

Jail Suicide Assessment Tool

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Users Manual

(2002)

Introduction

The Jail Suicide Assessment Tool (JSAT) is a suggested interview format for conducting structured suicide risk assessment interviews with adults who are incarcerated. The foundation of the JSAT is based upon two points: 1) The kind of information obtained through a structured clinical interview is superior to the results of any single psychological test or scale, and 2) The essential feature of assessing suicidal risk is informed, professional judgment. *The primary purpose of the JSAT is to cue correction-based mental health practitioners in the gathering of information generally viewed as essential in the decision making process for assessing suicide risk.* This instrument can also be used to train staff, objectively evaluate mental health practices, clarify processes for litigation purposes, while serving as a point for future research and agency policy discussion.

Origin

The JSAT is patterned after the Prison Suicide Risk Assessment Checklist (PSRAC), which was developed by a team of mental health professionals employed by the Federal Bureau of Prisons (Wedeking, Carlson, Johnson, Ray, and Levins, 1997). They collectively reviewed available literature, completed hundreds of suicide risk assessments on federal prisoners, and gathered data on factors commonly associated with prisoner suicide risk (see Appendix A). The JSAT improves upon the PSRAC by expanding categories, clarifying language, and utilizing a broader response format.

Overview

The JSAT consists of twenty-four categories arranged in such a manner that the primary purpose of the interview is not immediately revealed, rapport building is facilitated, and essential information is obtained. Each category has cue words to prompt the clinician during the interview. Clinicians use professional judgement to rate each category as "+" (a positive indication of stability), "n" (a neutral finding), or "-" (a negative sign in the direction of potential suicide risk). Rating categories in this manner identifies areas of support and/or concern as related to suicide risk. The process lends itself well to topic-specific crisis counseling. It is also a vehicle whereby clinicians can conceptualize changes in functioning over time (e.g., during a suicide watch, post-crisis follow up). Categories are not weighted nor is a score derived. *The primary benefit is the gathering of essential information so that an informed, clinical decision can be made.*

The process of developing specific questions to get at an understanding of the prisoner's current status in relation to any given risk factor is entirely dependent upon the training, skill level, and personal preference of the clinician. The recommendation is that clinicians begin by asking general, open-ended questions and then follow up with specific, more pointed questions as appropriate. The JSAT appears in full on the following page.

JSAT

(Jail Suicide Assessment Tool)

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-
- + n - **A. Important relationships:** who, last contact, support, well-being, concerns, unresolved loss
-
- + n - **B. Social status:** sudden change, culture shock, predator to victim, gang issues
-
- + n - **C. Legal status:** pre-trial, recently sentenced, 20+ year sentence, new charges, high-risk group
-
- + n - **D. Institutional adjustment:** current adjustment, history of disciplinary actions, perceived safety
-
- + n - **E. Physical health:** perception of health, medical/medication concern, life-threatening condition
-
- + n - **F. Physical pain:** pain, intensity, duration, ability to tolerate
-
- + n - **G. Chemical abuse/use:** history of substance abuse, signs of intoxication or withdrawal
-
- + n - **H. Psychiatric treatment:** counseling, medication, compliance, hospitalization, diagnoses
-
- + n - **I. Mental status:** orientation, mood, affect, thought content, agitation
-
- + n - **J. Depression (current signs):** severity, obvious symptoms, subtle signs
-
- + n - **K. Reality testing (current signs):** hallucinations, content, delusions, negative signs
-
- + n - **L. Character:** antisocial, narcissistic, borderline, dependent, histrionic, etc.
-
- + n - **M. Hope:** future orientation, life goals, reasons to live, supportive faith
-
- + n - **N. Help self:** perceived ability to solve presenting problems
-
- + n - **O. Cognitive themes:** optimism, pessimism, exaggeration, negativism, shame, self-loathing
-
- + n - **P. Coping resources:** history of coping, current level of distress, level of perceived self-control
-
- + n - **Q. Measured reasoning:** sudden destructive action toward self/others, impulsive, a “hot-head”
-
- + n - **R. Self-harm history:** thoughts, plans, actions, circumstances, how discovered, intentions
-
- + n - **S. View of death:** desire to survive, ideas and attitudes about dying
-
- + n - **T. View of suicide:** study of, suicide of significant others, long history of thoughts/attempts
-
- + n - **U. Recent suicide signs:** self-harm action, preparations, notes/letters, changes noted by others
-
- + n - **V. Suicidal intention:** resolution to act, lethal plan with available means
-
- + n - **W. Cooperation:** rapport, therapeutic alliance, manipulative style, convincing contract
-
- + n - **X. False presentation:** secondary gain, factitious features, rare symptoms, unusual clustering

Category Ratings

The following are suggestions about ways to apply “+” and “-“ ratings to specific categories. These represent samples only, as it should be understood that the unique characteristics of a given case may not always neatly fit the category explored.

A. Important relationships: who, last contact, support, well-being, concerns, unresolved loss

“+” Supportive relationship outside of jail with regular contact; has no worries about well-being of loved ones.

“-“ No contacts outside of jail; emotionally significant relationship concern; painful, unresolved loss.

B. Social status: sudden change, culture shock, predator to victim, gang issues

“+” Perceives self as occupying an important social position; has completed education or a treatment program which is self-perceived as enhancing social position.

“-“ Sudden negative change in status, cultural fit, or perceived role toward others in current social milieu; current gang membership problems.

C. Legal status: pre-trial, recently sentenced, 20+ year sentence, new charges, high-risk group

“+” Showing clear signs of acceptance of a short/moderate prison sentence with no legal concerns; these prisoners often indicate they “know how to do time.”

“-“ Pre-trial status; recently sentenced; 20+ year sentence; new distressing legal charges; member of known high-risk group due to legal problems (e.g., Mariel Cubans, INS detainees facing dreaded deportation).

D. Institutional adjustment: current adjustment, history of disciplinary actions, perceived safety

“+” Shows excellent adjustment to prison; has had only minor disciplinary problems in the last two years; believes prison is a reasonably safe environment.

“-“ Poor adjustment to prison; disciplinary problems; believes personal safety is at risk.

E. Physical health: perception of health, medical/medication concern, life-threatening condition

“+” Describes current health in positive terms.

“-“ Perceives health situation as poor/bad; concerned about a distressing/potentially life-threatening health problem.

F. Physical pain: pain, intensity, duration, ability to tolerate

“+” No physical pain.

“-“ Experiences pain that is intense and/or persistent.

G. Chemical abuse/use: history of substance abuse, signs of intoxication or withdrawal

“+” No history of drug or alcohol problems.

“-“ Presently intoxicated or going through symptoms of withdrawal; recent history of drug or alcohol abuse.

H. Psychiatric treatment: counseling, medication, compliance, hospitalization, diagnoses

“+” No present concern or history of psychiatric problems.

“-“ Currently receiving or needing treatment for an Axis I psychiatric disorder; history of significant psychiatric concerns (e.g., hospitalization, medication).

I. Mental status: orientation, mood, affect, thought content, agitation

“+” Unremarkable mental status, positive mood, full range of affect.

“-“ Significantly impaired orientation; disturbed mood/affect; thought content or form showing signs of psychosis; severe anxiety; severe agitation.

J. Depression (current signs): severity, obvious symptoms, subtle signs

“+” No signs of depression.

“-“ Signs of depression ranging from mild with obvious symptoms to severe with subtle signs.

K. Reality testing (current signs): hallucinations, content, delusions, negative signs

“+” No current signs or history of psychosis.

“-“ Reported or suspected psychosis ranging from benign manifestations to distressing thoughts/experiences; negative signs.

L. Character: antisocial, narcissistic, borderline, dependent, histrionic, etc.

“+” No indication of prominent character disorder traits.

“-“ A diagnosed personality disorder; prominent, inflexible, maladaptive character traits which cause significant functional impairment or distress.

M. Hope: future orientation, life goals, reasons to live, supportive faith

“+” Clear future orientation with life goals and/or compelling reasons to live.

“-“ No future orientation or life goals; cannot identify reasons to live.

N. Help self: perceived ability to solve presenting problems

“+” Feels capable of meeting life challenges/complications.

“-“ Feels helpless to solve presenting problems.

O. Cognitive themes: optimism, pessimism, exaggeration, negativism, shame, self-loathing

“+” Instant view of world and self is enhanced by rational, positive cognitive attributes.

“-“ Immediate view of world and/or self is dominated by cognitive themes with negative attributions.

P. Coping resources: history of coping, current level of distress, level of perceived self-control

“+” Positive history for coping well during crises; convincingly presents self as fully in control of behavior and thoughts.

“-“ History of coping difficulties; currently distressed; low level of perceived self-control.

Q. Measured reasoning: sudden destructive action toward self/others, impulsive, a “hot-head”

“+” Convincing history of rational, thoughtful responses to life difficulties.

“-“ History of acting impulsively in a destructive manner toward self, others, or property; accepts label of self as a “hot-head.”

R. Self-harm history: thoughts, plans, actions, circumstances, how discovered, intentions

“+” Has never thought about or engaged in an act of self-harm.

“-“ Presents history of serious suicidal thoughts, plans, or actions.

S. View of death: desire to survive, ideas and attitudes about dying

Note: One means of assessing this category is to present the prisoner with a scenario involving a medical crisis which could lead to an untimely, natural death if untreated (e.g., heart-attack), then asking follow up questions to assess desire to survive as well as ideas and attitudes about dying.

“+” Convincingly expresses a desire to survive.

“-“ Would welcome a natural death; can name good things that would occur as a result of dying.

T. View of suicide: study of, suicide of significant others, long history of thoughts/attempts

“+” Views suicide as undesirable and altogether negative; gives no history of significant other committing suicide.

“-“ studies or reads about suicide; has a history of significant other suicide; has a long history of suicidal thoughts or attempts.

U. Recent suicide signs: self-harm action, preparations, notes/letters, changes noted by others

“+” In the last six months has shown no outward sign of suicide risk.

“-“ Recent preparation for or attempt to engage in self-harm; recent changes noted by others suggesting suicidal theme (e.g., giving away possessions, isolating self from others, not taking meals).

V. Suicidal intention: resolution to act, lethal plan with available means

“+” Convincingly denies any intent to harm self.

“-“ Expresses desire to commit suicide in the near future; has a lethal suicide plan with available means.

W. Cooperation: rapport, therapeutic alliance, manipulative style, convincing contract

“+” Good rapport or therapeutic alliance between prisoner and clinician; easily and willingly enters into a convincing contract to seek help in times of crisis.

“-“ Poor rapport or therapeutic alliance between prisoner and clinician; manipulation suspected; unwilling and/or unable to enter into a convincing contract to seek help in times of crisis.

X. False presentation: secondary gain, factitious features, rare symptoms, unusual clustering

Note: Individuals who are malingering or feigning symptoms of suicide or mental illness may or may not be willing to engage in self-harm gestures in order to convince staff they are at risk. The issue, if present, needs to be explored and conceptualized.

“+” Interaction between prisoner and clinician appears to be straightforward and is without suspicion of false presentation.

“-“ Suspected malingering for a known secondary gain; factitious features present; rare or bizarre symptoms; symptoms not clustered around typical diagnostic criteria.

Complicated Cases

Usually, the clinical judgment of the interviewing clinician is enhanced sufficiently by the JSAT process and a decision regarding suicide risk is easily arrived at. However, some cases can be quite complicated. When that occurs, two additional activities are recommended. First, seek out a qualified mental health practitioner for consultation. Most of the time that will clarify the issues at hand and provide a sense of professional direction. Second, use “The Bottom Line Question” which asks: If the prisoner is not placed on a formal suicide watch, and if the prisoner commits suicide, could the decision be successfully defended in a court of law? Wrestling with this legal issue often provides clinical clarity.

The problem of “false positives” is a significant one, especially for the prison mental health clinician. If every individual presenting with a single high risk factor was placed on a suicide watch, many thousands of prisoners would be unnecessarily and continuously maintained on formal suicide watches, thus creating systemic resource burdens and violating the civil rights of many men and women. Again, clinical judgement must be the final deciding factor.

Final Comments

The question is often asked, “How long will it take to complete a JSAT?” The answer is this: as long as is necessary to arrive at a sound conclusion. Simple cases with cooperative prisoners may only take 30 minutes, but tough cases may take 2 hours or more depending on the details. That may seem like bad news for the clinician who already feels overwhelmed with multiple responsibilities and limited resources. However, there are very few professional activities that rival the critical importance of preventing suicide.

It is wise to be familiar with the professional literature on the topic of preventing suicide and assessing for risk. In Appendix B there is a brief bibliography for review.

Appendix A

Prison Suicide Risk Assessment Checklist

PRISON SUICIDE RISK ASSESSMENT CHECKLIST¹

Inmate Name: _____ Reg. No. _____
Date of Assessment: _____ Assessment Completed by: _____

1. SOCIAL-RELATIONAL:

- P² N/S A. **Significant Other(s) Status:** Marital/other relationships; last contact; recent/anticipated/feared change; informed of intent to end relationship; unresolved crisis; nearness to significant dates; etc.
- P N/S B. **Recent losses:** Deaths; imminent loss; unusual aspects; etc.
- P N/S C. **Status Issues:** Significant alteration of circumstances; unusual high risk groups; significant loss of status; predator to victim; gang issues; etc.

2. SITUATIONAL:

- P N/S A. **Criminal Justice Issues:** Time in prison; 1st timer; status in rel. to Court; high risk group status; government witness, etc.
- P N/S B. **Institutional Issues:** Institutional adjustment; disciplinary issues; transfer concerns; problems with others; etc.
- P N/S C. **Safety Issues:** Views prison environment as dangerous; identified conflict; level of fear; perception of ability to cope; etc.

3. MEDICAL:

- P N/S A. **Distressing Illness:** Significant medical concern; life threatening conditions; high risk groups such as cancer, AIDS; etc.
- P N/S B. **Pain (Physical):** Intensity and duration; ability to tolerate; strategies for dealing with; etc.
- P N/S C. **Chemical Abuse/Use:** History of abuse/use; current problem status such as withdrawal, intoxication; etc.

4. PSYCHIATRIC:

- P N/S A. **Treatment History:** Type of treatment including counseling, medication, outpatient, hospitalization; etc.
- P N/S B. **Current Status:** Diagnosis (Axis I, Axis II); medication compliance; command hallucinations; etc.

5. PSYCHOLOGICAL:

- P N/S A. **General Mental Health Status:** Current mental status; mood; acute perturbation; etc.
- P N/S B. **Hopelessness-Helplessness:** Absence of strong positive reasons to live; dependency issues; personal internal resources; unable or unwilling to continue search for solution to personal problem; sees factors in current situation as uncontrollable and/or unchangeable; current behaviors evidence of struggle for gaining or regaining control of life situations; etc.
- P N/S C. **Depression:** Obvious and subtle signs; severity; etc.
- P N/S D. **Pain (Emotional):** Heightened level of emotionality in relation to pain; low frustration tolerance level expressed in relation to pain; self-assessment of pain as intolerable; etc.
- P N/S E. **Negative Cognitions (Emphasizing Self Concept):** Shame, self-loathing, and/or perceived humiliation; pessimistic world view; exaggeration of problems; inability to articulate positive alternative(s); low self-esteem; etc.
- P N/S F. **Coping Resources:** Inability to articulate cogent reasons for living; history of serious deficits in coping; evidence for major deficits in basic living skills; presence of constriction (e.g., unable to see alternatives to present difficulties and distressing personal problem); etc.

PRISON SUICIDE RISK ASSESSMENT CHECKLIST - PAGE 2

6. HISTORICAL:

- P N/S A. **Self-Destructive:** Past suicide attempt/ gestures; methods; lethality; intentions; how discovered; circumstances; etc.
- P N/S B. **Impulsivity:** History of impulsive acting out; perceived level of self-control; frustration tolerance; violent acts; etc.
- P N/S C. **Personal Awareness Issues:** Significant others with history of suicide; any personal contact with suicidal individuals; other unusual factors such as fascination with suicide through reading, religious suicide cult ideology; etc.

7. BEHAVIORAL:

- P N/S A. **Self-Destructive:** Recent self-inflicted injury or suicide attempt; type; lethality; etc.
- P N/S B. **Withdrawal:** Isolation; reduced interaction with others including inmates, staff, family; cessation of eating; etc.
- P N/S C. **Changes:** Evidence of significant changes on variety of fronts: interpersonal, eating, sleeping, hygiene; etc.
- P N/S D. **Related Actions:** Hoarding medications, stealing medications, buying drugs; collecting materials such as making a rope; writing a letter with death references; suicide note; making final arrangement; putting affairs "in order"; etc.

8. MOTIVATIONAL:

- P N/S A. **Intentionality:** Desire to die, escape, effect change and solve problem through death; malingering, feigning, or factitious features; intent communicated; ambivalence; etc.
- P N/S B. **Plan:** Specific plan; lethality; means available; etc.
- P N/S C. **Goals:** Death as an escape; imagined scenes of life after death in peaceful setting; no long or short range goals; unwillingness to work with clinician, no therapeutic alliance; unwillingness to convincingly contract to seek help in crisis; etc.

1. The "Prison Suicide Risk Assessment Checklist" was developed by the psychology services staff at the Federal Transfer Center, Oklahoma City, Oklahoma in 1997: David F. Wedeking, Ph.D., David K. Carlson, Psy.D., Theresa L. Johnson, Ph.D., Richard R. Ray M.S., and Katie N. Levins, M.A.

2. P stands for "Potential Problem Area Identified"; and, N/S stands for "Nothing Significant Noted".

Appendix B

Suicide Prevention Bibliography

Bibliography

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