U.S. Marshals Service

Suicide Prevention Training
U.S. Marshals Service
Suicide Prevention Training

Presenters

**Robert Nagle, Psy.D.**
Federal Bureau of Prisons
National Suicide Prevention Coordinator

**Claudia Hill-Bickham, B.S.**
Correctional Subject Matter Expert
Correctional Management and Communications Group

**Theo Anderson, M.A./MBA**
Chief, Detention Standards and Compliance
Headquarters United States Marshals Service Prisoner Operations Division

**Anita Pollard, Capt, USPHS, M.S.B/RN**
National Institute of Corrections
Overview

Psychology of Suicidal Prisoners

Bureau of Justice Statistics and Analysis

Suicide Resistant Cells

National Resources & Information
Robert Nagle, Psy.D.

Federal Bureau of Prisons

National Suicide Prevention Coordinator
“Homo sapiens are relational creatures; we live in family units, tribes, villages, and cities...Most suicides can almost always be linked to interpersonal issues.”

(Jobes in Flemons & Grolnick)
**Inmates:**

1. in pre-trial status.

2. experiencing a mental illness, including a personality disorder.

3. in restrictive housing units (i.e., Special Housing Unit, Special Management Unit, mental health seclusion, and Secure Treatment Programs).

4. convicted of a sex offense.
Vulnerability

**SITUATIONAL TRIGGERS**

- Break up of relationship, bad news
- Visit does not happen
- Threats, bullying, debts
- Sleeplessness
- Disciplinary Sanctions
- Transfers
- Unexpected Sentence
- Peer suicides or attempts
- Increase in any prison stress
Why Death by Suicide Now?

- Suicidal crises usually emerge from problems with relationships.

- Something or someone has touched on the inmate's sensitivity (i.e., perceived rejection, frustrated need, breakup).

- Usually a perceived rejection or slight by a person playing a significant role in their life.
Exploiting a Vulnerability

- Violence & intimidation from other prisoners
- A sense of helplessness
- Role minimization and/or deprivation
- Grief when family are experiencing social problems
- Cumulative impact of limited privacy & autonomy over ones daily routine
Suicides in secure units occur in single cells

- Double Cell all inmates unless there is a compelling reason not to do so
- Place at-risk inmates in higher visibility cells
- Reduce or eliminate the presence of tie-off points
Suicides most frequently occur in private spaces such as bathrooms, showers, mop closets, or cells.

Important prevention measures include frequent rounds, not allowing inmates to cover windows, and establishing professional and meaningful relationships.
WARNING SIGNS Specific to Inmates

- Suicidal threat anytime
- Rehearsal behaviors observed by staff
- Trying to obtain a single cell
- Hording medication
Four Basic Responses

1. LISTEN and HEAR
2. Take thoughts and feelings seriously.
3. Support and affirm.
4. Refer to Psychologist, medical professional, or shift supervisor.
Four Staff Responsibilities

1. **Recognize warning signs** that tell us inmates may be experiencing problems.

2. **Communicate concern and empathy** to the behavior and take appropriate actions.

3. **Respond correctly** to those problems.

4. **Follow-up and monitor** inmates who have been identified and treated.
Summary (Robert Nagel)

Each of us has important Responsibilities with Suicidal Inmates:

- Consider the inner world of these inmates and communicate concern and empathy for their distress.
- Recognize when conditions for a suicide “perfect storm” exist (vulnerability, prison induced stress, situational triggers).
- Respond correctly to the behavior.
- Follow-up on and monitor inmates who have been identified and referred.
Claudia Hill-Bickham, B.S.
Correctional Subject Matter Expert
Correctional Management and Communications Group
Suicide Statistics – Who?

- **93%** male
- **67%** white
  (*15.1% Black / 12.1% Hispanic*)
- Average age: **35**
- **38%** had a history of mental illness
  (*40% History Psychotropic Medication*)
- **34%** had a history of suicidal behavior
  (*43% Held on violent charges*)
Suicide Statistics – When?

- **31%** found dead 1 hour+ after last observation
- **24%** occurred within first 24 hours
- **27%** between 2 - 14 days
- **20%** between 1 - 4 months
- **8%** were on suicide watch
- Evenly distributed throughout the year

*(seasons & holidays did not contribute to more suicides)*
Suicide Statistics – How?

- **93%** used hanging as the method
  - **66%** used bedding materials as the instrument
  - **30%** used bed/bunk as the anchoring device
  - Other anchoring devices: door hinge/knob, air vent, window frame, towel hook, shelf, shelf, seat, plumbing fixture, sprinkler head, light fixture

- **2nd** most popular method is drug overdose
  - Drug hoarding
  - Cleaning chemicals
Facility and Gender Comparisons

So how do jails compare against other detention or prison facilities with the number of inmate suicides.

- The first graphs compares suicides the number of suicides committed by men and women with in the community in the United States. The overall number in light blue represents 11 suicides per 100k persons.
- Men have a higher rate than women at 18 suicides per 100k as compared to women at 4 per 100k.
- The State prisons did not separate data for men and women but revealed a rate of 14 suicides per 100k.
- In Federal prisons the rate was the same for males and females at 10 per 100k.
- In Jails the suicide rate is 36 per 100k.
- A National Institutes of Corrections study in 1986 revealed there were 107 Jail suicides per 100k.

- In 2002 a Bureau of Justice and Statistics study revealed the rate had fallen to 47 Jail suicides per 100k;

- The most current Bureau of Justice and Statistics as of 2006 reveal a continued decline reflecting 36 Jail suicides per 100k.

- Overall the data reveals jails have experienced a 50% decline over a 20 year period in the jail suicide rate for prisoner populations over 100k.
Theo Anderson, M.A./MBA

Chief, Detention Standards and Compliance

Headquarters United States Marshals Service Prisoner Operations Division
Keep Sight Lines Open

Frequent Checks

- Attention
- Training
- National Standards
- Policies and Procedures
- Accountability
- Supervision
- Litigation

Lighting Control
CO’s control Cell lighting **NOT** the prisoner!

Jail Suicides
Increased awareness & assessment of the threat of a suicide... comprehensive suicide screening at intake. Increased communication and observation by CO’s assigned to housing units... Find out what’s going on.

Facility policies, procedures and post orders should clearly include suicide prevention guidance.

Staff supervision with regular 15 minute bed checks with documentation in daily logs or via electronic data keeping.

Don’t allow the use of privacy obstruction devices (towels, clothing or anything that blocks the full view at all times into a cell.)
"Institutionalize" suicide prevention and response practices.

Training when coupled with suicide-resistant cells reduces the opportunity and capability for suicide; Together they will still not 100% fully protect residents/inmates from self-harm.
Can you see into the entire cell?

☑ from the normal working position?
☑ w/o removing a window cover?
Know the rules and guidance for use of Self Restraint Chairs and Tie Down Beds!
Know your Surroundings!
U.S. Marshals Service
Suicide Prevention Training

Eliminating the Anchoring Point

- Doors
- Light Fixtures
- Vents and Grills
- Shelves & Accessories
- Windows
- Showers
- Plumbing
- Sprinkler Heads
- Bunks
Eliminate Anchoring Points
U.S. Marshals Service
Suicide Prevention Training

Light Fixtures

Eliminate Anchoring Points
Vents Should Have:
3/16” or Smaller Openings
(1/8” Preferred)

Eliminate Anchoring Points
Eliminate Anchoring Points
Eliminate Anchoring Points
Sprinkler Heads

SAFER

LESS SAFE

Eliminate Anchoring Points
Eliminate Anchoring Points

NOTE:
Cell Doors should swing OUT!

SAFER

LESS SAFE
Eliminate Anchoring Points
Cell Shelving

Eliminate Anchoring Points
U.S. Marshals Service
Suicide Prevention Training

Cell Accessories

SAFER  LESS SAFE

Eliminate Anchoring Points
Other Considerations