal for casework on the living unit.

III. CRISIS

A. Any student who seriously talks about suicide or attempts an act of self-destruction can receive the following services as determined by the living unit staff:

1. Medical attention if injury occurs.
2. Student will receive interview to determine suicide potential. VS Form 367.4—Potential Suicide Observation, will be used to record this information.
3. Student to Rio Vista detention for protective custody. Place on TV observation or on 15-minute observation intervals. (Use VS Form 367.5 for documentation). If student injury, take to medical clinic and then to Rio Vista.
4. Mandatory psychiatric evaluation while on Rio Vista with written Psychiatric Contact Note (VS Form 231), including prognosis recommendation.
5. Student will be seen daily while on Rio Vista by a staff from his/her living unit. This staff should be one specially trained in suicide prevention. Staff will discuss the crisis with the student in detail and give the T.T.S. information about readiness for return to living unit.
6. Release—decision is to be made by Program Manager with psychiatric consultation available.
7. Aftercare—PA/CS plans to include this crisis and its impact into ongoing treatment plan. If significant suicide attempt is made, a debriefing of event will occur, including how incident could affect staff and students.

IV. PAROLE Board Case Report should include how suicidal behavior was handled as:

A. Goal oriented
B. Crisis handling
C. Reference to written psychiatric reports
D. Treatment recommendation for care in community

V. TRAINING

All staff at Ventura School to receive a two-hour general training on suicide prevention and detection. Written pamphlets to be passed out. Use of Forms VS 231, 367.1, 367.2, 367.3, 367.4 and 367.5 will be reviewed.

PA/CS and one YC of each living unit plus all staff on Monte Vista/Rio Vista to receive advanced training on handling suicide attempts, emphasizing crisis intervention and how to *not* reinforce suicidal behavior.

NOTE: Alborado—Specialized Program Counseling—will provide their own procedures to their assigned students. There may be an occasional need for use of RV's TV monitor room for observation, if their TV rooms are occupied.

APPENDIX

State of California
Department of the Youth Authority

MED/PSYCH SUICIDE POTENTIAL REFERRAL
(FAST TRACK)
VS 367.1 (2-1-81)

_____ _____ _____ _____
Student's Name Y.A. # Cottage Date

A preliminary review of the file indicates:
____There is a history of suicidal thoughts or behavior.
____There is a history of suicide or suicide attempts in immediate family members or significant others.

COMMENTS: _____

REFERRED BY: _____
Signature

Route to: Chief Medical Officer or Staff Psychiatrist
cc: Field File
cc: Team File

State of California
Department of the Youth Authority

PSYCHIATRIC CONTACT NOTE
VS#231

Student's Name _____ Cottage _____ Date _____
WRITTEN REPORT WILL FOLLOW BY: _____
Date

Seen for:	*Amenable*	*Date*		*Date*
Evaluation	_____ Yes No	_____	Medication	_____
Psychotherapy	_____ Yes No	_____	Crisis Intervention	_____
			Other_____	_____

COMMENTS: _____

_____
Signature

ROUTE TO:

State of California
Department of the Youth Authority

SUICIDE PREVENTION INTERVIEW
VS 367.3

_____ _____ _____ _____
Student's Name Y.A. # Cottage Date entered VS

Initial interview with student:

I. Self mutilation by history or student's behavior ____ Yes ____ No
II. History of suicidal thoughts? ____ Yes ____ No
III. Method student described: ____ Hanging ____ Drugs ____ Weapon ____Other
Detailed description: _____

IV. Cause according to student: ____ Family related ____ Job Related ____ Peer related ____ Personal ____ Other _____
Describe circumstances: _____

V. Location: ___ Within an institution ___ Not within an institution
Describe circumstances: _____

VI. Multiple Attempts: ___ Yes ___ No
Describe dates if available: _____

COMMENTS: _____

_____ _____
Name of Interviewer Date of Interview

Route original to Chief Medical Officer or Staff Psychiatrist
cc: Field File
cc: Team File

APPENDIX

State of California
Department of the Youth Authority

MED/PSYCH FIELD FILE REVIEW

VS 367.2

TO BE COMPLETED BY LIVING UNIT PAROLE AGENT/CASEWORK SPECIALIST AFTER THOROUGH REVIEW OF FIELD FILE (WITHIN THREE WORKING DAYS OF STUDENT'S ARRIVAL AT VENTURA SCHOOL).

Student's Name	Y.A. #	Cottage	Date entered VS

	YES	NO	UNKNOWN
I. Is there any indication of previous suicidal throughts or behavior?	___	___	___
II. Is there a history of suicide or suicide attempts in immediate family members or significant others?	___	___	___
If I and/or II are Yes, document location where information found in file. Fast track to Chief Medical Officer or staff psychiatrist unless already identified by Classification Committee. Interview student if I is Yes, complete VS Form 367.3 and route.			
III. Is there a history of violent or explosive behavior?	___	___	___
IV. Is there a history of depression or mood problems?	___	___	___
V. Is there history of major hyperactive behavior that caused educational difficulties?	___	___	___
VI. Is there a history of previous psychiatric treatment or hospitalization?	___	___	___
VII. Is there a history of the immediate family members having psychiatric treatment or hospitalization?	___	___	___
VIII. Is there a history of student being on psychotropic medication?	___	___	___
IX. Is the student currently taking psychotrophic medication?	___	___	___
X. Is there a history of significant substance abuse?	___	___	___
XI. Are there previous psych/psycho reports in the file?	___	___	___
XII. Is there a history of previous physical problems such as a head injury or epilepsy?	___	___	___

COMMENTS: _____

_____

_____

DATE: _____ SIGNATURE: _____

Route to: Chief Medical Officer
cc: Field File
cc: Team File

State of California
Department of the Youth Authority

POTENTIAL SUICIDE OBSERVATION

VS 367.4

_______ Student's Name _______ Y.A. # _______ Cottage _______ Date entered VS

REASON FOR COMPLETING FORM (Check appropriate box)

____Specific suicide behavior has occurred
____Suicidal thoughts/talk
____Noticeable change in student's behavior

I. STUDENT'S BEHAVIOR WHEN OBSERVED BY STAFF:

____Appropriate
____Speech is too slow, fast, loud or slurred.
____Aggressive
____Inappropriately happy
____Mute
____Mumbling to him/herself
____Movements too slow or too fast
____Sullen
____Odd mannerisms or gestures
____Insomnia
____Loss of appetite
____Overly suspicious
____Expressionless face and/or voice
____Stuporous
____Depressed
____Crying
____Bizarre (briefly explain)
____Manipulative (briefly explain)
____Irrational (briefly explain)
____Other (briefly explain)

COMMENTS: ____________________

II. PRESSURES AND/OR PROBLEMS FACING WARD:

____Cottage related ____Peer related ____Personal
____Family related ____School related ____Don't know
____Other (briefly explain) ____________________

COMMENTS: ____________________

III. SIGNS OF STRENGTH

____Cooperative ____Talkative ____Discussed problems
____Remorseful ____Calm ____Rational
____Other (briefly explain) ____________________

COMMENTS: ____________________

IV. OTHER RELATIVE INFORMATION: ____________________

_______ Signature of Observer _______ Date

Route to: Chief Medical Officer or Staff Psychiatrist
cc: Field File
cc: Team File

State of California
Department of the Youth Authority

SUICIDE CRISIS SAFETY CHECK

VS 367.5

Date Initiated: ____________
Date Completed: ____________

SUICIDE CRISIS SAFETY CHECK

_______ Student's Name _______ Y.A. # _______ Cottage _______ Place where student under surveillance

Student to be safety checked every 15-minutes unless on continual TV surveillance.

TIME	*STAFF*	*TIME*	*STAFF*	*TIME*	*STAFF*
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
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___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___

UPON COMPLETION OF FORM, ROUTE TO PROGRAM MANAGER

APPENDIX

LOS ANGELES COUNTY
PROBATION DEPARTMENT

STAFF TRAINING OFFICE

PROGRAM: Suicide & Self Injury Prevention Training
DATES:
TIME:
TRAINERS:
METHODOLOGY: Lecture, Guided Group Discussion, Programmed Notes
FORMAT: Two 2-hour sessions three times weekly per Juvenile Hall—
Three courses weekly—camp facilities

PROGRAM PURPOSE

The Suicide and Self-Injury Prevention Training Course is a four-hour training seminar provided to Probation staff in our juvenile halls and camps. This course is designed to equip staff with an understanding of behavior dynamics characterizing the suicidal and self-injurious prone minor in detention. It also covers supervision approaches that ensure their safekeeping.

The Suicide and Self-Injury Prevention Course will enable staff to successfully supervise self-destructive children and thereby help alleviate problems associated with the suicidal and self-injurious minor in detention.

PROBATION DEPARTMENT STAFF TRAINING OFFICE

TITLE OF PROGRAM:
Suicide and Self-Injury Prevention Training Course

PROGRAM GOAL:
To increase staff effectiveness in the special handling of the suicidal and self-injurious minor.

PROGRAM OBJECTIVES:
As a result of this course, staff will be able to:
1. Identify operationally and empirically, minors under their supervision who have a serious self-destructive potential.
2. Take the appropriate action outlined in the Policy Manual required for handling the suidical and self-injurious minor.
3. Effectively supervise the suicidal and self-injury prone group member.
4. Establish the proper climate for the care and safekeeping of the suicidal and self-injurious minor.

SESSION I

TITLE:
Theory, Myths and Possible Causes of Suicide

SESSION OBJECTIVES:
As a result of this session, participants will be able to:
1. Identify the two basic drives in all people as discussed in class found in Freud's theory of suicide.
2. Explain the three commonly held myths about suicide discussed in class.
3. List seven of the eight possible causes of fear and depression in detention discussed in class.
4. Identify the three types of substances found in juvenile hall and camps that could be ingested resulting in a minor killing him/herself.

CONTENT:
—Statistics on suicide; national, local, departmental
—Human drives and suicide
—Commonly held myths on suicide
—Causative factors—fear and depression
—Suicidal vs. self-injurious minor

SESSION II

TITLE:

Prevention Strategies in Juvenile Hall and Camps

SESSION OBJECTIVES:

As a result of this session, participants will be able to:

1. List DSB and RTSB documents used for identifying suidical, self-injurious and other special handling cases.
2. Explain DSB and RTSB procedures for processing documents identifying "special handling" cases.
3. Identify the 11 of 13 behaviors characteristic of the potentially suicidal minor in detention discussed in class.
4. Explain six of the seven things staff can do to create a physically safe living environment.
5. List on-site resources for help with the suicidal and self-injurious minor.
6. Recite special instructions for handling an attempted suicide per DSB and RTSB Manual instructions.
7. Identify two major skills discussed in class staff must have to prevent suicide.

CONTENT:

—Suicide and special handling documents—Face Sheet—Daily Behavior Chart—Transfer Transmittal, etc.—Processing Procedures.
—Suicidal behaviors—tatooing self-inflicted burns—setting up self as victim —loss of appetite—sleep disturbance, etc.
—Maintaining security—building and room searches for self-destructive contraband—identification of environmental hazards.
—Use of psychiatric referrals—the Chaplain as a resource.
—Manual statements re: handling of suspected suicides—suicide attempts.
—Skill development for staff in handling self-destructive minors—recognition and concern.

LESSON PLAN: DEALING WITH THE SUICIDAL MINOR

OBJECTIVES:

At the end of this session, the participants will be able to:

1. Recapitulate Sigmund Freud's theory of suicide.
2. List the three most common methods of attempting to commit suicide by minors in detention.
3. List the rank of suicide among the various causes of death for adolescents.
4. Write down three functional (psychological) causes of suicides in detention.
5. List three substances that minors have been known to have access to in juvenile halls which could be ingested in attempting to commit suicide.
6. List five types of behavior that may indicate a minor's secret plan for self-destruction.
7. Write down two examples of what can be done to create a physically safe environment; and two examples of what can be done to create a psychologically secure environment.
8. Write down the first two steps a staff member should perform if he/she actually observed a suicide attempt.
9. List the seven steps to be followed in dealing with a minor who is threatening to commit suicide.

INTRODUCTION:

One of the prime responsibilities of juvenile hall is safekeeping. This means protecting the minor from him/herself and others.

In this lesson, we will be focusing on the minors doing harm to themselves by attempting or actually committing suicide. Your job of course is to prevent such occurrences.

I. **Suicide is listed as the tenth leading cause of death in the United States and ranks third as the cause of death among adolescents. At least 35,000 people each year commit suicide in the United States. The actual figure might be much higher. Some investigators estimate that 15% of all fatal automobile accidents are the results of suicidal intents.**

How many suicide attempts were there last year at Central Juvenile Hall? (155)

A. In many instances the attempted or successful suicide was very possibly an expression of anger.
B. Some commonly shared child beliefs are "I'll get even with them . . . someday" or "When I'm gone . . . then, they'll feel bad."
C. The major factor involved in suicide in all age groups appears to be the loss or separation from a loved one.

II. **There are many theories regarding the motivations which can cause a human being to take his own life. One of the more popular ones is that of Sigmund Freud. In his paper "Mourning and Melancholia", his theory of suicide is presented.**

A. According to Freud, there are two kinds of drives: One is the life instinct, or Eros; the other, the death, destructive, and aggressive drive, or Thanatos. For Dr. Freud, death is more than a bodily event. DEATH IS WILLED.
B. There is a constant shifting of the balance of power of the two polar instincts. Eros ages. Ageless Thanatos may assert itself "until it, at length, succeeds in doing the individual to death."
C. Thus, suicide and murder are aspects of Thanatos' impulsive and devastating action. Murder is aggression turned upon another; suicide is aggression turned upon the self. Freud's implicit value of judgment is that murder is to be disapproved and prevented be-

cause it is highly destructive. Suicide, too, is murder in the 180th degree and must also be disapproved and prevented.

III. Myths about Suicide

A. One of the most unfortunate myths about suicide is that people who threaten suicide will not make such an attempt. This isn't true. Numerous studies on completed suicides show approximately 10% of suicides had communicated suicidal intent within three months of the fatal suicidal attempt. A large percent of individuals who committed suicide sought help during the two weeks prior to the fatal suicide attempt.

B. An unsuccessful suicidal attempt indicates that the person was not serious about ending his own life. Uninformed individuals are particularly prone to assume that a mild self-injury suggests that the individual was only faking, just trying to get attention.

Systematic studies have shown, however, that approximately 12% of individuals who make non-fatal suicide attempts will make a second and successful attempt within two years. Furthermore, there is no relationship between the degree of medical damage in a non-fatal attempt and the likelihood of a later completed suicide.

The initial attempt is often like a trial run that enables the patient to prepare more adequately for a later successful attempt.

C. Another myth is that questioning a depressed person about the presence of suicidal ideas may "put the idea in his head", or make it more acceptable for him to commit suicide if he is already thinking about it. Actually, almost all clinicians agree that encouraging a patient to talk about his suicidal ideas often helps him to overcome them, and provides the necessary information for therapeutic intervention.

A potential helper tries to capitalize on an individual's arguments for preserving his life and to induce him at least to postpone irrevocable action until he had passed the crisis period. Professional intervention is generally indicated.

IV. Functional, organic and accidental causes of persons committing suicide in Detention Facilities.

A. Three functional (psychological) causes of suicides are extreme fear, depression and psychotic hallucinations.

B. Fear and depression strong enough to cause a suicide attempt may be triggered by the following:

1. Bad news (sickness or death at home, rejection by family or girlfriend or boyfriend).
2. Homosexual rape.
3. No news.
4. Sudden confinement (first offender).
5. Unexpected disposition by the court.
6. Guilt arising from a crime committed by the individual which had particular unpleasant overtones (child molesting, murder of a relative or close friend).
7. Receiving a beating from another minor or a Deputy Probation Officer.
8. Being subjected to psychological abuse from his peers or staff in a living situation with an unhealthy climate.

C. Psychotic hallucinations can be experienced by a person who has temporarily lost touch with reality. They may give the minor the feeling that he hears or sees things. These apparent sensations may scare or even "instruct" him to kill himself or someone else. Such an individual should be confined in a safe, secure setting and supervised closely. Psychotic break.

D. Deaths can also result from organic (physical) problems such as drug overdose or withdrawal and delerium tremens. Though these conditions do not usually induce a person to take his own life, they present the same danger as suicide because death might result if the individual is left alone and unaided.

Accidental Suicides. Such deaths usually occur in instances when an individual is attempting to get intoxicated by taking in some type of substance.

1. Drinking some substance normally used for cleaning.
2. Ingesting medication in an overdose amount. The minor may have stolen the medication or simply faked taking it, and saved up a lethal dosage which he takes in an attempt to get "high".
3. Sniffing a spray deodorant or other substances is a common way used by minors to get intoxicated that may be lethal.

Extreme care should be taken to see that harmful substances are kept locked up or only used under supervised conditions.

V. Preventing Suicides:

A. Recognition of potential suicides. We have already discussed some of the possible psychological, organic and accidental causes of suicide. It is very important to recognize and understand some clues given out by individuals who have a high potential for committing suicide.

B. It is important to understand that people in a suicidal crisis do call for help. Indeed, we interpret their communications as a "cry for help." Suicidal people are ambivalent about suicide. They wish to die, and they want to be helped. Understanding this basic fact permits the first step in prevention. Let's look at some facts regarding adolescent suicides.

1. For each person in the adolescent age group who commits suicide, there are 40 or 50 who have attempted to do so in varying degrees of seriousness.
2. About two or three times as many girls as boys attempt suicide.
3. Male suicides outnumber female by more than two to one.
4. The mode of death chosen by male adolescents is more violent.

The majority of boys used guns or hanging as the suicide method. Most of the girls used pills.

C. Children have many ways of revealing their secret plans for self-destruction. Observing behavior of minors in an institutional setting offers many examples such as:
   1. Painful tatooing.
   2. Scars from previous attempts.
   3. Sniffing toxic substances.
   4. Self-inflicted cigarette burns.
   5. Habitual accidents which result in injuries.
   6. Setting up fights with larger persons where the initiator is regularly the victim.
   7. Many will tie in their favorite saying with their self-destructive intentions. Such as: "Born Loser," "Mi Vida Loca," "Born to Raise Hell," "Born to Lose," and "Love Hate."
   8. Drawing self-destructive or violent pictures.
   9. Loss of appetite. This of course may be reflected in substantial weight loss.
   10. Sleep disturbance. Minor only sleeps for short periods of time.
   11. Constantly criticizing himself and in general displaying a demeanor and attitude of worthlessness.
   12. Complete and sudden social withdrawal from the group.
   13. A sudden appearance of tranquility in a previously agitated minor is a danger sign that is often misinterpreted as a sign of improvement. It may be an indication that a person has made a very final decision about his life, to end it.

D. Creating and maintaining a safe and secure environment.
   1. Physical:
      a. The living units should be free from potential weapons or harmful substances.
      b. Needed repairs and hazardous conditions should be reported immediately.
      c. Thorough security check of the living units and grounds should be made regularly.
      d. All broken glass, empty metal containers and other types of contraband should be secured and moved from the areas to which the inmates have access as soon as possible.
      e. Strict control of cleansing substances and equipment should be imposed.
      f. Close supervision of the ingesting of medication.
      g. Complete and thorough skin searches should be conducted on the minors as the need arises, and any contraband found should be confiscated.
   2. Psychological:
      a. Staff working in institutions should strive to create a psychologically wholesome environment. An environment in which all minors can live free from fear of attacks of one kind or another from the other members of the group such as, verbal abuse by staff, and pressure, threats and intimidations from minors in the group.
      b. Staff should be readily available for counselling in an understanding manner with youngsters who are experiencing the trauma of life in a detention setting, especially "first timers".
      c. Staff should be made aware of the referral process for possible resources to help youngsters who are extremely depressed or in a so-called "suicidal mood," i.e., neuropsychiatric referrals, the hot-line of the Los Angeles Suicide Prevention Center, and Chaplains of the various religious organizations.

F. What should you do if you actually observe a suicide attempt in progress?
   1. Alert another staff member of the problem.
   2. Take steps to climinate the immediate danger.
   3. Steps to take in case of these following types of suicide attempts:
      a. If the victim is attempting suicide by hanging, do the following:
         (1) Loosen the apparatus he is using and take him down.
         (2) Contact the medical staff and Movement and Control.
         (3) If he is not breathing, begin mouth-to-mouth resuscitation immediately.
         (4) If the heart has stopped beating, start rhythmically pressing his chest.
         (5) The average person will die in 4 to 6 minutes if his oxygen supply is cut off.
      b. If the victim has been cut, take these steps:
         (1) Stop the bleeding by use of direct pressure or use of pressure points.
         (2) Contact the medical staff and Movement and Control.
         (3) If a large blood vessel is cut, a person can bleed to death in one (1) minute or less.
      c. Comprehensive Special Incident Reports will be required in all such cases.

G. Steps to be taken in dealing with a person threatening to commit suicide—this could be a situation where a mnor is threatening to slash his wrists, or threatening to jump from a tall structure, etc.
   1. Position yourself so that you can observe and be seen by the minor.
   2. Have someone notify your supervisor or the Officer of the Day.
   3. Have the other minors move away from the area.
   4. Avoid making a sudden move or doing anything which the minor might interpret as threatening.
   5. Attempt to assure the minor of your concern about him. Appeal to his native will to live.
   6. Move slowly and calmly toward him.

7. Try to get the minor to give up the attempt to take his life. After all such efforts have failed, or suicide appears imminent, it will be necessary to restrain the minor with appropriate assistance.
8. Once the minor is restrained, isolate him/her and refer him/her to the medical and/or psychiatric staff.
9. Comprehensive Special Incident Report.
10. Be sure to note on POP board and chart.

ADMINISTRATION OF JUSTICE DEPARTMENT
REGIONAL CRIMINAL JUSTICE TRAINING CENTER
MODESTO JUNIOR COLLEGE WEST

TRAINING MANUAL FOR TELEPHONE EVALUATION AND EMERGENCY MANAGEMENT OF SUICIDAL PERSONS

Suicide is one of the most difficult problems confronting persons in the helping professions. This applies not only to the professional therapist but to all the occupations concerned with health and well-being of the public. It is rare that any psychiatrist, psychologist, social worker, nurse, physician, clergyman, policeman or educator can conduct his affairs without at some time being faced with the need to evaluate and handle a suicidal situation.

Suicide as a term

Confusion often accompanies the use of the term suicide. One result of this confusion is the indiscriminate application of the term suicidal to patients with the implication that all such persons are in equal lethal danger. Experience has shown that suicidal persons vary in lethal potentiality from minimal to highly serious, and that each person requires individual, careful evaluation. Suicide is an ambiguous concept leading to confusions of behavior, end-result, and intention. When a person is called suicidal, these aspects must be clarified.

Characteristics of the suicidal situation

Crisis: The suicidal person is usually in the midst of crisis. Crisis has been defined (by Webster) as a "turning point in the course of a situation," and "a situation whose outcome decides whether possible bad consequences will follow." Gerald Caplan has defined crisis as a "disorganization of homeostasis (when faced with a problem) . . . which cannot be solved quickly by the individual's normal range of problem-solving mechanisms." For the person in a suicidal crisis, the principal factors are the overwhelming importance of an intolerable problem and the feelings of hopelessness and helplessness. The pressure of these feelings force him toward some actions for immediate resolution. These actions may be maladaptive, as in suicide attempts.

Crisis provides an unusual opportunity for therapeutic intervention. Crisis, by definition, implies a state that cannot be tolerated indefinitely. Something must change. The initiation and timing of therapeutic efforts during the crisis can influence the situation toward a favorable outcome.

Ambivalence: One of the features characterizing the suicidal person is ambivalence, expressed through feelings of wanting to die and wanting to live, both occurring at the same time. An example of ambivalence is the person who is angry at a love object over a real or imaginery hurt and is filled with strong feelings of both love and hate for the other. Such a person may

ingest a lethal dose of barbiturates and then call someone for rescue before he loses consciousness. The relationship and strength of the two opposing impulses to live and to die will vary for different persons, and also within the same person under different conditions. Most people have a stronger wish to live than to die. It is this fact of ambivalence which makes suicide prevention possible. In working with a suicidal person it is necessary to evaluate both motives and their relationship to each other and to ally oneself on the side of the fluctuating wish to live.

Communication: Suicidal activity is frequently a desperate method of expressing feelings of hopelessness and helplessness. Suicidal people are reduced to this method when they feel unable to cope with a problem and feel that others are not perceiving or responding to their need for help. The suicidal behavior thus becomes a claim for the attention which they feel they have lost. The communication may be in terms of verbal statements such as "I no longer want to live" or "I am going to kill myself"; or it may be in terms of actions such as the procuring of pills or guns, a sudden decision to prepare a will, or the giving away of treasured possessions. The communication may also be either direct or indirect and is frequently aimed at a specific person. When it is indirect, the problem is to recognize the intent of the disguised message and to understand the real content of the communication. Recognition of the communication aspects of suicidal behavior facilitates a more accurate evaluation of the various factors in the situation and allows for a more appropriate and helpful response.

The worker in suicide prevention

The effect of the suicidal communication: The suicidal behavior can further be understood in terms of the effect upon the recipients of the communication. For example, the communications may arouse feelings of sympathy, anxiety, anger, hostility, etc., in family or friends. Similar feelings may be aroused within the worker unless he can anticipate and counteract such reactions in himself. A universal tendency of which the worker must be aware is the desire to be omnipotent. Then (but only then) he would be able to solve all the problems and meet all of the demands of every patient. Intensely dependent patients attribute tremendous powers to the potential rescuer.

Many suicidal situations will arouse within the worker feelings of anxiety and self-doubts of his adequacy to handle the critical situations. While a moderate level of anxiety is appropriate, too much anxiety may seriously hamper the worker, especially if it is transmitted to the patient who, at this point, is depending upon the worker to help him solve his problems. The suicidal person who feels helpless and lost, perceiving excess anxiety in the worker, may lose his hope in the possibility of being helped. As in other aspects of life, suicide prevention workers develop confidence and poise with training and experience.

Feelings about death: Death is a part of life and living, but in our culture it has always been surrounded by powerful taboos. The taboos and the feelings they arouse may affect the worker and even interfere with the interaction with the patient, unless the worker is sensitive to his own feelings

about death. Whatever his own feelings, the worker must avoid any tendencies toward moralistic attitudes toward death and suicide. The worker's point of view, within the professional situation, must be that death is to be prevented, if possible; but he should recognize the existence and merits of other viewpoints.

Basic principles of suicide prevention

The following comments are offered as guidelines for effective and comfortable functioning in working with suicidal persons. It is, of course, impossible to anticipate every situation.

In most cases, suicidal crises will go through several stages in resource utilization. In the early stages, the person first comes to the attention of family, relatives and friends. In the second stage, he may come into contact with front-line resources, such as family physician, clergyman, police, lawyers, school personnel, and public health nurses. If the suicidal tendencies persist, the next line of resources is called into play, the professional person and agency. The final resource may be the hospital. The professions involved will include psychiatry, psychology, psychiatric social work, and psychiatric nursing. Agencies in the community most often involved will be mental hospitals, general hospitals, psychiatric clinics, social work agencies and various service agencies such as family service, vocational rehabilitation, and employment offices. Probably, with the current development of community mental health centers and the movement toward more immediate response to both physical and emotional illnesses, the professional persons and agencies will be contacted earlier and more directly.

Recently, suicide prevention services have been started in various cities throughout the country. They are characterized by two essential components, no-waiting service and twenty-four hour availability. They offer varying degrees of service, but primarily, they all have in common working on the telephone. Many suicidal persons will no doubt be contacting these specialized suicide prevention centers.

The handling of a telephone call from suicidal persons generally involves six steps. They may or may not occur concomitantly.

A. Establishing a relationship, maintaining contact, and obtaining information.
B. Identification and clarification of the focal problem(s).
C. Evaluation of this suicidal potential.
D. Assessment of strength and resources.
E. Formulation of a therapy plan and mobilization of patients' and others' resources.

Each of the steps is discussed in detail below:

A. Establishing a relationship, maintaining contact, and obtaining information:

In general, the worker should be patient, interested, self-assured, hopeful, and knowledgeable. We will want to communicate by his attitude that the

person has done the right thing in calling and that the worker is able and willing to help. By the fact of his call, the patient has indicated a desire for help with his problems. He should be accepted without challenge or criticism and allowed to tell his story in his own way, the worker confining himself to listening carefully to the information volunteered. The response, both in terms of attitude and tone on the telephone will make a significant impact.

Sometimes, because the patient will not have a clear idea of the agency's functions, it will be necessary to make clear the services offered. For example, the patient may request financial aid or a home visit, and, if these are not part of the service, this must be clearly stated.

A call should be initiated with a clear identification of the worker, and a request for the name and telephone number of the caller. Names and phone numbers of interested other persons such as family, physicians, close friends, or others who might be possible resources in the situation should also be obtained. The worker's immediate goal is to obtain information to be used in an evaluation of the suicidal potentiality. This is usually best accomplished by asking direct, specific questions about his suicidal feelings and plans. For example, "How do you plan to commit suicide?" "Have you pills or gun?" "When?" etc. It is the patient's reason for calling, and to talk about it without undue anxiety is helpful in reducing the patient's own anxiety about his suicidal impulses.

B. Identification and clarification of focal problems

The suicidal patient often displays a profound sense of confusion, chaos and disorganization. He is unclear about his main problem and has become lost in details. One of the most important services of the worker is to help the patient recognize and order the central and the secondary problems. For example, a woman caller presented a profusion of symptoms with feelings of worthlessness, despair, and inadequacy, saying she was not a good mother, she couldn't manage her housework, and her family would be better off without her. All this was accompanied by incessant weeping. Questioning revealed that her main problem lay in her relationship with her husband. A statement to this effect provided her with an authoritative definition of her central conflict and she was now able to address herself to this identified problem more effectively.

In some instances the caller may be clear about his central problem, but indicates that he has exhausted all his own alternatives for solution. The worker, as an objective outsider, might be able to provide a number of additional alternatives for the patient to consider.

C. Evaluation of suicide potential

The suicide potential refers to the degree of probability that a patient may kill himself in the immediate or relatively near future. A number of criteria to evaluate suicide potentiality have been developed out of research and experience at the Los Angeles Suicide Prevention Center. Suicidal potentiality will vary in terms of lethality from minimal, in which there is no danger of loss of life, to maximal, in which the possibility of death occurring is great and immediate.

As soon as the worker begins to talk with a suicidal caller, the worker has assumed some responsibility for preventing the suicide. To do so the worker must have an accurate evaluation of the lethal risk within the suicidal behavior. The plan of action formulated by the worker will depend upon the evaluation of the suicidal risk plus an appraisal of the patient's focal problem, his personality and available resources. The criteria for evaluation of suicide potential follow:

1. *Age and sex:* Both statistics and experience have indicated that the suicide rate for committed suicide rises with increasing age, and that men are more likely to kill themselves than women. A communication from an older male tends to be most dangerous; from a young female, least dangerous. Young people do kill themselves, even if the original aim may be to manipulate and control other people and not to die. Age and sex thus offer a general framework for evaluating the suicidal situation, but each case requires further individual appraisal, in which the criteria which follow are most useful.

2. *Suicide plan:* This is probably the most significant of the criteria of suicide potentiality. Three main elements should be considered in appraising the suicide plan. These are (a) the lethality of the proposed method, (b) availability of the means, and (c) specificity of the details. A method involving a gun or jumping or hanging is of higher lethality than one which depends on the use of pills or wrist cutting. If the gun is at hand, the threat of its use must be taken more seriously than when the person talks about shooting himself but has no gun immediately available. In addition, if the person indicates by many specific details that he has spent time and made preparations, such as changing a will, writing notes, collecting pills, bought a gun, and set a time, the seriousness of the suicidal risk rises markedly.

Another factor in the rating of the suicide plan arises when the details are obviously bizarre. Further evaluation of the plan will depend in large degree upon the patient's psychiatric diagnosis. A psychotic person with the idea of suicide is a high risk and may make a bizarre attempt as a result of psychotic ideation.

3. *Stress:* Information about the precipitating stress usually is obtained in answer to the question, "Why are you calling at this time?" Typical precipitating stresses are losses, such as: loss of a loved person by death, divorce or separation; loss of job, money, prestige or status; loss of health through sickness, surgery or accident; threat of prosecution, criminal involvement or exposure, etc. Sometimes increased anxiety and tension appear as a result of success, such as promotion on the job and increased responsibilities. Stress must always be evaluated from the patient's point of view and not from the worker's or society's point of view. What might be considered minimal stress by a worker might be felt as severe for the patient. The relationship noted between stress and symptoms (next criterion) is useful in evaluating prognosis. In general, if stress and symptoms are great, the action response of the worker must be high. In contrast, if symptoms are severe, but stress is low, either the story may be incomplete or the person is chronically unstable and will give a history of prior similar crises in his life.

4. *Symptoms:* Suicidal symptoms occur in many different psychological

states. Among the most common are depression, psychosis, and agitation. Evidence of a severe depressive state may be elicited with questions about sleep disorder, loss of appetite, weight loss, social withdrawal, loss of interest, apathy and despondency, severe feelings of hopelessness and helplessness, and feelings of physical and psychological exhaustion. Psychotic states will be characterized by delusions, hallucinations, loss of contact or disorientation, or highly unusual ideas and experiences. Agitated states will show tension, anxiety, guilt, shame, poor impulse control and feelings of rage, anger, hostility and revenge. Of most significance is the state of agitated depression in which the person may feel that he is unable to tolerate the pressure of his feelings and anxieties and exhibits marked tension, fearfulness, restlessness, and pressure of speech. The patient feels he must act in some direction in order to obtain some relief from his feelings. Alcoholics, homosexuals, and drug addicts tend to be high suicidal risks.

5. *Resources:* The patient's environmental resources are often critical in determining whether or not the patient will live. Inquiry should be for resources which can be used to support him through the severe suicidal crises. These may consist of family, relatives, close friends, physicians or clergymen. If the patient is already in contact with a therapeutic agency or a professional therapist, the first consideration should be the possibility of referral back to the therapist or agency. Another resource may be the patient's work, especially when it provides him with self-esteem and gratifying relationships. Related to this is the patient's financial status which may influence the availability and location of immediate physical and psychological care.

Sometimes the patient and family try to keep the suicidal situation a secret, or even to deny its existence. As a general rule this attempt at secrecy and denial must be vigorously counteracted and the suicidal situation dealt with openly and frankly. A general principle is that it is usually better both for the worker and for the patient when the responsibility for a suicidal patient is shared by as many people as possible. This gives the patient the feeling he lacks, that others are interested and ready to help him. Where there are no apparent sources of support, the situation should be considered more ominous. The same evaluation may be applied when resources are available but have become exhausted or hostile, as when family and friends have turned away and now refuse to be concerned with the suicidal patient. In most cases people respond to crises and will help if given an opportunity to do so.

6. *Life style:* This criterion of the person's general functioning refers to a stable versus an unstable style of life, and includes an evaluation of the suicidal behavior of the patient as acute or chronic. The stable person will report a consistent work history, stable marital and family relationships, and no history of prior suicidal behavior. If serious attempts were made in the past, the current suicidal situation may usually be rated more dangerous. The unstable personality may include severe character disorders, borderline psychotics, and persons with repeated difficulties in main areas of life functioning, such as interpersonal relationships and employment. Acute suicidal behavior may be found in either a stable or an unstable personality; chronic suicidal behavior is found only in an unstable person. With stable persons

undergoing a suicidal crisis, usually in reaction to a specific stress, the worker should be highly responsive, active and invested. With unstable persons, the worker generally should be slower and more thoughtful, reminding the caller that he has weathered similar crises in the past. The main goal will be to help him through another crisis, to restore order, and to help him stay in an interpersonal relationship with a stable person or resource.

7. *Communication aspects:* The communication aspects of the suicidal situation are revealing. The most important question is whether or not communication still exists between the suicidal person and other people. The most alarming signal is when communication with the suicidal person has been completely severed. This can be an indication to the worker that the suicidal person has lost hope in any possibility of rescuing activity.

The form of the communication may be significant. In type, the communication may be either verbal or non-verbal, and, in content, it may be either direct or indirect. A serious problem in the suicidal situation occurs when the person engages in non-verbal and indirect communication. These "action communications" imply that the interchange between the suicidal person and others around him is unclear and frequently raises the probability of acting out of the suicidal impulses. In addition, if the recipient of the communication tends to deny the existence of things which upset him, it may be very difficult for him to appreciate or even recognize the suicidal nature of the communications. In general, one of the primary goals of the worker is to open up and clarify the communications among all who are involved.

The content of the communications may be directed to one or more significant persons in his environment with accusations, expressions of hostility, blame, and implied and overt demands for changes in behavior and feelings on the part of others. Other communications may express feelings of guilt, inadequacy, worthlessness, or indications of strong anxiety and tension. When the communication is directed to specific persons, the reactions of these persons are important in the evaluation of the suicidal danger. These reactions are detailed in the following section.

8. *Reactions of significant other:* The significant other may be judged by the worker either as non-helpful, or even injurious, in the situation and therefore no possible assistance for the patient, or he may be seen as helpful and a significant resource for rescue. The non-helpful significant others either reject the patient or deny the suicidal behavior itself and withdraw both psychologically and physically from continued communication. The significant other may resent the increased demands, the insistence on gratification of dependency needs, the dictum to change his behavior. In other cases, one may see helpless, indecisive and ambivalent behavior on the part of the significant other and the strong feeling that he does not know what the next step is and has given up. This latter reaction of hopelessness gives the suicidal person the feeling that aid is not available from a previously dependable source and may increase the patient's own feelings of helplessness.

By contrast, a helpful reaction from the significant other is one in which the significant other recognizes the communication, is aware of the problem that needs to be dealt with and seeks help for the patient. This is an indication

to the patient that his communications are being attended to and that someone is doing something to provide help for him.

9. *Medical status:* The medical situation of the patient may reveal additional important information for evaluating the suicidal potentiality. The patient, for example, may be suffering from a chronic, debilitating illness which has involved considerable change in self-image and self-concept. For persons with chronic illness, the relationship with their physician, their family or a hospital will be of most importance. It is a positive sign if the patient continues to see these as resources for help.

The patient may be suffering from ungrounded fears of a fatal illness, such as cancer or brain tumor, and indicate a preoccupation with death and dying. There may be a history of many repeated unsuccessful experiences with doctors or a pattern of failure in previous therapy. These symptoms are of importance because of their possible effect on the significant others and doctors, exhausting them as resources for the patient.

In general, no single criterion need be alarming, with the possible exception of the one: having a very lethal and specific plan for suicide. Rather, the evaluation of suicidal potential should be based on the general pattern of all the above criteria within the individual case. For example, feelings of exhaustion and loss of resources might well have different implications in two patients of different ages. Thus, a 25-year old married man stated that he was tired, depressed, and was having vague ideas about committing suicide by driving into a freeway abutment. There was no history of prior suicidal behavior. He reported difficulty in his marriage and talked of separation, but he was still in contact with his wife and was still able to work on a job that he has had for many years. This case was considered a low suicide risk. A contrasting case of high risk was a 64-year old man with a history of alcoholism who reported he had made a serious suicide attempt one year ago and was saved when someone unexpectedly walked in and found him comatose. He recounted a history of three failures in marriage, and many job changes in the past year. He further stated that his physical health had been failing, that he had no family left and he was thinking of killing himself with a gun he had in his house.

D. Assessment of patient's strengths and resources

It is as important to assess the patient's strengths and resources as it is to evaluate the pathological aspects of the picture. Frequently the patient will present alarming serious negative feelings and behaviors. These may be mitigated, however, by a number of positive features still present within the situation. For example, one indication of important internal resources may be the patient's reaction to the worker's first attempts to focus the interview. If the patient is able to respond to the worker, accepting suggestions and directions, this is an important hopeful sign. Improvement in mood and thinking within the course of one interview is a positive sign and indicates the patient's ability to respond to proferred help.

E. Formulation of a therapeutic plan and mobilization of patients' and others' resources

The plan formulated for the patient will be determined by the evaluation of the patient's suicidal status and the information obtained about him and his resources. In general, those cases with the higher suicidal potential will require the most activity on the part of the worker. An evaluation of high suicide potential in a situation which appears out of control will usually require immediate hospitalization. In our experience, however, only ten percent of the cases require this action. Family or close friends should be contacted to help bring the situation under control and to take the patient to the hospital. They should be instructed not to leave the patient alone. Most calls received by the worker are of low suicidal risk. Some of them can be handled satisfactorily by simply providing sympathetic and understanding listening with only telephone counseling and advice.

Most cases, however, will require more action on the part of the worker, usually in the process of referring the patient to another resource in the community. The type of referral will depend upon the evaluation of the problem. The referral may be to either a non-professional or a professional resource or to both. Although most calls are not serious in terms of suicide, the callers do have serious life problems for which they need help. The suicide call is a "cry for help" with these problems.

If the call comes at night, the worker should keep in mind that most problems are magnified during the nighttime hours. An immediate goal would be to help the patient get through the night. The worker should strive to get sufficient information to determine if it is a high risk emergency requiring an immediate action.

In the highly unusual event that a person is calling in the midst of his suicide attempt (one to two percent of the calls), as much information as is necessary to identify the patient or the caller should be obtained and the informant should be instructed either to take the patient to an emergency hospital, to call his personal physician, to call an ambulance, or to call the police. The aim at that time is to provide the patient with immediate medical attention.

At this point it is important to note an important aspect of the worker's responsibility. The worker might make a referral for the patient to one of the resources within the community, but the moral responsibility for the patient remains his until this responsibility is assumed by the other resource. The worker must not assume his responsibility has been discharged until he is assured that responsibility for care of the patient has been accepted elsewhere.

In general, if there is any question or doubt about the evaluation of the suicidal situation of the patient, he should be referred to a professional person for a complete evaluation. A patient with a suicidal problem that is not immediately serious but who presents emotional disturbances, may be referred to a psychiatric clinic, private therapist or a family agency. Usually such resources will require a waiting period and the referral to such agencies will depend upon whether or not the patient can sustain the interim period. A resource book showing available psychiatric and social agencies in the com-

munity is especially useful.

In suicide prevention, there will always appear, despite experience and knowledge, some cases which will arouse anxiety and tension in the worker. The most constructive way to handle these feelings is through informal discussions and consultation with colleagues which generally provide at least two measures of help. Not only is there a sharing of anxiety and responsibility, but there is benefit from discussion of the problem. Regular meetings for training films, lectures by professionals who have had special experience, or case presentations help maintain morale and improve service. Comments on the problem cases of other workers should be directed toward evaluating the difficulties and offering constructive help. Every worker should be prepared for some failures. A recommended method for handling the grief experienced by workers when the suicide of a caller could not be prevented is to have a conference about the case in the spirit of mutual sympathy and support, and with the hope of learning more. In its many aspects suicide is still an enigma and there is much to be learned.

Resources:

The following are detailed suggestions about general and community resources for use in suicidal situations. Any one or combinations of these resources should be considered as imaginatively and constructively as possible. The worker should not allow himself to be constrained by conventional practices. In general, the resources will be of two types, non-professional and professional.

1. Non-professional resources

a. Family. The family is often neglected as a resource but is one of the most valuable at the time of crisis. The patient should be encouraged to discuss his situation and problems with his family. If it is considered important that someone be with the patient during the crisis, the family members should be called and apprised of the situation even though the patient may be reluctant. The patient is usually informed first that his family will be called. Also, the family must be involved in accepting responsibilities for the emergency and in helping the patient get the treatment which has been recommended.

b. Friends. Close friends often can be used in the same way families have been used. For example, the patient can be encouraged to have a friend stay with him during a difficult period. The friend may also be helpful in talking things out and in giving a feeling of support.

c. Family physician. People often turn to their family doctors for help and physicians often serve as supportive authority figures. The patient usually has a good relationship with his doctor and should be encouraged to discuss his problems with him. Physicians can also be helpful in cases where medication or hospitalization is required.

d. Clergy. If the caller is close to his church he should be encouraged to discuss his situation with his clergyman.

e. Employer. When the patient's occupation is involved and there is considerable question about his feelings of self-esteem because of vocational difficulties, the patient can be encouraged to talk about these difficulties with his employer.

f. Police. In metropolitan areas police should be utilized only in cases of clear and immediate emergency, e.g., if the suicide attempt is about to occur or has occurred. The patient may need prompt medical attention and the police are often the ones who can procure it for him most quickly. The police are able to take the responsibility for involvement with a patient and may hospitalize when necessary. It should be remembered, however, that the police are not to be used simply as an ambulance or transportation system. As a general rule, the police should be involved as little as possible, but when the decision to use them is made it should be carried through with firmness and dispatch. The two main criteria will be when the patient is helpless and hurt. In smaller cities the police may be involved as a prime resource for anyone in trouble.

g. Emergency Hospital. Usually the patient or his family or the caller will know of private emergency hospitals in his area. The worker should know about city and county hospitals available for emergency medical treatment hospitalization. The police will generally use city and county hospitals.

2. Professional Resources.

a. Own Agency. The worker may wish to refer the patient to his own agency in those cases where it is felt there is a high suicide potential and where there is need for more intensive, careful further evaluation. Giving the patient an appointment gives the patient a task and a purpose to his immediate future. This resource, of course, can be used only when the agency includes facilities for personal interview and evaluation.

b. Social Work Agencies and Community Psychiatric Clinics. In those cases where the suicide danger has been evaluated as low or perhaps not even the primary problem, a referral to a family service agency or community psychiatric clinic can be considered. These are often the treatment medium of choice for patients in whom the underlying problem may be seen as marital discord, family conflict, or chronic personal and social maladjustment. The worker should be familiar with the social work agencies or community psychiatric clinics within the community and referrals can be made to those near the patient. Often, a referral to an agency which works primarily with persons of the patient's own religion is more desirable. Other considerations are fees and hours which will be compatible for the patient.

c. Private Therapists. Some calls are from people looking for psychiatric treatment. The worker should be familiar with private therapists for appropriate recommendation in such cases. If the patient indicates that he is already in treatment, he should be encouraged to return to his own therapist.

d. Psychiatric Hospital. If the community contains a psychiatric hospital or a general hospital with a psychiatric ward where patients can be hospitalized, a liaison with such facilities is most important. Generally, referral to such a resource is made when it is thought the patient is so disturbed that he might seriously harm himself or others, and/or he is so disorganized he can no

longer exercise judgment or direction of his affairs. It might be necessary to have family or friends take the patient to the hospital if the patient himself is incapable of getting there.

Some typical calls

Following are some illustrations of what may be considered typical calls. A description is given of the caller and the problem presented and suggestions will be made for the handling of the call. It should be remembered that these are examples which have been generalized for teaching purposes and that calls do not always fall exactly within these given descriptions.

1. A woman, between 30 and 40 years old, calls at night saying that she doesn't understand why she feels so depressed. She states she is alone, complains of not being able to sleep, having troubled thoughts and feels that she needs to talk to someone. Sometimes she will say that she really doesn't want to kill herself but she has had suicidal thoughts over many months or years. She may be agitated, depressed, weeping, as if she is having a hysterical breakdown. She may be demanding and asks what can be done to help her right now because she feels she is not able to get through the night. Questioning will reveal she has had many similar episodes before. Probably she is reacting to some interpersonal conflict such as an argument with a family member or close friend.

It is best to listen patiently and wait for the opportunity to point out realistically that things look worse at night, but that is not the best time when she can get help for herself. She should be advised to call her doctor or social work agency or clinic in the morning so as to arrange a program of help for herself. It may be helpful to suggest that she call a close friend or relative to come and be with her during this difficult night.

2. A woman sounds as if she were between 20 and 35 years old, but who will not identify herself. She asks what can the Suicide Prevention Center do for a person who doesn't want to live anymore, and generally takes a challenging position. The caller sounds controlled, makes vague allusions to a long-standing problem, and wants to know what you can do about it. Frequently these no-name callers are either in psychotherapy or have been recently interrupted.

The worker should point out that the caller has responsibility to clarify his request and cooperate if he is to receive help. You must know who he is and about his situation before you can assist him. If he tells you he has a therapist, and who he is, you should refer him back to the therapist. Tell him that you will call the therapist to notify him that the patient had called you.

3. A woman between 40 and 55 calls about herself, complaining that she is very depressed, feels lonely and tired, and feels that no one is interested in her. She talks about many physical and medical problems. She says that she feels her doctor is not helping her enough and that her husband is not paying enough attention to her. She will say that she feels like her life is over, and there is no point in continuing to live.

An effort should be made to talk with the husband and to discuss with him how his wife is feeling. Both the patient and the husband should be encouraged to talk with the family physician at the first opportunity about the patients depression. You may offer to call the physician, too, in order to enlist his aid. If none of these resources seems available, the patient may be asked to come in for an appointment.

4. A man between 18 and 30 sounds evasive and anxious on the phone and is reluctant to give his name. He talks about having a problem which he is hesitant to identify, and states he is calling for help because the only solution he can think of is to kill himself. His suicide plan will be an impulsive one, like smashing his car up on the freeway, or cutting himself with a razor blade. This man often has a personal problem about which he feels guilty, such as homosexuality.

This patient should be encouraged to seek help for himself. You should commend him for having done the right thing in calling you as a beginning effort to get help for himself. You might suggest a resource where he might go, such as a psychiatric clinic, private therapist, physician, or school counselor.

5. A man between 25 and 40 complains that his life is just a mess because of his bungling. He talks about having gotten himself into such a jam, either financially or with his family or on the job, that he feels the only way out is to kill himself. Often, he will be reacting to a specific, recent setback in his life.

He should be told that he is reacting to a specific stress, and that he needs help with that particular problem about which he feels helpless and hopeless. He should be reminded that he was able to function well before he had his setback, that he is suffering from a depression which is most often time-limited and temporary and that he needs help to get back on his feet again. He should be encouraged to come in for an appointment, and every effort made to help him resolve the stress and get through the crisis.

6. A man about 50 or so sounds very depressed and discouraged and seems apologetic about calling and troubling you. He may complain about a physical problem which has prevented his working, and feels now that he is beyond help. His general feelings about himself are that he is old and infirm and a burden on others. When asked what his suicidal thoughts are he talks about specific plans for killing himself.

Friends, family and resources should be mobilized and involved. The patient should be told that help is available to him. He should be told to come in for an appointment and his family should be impressed with the need to follow through. If he fails to come in, then he should be called back and contact maintained until someone takes responsibility for treatment of such a high suicidal risk.

7. A family member or friend calls about a person who is described as depressed, withdrawn, or has shown some behavioral or personality change. The patient may have told them that he is planning to kill himself and even discussed a specific plan with them, or, he may have generally talked about wanting to end his life. The caller is asking how serious the situation is and what he should do.

The caller should be advised to contact the patient and let him know he is concerned about him and trying to get help. He should be told to have the patient call you, so that the patient will have the feeling that help is being obtained for him, and, also, you will have an opportunity to evaluate the situation with the patient. You should maintain your contact with the initial caller and keep him apprised of what is happening, maintaining him as a resource to help, if need be. The recommendation to the patient will depend on the evaluation of the lethal potentiality.

8. The caller is a neighbor or friend and is concerned about someone he knows. He may be reluctant to identify himself or to involve himself in any responsibility but requests that you do something about the person he is concerned about. He is not able to give too much detail or information about the situation which concerns him.

You should get as much information as you can and encourage him to let the person know that he is concerned for him and to advise the patient to call you. You should point out that it would be unrealistic for you simply to call someone without being able to say who notified you. The caller should be told that it is his responsibility to be involved if he is really concerned about a person who is suicidal.

9. A physician, minister, police officer, or similar person in a position of responsibility calls about a case. Frequently, the call is about someone who has just been rescued after a suicide attempt.

Get as much information as possible to evaluate the situation. If the patient is still threatening suicide, hospitalization should be considered. If the patient seems calmed down and under control, then he should be encouraged to seek professional help. Your informant should be encouraged to demonstrate his continued interest in the patient and offer counseling.

10. The caller tells you about a neighbor or family member who is being physically restrained from attempting suicide and the patient cannot be left unattended. The patient is described as psychotic and determined to kill himself.

The caller should be advised to take the patient to the nearest psychiatric hospital or to the psychiatric unit of the County General Hospital. It should be emphasized that harmful drugs or objects should be removed from the patient's environment and someone should always be with him.

11. In the unusual event that you get a call from someone who is attempting suicide while telling you about it, you should keep the person on the phone. Get his name, phone number, address, and information about his attempt. Try to learn specifically what he has ingested or what he is doing. Call the police and identify yourself, give them all the pertinent information and ask them to investigate.

Los Angeles County Sheriff's Department

Mental Status Interview

One way to begin the interview is with questions that afford a measure of the degree of integrity in the mental processes of the subject. False or exaggerated answers to most of the questions listed below do not necessarily invalidate later responses during the interview, but suggest that the examiner be alert for signs of carelessness, confusion or specific behavioral trends where the subject attempts to portray the most favorable self-image.

1. Do you become angry once in a while?
2. Are you kind to people you don't like?
3. Do you always tell the truth?
4. Do you like to know important people?
5. Have you gossiped at various times?
6. Do you ever laugh at a dirty joke?
7. Sometimes do you feel like swearing?
8. Is it necessary to keep a promise?
9. Would you rather win than lose?
10. Do you read every editorial daily?

Sensory Defects

Some noteworthy psychopathological effects may be associated with disorders or weaknesses in one or more sensory organs.

The significance of visual impairment has been known to have a marked bearing on contact with the immediate environment. The hard of hearing or deaf person may display tendencies toward inadequacy, inferiority, suspiciousness and depression. Defects in other areas as cutaneous, gustatory, olfactory, kinesthetic and vestibular, may also influence behavior, ever so slightly. The following questions are arranged to elicit desired information in the sensory categories:

1. Do you ever/always wear glasses?
2. Do your eyes bother you much?
3. Do you have to rub your eyes often?
4. Have you any trouble hearing?
5. Do your ears ache at any time?
6. Are you able to hear low sounds?
7. Do your hands or feet get numb?
8. Can you feel what you touch?
9. Which hand is more sensitive?
10. Have you any unusual tastes?
11. Can you taste different foods?
12. Do you have any food preferences?
13. Do you experience unusual odors?
14. Describe various odors around you.
15. How do you feel when walking?
16. Can you feel your arm movements?

17. How does it feel to move your eyes?
18. Do you have difficulty standing?
19. What does it feel like to move?
20. Can you turn your body easily?

Perceptual Tests

Normal perception is a realistic interpretation of external stimuli. Illusions are false perceptions of external stimuli and may be considered abnormal when they are peculiar to the subject only. These questions may suggest the possibility of illusions:

1. Do you always see things clearly?
2. Do you misidentify people easily?

Hallucinations are false perceptions in the absence of external stimuli. They may occur in any modality; but are found more often in the auditory field. Not all hallucinations are signs of a psychosis, since normal persons have hallucinatory-like experiences while dreaming during sleep. The very thirsty, the hungry, the excessively fatigued and the extremely tense may also hallucinate. Alcohol and various drugs can induce hallucinations. To be psychotic, however, one must hear voices, see visions or smell unusual odors and accept them as being real. Among the questions designed to disclose hallucinations, these were selected:

1. Is your imagination very active?
2. How often do you dream while awake?
3. Have deceased loved ones appeared to you?
4. Have you seen God or Jesus at some time?
5. When did any of this first happen?
6. Have you ever heard your name when alone?
7. Do you enjoy talking with yourself?
8. If so, describe how all this occurred.
9. How do these experiences affect you?
10. Are you able to do anything with them?

Motoric Behavior

Signs of motor disorders are evident when the response mechanisms are increased, decreased or inappropriate to the stimulation. Note should be made if the subject is overactive, falls easily or is slow-moving. Does he have convulsions? Are they often, seldom, severe or mild? Questions which may be used to evaluate motoric responses are:

1. Do you become restless or excited often?
2. How do you feel if others get very active?
3. Have you ever had a convulsion or seizure?
4. Do you usually move more slowly than others?
5. Are you as active since you came here?
6. Have you ever been unconscious?

Observe how the subject walks. Does his gait resemble any of the following? Alaxia—uncertain leg movements. Scissors—shuffling, knock-knees.

Parkinsonian—shuffling on toes. Spastic—feet scarcely raised. Cerebellar—staggering. Waddling—duck-like manner.

How does the stream of mental activity sound? Does the subject talk rapidly or slowly? Much or little? Not at all? Does he ramble or develop a point to be easily distracted? Does he joke, or pun or swear? Does he repeat your questions? Does he mimic your words or actions? Are his answers irrelevant? Is he defensive, evasive, resistive or frank? Is his speech coherent and spontaneous? Is the subject able to recognize familiar objects? Has he lost the ability to read?

You may ask the subject to repeat these or similar phrases:

1. She picked thistles.
2. Try three threads.
3. She sells silk.
4. Ragged rascal ran.
5. Round rugged rock.

Does the subject appear restless? Compulsive or destructive? Dangerous to self or to others? Be alert for suicide if subject's energy is high and narcissim is low, that is, being hyperactive and having little personal worth.

Affective Display

Affect subsumes emotions, feelings and moods. It implies that the effective state is more lasting, more pervasive; it is not fleeting, not transient as in an emotional reaction only. To evaluate affect, look for alternating moods of joy and sadness. Is the affective display appropriate to the situation? Is it shallow and incongruous? Does the subject jest about tragic events? Weep when others are happy? Is the subject introverted? Does the subject prefer to be alone? Does the subject lack initiative? Are there signs of depression? It is important to differentiate depression from withdrawal. In depression, affect is deep and melancholic. In withdrawal, affect is flat and dissociated. Questions that may be used to evaluate affect are as follows:

1. How do you feel now?
2. Do you have any aches?
3. Are you anxious or tense?
4. Do you get blue or sad?
5. Under what conditions?
6. Does life seem worthwhile?
7. Do you feel excited or high?
8. What brings on these feelings?
9. When do they begin and end?
10. Does medicine help you?
11. What makes you angry?
12. How do you handle temper?
13. Have you been afraid recently?
14. What do you fear the most?
15. How long have you felt this way?

Intellectual Areas

Intellectual disorders involve deterioration at varying degrees in the process of thinking. A faulty intellect may be absorbed or preoccupied with inner promptings and may fail to comprehend or to retain new ideas. It may manifest disorientation for person, place and/or time. It may have amnesia for remote, recent and/or anterograde events. It may express few ideas, loose association of ideas or flight of ideas. It may produce circumstantial irrelevant speech; it may dwell on obsessive matters. It may harbor delusions or bizarre beliefs and hold them regardless of factual data proving them to be unreal. It may have difficulty in judgment, impairment in intelligence and distortion in insight. Among the numerous questions to demonstrate intellectual disorders, these have been selected:

Orientation

1. What is your full name?
2. Who brought you here?
3. Where is your home?
4. Do you know where you are now?
5. Have you ever lost track of time?
6. What is the complete date today?

Memory

1. When and where were you born?
2. How old are you now?
3. When did you begin school?
4. Where did you attend school?
5. When did you leave school?
6. Were you held back in any grade?
7. What time did you get up today?
8. What did you have to eat?
9. Where are you now employed?
10. How long have you been there?
11. What kind of work do you do?
12. What is your annual income?
13. How many jobs have you held?
14. Have you any trouble with memory?
15. How long does it usually last?

Ideation

1. Are you confused at times?
2. Do you have many ideas?
3. What do you do about them?
4. How do you control your ideas?
5. Do you have few ideas?

Delusions

1. How do people treat you?
2. Do they often notice you?

3. Does anyone talk about you?
4. Are you being watched?
5. Has anyone frightened you?
6. Do you have unusual talents?
7. Can you influence others' minds?
8. Does anyone control your thoughts?
9. Have you much money or property?
10. Do you have famous relatives?
11. How is your appetite these days?
12. Does food taste all right?
13. Is your body usually healthy?
14. Do you have any organs missing?
15. Has God been very good to you?
16. Do you wonder if prayer has value?
17. Do you believe Jesus was also God?
18. Does your religion differ from many?
19. Do you always attend church?
20. Do you believe in life after death?

Judgment

1. How are an orange and an apple alike?
2. Do a mistake and a lie differ?
3. In what way are 25 and 64 similar?
4. What are you going to do today?
5. How do you spend most of your money?
6. What are your plans for the future?

Intelligence

Intelligence is classified as subnormal, borderline, dull normal, average, bright normal, superior or very superior. Record the name of the intelligence scale, the Intelligence Quotient and/or Mental Age, the subtest scatter and the norms, when available. If the I.Q. is subnormal and there is also a history of developmental retardation and social incompetence, a diagnosis of mental deficiency may be indicated.

Since 1952, the degrees of intellectual deficiencies have been designated as mild, moderate and severe by the Diagnostic and Statistical Manual of the American Psychiatric Association. The publication of this manual helped those states that maintain statistical offices to standardize procedures. Before that, retardates were classified as morons, imbeciles and idiots, well-intended concepts but crude attempts to describe the degrees of deficiencies in legal-medical language. Now these terms are harsh sounding and have historical value only.

In 1959, the American Association on Mental Deficiency issued a Manual which created some confusion for mental health workers. Institutions and clinics for the mentally retarded began to use the AAMD manual while hospitals and clinics for psychiatric disorders continued to refer to the APA Manual. But in 1968, the APA revised its Diagnostic and Statistical Manual, thus

narrowing the differences between the two groups. The table below compares and clarifies the 10 variations:

Degrees of Deficiency

American Psychiatric Association		American Association on Mental Deficiency	
Degree	IQ	Degree	IQ
Borderline	68–85	Borderline	70–84
Mild	52–67	Mild	55–69
Moderate ..	36–51	Moderate	40–54
Severe	20–35	Severe	25–39
Profound ..	19–Low	Profound ..	24–Low

Insight

Insight may be judged parenthetically as adequate, inadequate, or distorted insofar as it coincides with the subject's awareness of factors in own behavior, and ability to react in a realistic and responsible manner. Distorted Insight is usually in evidence when the subject has no awareness of own behavior and continues to act in a bizarre and unrealistic manner. Questions to elicit insight and aid in determining the degree are:

1. Do you ever lose track of time?
2. What may cause this confusion for you?
3. Do you have tension in the head?
4. What causes these sensations?
5. How do your emotions affect your body?
6. Does nervousness ever upset your stomach?
7. Is there anything wrong with you?
8. Have you worried about your mind?
9. What kind of a place is this?
10. Are all of the people here very sick?

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