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Adapting the Collaborative Assessment and Management of Suicidality (CAMS) to Correctional Settings

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Abstract

Inmate suicide is an increasing problem in prisons and jails across the United States of America. This Doctoral Specialty Project highlights the current protocols in place for inmates experiencing suicidal ideation in various correctional settings, including the Federal Bureau of Prisons (FBOP), several state prisons and local jails across the U.S. This project introduces the entirety of the Collaborative Assessment and Management of Suicidality (CAMS) framework as a possible suicide assessment and intervention tool that could streamline suicide focused evaluation and treatment across correctional settings, thus increasing continuity of care. Specifically, this project focuses on the effectiveness of existing adaptations of CAMS in various settings such as inpatient hospitals and community outpatient treatment. Suggested adaptations to CAMS, specific to the correctional setting, will be highlighted. The reasons CAMS is thought to be an effective assessment and treatment protocol in corrections settings will be discussed. Lastly, the outcomes of those currently using CAMS in correctional settings will be evaluated.

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Section I: Introduction

Statement of problem

The rise in deaths by suicide in the United States has continually grown in recent years. According to the World Health Organization, around 800,000 individuals die by suicide each year (Canning, 2016). According to the National Institute of Mental Health (2019), suicide was the second-leading cause of death among people ages 10 to 34, the fourth-leading cause of death among people ages 35 to 54 and the tenth-leading cause of death for the population overall. Even more astounding, however, is the rate of completed suicides in correctional settings. According to a 2020 Bureau of Justice Statistics report, a total of 255 state prisoners died by suicide in 2016, reaching a 16-year high. Further, the average rate of suicides from 2001-2016 for male state prisoners was 17 deaths per 100,000 inmates and 13 per 100,000 female state prisoners. For federal prison inmates, the rate of death by suicide is 10 in 100,000 (Carson & Cowhig, 2020). In 2006, there were 38 suicides per 100,000 inmates in detention facilities, which was approximately 3 times greater than the rate of suicides in the general population (Hayes, 2012). Some estimate the rate of suicide in correctional facilities to be between 5-8 times that of the general population (Pratt, Gooding, Awenat, Eccles & Tarrier, 2016). Between 2000 and 2012, suicide was the leading cause of death for American jail inmates (Canning & Dvoskin, 2016).

Although suicide rates in correctional settings have been increasing, the breadth of treatment for suicidal inmates still varies across institutions and in some cases, is not robust enough to fulfill the current need (Cloud, 2014). This paper will be focused on adapting the Collaborative Assessment and Management of Suicidality (CAMS) by David Jobes for suicidal inmates in state and federal prisons as well as local jails, not only suggesting a unified way to

approach assessment and treatment of all suicidal inmates in correctional settings across the country, but also safeguarding clinicians if a completed suicide were to occur throughout the course of treatment.

Significance of issues

According to Johnson (2019), twenty-seven federal inmates died by suicide in the fiscal year that ended in September 2018. This was the largest number in at least the past five years, according to prison system records. Although death by suicide overall has decreased since the 1980's, death by suicide in correctional settings is still a significant problem, as suicide is consistently among the top three causes of inmate deaths in state and federal prisons (Winters et al., 2017).

Although the negative stigma of mental health treatment is beginning to decrease throughout society, therefore increasing utilization of mental health services, mental health issues are on the rise in correctional settings such as prisons and jails. Famous individuals dying by suicide in correctional institutions have brought mass media attention to the problem of death by suicide in jails and prisons. Jeffrey Epstein and Aaron Hernandez are just a few who have died by suicide while incarcerated, which have brought awareness to the increasing challenge of keeping inmates safe in a correctional system. The increasing emphasis on mental health treatment should be focused where the need lies. With the research showing the rise of suicides in correctional settings, our efforts need to be on increasing and improving mental health services in prisons and other correctional institutions.

Purpose

There are multiple purposes of this Doctoral Specialty Project, one being to illuminate the growing rate of suicides in correctional facilities throughout the United States of America. Further, this paper will discuss idiosyncratic challenges that inmates bring to mental health treatment, and risk factors for suicide that are unique to inmates. Another purpose is to highlight what is currently in place to assess and prevent inmate suicide in various correctional systems including the Federal Bureau of Prisons in the United States, state prisons and local jails throughout the U.S. The third purpose of this project is to introduce the Collaborative Assessment and Management of Suicidality (CAMS), discuss its use with various populations, and suggest adaptations to this framework which are necessary for the unique correctional setting. Different components of the CAMS protocol will be discussed, in addition to corrections specific adaptations of these components. Lastly, the implementation and outcomes of a project wherein CAMS is currently being conducted in correctional settings throughout the state of California will be discussed.

Section II: Literature Review

Suicide Statistics

According to the National Institute on Mental Health (2019), suicide was the second leading cause of death for ages 10-14, 15-24 and 25-34 in 2017. Suicide was the fourth leading cause of death for ages 35-44 and 45-54 in 2017. Overall, suicide was the tenth leading cause of death for all ages in 2017. For the total population, suicide increased from 10.7 per 100,000 people in 2001, to 14.0 per 100,000 in 2017. For men specifically, suicide rates increased from

18.2 per 100,000 in 2001 to 22.4 per 100,000 in 2017. Overall, rates of suicide are on the rise (National Institute on Mental Health, 2019).

Bureau of Justice Statistics

An estimated 6,613,500 persons were under the supervision of U.S. adult correctional systems on December 31, 2016. However, the incarceration rate has declined since 2009 and is currently at its lowest rate since 1996. In 2014, six percent of all black males ages 30 to 39 were in prison, compared to two percent of Hispanic and one percent of white males in the same age group. In 2016, over 1 million people were sentenced to a state prison in the United States (Bureau of Justice, 2019).

As of March, 2020, there are approximately 175,483 federal inmates incarcerated in the Federal Bureau of Prisons (FBOP) custody, privately managed facilities, and other facilities included within the FBOP. The FBOP reached its peak inmate population in 2013 at 219,298 inmates. Since 2013 the federal inmate population has continued to decrease due to efforts to implement programming including good conduct time release and time off incentives including those proposed in the Congress First Step Act of 2018 for participating in programming. Males overwhelmingly make up the majority of inmates, with 92.9 percent of federal inmates being male. Inmates ages 36-40 make up the highest percentage of incarcerated people, at 18.2%. Hispanic inmates make up 32.1% of incarcerated inmates, while Non-Hispanic inmates make up the other 67.9%. Additionally, 58.6% of inmates are White, 37.5% are Black, 2.3% are Native American and 1.5% are Asian. 45.2% of those incarcerated are for drug crimes, with the next highest percentage of crime involving weapons, explosives or arson (Federal Bureau of Prisons, 2019).

There were approximately 745,200 people incarcerated in local jails across the country in 2017 according to a 2018 report by Bureau of Justice Statistics. Men are incarcerated in jails at a rate of 5.7 times higher than females and the estimated average jail time in 2017 was 26 days. Further, from 2005 to 2017, the jail incarceration rate for white males increased by 12%, while the jail incarceration rate for African American males decreased by 23%. Hispanic males accounted for 15% of all jail inmates in 2017, while white males accounted for 50% and black males accounted for 34%. From 2005 to 2017, rates of female incarceration increased by 20%, while rates of male incarceration decreased by 3%.

Mental Illness and Suicidal Ideation in Incarceration

According to Baillargeon et al. (2009), the deinstitutionalization of mentally ill patients, combined with the limited availability of community mental health programs, has contributed to an increase in the number of those with severe mental illness who are incarcerated in the United States. Mental illness among prisoners consistently exceeds rates of the same disorders in the general population. Additionally, correctional facilities in the United States are considered to be one of the largest providers of mental health services in the country. (Gonzalez and Connell 2014; Cloud, 2014). For many, prison may present a rare opportunity to receive mental health treatment that wouldn't be available or affordable in the community (Liebman et al. 2013). However, because of budgeting, low numbers of staff, and other institutional-related factors, mental health services are not always as robust as the need in correctional settings (Cloud, 2014).

Many experts agree that the prison population is subject to many of the same risk factors as those in the general population, however inmates present with their own unique set of risk factors as well. Risk factors for suicidal behavior in inmates can be divided into four distinct

categories. The first category is demographic risk factors. These include being young, male, having a prior criminal history, low education level, being Caucasian and single. Next is clinical factors for risk of suicide. These include personal and familial history of psychiatric disorders, parental substance abuse, and violence (Barker, Kolves, and De Leo, 2014). The prevalence rate for serious mental illnesses such as schizophrenia, bipolar disorders, depressive disorders, and psychotic disorders is continuously higher in prisons than in the community (Canning et al., 2016). The third category of risk factors for inmates include psychosocial factors including poor coping skills, past suicide attempts, stressful life events and family conflict (Barker, Kolves, and De Leo, 2014). Similar to risk factors for those living in the community, previous suicide attempts and having a psychiatric disorder are the most important risk factors for suicide among inmates. The fourth category of risk factors is institutional factors such as overcrowded living conditions, bullying and harassment, being in a new environment, life imprisonment sentences, isolation, lack of staff supervision and disciplinary action. (Barker, Kolves and De Leo, 2014). Having a mental disorder, combined with transitioning to and living in a stressful correctional environment, increases the risk for suicide among prisoners (Canning et al., 2016). Coping with a prison environment that embodies fear, distrust and a lack of control can leave prisoners feeling overwhelmed and hopeless, leading some of them to choose suicide as a way to escape (Pratt, 2016).

More than 16% of inmates booked into jails each year have mental illness. Suicide is one of the leading causes of death in local jails and approximately 48% of jail suicides take place within the first week of the person being detained. Further, a quarter of jail suicides take place either the day of admission to jail or the next day (Berman, A. & Canning, R.D., 2021).

It has been found within the literature that around 95% of inmates had experienced at least one traumatic event in their lives (Komarovskaya et al, 2011). This statistic is often reported to be even higher for incarcerated females. Specifically, 6 in 10 women report physical or sexual abuse prior to incarceration. Women report astoundingly high rates of violent victimization, childhood abuse and other forms of trauma. DeCou (2017) notes that for women, lifetime physical and sexual victimization are unique predictors of suicidality, relative to other forms of trauma exposure. While male inmates reported higher rates of witnessing harm to others in childhood (22.4%) and adolescence (43.25%), female inmates reported higher rates of interpersonal sexual trauma in childhood (31.2%), adolescence (35.3%), and adulthood (27.7%) (Komarovskaya et al. 2011). Inmates are not only bringing with them their own trauma histories, but the incarcerated population itself is considered a traumatized community. These factors can combine to elevate the risk for suicide for both male and female inmates.

Inmates with major psychiatric disorders are more likely than those without to have had previous incarcerations (Baillargeon, Binswanger, Penn, Williams & Murray, 2009). A significant percentage of incarcerated women have preexisting mental health conditions, which are likely to be exacerbated by their trauma histories as well as their incarceration. Inmates with Bipolar disorders were found to be 3.3 times more likely to have had four or more previous incarcerations compared to inmates with no major psychiatric disorder (Baillargeon et al., 2009).

Limitations of Suicide Intervention in Corrections

Mathias (1985) states that prisons are breeding grounds for feelings of paranoia and suspiciousness between both prisoners and staff. He notes that staff often assume inmates

are trying to manipulate or trap them, and inmates assume that anything done to them by staff is deliberately dehumanizing and demeaning. Often, inmates see psychologists represented as authority in the prison and as someone who could affect their parole outcomes. He adds that trust, which is inevitably essential to a therapeutic relationship, can never be fully established in a correctional environment (Mathias, 1985).

Inmates' attitudes toward rehabilitation programs also tend to be negative as inmates do not want to expose themselves or their vulnerabilities. Suspiciousness is a prominent obstacle to getting help, because inmates view therapists as "cops" and treatment sessions as snitch sessions. Inmates might also be fearful of how documentation of their mental health services could be used against them as they progress through the criminal justice system and regarding their release. (Morgan, Rozycki and Wilson 2004). Because of this, inmates might be hesitant in expressing themselves to a psychologist, for fear of how it might affect their good conduct time, probation, and halfway house ability, among other things.

In prison, being identified as a high risk for suicide and placed on suicide watch does not typically carry a positive connotation. Therefore, inmates will often deny suicidal ideation so as to stay in general population housing units and avoid being sent to other areas of the prison. However, when prisoners are experiencing suicidal ideation, and psychologists believe they are at imminent risk of harm to themselves, it is sometimes necessary to place an inmate on suicide watch if this is the least restrictive option for keeping them safe. For safety reasons, the area designated for suicide watch is not the most comfortable place to be. Often prisoners are stripped of their designated belongings and clothing, and sent to a cell where they are housed alone or with one other inmate where they will be observed constantly. Knowing that they will be housed

under such conditions can discourage prisoners from being truthful about their suicidal intentions (Canning & Jvoskin 2016). Prisoners may deny experiencing suicidal ideation, therefore putting themselves at further risk.

Federal Bureau of Prisons Current Policy on Suicide Assessment and Intervention

The Federal Bureau of Prisons has updated suicide specific policies in place to direct staff on how to refer, assess and treat inmates who might be at risk of suicide.

Referrals

According to the Program Statement in the Suicide Prevention Program as outlined in the Bureau of Prison's Policy,

> *"any staff member who has reason to believe an inmate may be suicidal should: maintain the inmate under direct observation, contact the shift lieutenant for assistance, and during regular working hours, contact the program coordinator or designee (any other available psychologist), during non-routine working hours, the Shift Lieutenant will contact the on-call psychologist and continue direct, continuous observation, or immediately place the inmate on suicide watch"* (Federal Bureau of Prisons, 2007; See Appendix A).

The BOP policy on suicide prevention (2007) states that during working hours, inmates referred for assessment of suicide will be seen on a priority basis. During non-regular hours, the Program Coordinator consults with staff and may choose to see the inmate immediately or have the inmate placed on suicide watch. In either case, the inmate will receive an individual assessment within 24 hours of the suicide assessment referral.

Assessment

The BOP policy (Federal Bureau of Prisons, 2007) states that a suicide risk assessment will be completed when: staff refer an inmate to psychology services that they feel may be at risk for suicide, an inmate's written or verbal behavior is suggestive of suicide, an inmate exhibits behavior indicative of self-harm, or any other condition is present that would lead a clinician to believe an assessment is necessary. According to the BOP suicide prevention policy (2007), the Suicide Risk Assessment (SRA) is to be completed in the Psychology Data System (PDS) within 24 hours of any incidents outlined previously. At a minimum, the SRA will include: reason for referral, assessment of risk factors, risk assessment findings, diagnosis, and follow-up recommendations.

Intervention

Upon completion of the SRA, the Program Coordinator determines the intervention that best meets the needs of the inmate. The Program Coordinator or designee will assume responsibility for the recommended intervention and clearly document the rationale for the specific intervention.

If the Program Coordinator determines that the inmate does not appear imminently suicidal, they will document in writing the basis for this conclusion and any treatment recommendations made for the inmate. This documentation and information will be placed in the inmate's medical, psychology, and central file.

If the Program Coordinator determines the individual to be at imminent risk for suicide, they will be placed on suicide watch in the institution's designated suicide prevention area. "The actions and findings of the Program Coordinator will be documented, with copies going to the

central file, medical record, psychology file, and the Warden" (Federal Bureau of Prisons, 2007). Once an inmate has been placed on suicide watch, the watch cannot be terminated, under any circumstance, without the Program Coordinator or designee performing a face-to-face evaluation with the inmate. Only the Program Coordinator has the authority to take an inmate off suicide watch. The post-watch report should be completed in PDS either prior to terminating the watch, or as soon as possible following watch (Federal Bureau of Prisons, 2007). See Appendix A for the full Bureau of Prisons Suicide Policy.

Suicidality Training for Clinicians

All health care workers should have some knowledge about suicidal behavior, but often, there are specific gaps in medical health professional's knowledge. One of these gaps is the rate of suicide in special populations such as prisons (Smith, Silva, Covington & Joiner, 2014). In a study of medical health care clinicians' knowledge on suicide, many participants did not know that adults 65 and older are at a greater risk for suicide than adolescents and young adults. Over two thirds of medical health care providers were not aware of the extremely high rate of suicide in people with severe mental illness compared to the general population, and more than half of the respondents endorsed a common misperception that individuals with Borderline Personality Disorder (BPD) frequently gesture but do not really intend to kill themselves (Smith et al., 2014).

The Federal Bureau of Prisons (FBOP) offers a public program statement on suicide prevention training for their staff on their website. Their statement is as follows:

> "*The Bureau of Prisons (Bureau) operates a suicide prevention program to assist staff in identifying and managing potentially suicidal inmates. Each Warden will ensure that a suicide prevention program is implemented consistent with this policy. In addition,*

> *Wardens will facilitate a discussion regarding the issue of suicide at department head meetings, staff recalls, lieutenants' meetings, etc., to heighten staff awareness about the need to detect and report any changes in inmate behavior that might suggest suicidal intent*" (Federal Bureau of Prisons, 2007.)

The program objectives as stated by the FBOP (2007) include: 1. All institution staff will be trained to recognize signs and information that may indicate a potential suicide, 2. Staff will act to prevent suicides with appropriate sensitivity, supervision and referrals. 3. Any inmate clinically found to be suicidal will receive appropriate preventive supervision, counseling and other treatment.

Because staff such as correctional officers, unit team staff and medical staff are often the first to identify signs of potential suicidal behavior due to the frequency of their interactions with inmates, the BOP requires all staff to be trained on identifying signs of suicidality. The training for all staff is to be included in the Introduction to Correctional Techniques (ICT) curriculum. The BOP policy also states that training in local suicide prevention procedures will be provided during Annual Training (AT) which occurs on a yearly basis at all institutions. The training for staff focuses on: identifying suicide risk factors, the typical inmate profiles of completed suicides, recognition of potentially suicidal behavior, appropriate information associated with identifying and referring suicidal inmates, how to respond to a suicidal emergency, and the name of the program coordinator and location of suicide watch area (Federal Bureau of Prisons, 2007). Non-clinical staff such as correctional officers or medical staff are trained to refer potentially suicidal inmates to psychology staff immediately. Psychology staff then meet with the inmate to determine level of risk and whether a placement on suicide watch is warranted.

Suicide Intervention in Correctional Settings

In 1999, The World Health Organization (WHO) along with the International Association for Suicide Prevention (IASP) released a guideline entitled "Preventing Suicide in Jails and Prisons." However, despite the increased awareness and attention to suicidal behavior in the community setting, there still seems to be limitations to implementations of evidence-based treatment programs focusing on reducing suicidal behavior in correctional settings (Barker, Kolves and De Leo (2014).

While there is not an abundance of evidence-based treatments (EBT) for suicide, a few exceptions stand out according to Jobes (2017). Dialectical Behavior Therapy (DBT) and Cognitive-Behavioral Therapy (CBT) are noted to be two of the most well researched EBT's for treating clients with suicidal risk. These two evidence-based interventions are currently either being used with inmates or researched to be used with inmates.

Dialectical Behavior Therapy (DBT) is one of the well-researched evidence-based therapies for suicide specific treatment and has been found to be effective in multiple randomized controlled trials (Jobes, 2017). DBT was developed by Marsha Linehan and was originally created to address the needs of chronically suicidal and parasuicidal females diagnosed with Borderline Personality Disorder (BPD) (Berzins & Trestman, 2004). DBT was the first empirically supported treatment for this population, characterized by interpersonal dysfunction, anger management difficulties, self-harming behaviors, affective lability, and cognitive disturbances. DBT combines strategies of behavior therapy and mindfulness practices. The dialectic aspect of DBT is the balance between validation and acceptance of individuals as they are.

In a study described by Berzins & Trestman (2004) comparing DBT to treatment-as-usual (TAU), DBT significantly reduced anger, suicide attempts, parasuicidal behavior, and the length of inpatient psychiatric stays. Additionally, Wahl (2011) describes a study that shows that the delivery of a partial component of DBT could be a useful alternative for correctional institutions when the comprehensive DBT program is not feasible. This study found that 42% of participants showed significant improvement in mindfulness practice, 26% showed significant improvement on the measure of anger expression, and 17% showed significant improvement on the measure of borderline symptomology. Further, there was a significant increase in the usage of adaptive skills between weeks one and two of treatment and a significant decrease in institutional infractions from the month prior to treatment to the month after treatment.

Further, there are two versions of suicide specific Cognitive Behavioral Therapy called Cognitive Therapy-Suicide Prevention (CT-SP) developed by Brown et al., (2005) and Brief Cognitive Behavioral Therapy (BCBT) developed by Rudd et al., (2015). Jobes (2017) posits that both CT-SP and BCBT have been shown to decrease suicide attempt behaviors by 50% and 60%, respectively, when compared to treatment as usual (TAU). Further, Brief Cognitive Behavioral Therapy specifically for suicidal inmates has been adapted by Bryan Craig and David Rudd, entitled Brief Cognitive Behavioral Therapy for suicide prevention. This manualized treatment consists of 12 sessions focused on psychoeducation, stability, and relapse prevention for an inmate experiencing suicidal ideation (Craig & Rudd, 2018.)

Cognitive Behavioral Suicide Prevention (CBSP) developed by Tarrier et al., (2014) is a new suicide prevention treatment which is based on traditional CBT, but the aim is to deactivate the suicide schema which has been formed by the patient and instead activate more functional

thoughts, feelings and behaviors. This protocol is centered on a "theoretically derived psychological model of suicide behavior which has been empirically validated in people experiencing suicidality, psychosis and posttraumatic stress disorder" (Pratt, 2016). According to Pratt, the first sessions of CBSP focus on assessment of the patient's presenting problems, previous suicidal ideation and behavior, and treatment planning. During subsequent sessions, the clinicians supports the client in developing a set of coping skills and strategies to enhance resilience toward suicidal behavior. The final sessions focus on the development of maintaining a "well-being" plan that serves as a summary of completed therapeutic work. In a randomized control trial of 50 patients, the treatment group compared to the treatment as usual group was shown to be significantly superior on measures of suicide probability, suicidal ideation and hopelessness after an average of 24 sessions of CBSP (Pratt et al., 2016).

Because the Collaborative Assessment and Management of Suicidality (CAMS) is a therapeutic framework that is conducive to any theoretical orientation, any of these evidence-based treatments can be used in conjunction with CAMS to target the client's suicidal drivers and alleviate suicidal ideation throughout treatment in a correctional setting.

Assessment and Prevention of Jail Suicide

One difference between jails and prisons is that jails house pretrial detainees, meaning the majority of the people in a jail have not been convicted or sentenced. At times, jails also house those who have been convicted and have been given short term sentences. Although the primary goal of correctional settings is to enforce justice, legislation such as *Bell vs. Wolfish* has been passed directing that the state cannot punish a pretrial detainee. Officials involved in the corrections system must remain aware of such legislation, and provide and respond appropriately

to mental health treatment and needs of the detainees in their care (Ward, Bradley & Maschi, 2009).

Ward, Bradley & Maschi (2009) identified characteristics strongly related to completed suicides in jails such as intoxication, emotional state, psychiatric history, family history of suicide, lack of a social support system, and first incarceration. However, because jail employees are often overwhelmed and understaffed, a robust assessment of these risk factors is not always done; therefore staff are unaware of the characteristics a detainee might bring with them to incarceration, leaving them more vulnerable to completing suicide in jail (Ward, Bradley & Maschi, 2009).

Assessment for suicidal ideation in jails are often done within the medical screening and may include preliminary questions such as "Are you currently thinking of committing suicide?" and "Do you have a plan to commit suicide?" In addition to this preliminary assessment, jails might also use the Scale for Suicide Ideation (SSI), a 21-item rating scale measuring the inmates' behaviors, attitudes and plans to engage in suicidal behavior. If an inmate gives a positive reply for any of the questions on the SSI, it is recommended that a mental health professional follow up with the detainee immediately. Another commonly used instrument, the Jail Suicide Assessment Tool (JSAT), is a suggested interview format which assesses for suicide risk assessment to be used with incarcerated adults (Carlson, 2002).

Acknowledging the need to address suicides in correctional settings, the American Correctional Association (ACA) and the National Commission on Correctional Healthcare (NCCH) provided recommendations for jail-suicide-prevention programs. The twelve essential components the prevention programs should contain are: 1. Identification 2. Communication 3.

Training 4. Intervention 5. Assessment 6. Notification 7. Monitoring 8. Reporting 9. Housing 10. Review 11. Referral 12. Critical-incident debriefing. Further, establishing a system within jails focusing on continuity of care is essential in improving healthcare for detainees. Transitional planning for a detainee's future mental health services, whether in the community or various correctional institutions, is a vital aspect of a detainee's care and is still not being provided in some of the largest jails in the country. Pompili et. al., (2009) concludes that the best practices for preventing suicides in jail and prison settings should include the following elements: training programs, screening procedures, communication between staff, documentation, internal resources, and debriefing after a suicide.

Barker et al., (2014) conducted a literature review of various Suicide Prevention Programs (SPP) in jails across the United States and United Kingdom. It was found that when an SPP was implemented in the Galveston County Jail, including screening new inmates, giving specific attention to inmates during risky periods such as the 3 days before and after a court hearing, providing psychological support for inmates, and avoiding the isolation of suicidal inmates, the impact of the programs could be seen in a reduction in completed suicides. Further, Barker et al., (2014) describes an SPP implemented at the Elayn Hunt Correctional Centre (EHCC) based on the six components described by Hayes (1995) including staff training, intake screening and assessment, appropriate housing of suicidal inmates, appropriate levels of supervision according to active suicide risk, intervention procedures in the event of an attempt (staff first aid and availability of an ambulance for transportation to hospital), and administrative review following a suicide. They found that out of over 57,000 inmates who were processed through EHCC between 1983 and 1994, only one completed suicide. Lastly, a study of a large

metropolitan County Detention Center in the US recorded 9 suicides in 24 months, attributing this to lack of staff supervision, inadequate response time by medical staff, dangerous cell conditions and lack of staff training. A Suicide Prevention Program was implemented following the 9 completed suicides including measures such as improved staff training, identification and screening of all inmates on intake and for all inmates identified as being suicidal during their incarceration, improved communication between staff, the availability of suicide resistant housing, and appropriate staff intervention and use of first aid and cardiopulmonary resuscitation (CPR) when suicide attempts occur. This study reported that in the 18 months following the implementation of this SPP, no further suicides were recorded. This suggests that comprehensive Suicide Prevention Programs are effective in reducing the number of suicides recorded in jail and short term facilities (Barker, 2014).

Although there is legislation from the WHO and ISAP directing corrections staff to meet mental health needs of its population, this is not always feasible and funded appropriately. Because detainees often only spend a short period of time in a jail, there is not always sufficient mental health services that can be provided in this short term, understaffed, chaotic setting. Jails are often ill equipped, underfunded, and unprepared to respond appropriately to a variety of detainees' mental health needs (Ward, Bradley & Maschi, 2009). However, the above research shows that implementing comprehensive Suicide Prevention Programs are effective in reducing the number of suicides recorded in jail and short-term facilities. This doctoral specialty project suggests that the Collaborative Assessment and Management of Suicidality (CAMS) could function as an effective, comprehensive, suicide assessment and prevention framework that could create uniformity amongst SPP's in correctional settings across the country**.**

Section III: Goals of the program

CAMS Overview

According to David Jobes (2016), the Collaborative Assessment and Management of Suicidality is not a new psychotherapy. Rather, he states that it is a suicide-focused therapeutic framework guided by a unique multipurpose clinical tool called the Suicide Status Form (SSF). The SSF is a clinical roadmap, which guides assessments, treatment planning, and tracking of ongoing suicidal risk that also shows clinical outcomes. It provides both quantitative and qualitative assessment data. It can be said to function as a "therapeutic assessment" meaning that although it is assessment based, a main function of this tool is treatment planning. The SSF focuses on the development of a suicide-specific treatment plan that includes a stabilization plan and targets as well as treats the patient-defined suicidal drivers. The drivers of a client's suicidality are the issues that make suicide seem like a compelling option to the client. Jobes (2016) notes that CAMS as a suicide focused-therapeutic framework has a focus on suicide, is outpatient oriented, which means the target of CAMS is to keep the client out of the hospital, and that it is flexible and nondenominational, meaning a therapist practicing in any orientation may successfully use CAMS (Jobes, 2016). CAMS-guided care focuses on helping a patient learn to stabilize themselves through difficult suicidal moments while the client and clinician work collaboratively on the treatment of the client's suicidal drivers during ongoing sessions (Jobes, 2017).

Initial Session

In the initial session of CAMS, the clinician introduces the CAMS framework to the client, and describes the collaborative and honest nature of the framework. The clinician begins

the discussion about suicide with informed consent. Jobes (2016) states that in his own version of informed consent, he acknowledges that the patient can of course kill themselves, and there is little he (as the clinician) can do about it. He also states that it is the client's life and up to them whether they live it. He goes on to say that from a clinical standpoint, there is a dilemma because state laws and clinical standards of care require the therapist to "take action" if he perceives the client to pose a clear and imminent danger to themselves. Further, he tells the client that he might have to commit the client to an inpatient setting against their will. And though he does not want any of his patients to die by suicide, he understands that sometimes there is no other way to cope. Additionally, he proposes CAMS as an evidenced-based treatment designed to save the client's life and that the research shows that most suicidal people respond to this particular treatment within 3 months. He asks the client to give it a try, tells them they have everything to gain and really nothing to lose. Jobes (2016) admits that mental health professionals often think that this introduction is too provocative, however he asks clinicians to place themselves in the mindset of a suicidal person. He notes that in his experience, this particular kind of informed consent actually comforts and reassures the suicidal person, making the patient less inclined to see their clinician as a potential adversary and more likely to see him as an ally. Lastly, the clinician asks for permission to sit next to the patient throughout the duration of the sessions to reinforce the collaborative nature of the treatment. Within the initial session, the clinician and client complete the initial session of the CAMS protocol together, which includes sections A through D (See Appendix B).

Suicide Status Form

The Suicide Status Form (SSF) is a multipurpose clinical tool that serves as a roadmap for CAMS-guided care for clients with suicidal ideation. It includes aspects of engagement, assessment, treatment-planning, tracking, updating, and outcome/disposition (Jobes, 2016). The SSF is typically used with patients who are currently suicidal, but is effective in determining level of suicide risk with clients that clinicians think might become suicidal. To correctly use CAMS, the SSF sections A through D must be completed in the initial session with a client. In subsequent sessions, there are additional tracking and treatment plan updates that must be completed. In all interim sessions, the same version of the SSF Tracking/Update document is used. In the final session of CAMS, the Outcome/Disposition version of the SSF is administered (Jobes, 2016) (See Appendix B).

Section A of the SSF Core Assessment is the rating scale that is used in all phases of CAMS. It contains six assessment variables including: psychological pain, stress, agitation, hopelessness, self-hate, and overall risk of suicide. Psychological pain is based on a construct called "psychache," which Jobes (2016) describes as a profound, unbearable suffering that exists at the heart of every client's suicidality. The variable of stress refers to external psychological pressures and demands that create significant distress, which affect and overwhelm the individual. The agitation variable can be described as the state of being emotionally upset or disturbed, and leads to a patient's impulsive desire to do something to change the current unbearable situation. Hopelessness is the expectation that a negative situation will not ever get better, no matter what the client may do to try to change their situation. Jobes (2016) notes that this construct is important, because according to the research, there is no other single risk-factor

that has been more highly correlated with completed suicide than hopelessness. The fifth variable, self-hate, can be said to capture two components of suicidal ideation, including the need for escape and the "malignant role of suicidal self-loathing" (Jobes, 2016). The sixth variable of the SSF Core Assessment is overall risk of suicide. This variable can be said to capture the generic overall behavioral possibility of suicide. This can satisfy the problem of the medical-legal challenge to determine whether there is a clear and imminent risk for suicidal behavior. A client is essentially telling the therapist how likely they are to kill themselves in this moment.

Self-versus relational suicide risk

Jobes (2016) hypothesizes that suicidal states exist on a spectrum from intrapsychic to interpsychic. He poses that some suicidal people are preoccupied with their own internal thoughts and feelings, however for others, there is a distinctly relational preoccupation driving their suicidal ideation (Jobes, 2016). Examples of self-focused, intrapsychic suicidal tendencies include thoughts of hopelessness, and feelings of being a failure in career or life goals. Examples of other-focused, interpsychic suicidal tendencies can include thoughts of disappointing others or being a burden to loved ones. He argues that those with self-focused suicidality may be more at risk of dying by suicide while those with a relational focus may be more at risk for a nonfatal suicide attempt. To assess this specific factor of suicide risk, the SSF has two 5-point rating scales pertaining to the patient's perception that their suicidal risk is self-versus other-focused (Jobes, 2016). This can be an important tool to use when developing interventions for suicidal drivers.

Reasons for living/Reasons for dying

Jobes (2016) states that most suicidal patients who are talking to a clinician about their suicidality are ambivalent. They have reasons to die, but at the same time, they also have reasons to live. If they weren't ambivalent about suicide, they'd be dead. For this reason, Jobes (2016) includes the Reasons for Living (RFL) and Reasons for Dying (RFD) rating scale on the SSF. This assessment tool prompts the suicidal client to list up to five Reasons for Living and five Reasons for Dying. Then it asks the client to rank order them in terms of importance from 1 to 5. Some research done on non-suicidal and suicidal samples have shown that there is an inability of suicidal people to protectively think about the future and have hope that might help them get through the difficult time in their lives. The non-suicidal clinical sample endorsed more reasons for living related to Hopefulness for the future, Plans and Goals and Beliefs than did the suicidal sample (Jobes, 2016).

One thing response

The One Thing response is used to gather information from the client about the one thing that would effectively eliminate their suicidality, or reasons for dying. The response to this question can be clinically useful in informing treatment planning with the client (Jobes, 2016).

Risk Factor assessment

The Risk Factor assessment includes 14 empirically based warning signs that are included among the best variables for assessing suicidal risk. Through research, these variables have been proven to be a valuable list of suicide-risk and warning sign variables with validated empirical support (Jobes, 2016). The risk factors include suicidal ideation, plan, preparation, rehearsal and behaviors including past suicide attempts. It goes on to assess for impulsivity,

substance abuse, significant loss, relationship problems, feeling like a burden to others, health/pain problems, sleep problems, legal/financial issues, and shame.

Treatment Planning

The treatment planning section of the SSF is informed directly from the collaborative assessment from Sections A and B. A unique aspect of CAMS is the fact that unlike traditional treatment planning, wherein the clinician would solely write up the client's treatment plan, in CAMS, a collaborative treatment planning approach is emphasized. This allows the client to act as a coauthor of their treatment plan (Jobes, 2016). With CAMS, the goal is to consider which interventions are necessary to justify continuing outpatient care. Within the SSF treatment plan, there are sections for Problem Description, Goals and Objectives, Interventions, and Durations. In these sections, the first problem according to Jobes (2016), is always Self-Harm Potential and the Goals and Objectives section always emphasizes "Safety and Stability." The number-one clinical problem, self-harm, is non-negotiable. Self-harm must be addressed within the treatment planning section for as long as the client is participating in CAMS. If the client and clinician are not able to sufficiently address the number one problem of self-harm potential through their collaborative treatment planning and the development of a stabilization plan, "an inpatient hospitalization may be necessary as the only means of ensuring the patient's immediate physical safety in accordance with state law" (Jobes, 2016). Problems 2 and 3 of the treatment plan are collaboratively generated with information derived from sections A and B of the SSF. The client has a significant amount of responsibility in determining what they think are their main drivers for their suicidal ideation. These are then listed as problems 2 and 3 and the pair determines the goals and objectives for each problem. Once the problems and goals are identified, the dyad can

decide what the best interventions are for each problem, and list the duration they think will be necessary for each intervention to be effective. The drivers, or problems, can be redefined at each session to more specifically identify and tailor the client's main drivers for their suicidal ideation.

Stabilization plan

Within the treatment planning section of the initial session of CAMS, the clinician and client collaboratively author a stabilization plan. This plan is used to facilitate and enhance patient safety and stability. This plan provides steps to help guide the client through a suicidal crisis and prevent the need to resort to self-harm behaviors or suicide. The stabilization plan includes Ways to reduce access to lethal means, Things I can do to cope differently when I am in a suicide crisis, Life or death emergency contact number, which includes the suicide hotline number, People I can call for help or to decrease my isolation, and Potential barriers to treatment. Together, the clinician and client can come up with coping skills and ideas for the client to try when they are in a suicidal crisis (Jobes 2016). The client receives a copy of the stabilization plan to keep with them to refer to when they are in a suicidal crisis, either as a paper copy, or a picture on a mobile device.

Supplemental clinical documentation

At each phase within CAMS, there are specific pages of documentation that are loosely referred to as the "HIPAA pages" of the SSF. These pages provide a way of maintaining a comprehensive medical record that complies with HIPAA regulations. Careful documentation in relation to malpractice litigation is important, and the SSF has been constructed to both decrease malpractice liability and function as a HIPAA-compliant, comprehensive medical record. On this

page, there is a Mental Status Exam, Diagnostic Impression, Patient's Overall Suicide Risk Level, and Case Notes section for the clinician to fill out following each session (Jobes, 2016). These pages are unique to CAMS as they give the clinician a way to justify their reasoning for continuing to see the client on an outpatient basis, even though they are verbalizing suicidal ideation. These pages could be used in court if necessary, were the client to complete suicide during the course of treatment.

Tracking/update sessions

The client's suicidality will be clinically "tracked" using the SSF Tracking/Update form during each session until their suicidal risk is eliminated or other outcomes occur, such as referral to another clinician, or treatment dropout. Each CAMS Interim session begins with a patient rating of the six SSF Core Assessment variables and includes an update of the client's suicide specific treatment plan. After each interim session, the clinician documents their opinion of the client's suicide risk level and fills out the related HIPAA page to complete the comprehensive medical record (Jobes, 2016). The clinician continues to use the Tracking/Update forms throughout the course of treatment.

Outcome/disposition session

CAMS as a clinical intervention ends when criteria for "resolution" are met. This happens when three consecutive session are rated as low overall suicide risk and the client has consistently and successfully managed their suicidal thoughts, feelings and behaviors. The SSF Outcome/Disposition documentation is administered and the session ends with the completion of the client's treatment outcome and disposition. However, no matter what the reason for concluding treatment may be, including incarceration, dropout, or hospitalization, the

Outcome/Disposition form should be used to document the ending of treatment, to ensure a complete medical record (Jobes, 2016).

CAMS Outcomes vs. Treatment as Usual (TAU)

Jobes (2016) states that CAMS is flexible and designed for adaptation, and it is considered "nondenominational." Clinicians of various therapeutic orientations can effectively use CAMS when working with suicidal clients. Jobes emphasizes that he wants clinicians to retain their own clinical skills, judgments and treatment approaches when he is training them in CAMS. He encourages providers to practice in their typical style, within the flexible, adaptive CAMS framework (Jobes, 2016).

In a study comparing CAMS to treatment as usual (TAU) by Jobes et al., (2005), patients who were treated with CAMS resolved their suicidality an average of 4 sessions earlier than those in the TAU condition. This data also suggests that the collaborative nature of CAMS is more effective than other, more "directive" treatments. Further, this study found that patients in the CAMS condition attended significantly fewer non-mental health care appointments (Jobes et al., 2005). This result suggests that as patient's mental health improved, so too did their physical health.

The CAMS framework has already begun to be adapted to many different settings. As feasibility trials become more common, CAMS has become more widespread and is being implemented in different settings than it was initially developed for. CAMS has already been found to have a positive outcome when compared to treatment as usual in an outpatient setting, as stated above. Further, in another study by Comtois et al. (2011), CAMS was compared to Enhanced-Care as Usual (E-CAU) in a study of next-day appointment services in an outpatient

crisis intervention treatment setting. In this study, participants reported higher satisfaction with CAMS vs. E-CAU, and CAMS participants had improved more at a 12-month assessment on suicidal ideation, mental health symptoms, and hope.

The Menninger Clinic has also developed the Collaborative Assessment and Management of Suicidality- Menninger (CAMS-M). This protocol is an inpatient psychiatric adaptation and implementation of the CAMS framework. Upon their initial implementation of CAMS-M, preliminary data indicated that CAMS-M patients showed significant improvement on various measures, including suicidal ideation. Notably, they determined that both patients and clinical staff anecdotally reported a high level of acceptability with the CAMS-M framework. The authors of this study concluded that CAMS-M represents a promising innovation in the treatment of suicidal psychiatric inpatients (Ellis, Daza & Allen, 2012). A formal study done with inpatients treated with CAMS-M at the Menninger Clinic found statistically and clinically significant reductions in depression, hopelessness, suicidal ideation, suicide-relevant cognitions and theorized suicide drivers such as psychological pain and self-hate. Further, the therapeutic alliance over the course of treatment was found to be higher with patients and therapists using the CAMS-M framework, suggesting that therapists were focused on partnering with patients around the issues of suicide and safety (Ellis, Green, Allen, Jobes & Nadorff, 2012).

Why CAMS is Suggested for Correctional Settings

The assessment and treatment of suicidality is difficult in any setting and much more so in a setting as unique as a prison or other correctional setting. According to Jobes (2016), one of the most common problems with assessing for suicide in a prison is the problem of discerning “genuine” versus “manipulative” (instrumental) suicidal risk. Add to this the politics of mental

health care in correctional settings and the aspect of liability if a patient should die by suicide, and this results in one of the most challenging clinical settings imaginable. However, Jobes (2016) goes on to say that there are four reasons CAMS would be effective with the inmate population. One being that there are usually less time pressures, allowing clinicians to work with the client as long as there is some progress. Another reason being that the thorough assessment of risk using the SSF in CAMS would be helpful in discerning genuine versus feigned suicidal risk. The third reason Jobes (2016) believes CAMS would be useful in a prison setting is because CAMS documentation is helpful from a liability standpoint and lastly because "incarceration increases suicidal risk; thus, it follows that using an evidence-based suicide-specific treatment makes sense for a uniquely at-risk population" (Jobes 2016).

Expanding on the topic of liability, Jobes (2016) states that many malpractice cases arise in the event of the failure of the clinician to detect and assess a client's suicide risk. Malpractice cases concerning clients who complete suicide during the course of therapy is a rising concern in the field of psychology. Jobes (2016) suggests that using CAMS and the SSF correctly with a suicidal patient should essentially eliminate this specific malpractice concern. Having a complete medical record, including documentation of the client's risk level for each session and reasoning why the clinician felt the inmate was keeping themselves safe in general population as opposed to placing an inmate on suicide watch, is a safeguard in the event that the client completes suicide during the course of therapy.

Recently the National Action Alliance for Suicide Prevention (NAASP) made recommendations about the need for organizations to adopt assessment and treatment methods that are evidence-based (Clinical Care and Intervention Task Force 2014). The highly controlled

nature of the prison environment demands significant adaptations to the content and structure of any mental health intervention, which then runs the risk of compromising the integrity of the evidence-based interventions. However, without these adaptations, most evidence-based interventions are not considered feasible for the unique prison environment (Liebman et al. 2013). Canning (2016) outlines many important elements in suicide prevention including screening, assessment, clinical interventions and treatments, suicide observation, treatment concerns, conditions of confinement, and discharge planning.

Many of the essential elements of suicide prevention that Canning (2016) outlines are found conveniently within CAMS. For example, regarding assessment of suicide risk in prison, Canning (2016) notes that suicide risk assessment may be the most difficult task a clinician has to perform, whether in a community or a correctional setting. Canning states that the standard of care in suicide risk assessment is the evaluation and documentation of risk and protective factors, formulation and justification of a risk level, and treatment plan based on the data gathered (Canning, 2016). Additionally, he states that suicide risk waxes and wanes over time, rather than remaining static. Therefore, suicide risk assessment is a process instead of a one-time event. Using the CAMS SSF in each session is useful in assessing suicide risk over time, instead of only at one static point in time. The American Association of Suicidology has published a set of 10 warning signs of suicidality, including: ideation, substances, purposelessness, anxiety, feeling trapped, hopelessness, withdrawal, agitation/anger, recklessness and mood instability. The CAMS SSF along with Section B, filled out during the initial session of CAMS, can determine a majority if not all of these risk factors for the client. This gives a holistic view of the suicidality of the client in one 60-minute session. Additionally, Canning (2016) suggests that one of the

most useful and important questions to ask an inmate who is contemplating suicide is “How are you still alive?” This essential element is provided in the initial session of CAMS when the client is asked to write down and rate their reasons for living. This gives the inmate a chance to tell the clinicians about their protective factors, so that the clinician can then use these protective factors to inform the safety plan. While Canning (2016) states that no one tool can substitute for clinical judgement, he does suggest that a well-constructed clinical form can provide documentation that the clinician covered all the bases of a complete risk assessment. The CAMS SSF does in fact cover all the bases of a reasonable and adequate risk assessment and can serve as legal documentation should a suicide happen while an inmate is participating in CAMS.

Further, Canning (2016) references the necessity of a “safety plan” that outlines the enhancement of protective factors, and reduction of risk factors. The stabilization plan of the CAMS protocol effectively targets these goals, asking the client how they can reduce access to lethal means, who they can call in times of a crisis, and what means they can use to effectively cope when feeling acutely suicidal. The article also mentions the need for a treatment plan that includes measurable outcomes. The CAMS protocol includes a specific treatment plan, where the clinician and client collaboratively plan interventions to target and reduce the client’s “drivers” of suicidality. This is parallel to Canning’s suggestion that suicide-specific treatment planning should target the specific problems that may have led to or impacted the client’s suicidal ideation.

Not only would CAMS streamline the process of assessing and treating suicidal ideation in correctional settings, it would also ensure that each incarcerated inmate experiencing suicidal ideation in the United States is treated with the same protocol, regardless of where they were

incarcerated. This would allow inmates to transfer facilities, as is common, and continue to receive the same level of care at each institution. This not only allows for continuity of care, but also keeps the inmate engaged and invested in their own treatment. Further, the widespread implementation of CAMS in correctional settings would provide complete documentation for all clinicians of their client's risk for suicide, and would effectively hold up in legal situations if a malpractice case were pursued following an inmate suicide.

According to Hayes (2002), though most, if not all facilities have some sort of suicide prevention program or policy in place, they lack the comprehensiveness that is necessary in truly reducing suicidal behavior within a correctional system. For example, though a facility might provide suicide-prevention training to staff, most trainings are 2 hours or less in duration, and though facilities might indeed have an assessment protocol, it might not be detailed or comprehensive enough to accurately predict an inmate's risk level for suicide. By implementing the CAMS protocol for assessing and treating suicide in all corrections facilities, a comprehensive assessment is ensured, as well as a framework shown to have positive outcomes in various settings for treating suicide.

Adaptations to CAMS for Correctional Settings

While CAMS is an effective, robust, suicide assessment and treatment framework for a general outpatient setting, correctional settings have unique characteristics that aren't present in community mental health or outpatient care. For this reason, there would need to be some specific adaptations made to the way a clinician in a correctional setting uses CAMS with inmates. Although there aren't many changes for CAMS to be effective in this setting, the adaptations that are necessary are important to discuss.

Training

Because CAMS is relatively new in the world of suicide prevention, a small number of clinicians are trained in using or supervising this approach. There are many opportunities to become trained in CAMS, and if correctional institutions around the United States were to implement CAMS as their primary suicide assessment and treatment protocol, they could mandate their psychology staff to become trained in this specific treatment framework. This would allow all inmates with suicidal ideation to be treated with the same protocol and allow all psychology staff to use and supervise the execution of CAMS. In some state prisons in California, psychologists attended a CAMS training before implementing the framework into their facilities. Though some clinicians had hesitations about implementing CAMS, and realized that some aspects of CAMS had to be adjusted, both the inmates and clinical staff reported satisfaction upon utilizing this protocol in correctional settings (Crumlish, 2020).

One of the core facets of CAMS asks the client and clinician to be completely honest. In prison however, self and emotional expression are not always in the client's best interest. Instead, safety is typically the most important factor for an inmate to consider. Inmates don't always open up to other inmates, and especially not to correctional psychologists. There is already a sense of mistrust between inmates and anyone who might be considered law enforcement or "cops." (Morgan et al. 2004). Additionally, many inmates might be under the assumption that if they verbalize suicidal ideation, they will immediately be placed on suicide watch, separated from the rest of the population and their belongings. "Inmates view therapists as cops and…may also be fearful of how documentation of mental health services may be used against them as they progress through the criminal justice system" (Morgan et al. 2004). Inmates

may be under the impression that if they verbalize suicidal ideation they will be punished, get their good time taken away, or be removed from their current programming.

One thing each clinician can do to elicit trust and honesty from the inmate is to outline their specific institution's policy on suicidal ideation at the outset of starting CAMS. For example, a clinician can disclose to the inmate that CAMS is a protocol uniquely designed to target drivers of suicidal ideation, and therefore the inmate needs to be as honest as possible when working with the clinician regarding their suicidality. The clinician should also let the inmate know that if they feel the inmate is imminently suicidal and cannot be kept safe in their general housing unit, a suicide watch may be implemented in the interest of the inmate's immediate safety. Explaining expectations and possible outcomes to the inmate at the beginning of therapy may alleviate some of the inmate's concerns regarding how open and honest to be with the clinician.

Instructions

In regards to the instructions, CAMS instructs the clinician to sit next to the client to enhance the collaborative nature of the protocol. However, when working in a prison setting, close contact with an inmate is not in the best interest of a clinician's safety. Specifically, clinicians working in the state prisons in California who implemented CAMS had objections about trying CAMS in correctional settings because of the specific instruction to sit next to the client (Crumlish, 2020). Keeping a safe distance between the clinician and inmate is considered ideal and safer for everyone involved, and is still conducive to the effectiveness of CAMS. In some correctional institutions, the clinician might even need to see the client through a glass or metal barrier. In sessions of CAMS that are done with distance or barriers between the client and

clinician, one way to continue the collaborative nature of the CAMS framework is to allow the inmate to have their own version of the Suicide Status Form (SSF). When utilizing the SSF, the therapist and inmate can each follow along with the assessment, both writing the inmate's answers on their respective SSF forms. The therapist can periodically show his/her version of the SSF to the inmate to make sure they are correctly tracking what the inmate is answering for each question. This can be a way to build rapport between the inmate and clinician as well as to encourage the collaborative nature of the framework, while keeping safety and distance as a priority. Each session can be done in this way, where the inmate and clinician each fill out their own SSF assessment, and the clinician checks to make sure they are transcribing the inmate's answers correctly.

Suicide Status Form (SSF)

When filling out the SSF Initial Session form, the inmate might have some difficulty, possibly with reading or comprehension depending on each inmate's ability level. The clinician is there to help the inmate when they get stuck on certain items or need clarification. First, the inmate must rate their psychological pain, stress, agitation, hopelessness, self-hate and overall risk of suicide. Next, the inmate will rate how much their suicidality is related to thoughts and feelings about themselves vs. others. This part is fairly straightforward, and though the clinician may need to answer some questions about this section, there are no necessary adaptations to this particular section for correctional settings.

One section the inmates may have difficulty with is the "reasons for living" section. Although there are no necessary adaptions to be made to this section, a clinician working with an inmate might need to offer more support for this section in particular. For example, if an inmate

has a longer sentence, little or no family support, feels they are a burden or disappointment to their family, or have fewer protective factors in general, they may not be able to identify any reasons for living. Although those in the community similarly find it difficult to find reasons for living when they are feeling suicidal, a clinician working with an inmate in particular might try to elicit some general reasons for living and help the inmate look toward life after prison. According to Crumlish (2019), because CAMS targets direct and indirect drivers of suicidality, clinicians who are new to CAMS are often surprised to find that inmates report much different drivers of their suicidality than clinicians initially anticipate. Getting to the correct driver of the inmate's suicidality lends more options to the clinician in moving forward with effective treatment. For example, clinicians might assume that an inmate's suicidal drivers are associated with their legal struggles, fear of imprisonment, or anxiety about their sentence. However, clinicians are often surprised to find that inmate's suicidal drivers are similar to the drivers of clients in the community. These drivers often center on experiencing anxiety about the future, an inmates own self-esteem, and being apart from family/spouses. In a phone interview, Dr. Crumlish (2020) notes that although inmate's drivers are often not "fixable," they are treatable. Crumlish (2020) states that she tries to "get people to think about suicide as a coping strategy for a driver that is treatable." So, for example, if an inmate is sentenced to life, their driver for suicidality may be that they are apart from their spouse, and this is a driver that is treatable. Clients in the community can lose spouses or family members by way of divorce, separation, or death, and those clients might become suicidal with the loss of their family member as their main driver. In these cases, grief work can be done in therapy, within the context of CAMS to treat the

client's driver. Though the driver is not "fixable," it is something that can be treated in therapy for both inmates and members of the community.

Stabilization plan

The stabilization plan within CAMS includes multiple sections in which an inmate might have difficulty. Aspects of the Stabilization Plan and ways to overcome struggles they present in the prison setting are outlined below.

Ways to reduce access to lethal means

Inmates do not have access to the same means of suicide as those in the community. For example, common means to suicide in the community are firearms, medication overdose, and hanging or asphyxiation, among others (National Institute of Mental Health, 2019). However, in a correctional setting, the same means are not always available. Of those that are available such as medication and asphyxiation, special precautions need to be taken to further reduce access to these means of suicide that might not be necessary in the general population.

If the inmate expresses that their means to suicide is hanging, bed sheets and other clothes that can be used to complete suicide can be reduced or removed, or at least monitored. However, if the inmate describes their preferred means to suicide is banging their head on a hard surface, this is something that cannot be taken away. In this case, the inmate might need to be placed on suicide watch so that a staff member has a constant visual on the inmate. Additionally, if an inmate describes their means to suicide is by overdose, they might be planning to store medications, either their own prescribed medications, or by receiving medications from other inmates. This could be monitored by placing the inmate on restricted access to medications, wherein they are dosed each day by medical personnel, instead of allowed to self-carry their

medications. However, if an inmate's preferred method is overdose, keeping them away from other inmates' medications doesn't have a simple solution. In order to truly reduce access to a variety of means in a correctional setting, a placement on suicide watch might be warranted.

Things I can do to cope differently

The stabilization plan includes a section detailing activities the client can engage in to distract and work through a suicidal crisis. Some common answers from clients for this section are "take a walk," "take a shower," or they might suggest a hobby that they like such as crocheting, drawing, working out, or swimming. For inmates, because they might be on a strict schedule or have limited access to recreational areas, they may become suicidal at a time when they are scheduled to be working, taking classes, or are limited by movement restrictions. Their abilities to distract themselves might be more limited than would be for someone who isn't bound by a strict time and movement schedule in a correctional setting. Further, if the inmate is housed in the special housing unit (SHU), their physical activity is limited, or even restricted fully. Often times in the community, the client doesn't remember their stabilization plan, so they carry a copy of it with them or as a picture on their phone. Inmates placed in special housing units or suicide watch aren't allowed to bring belongings with them, such as paper, notebooks, or books. In this case, the inmate would need to remember their stabilization plan, or at least remember the things they listed as distracting activities to get through a suicidal crisis. Because they might be limited in movement, or in the SHU without any of their belongings, some activities that inmates could do in a suicidal crisis would need to be cognitively-based activities such as reciting mantras, humming, singing, meditations, quoting scripture, praying, etc.

People I can call for help or to decrease my isolation

The stabilization plan has a section for the client to write down three supportive people they could call in a suicidal crisis. An inmate could write down three people they could call, however due to scheduling, lack of funds or other restrictions, they may not have phone access depending on when they experience a crisis. For example, if they become acutely suicidal during their work detail, at night, or at a time when they run out of money to use the phone, they won't have access to call the supports they outlined in the stabilization plan. For this section, the inmate might need to additionally write down three people at the institution they could speak to when they are in the midst of a suicidal crisis including other inmates or staff. Inmates are informed upon entering the institution that if they become suicidal and are in danger of hurting themselves, they are to immediately tell any staff person, so psychology staff on duty can be contacted. While the "who to call" section is very important in the community where immediate access to mental health professionals is not always available, it might be less important in a prison, where the inmate has access to psychology staff in the case of an emergency.

Attending Treatment as Scheduled

The end of the Stabilization Plan includes a section which allows the client and therapist to brainstorm possible treatment rejecting behaviors and barriers to treatment for the client. In this section, clients can attend to scheduling conflicts, transportation issues, or other treatment rejecting behaviors they can foresee being an obstacle to them consistently participating in treatment. There is also a section where the therapist and client can collaboratively come up with potential solutions to these barriers. In a prison setting, potential barriers to therapy will be different than they are in the community. For example, an inmate will not have transportation

issues, but they could possibly have scheduling conflicts depending on their work schedules and other programing they might participate in, such as GED classes and substance abuse treatment groups, among others. Further, inmates might display treatment rejecting behavior, for example coming to therapy but not engaging, or even missing sessions to participate in other activities such as sleeping, exercising, or eating that aren't time-restricted such as therapy sessions. In the Potential Barriers to Treatment section, the clinician can help the inmate come up with solutions to any barriers they can foresee.

In conclusion, though there aren't an abundant amount of necessary changes for CAMS to be effective in a prison environment, there are some very important nuances to be aware of when using this protocol with inmates. Creating physical distance between inmate and clinician, adapting the SSF and stabilization plan, and offering extra support are just a few considerations presented for those wanting to implement CAMS in correctional settings.

CAMS in the California Correctional System

CAMS has begun to be implemented in a large state correctional organization with inmates for the past three years in the state of California (Crumlish, 2019). This is the first systematic use of CAMS in any correctional institutions. Though there are not currently any official results of the effectiveness of this particular implementation, it is the opinion of the clinical staff involved in this project that CAMS has shown to provide a streamlined way to assess suicide risk, identify drivers of suicide, and create a stabilization plan with effective coping strategies in the correctional setting. As a result of the implementation of CAMS in correctional institutions in California, clinicians reported feeling more confident in their assessment of risk, and reported a positive experience using the SSF to identify drivers and

create alternative coping strategies. Of note, in addressing the problem of inmates using suicide as a motive to gain incentives, Crumlish (2019) stated that inmates who were malingering suicidal ideations were resistant to the use of CAMS and refused to participate in the collaborative CAMS process, or actually admitted that they were using suicide to get other needs met.

In settings where clinicians only meet with an inmate for one or two sessions, such as in short-term jail or transfer facilities, a one-session model of CAMS was used successfully (Crumlish, 2019). In this model, an Initial Session SSF was used, with an emphasis on creating a CAMS Stabilization Plan so the inmate can begin using alternative coping strategies. Once the session was complete, the clinicians could enter the direct and indirect drivers of the inmate's suicidality into their medical record, so that any clinician treating the particular inmate in the future has access to continue targeting and treating their drivers of suicide. The article poses that as more clinicians are trained in CAMS, it is more likely that inmates who move from facility to facility will be engaged in continuous CAMS care, improving the odds that the inmate's risk level for suicide will decrease.

Inmates have reported that they enjoy the collaborative nature of the CAMS process, as well as learning alternative coping strategies to implement when in suicidal crises. Clinicians who have been trained with CAMS in this setting have reported that they prefer CAMS over other assessment measures and have confidence in suicide prevention efforts. In some cases, over the three-year study, disruptive behaviors have decreased and inmates have reduced suicidal behavior (Crumlish, 2019).

Although there are not any official results providing data that CAMS would be efficient in a correctional setting, the preliminary information provided by this early implementation of CAMS in California correctional systems, as well as the results CAMS has displayed in similar brief settings, suggests CAMS is a promising tool that could have positive results in this novel setting.

Effectiveness of CAMS in Jail and Brief Treatment Settings

Hesitations about using CAMS in correctional settings often center on the brief nature of an inmate's stay in a particular institution. Inmates can be shuffled around from jail to courthouse, and institution to institution. Before inmates are sentenced in a permanent institution, they might not stay in one place for long. However, jails have the highest rates for suicides among correctional settings, therefore suicide risk assessment is a necessary priority in jails. Most jail suicides occur within the first 10 days (Canning, 2020) of the inmate's arrival. As there are more inmates serving terms in local jails than there used to be, leading to people spending up to one or two years in jails, there is more pressure on jails to provide mental health services than ever before. However, jails are built around a crisis intervention model because many people who find themselves in jail are inebriated, intoxicated, experiencing psychosis, or needing to detox from substances before they can engage in any productive treatment. Because of understaffing and a smaller window of opportunity to intervene with clients, there is less suicide specific treatment available for those serving time in jails (Canning, 2020).

For these brief settings, Jobes (2016) describes the creation of CAMS Brief Intervention (CAMS-BI). This is a one-time suicide specific intervention using the first session of CAMS, with no expectations of continuing care. The patient learns basic information about their suicide

risk, and develops a CAMS Stabilization Plan with the clinician. Patients might also receive a "Coping Care Package," which includes various helpful brochures, hotline numbers and resources. According to Jobes (2016), CAMS-BI largely targets patients who are not interested in ongoing mental health care as well as those presenting in emergency departments or being discharged from inpatient hospital care. Because emergency departments are primarily focused on assessment and disposition of the client, they can easily implement an expedited CAMS assessment using sections A and B of the SSF and identify potential suicidal drivers. CAMS as an initial assessment in emergency rooms has application for jails and other short-term crisis management situations a well. As stated above, in these brief sessions, the focus is on section A of the SSF and obtaining the client's main suicidal drivers as well as creating a solid stabilization plan for the client to take with them when they inevitably get released or transferred to a more permanent setting such as a state or federal prison (Crumlish 2019).

Program Review

To ensure adherence to the CAMS protocol, all corrections staff would need to first attend a CAMS training, given by a certified CAMS trainer. The staff would then be supervised via phone supervision by a CAMS certified trainer to ensure they are following adherence to the CAMS protocol. Staff at various institutions can become certified in CAMS if deemed necessary by their specific institution to offer supervision to those at their facility and surrounding facilities. Supervised clinicians can track the number of successful CAMS cases, in which a client resolves or successfully completes CAMS, as well as the number of unsuccessful CAMS cases, due to therapy drop-out, release or transfer from prison, or completed suicide. This information can be used to analyze how successful the CAMS protocol is in this unique

environment. Additionally, analyzing outcomes of treatment as usual (TAU), and the number of completed suicides within a control group compared to the number of completed suicides within the CAMS treatment group could offer data on CAMS efficacy compared to TAU within a correctional setting. The outcomes from clients participating in CAMS can then be compared to the outcomes from the treatment as usual groups to analyze whether CAMS is more or less effective as a suicide specific protocol than treatment as usual at correctional facilities.

Conclusion

Currently, the Bureau of Prisons has an effective protocol for assessing and treating suicidal ideation in inmates. Specifically, they employ a series of steps that staff are required to take when an inmate voices or shows signs of suicidal ideation. If an inmate is determined by any staff to be at risk for suicide, or exhibiting suicidal behavior, they are immediately referred to a psychologist, who meets with the inmate, creates a safety plan to keep the inmates safe in their current environment, or a suicide watch is considered warranted and they are moved to a more secure suicide watch area. In cases where the inmate is considered safe in general population, they are permitted to stay in their original housing designation, and work with the psychologist to treat their suicidal cognitions. Cognitive Behavior for Suicide Prevention and Dialectical Behavior Therapy are both currently being used to treat suicidal inmates in various correctional settings. Other correctional settings such as jails and state prisons also have their idiosyncratic methods for assessing and treating suicidal ideation and risk, including general correctional intakes for assessment, crisis intervention methods including CBSP and DBT, and other various mental health treatment services. Each correctional system has their own unique method to assessing and treating suicidality, most of which do not currently include a framework

such as CAMS which offers a comprehensive assessment, treatment modality and medical record all in one simple tool. Implementing the use of the CAMS protocol across all correctional systems could create uniformity and streamline the assessment and treatment of suicide risk and suicidal ideation.

There are many benefits to adopting the CAMS framework in treating suicidal clients. According to Jobes (2017), of the existing proven effective treatments for suicidal risk, CAMS offers the most flexibility, is easy to learn and does not require clinicians to use an unfamiliar theoretical model to provide suicide specific care. As a therapeutic framework, CAMS enables the clinician to practice their usual approach to treatment, and ensures they are targeting the client's suicide specific drivers. Many CAMS clinicians feel comforted by having a structured but flexible clinical protocol for treating suicidal clients. There can also be comfort in knowing that CAMS is proven to be effective through clinical research with various populations and that correct SSF documentation should significantly reduce the risk of malpractice liability (Jobes, 2017).

The Collaborative Assessment and Management of Suicidality by David Jobes (2016) would be a promising addition as an evidence-based framework for assessing and treating suicidality that can not only be used as part of a client's medical record, but is also effective documentation in the case of a completed suicide and potential legal action. Using CAMS can streamline the clinician's duties by putting all the tools needed for assessing and treating a suicidal client, as well as documenting and defending the client's risk level, in one concise record. The level of suicide specific care and documentation within CAMS far exceeds the existing standard of care, according to Jobes (2017).

Further, CAMS has shown efficacy and promising results being used in prisons across the state of California, as well as in other settings including inpatient psychiatric hospitals. CAMS is only going to continue to be adapted for various settings and populations in need of an effective suicide management framework. Because CAMS would unite, simplify and streamline the correctional system's treatment of suicidal inmates, as well as provide continuous care for inmates who are transferred to different facilities or to the community, this project suggests correctional facilities across the United States would benefit from adopting this particular framework for assessing and treating suicidal inmates.

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APPENDIX A

U.S. Department of Justice
Federal Bureau of Prisons

Program Statement

OPI: CPD/PSB

NUMBER: P5324.08

DATE: 4/5/2007

SUBJECT: Suicide Prevention Program

RULES EFFECTIVE: 3/15/2007

1. **PURPOSE AND SCOPE.** The Bureau of Prisons (Bureau) operates a suicide prevention program to assist staff in identifying and managing potentially suicidal inmates. Each Warden will ensure that a suicide prevention program is implemented consistent with this policy. In addition, Wardens will facilitate a discussion regarding the issue of suicide at department head meetings, staff recalls, lieutenants' meetings, etc., to heighten staff awareness about the need to detect and report any changes in inmate behavior that might suggest suicidal intent.

2. **SUMMARY OF CHANGES.** This re-issuance adds the following new procedures for preventing inmate suicides:

a. Suicide prevention training will include three mock suicide
emergencies per year, one on each shift. One of these exercises

must be conducted in the Special Housing Unit (SHU) during the morning or evening watch.

b. Specific minimum criteria that must be included in a Suicide Risk Assessment and a Post-Watch Report are delineated.

c. Designation of a room for suicide watch outside of the Health Services area requires written approval of the Regional Director.

d. Specific criteria that exclude an inmate from consideration for an inmate companion position are delineated.

e. Correctional Services will notify Psychology Services when an inmate requests protective custody (PC). Psychology Services will no longer be required to monitor SENTRY for entry of a PC code.

3. **PROGRAM OBJECTIVES.** The expected results of this program are:

a. All institution staff will be trained to recognize signs and information that may indicate a potential suicide.

b. Staff will act to prevent suicides with appropriate sensitivity, supervision, and referrals.

c. Any inmate clinically found to be suicidal will receive appropriate preventive supervision, counseling, and other treatment.

4. **DIRECTIVES AFFECTED**

a. **Directive Rescinded**

P5324.05 Suicide Prevention Program (3/1/04)

b. **Directives Referenced**

P5270.07 Inmate Discipline and Special Housing Units (12/29/87)
P5290.14 Admission and Orientation Program (4/3/03)
P5310.12 Psychology Services Manual (8/13/93)
P5566.06 Use of Force and Application of Restraints (11/30/05)
P6031.01 Patient Care (1/15/05)
P6340.04 Psychiatric Services (1/15/05)

c. Rules cited in this Program Statement are contained in

28 CFR 552.40 through 552.41.

5. **STANDARDS REFERENCED**

a. American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4084,4-4084-1,4-4370M,4-4371M,and 4-4373M.
b. American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-7B-08,4-ALDF-7B-10,4-ALDF-7B-10-1,4-ALDF-4C-29M,4-ALDF-4C-30M,and 4-ALDF-4C-32M.

6. **INSTITUTION SUPPLEMENT.** See Section 7a.

7. **POLICY.** Each Bureau institution, other than Medical Referral Centers (MRCs), will implement a suicide prevention program that conforms to the procedures outlined in this policy. Each Bureau medical center is to develop specific written procedures consistent with the specialized nature of the institution and the intent of this policy.

a. **Medical Referral Centers.** MRCs serve a unique evaluation/treatment function addressing the needs of a wide range of inmates, while meeting community standards of care. Psychology Services is responsible for developing an Institution Supplement that describes local procedures for managing the Suicide Prevention Program's components.

MRC psychologists are to document significant treatment information in the Psychological Data System (PDS) so that the information is readily available for post-discharge treatment.

b. **Residential Reentry Center Contract Facilities.** When contracts for outside facilities (including Residential Reentry Centers (RRCs)) are used, the Statement of Work will include a suicide prevention plan or program that meets accepted Bureau standards.

Community Corrections Managers (CCMs) will monitor contract facilities regularly to determine their capability to manage at-risk populations effectively. The CCM will consult the Regional Psychology Services Administrator if questions arise about the adequacy of a contract facility's Suicide Prevention Program or about the need to transfer a suicidal inmate to a different

facility. The CCM will contact Central Office Psychology Services when there is system-wide or interagency issues. In the event of a suicide, all possible evidence and documentation will be preserved to provide data and support for subsequent investigators doing a psychological reconstruction. Ordinarily, the Regional Director will authorize an after-action review of a suicide at a RRC, to be conducted by the Regional Psychology Administrator. The findings will be documented as a Psychological Reconstruction Report as outlined in Attachment A.

c. **Privately-Managed Contract Prisons.** Private security contract facilities maintain a suicide prevention and intervention program in compliance with American Correctional Association (ACA) standards. Ordinarily, the Assistant Director, Correctional Programs Division, will authorize an after-action review of a suicide at a contract private prison, to be conducted under the direction of the Central Office Psychology Services Administrator. The findings will be documented as a Psychological Reconstruction Report as outlined in Attachment A.

8. **PROGRAM ADMINISTRATION.**

a. **Program Coordinator.** Each institution must have a Program Coordinator for the institution's suicide prevention program. The Program Coordinator shall be responsible for managing the treatment of suicidal inmates and for ensuring that the institution's suicide prevention program conforms to the guidelines for training, identification, referral, assessment, and intervention outlined in this policy.

Ordinarily, the Chief Psychologist will be the Program Coordinator. The Program Coordinator's responsibilities will not
be delegated to staff other than a doctoral-level psychologist.

The Program Coordinator, in conjunction with institution executive staff, must ensure that adequate coverage is available when he or she is absent from the institution for training, annual leave, etc.

b. **Training.** While the initial period of incarceration is often a critical time for detecting potential suicides, serious suicidal crises may arise at any time. Line staff are often the

first to identify signs of potential suicidal behavior based on their frequent interactions with inmates.

The Program Coordinator is responsible for ensuring that appropriate training is available to staff. The Program Coordinator will ensure that all staff will be trained (ordinarily by psychology services personnel) to recognize signs indicative of a potential suicide, the appropriate referral process, and suicide prevention techniques.
Wardens will include discussions of suicide prevention at department head meetings, staff recalls, etc., to remind staff of
the need to observe inmates constantly for signs of suicidal behavior.

1) **Training for All Staff.** Suicide prevention training will be included in the Introduction to Correctional Techniques curriculum. Training in local suicide prevention procedures will be provided during Institution Familiarization Training and Annual Training (AT) at all institutions.

Training for staff will focus on:

- identifying suicide risk factors;
- typical inmate profiles of completed suicides;
- recognition of potentially suicidal behavior;
- appropriate information associated with identifying and referring suicidal inmates;
- responding to a suicide emergency (e.g., a suicide in progress), including location and proper use of suicide cut-down tool; and
- name of Program Coordinator, location of suicide watch room, etc.

2) **Supplemental Speciality Training.** The Program Coordinator will offer supplemental training to staff having frequent inmate contacts. Ordinarily, supplemental specialty training for health services staff (i.e., Physician's Assistants, Nurse Practitioners, Emergency Medical Technicians, Registered Nurses), lieutenants, and correctional counselors is offered approximately six months after the conclusion of institution AT. It is encouraged that this training be provided during regularly scheduled meetings when possible.

3) **Supplemental Training for Special Housing Unit (SHU) Staff.** Information about recognizing potentially suicidal inmates and procedures to follow will be included in the SHU post orders. Attachment B is an example of post orders for suicide prevention in a SHU.

4) **Emergency Response Training.** At a minimum, the Captain and Chief Psychologist will jointly conduct three mock suicide emergencies yearly, one on each shift, approximately four months apart. Complexes will complete the exercises separately at each institution within the complex.

- Within the calendar year, at least one of these exercises will be conducted in the SHU during the evening or morning watch. (Institutions that do not have a SHU [e.g., Camps] are exempted from this requirement, but are still required to conduct three mock suicide emergencies yearly).
- Confirmation of mock suicide emergency training will occur in writing to the Associate Warden over Psychology Services with a copy to the Suicide Prevention Program Coordinator for placement in a training documentation file. See sample memorandum format in Attachment C.
- This training is in addition to the supplemental speciality training for lieutenants, health services staff, and correctional counselors.

9. **IDENTIFICATION OF AT-RISK INMATES.**

a. **Medical Staff Screening.** Medical staff are to screen a newly admitted inmate for signs that the inmate is at risk for suicide. Ordinarily, this screening is to take place within twenty-four hours of the inmate's admission to the institution.

 The Physician's Assistant/Nurse Practitioner (PA/NP) will refer suicidal or emotionally disturbed inmates on an emergency basis to the Program Coordinator or designee.

b. **Psychological Intake.**

1) **Pre-Trial Detainees, Pre-Sentence Detainees, and Holdovers in MCCs, MDCs, FDCs, FTCs, or Jails.** Because of the high rate of

admissions and short length of stay in MCCs, MDCs, FDCs, FTCs and Detention units, the comprehensive psychological intake conducted by Psychology Services ordinarily will be performed only on inmates who are suspected of being suicidal or appear psychologically unstable (e.g., mental illness or significant substance abuse withdrawal), or who request services via the Psychology Services Inmate Questionnaire.

2) **Newly Assigned or Writ-Return Inmates.** For newly assigned designated inmates or writ-return inmates, a psychologist will conduct a comprehensive psychological intake within 14 days of the inmate's admission to the institution.

3) **Transferred Inmates.** For transferred inmates, a psychologist will conduct a comprehensive psychological intake within 30 days of the inmate's admission to the institution if the psychologist determines it is clinically warranted based upon the PSIQ and other available inmate records.

c. **Inmates in SHUs.** Inmates in Administrative Detention or Disciplinary Segregation status often may be at higher risk for suicidal behavior. Inmates being transferred into the SHU will be monitored for signs of potential suicide risk (e.g., crying, emotionally distraught, threats of self-harm, or engaging in misconduct to purposefully effect removal from the general population). Inmates exhibiting such behavior will be referred to the Shift Lieutenant.

1) **Protective Custody (PC) Inmates.** Inmates requesting protective custody or demanding to be housed alone may actually be contemplating suicide. When an inmate requests protective custody or demands to be celled alone, Correctional Services staff will immediately:

- notify the Program Coordinator or designee in Psychology Services during normal business hours, or
- during non-routine working hours notify the on-call psychologist.

The PC inmate should be screened for suicidal ideation **within 72 hours** of being placed into SHU. When clinically indicated by this screening, a formal Suicide Risk Assessment will be conducted.

The Program Coordinator will work closely with custody staff to
monitor each PC inmate's mental status for behavior (e.g., hopelessness, anxiety, increasing agitation, depression, psychoses) that suggests a need for an increased level of services.

2) **Inmates Requiring Special Precautions.** The Program Coordinator will provide SHU staff with a list ("hot list") of inmates with mental health conditions who may become dangerous, self-destructive, or suicidal when placed into the SHU.

- This list will be updated as needed and distributed to Correctional Services, Health Services, and Unit Team staff. This list will be made available to all staff.
- When an inmate on this "hot list" is placed into the SHU, a Correctional Services Supervisor will notify Psychology Services immediately.

3) **SHU Custodial Issues.**

A) **Program Coordinator Involvement.** At a minimum, the Program Coordinator or designee will make weekly rounds of SHUs and consult with staff in those areas concerning any inmates needing special attention.

B) **Review of Lieutenant's Log.** The Program Coordinator will review the Lieutenant's log each working day to determine if an inmate with mental health problems has been placed in the SHU. A psychologist will see the inmate as soon as possible to assess the inmate's mental status and alert SHU staff.

C) **Health Services.** Health Services policy contains procedures to ensure inmates placed in SHU continue to received needed medications.

- Psychology Services will be notified whenever an inmate refuses or misses his/her medication. If the inmate has the potential to become violent, self-destructive, or suicidal without the medication, psychologists will notify SHU staff of this.

D) **Suicide Rescue Tool.** Every SHU will be equipped with a suicide rescue tool(s) that is sharp, stored in a secure location, and readily available. All SHU staff will be trained to use the tool and in the procedures for responding to a suicide emergency.

E) **Inmate Removal from the SHU.** The Program Coordinator will arrange to have an inmate exhibiting significant potential for suicide removed from the SHU and placed on suicide watch. Ordinarily, once the crisis is over, the inmate will be returned to the SHU to satisfy any sanction that was imposed.

d. **Staff Referral. Any staff** may identify an inmate as potentially suicidal **at any time** based upon the inmate's observed behavior.

STAFF MUST NEVER TAKE LIGHTLY ANY INMATE SUICIDE THREATS OR ATTEMPTS OR ANY INFORMATION OR HINTS FROM OTHER INMATES ABOUT AN INMATE BEING POTENTIALLY SUICIDAL.

Any staff member who has reason to believe an inmate may be suicidal should:

- ordinarily maintain the inmate under direct, continuous observation,
- contact the Shift Lieutenant for assistance, and
- during regular working hours, contact the Program Coordinator or designee (i.e., any other available psychologist).
- During non-routine working hours, the Shift Lieutenant will contact the on-call psychologist and continue direct, continuous observation, or immediately place the inmate on suicide watch.

  In emergency situations, the Shift Lieutenant will immediately place the inmate on suicide watch. It should be noted that in emergency situations **any staff** member may place an inmate on suicide watch. Special procedures may apply to MRCs where the initiation of suicide watch may be limited to specific clinical staff.

  e. **Inmate Referral.** In addition to staff, inmates can play a vital role in helping to prevent inmate suicides. To

facilitate this process each institution will encourage inmate referrals by:

- including a statement in the institution inmate handbook/orientation materials encouraging inmates to notify staff of any behavior or situation that may suggest an inmate is upset and potentially suicidal,
- incorporating the topic of inmate referrals into the Admissions and Orientation lesson plan for Psychology Services,
- placing posters in each housing unit addressing the topic, and
- ensuring that the information is made available to inmates in multiple languages as appropriate, particularly Spanish.

10. **SUICIDE RISK ASSESSMENT OF IDENTIFIED INMATES.** During regular working hours inmates referred for assessment of suicide potential will be seen on a priority basis. During non-regular hours, the Program Coordinator or designee should consult with institution staff and may choose to see the inmate immediately or have the inmate placed on suicide watch. In either case, the inmate will receive an individual assessment within 24 hours of referral.

A Suicide Risk Assessment will be completed when:

- staff refer an inmate to Psychology Services because the inmate may be at risk for suicide (e.g., the inmate refuses his or her property, talks about ending his or her life),
- an inmate's written or verbal behavior is suggestive of suicide,
- an inmate exhibits behavior suggestive of self-harm, or
- any other condition is present that would lead the clinician to believe an assessment is warranted.

Ordinarily, the Suicide Risk Assessment will be completed in PDS within 24 hours of the incidents outlined above. At a minimum, the Suicide Risk Assessment will include:

- reason for / source of referral,
- risk factors assessed,
- risk assessment findings,
- diagnosis, and
- follow-up recommendations.

When a staff member has made a referral based on observed behavior, the psychologist who interviews the inmate will also make every effort to interview the staff member who observed the behavior. The staff member's comments will be included in the report/clinical notes.

11. **INTERVENTION.** Upon completion of the suicide risk assessment, the Program Coordinator or designee will determine the appropriate intervention that best meets the needs of the inmate. Because deliberate self-injurious behavior does not necessarily reflect suicidal intent, a variety of interventions other than placing an inmate on suicide watch may be deemed appropriate by the Program Coordinator, such as heightened staff or inmate interaction, a room/cell change, greater observation, placement in restraints, or referral for psychotropic medication. In any case, the Program Coordinator or designee will assume responsibility for the recommended intervention and clearly document the rationale.

a. **Non-suicidal Inmates.** If the Program Coordinator determines that the inmate does not appear imminently suicidal, he/she shall document in writing the basis for this conclusion and any treatment recommendations made. This documentation will be placed in the inmate's medical, psychology, and central file.

b. **Suicidal Inmates.** If the Program Coordinator determines the individual to have an imminent potential for suicide, the inmate will be placed on suicide watch in the institution's designated suicide prevention room. The actions and findings of the Program Coordinator will be documented, with copies going to the central file, medical record, psychology file, and the Warden.

12. **SUICIDE WATCH.**

a. **Housing.** Each institution must have one or more rooms designated specifically for housing an inmate on suicide watch. The designated room must allow staff to maintain adequate control of the inmate without compromising the ability to observe and protect the inmate.

- The primary concern in designating a room for suicide watch must be the ability to observe, protect, and maintain adequate control of the inmate.
- The room must permit easy access, privacy, and unobstructed vision of the inmate at all times.
- The suicide prevention room may not have fixtures or architectural features that would easily allow self-injury.

Inmates on watch will be placed in the institution's designated suicide prevention room, a non-administrative detention/segregation cell ordinarily located in the health services area. Despite the cell's location, the inmate will not be admitted as an in-patient unless there are medical indications that would necessitate immediate hospitalization.

Placement of a suicide watch room in a different area may be warranted given the unique features of some institutions.

- However, designating a room for suicide watch outside of the Health Services area requires written approval of the Regional Director. Such rooms must meet all of the
- Administrative detention and disciplinary segregation cells will not be designated or approved as suicide watch cells.
- Under emergency conditions a suicidal inmate may be placed temporarily on suicide watch in a cell other than the institution’s designated watch room. The inmate must be moved to a designated suicide watch room as soon as one becomes available.

b. **Conditions of Confinement.** While on suicide watch, the inmate's conditions of confinement will be the least restrictive available to ensure control and safety. The inmate on watch will ordinarily be seen by the Program Coordinator on at least a daily basis. Unit staff will have frequent contact with the inmate while he/she is on watch. Ordinarily, the Program Coordinator or designee will interview or monitor each inmate on suicide watch at least daily and record clinical notes following each visit.

The Program Coordinator or designee will specify the type of personal property, bedding, clothing, magazines, that may be

allowed.

- If approved by the Warden, restraints may be applied if necessary to obtain greater control, but their use must be clearly documented and supported.
- Any deviations from prescribed suicide watch conditions may be made only with the Program Coordinator's concurrence.
- The Program Coordinator will develop local procedures to ensure timely notification to the inmate's Unit Manager when a suicide watch is initiated and terminated. Correctional Services staff, in consultation with the Program Coordinator or designee, will be responsible for the inmate's daily custodial care, cell, and routine activities.
- Unit Management staff in consultation with the Program Coordinator will continue to be responsive to routine needs while the inmate is on suicide watch.

c. **Observation.** For **all** suicide watches:

- Any visual observation techniques used to monitor the suicide companion program will focus on the inmate companion and/or the inmate on suicide watch only.
- The observer and the suicidal inmate will not be in the same room/cell and will have a locked door between them.
- The person performing the suicide watch must have a means to summon help immediately (e.g., phone, radio) if the inmate displays any suicidal or unusual behavior.
- The Program Coordinator will establish procedures for documenting observations of the inmate's behavior in a Suicide Watch log book, which will be maintained as a secure document. Staff and inmate observers will document in separate log books. Post Orders will provide direction to staff on requirements for documentation.

1) **Staff Observers.** The suicide watch may be conducted using staff observers. Staff assigned to a suicide watch must have received training (Introduction to Correctional Techniques or in AT) and must review and sign the Post Orders before starting the watch. The Program Coordinator will review the Post Orders annually to ensure their accuracy.

2) **Inmate Observers.** Only the Warden may authorize the use of inmate observers (inmate companion program). The authorization for the use of inmate companions is to be made by the Warden on a case-by-case basis. If the Warden authorizes a companion program, the Program Coordinator will be responsible for the selection, training, assignment, and removal of individual companions. Inmates selected as companions are considered to be on an institution work assignment when they are on their scheduled shift and shall receive performance pay for time spent monitoring a potentially suicidal inmate.

d. **Watch Termination and Post-Watch Report.** Based upon clinical findings, the Program Coordinator or designee will:

1) Remove the inmate from suicide watch when the inmate is no longer at imminent risk for suicide, or
2) Arrange for the inmate's transfer to a medical referral center or contract health care facility.

Once an inmate has been placed on watch, the watch may not be terminated, **under any circumstance**, without the Program Coordinator or designee performing a face-to-face evaluation. Only the Program Coordinator will have the authority to remove an inmate from suicide watch. Generally, the post-watch report should be completed in PDS prior to terminating the watch, or as soon as possible following watch termination, to ensure appropriate continuity of care. Copies of the report will be forwarded to the central file, medical record, psychology file, and the Warden. There should be a clear description of the resolution of the crisis and guidelines for follow-up care.

At a minimum, the post-watch report will include:

- risk factors assessed,
- changes in risk factors since the onset of watch,
- reasons for removal from watch, and
- follow-up recommendations.

13. **INMATE OBSERVERS - INMATE COMPANION PROGRAM.**

a. **Selection of Inmate Observers.** Because of the very sensitive nature of such assignments, the selection of inmate observers requires considerable care. To provide round-the-clock observation of potentially suicidal

inmates, a sufficient number of observers should be trained, and alternate candidates should be available. Observers will be selected based upon their ability to perform the specific task but also for their reputation within the institution. In the Program Coordinator's judgement, they must be mature, reliable individuals who have credibility with both staff and inmates. They must be able, in the Program Coordinator's judgement, to protect the suicidal inmate's privacy from other inmates, while being accepted in the role by staff. Finally, in the Program Coordinator's judgement, they must be able to perform their duties with minimal need for direct supervision.

In addition, any inmate who is selected as a companion **must not:**

- Be in pre-trial status or a contractual boarder;
- Have been found to have committed a 100-level prohibited act within the last three years; or
- Be in FRP, GED, or Drug Ed Refuse status.

b. **Inmate Observer Shifts.** Observers ordinarily will work a four-hour shift. Except under unusual circumstances, observers will not work longer than one five-hour shift in any 24-hour period. Inmate observers will receive performance pay for time on watch.

c. **Training Inmate Observers.** Each observer will receive at least four hours of initial training before being assigned to a suicide watch observer shift. Each observer will also receive at least four hours of training semiannually. Each training session will review policy requirements and instruct the inmates on their duties and responsibilities during a suicide watch, including:

- the location of suicide watch areas;
- summoning staff during all shifts;
- recognizing behavioral signs of stress or agitation; and
- recording observations in the suicide watch log.

d. **Meetings with Program Coordinator.** Observers will meet at least quarterly with the Program Coordinator or designee

to review procedures, discuss issues, and supplement training. After inmates have served as observers, the Program Coordinator or designee will debrief them, individually or in groups, to discuss their experiences and make program changes, if necessary.

e. **Records.** The Program Coordinator will maintain a file containing:

- An agreement of understanding and expectations signed by each inmate observer;
- Documentation of attendance and topics discussed at training meetings;
- Lists of inmates available to serve as observers, which will be available to Correctional Services personnel during non-regular working hours; and
- Verification of pay for those who have performed watches.

f. **Supervision of Inmate Observer During a Suicide Watch.** Although observers will be selected on the basis of their emotional stability, maturity, and responsibility, they still require some level of staff supervision while performing a suicide watch.

- This supervision will be provided by staff who are in the immediate area of the suicide watch room or who have continuous video observation of the inmate observer.
- In all cases, when an inmate observer alerts staff to an emergency situation, staff must immediately respond to the suicide watch room and take necessary action to prevent the inmate on watch from incurring debilitating injury or death. In no case will an inmate observer be assigned to a watch without adequate provisions for staff supervision or without the ability to obtain immediate staff assistance.

THE DECISION TO USE INMATE OBSERVERS MUST BE PREDICATED ON THE FACT THAT IT TAKES ONLY THREE TO FOUR MINUTES FOR MANY SUICIDE DEATHS TO OCCUR

- Supervision must consist of at least 60-minute checks conducted in-person. Staff will initial the chronological log upon conducting checks.

g. **Removal.** The Program Coordinator or designee may remove any observer from the program at his/her discretion. Removal of an inmate observer should be documented in the records kept by the Program Coordinator.

14. **TRANSFER OF INMATES TO OTHER INSTITUTIONS.** The Program Coordinator will be responsible for making emergency referrals of suicidal inmates to the appropriate medical center. No inmate who is determined to be imminently suicidal will be transferred to another institution, except to a medical center on an emergency basis.

a. **Medical Center Referral.** Inmates who do not respond to treatment interventions and remain imminently suicidal require emergency hospitalization. Although a psychiatric referral may be indicated at any time, ordinarily the inmate shall be referred to a MRC after he or she has been on continuous watch for 72 hours. If the watch exceeds 72 continuous hours, the Program Coordinator must:

- Contact the Regional Psychology Administrator to discuss the case and determine if an emergency transfer is appropriate.
- If the decision is not to transfer the inmate to a MRC, the rationale for not initiating a request for emergency transfer must be documented in the PDS.

b. **Psychology Services at MRCs.** Psychology Services at each MRC will provide an appropriate intervention program for inmates who have been admitted for suicidal behavior. The program will include:

- assessment,
- therapeutic interventions, and
- discharge planning.

The discharge planning may include a request to designate an institution for the inmate that can provide the custody

and level of psychological service needed to prevent re-hospitalization.

c. Consultations. As part of the referral consideration process, it may be beneficial to consult with other mental health resources, MRC staff, or the Regional Psychology Services Administrator.

- To ensure maximum communication and tracking of suicidal inmates, the Program Coordinator will notify his or her Regional Psychology Administrator when a suicide watch is begun or terminated and when a suicide watch exceeds 72 hours.
- The Program Coordinator or designee will document the referral considerations and all actions taken in the inmate's PDS record.

d. **SENTRY "Psych Alert" Assignments.** It is critically important that other institutions are notified when they are to receive inmates with recent suicidal indications and are at risk for self-harm.

- The Program Coordinator must ensure that a suicidal inmate being transferred to a MRC is given the SENTRY "Psych Alert" assignment to signal all staff that serious psychological management problems and "continuity of care" issues are present.

15. **ANALYSIS OF SUICIDES.** If an inmate suicide does occur, the Program Coordinator will immediately notify the Regional Administrator, Psychology Services.

The suicide scene will be treated in a manner consistent with an inmate death investigation. All measures necessary to preserve and document the evidence needed to support subsequent investigations will be maintained or otherwise recorded adequately.

- In the event of a suicide, institution staff, particularly Correctional Services staff, and other law enforcement personnel, will handle the site with the same level of protection as any crime scene in which a death has occurred.

- All possible evidence and documentation will be preserved to provide data and support for subsequent investigators doing a psychological reconstruction.

Ordinarily, the Regional Director will authorize an after-action review of the suicide to be completed by a psychologist from another institution or administrative office. Psychologists who have previously been involved in treatment of the inmate or in peer consultation in the case shall not participate in the suicide reconstruction. The report will address all the areas listed in the "Guide for the Psychological Reconstruction of an Inmate Suicide" (Attachment A).

The Regional Psychology Administrator will also review the Mortality Review Report prepared by Health Services for additional information and to explain any discrepancies with the Psychological Reconstruction Report.

a. **Central Office Review.** The Regional Director will forward copies of the Psychological Reconstruction Report to:

- the Assistant Director, Correctional Programs Division;
- the Assistant Director, Health Services Division; and
- the Senior Deputy Assistant Director, Program Review Division.

b. **Special Review Committee.** The PRD Senior Deputy Assistant Director will submit the report to the Special Review Committee. The Special Review Committee will review the report and assess whether recommendations for corrective action will be addressed at the national or local institution level.

- The PRD Senior Deputy Assistant Director will be responsible for tracking corrective actions and verifying the corrective action is accomplished.

16. **CODE OF FEDERAL REGULATIONS.** Federal Regulations appear in bracketed bold text, as reproduced from volume 28 of the Code of Federal Regulations, Chapter 5. The federal regulations that bind Bureau staff to specific program practices are primarily intended to describe Bureau programs and inmate rights, privileges, or responsibilities to inmates and members of the public.

[§ 552.40 Purpose and scope.

The Bureau of Prisons (Bureau) operates a suicide prevention program to assist staff in identifying and managing potentially suicidal inmates. When staff identify an inmate as being at risk for suicide, staff will place the inmate on suicide watch. Based upon clinical findings, staff will either terminate the suicide watch when the inmate is no longer at imminent risk for suicide or arrange for the inmate's transfer to a medical referral center or contract health care facility.

§ 552.41 Program procedures.

(a) Program Coordinator. Each institution must have a Program Coordinator for the institution's suicide prevention program.

(b) Training. The Program Coordinator is responsible for ensuring that appropriate training is available to staff and to inmates selected as inmate observers.

(c) Identification of at risk inmates.

(1) Medical staff are to screen a newly admitted inmate for signs that the inmate is at risk for suicide. Ordinarily, this screening is to take place within twenty-four hours of the inmate's admission to the institution.

(2) Staff (whether medical or non-medical) may make an identification at any time based upon the inmate's observed behavior.

(d) Referral. Staff who identify an inmate to be at risk for suicide will have the inmate placed on suicide watch.

(e) Assessment. A psychologist will clinically assess each inmate placed on suicide watch.

(f) Intervention. Upon completion of the clinical assessment, the Program Coordinator or designee will determine the appropriate intervention that best meets the needs of the inmate.

§ 552.42 Suicide watch conditions.

(a) Housing. Each institution must have one or more rooms designated specifically for housing an inmate on suicide watch. The designated room must allow staff to maintain adequate control
of the inmate without compromising the ability to observe and protect the inmate.

(b) Observation.

(1) Staff or trained inmate observers operating in scheduled shifts are responsible for keeping the inmate under constant observation.

(2) Only the Warden may authorize the use of inmate observers.

(3) Inmate observers are considered to be on an institution work assignment when they are on their scheduled shift.

(c) Suicide watch log. Observers are to document significant observed behavior in a log book.

(d) Termination. Based upon clinical findings, the Program Coordinator or designee will:

(1) Remove the inmate from suicide watch when the inmate is no longer at imminent risk for suicide, or

(2) Arrange for the inmate's transfer to a medical referral center or contract health care facility.]

Attachment A

GUIDE FOR THE PSYCHOLOGICAL RECONSTRUCTION OF AN INMATE SUICIDE

Name:_____ Prepared by:_____
Reg. No:_____ Date:_____
Date of Birth:_____ Date of Death:_____

I. **Background Information**

Education
- Marital/Family Status
- Religious Preference/Involvement
- Race/Ethnic Background
- Offense
- Sentence/Time Served
- Occupational/Military History
- Release Plans

II. **Health Care and Personality Description**

- Physical Status-Functioning
  - Previous/Current
- Social Status-Functioning
  - Previous/Current
- Psychological Status-Functioning
  - Previous/Current
- Suicidal History
- Medication History
- Mental Health History
  - Diagnosis/Treatment
- Abuse History
  - Drug/Alcohol
- Assaultive History
- Institutional Infractions

III. **Antecedent Circumstances**

- Identifiable Stressors
- Staff Opinions
- Inmate Opinions
- Last Person to Have Contact
- Last Staff Contact

IV. **Full Description of Suicide Act and Scene (to include diagrams were appropriate)**

Date/Time of incident
Location
Method
Predictors of Suicidal Actions
Suicide Note
Other Relevant Information

V. **Conclusions/Recommendations**
VI. **List of Documents Examined**
VII. **List of Staff and Inmates Interviewed**

Attachment B

"SAMPLE"

SUICIDE PREVENTION INFORMATION

SPECIAL HOUSING UNIT ADDENDUM TO POST ORDERS

BOP HIGH RISK GROUPS

- **New Inmates** - The first few hours and days after admission can be critical. Newly incarcerated inmates may experience feelings such as shame, guilt, fear, sadness, anger, agitation, depression, relationship problems, legal concerns, hopelessness, and helplessness, which can contribute to increased suicide risk.
- **Protective Custody** - Inmates who volunteer to enter protective custody are at high risk for suicide, especially during the first 72 hours in SHU. These inmates should be referred to psychology services immediately.
- **Long-term Protective Custody Inmates** - These inmates are particularly vulnerable to depression that can lead to a suicide attempt, and should be monitored closely while they are in SHU.
- **Inmates Taking Medication for Mental Health Reasons** - These inmates are vulnerable to developing suicidal thoughts and attempting suicide by overdosing on their medication. Inmates on medication should be monitored to make sure they are not hoarding medication. Any signs of distress, deterioration in hygiene, or sudden changes in behavior should be reported to psychology.

FACTORS THAT CAN INCREASE THE PROBABILITY THAT AN INMATE MAY BECOME SUICIDAL:

- **Mental Health Factors**

  History of mental illness

  1. Is the inmate depressed, actively psychotic?
  2. Has the inmate been compliant with psychotropic medication?
  3. Have there been changes in eating, sleeping, hygiene, weight, recreation, activity level?

  Prior suicide attempt

  1. How lethal was the attempt?
  2. How many attempts have been made?

Inmate's current mood, affect, and behavior

1. Is the inmate emotionally upset, angry, easily agitated?
2. Are the inmate's thoughts clear and goal directed (vs. delusional or psychotic in nature)?
3. Is the inmate depressed, has there been a recent loss?
4. Has hopelessness persisted even after the depression has lifted?
5. Has the inmate given away property, revised a will, requested a phone call to say his goodbyes?

- **Medical Condition(s)/Chronic Pain**
  1. Does the inmate have a chronic life threatening medical illness?
  2. Has the inmate's overall health diminished recently?
  3. Is the inmate experiencing pain or other negative symptoms?
- **Relationship Difficulties**
  1. Has the inmate received a Dear John letter?
  2. Have communications and or visits decreased?
  3. Has there been a change in the relationship?
- **Situational Factors**
  1. Legal issues - pending indictment; loss of appeal to reduce sentence.
  2. Difficulties with staff or other inmates.
  3. Gambling debts, drugs.
  4. Ending of a close relationship with another inmate.
  5. Possible victim of a sexual assault.

REPORTING AND DOCUMENTING INMATE BEHAVIOR

- **Report Your Concerns** - Any inmate behavior(s) that is questionable and may reflect a change in mental health status should be reported to the Shift Lieutenant immediately.
- **During non-working hours** - Inform the Shift Lieutenant of any questionable inmate behavior. He/she will determine if the on-call psychologist needs to be contacted.
- **Segregation Log Book** - Any changes in inmate behaviors should be noted in the log book. A detailed note regarding the observed behavior is advisable. Documenting in the log

book serves two purposes. First, the entry serves as a means of communication for other staff members. Second, it provides an accurate account of activity during your shift. Documentation should be neat, legible, and professional.

RESPONDING TO A SUICIDE EMERGENCY

- A Segregation Officer observing an inmate in the act of committing suicide, causing other self-injurious behavior, or who appears to have committed suicide will call for back- up before entering the cell. The officer will notify the Control Center and the Lieutenant's Office by radio of the situation and request immediate back-up. BACK-UP MUST BE PRESENT IN ORDER TO ENTER A CELL.
- The "cut-down" tool is located in the storage closet on a shadow board. It is the #1 officer's responsibility to locate this item at the start of the shift. This tool is only authorized to be used in emergency situations. Miscellaneous use of this tool is not permitted and will result in dulling the blade of the tool.
- In the event an inmate commits suicide, the scene of the suicide will be treated in a manner consistent with the investigation of an inmate death. All measures necessary to preserve and document the evidence needed to support subsequent investigations will be maintained or otherwise adequately recorded.

Attachment C

"SAMPLE"

MEMORANDUM DOCUMENTING MOCK SUICIDE EMERGENCY TRAINING

DATE: **4/5/2007**
TO: **Name, Associate Warden**
FROM: **Name, Operations Lieutenant**
Subject: **Mock Suicide Emergency Training**

This memorandum documents a mock suicide emergency training exercise. This training exercise occurred in the Special Housing Unit on Morning Watch on today's date at 5:30 a.m.

Staff present were:
Name, Psychologist
Name, Operations Lieutenant
Name, Correctional Officer
Name, Correctional Officer
Name, Correctional Officer

The mock suicide emergency involved a hanging in a SHU cell. Staff responded quickly in notifying the Operations Lieutenant and Control. The Cut Down tool, AED, appropriate keys to allow access to the cell, and sufficient staff to open the cell door were assembled quickly (within XX minutes).

Staff discussed the exercise and response for training purposes.

(IN CASES WHERE RECOMMENDATIONS ARE MADE, TEXT CAN BE ADDED TO DESCRIBE THE RECOMMENDATION AND CORRECTIVE ACTION TAKEN, e.g.)
Staff suggested the key to the security cage housing the Cut Down tool be placed on the Operations Lieutenant's and Compound Officer's key rings. A security work order has been initiated to do this.

cc: Psychology Services, Suicide Prevention Training File

APPENDIX B CAMS SUICIDE STATUS FORM–4 (SSF-4) INITIAL SESSION

Patient:_____ Clinician:_____ Date:_____ Time: _____

Section A

Rate and fill out each item according to how you feel right now. Then rank in order of importance 1 to 5 (1 = most important to 5 = least important)

Rank		
_____	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain: 1 2 3 4 5 :High pain** What I find most painful is: _____	
_____	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress: 1 2 3 4 5 :High stress** What I find most stressful is: _____	
_____	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low agitation: 1 2 3 4 5 :High agitation** I most need to take action when: _____	
_____	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness: 1 2 3 4 5 :High hopelessness** I am most hopeless about: _____	
_____	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate: 1 2 3 4 5 :High self-hate** What I hate most about myself is: _____	
N/A	6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will *not* kill self) 1 2 3 4 5 :Extremely high risk (will kill self)**

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all: 1 2 3 4 5 : completely**

2) How much is being suicidal related to thoughts and feeling about others? **Not at all: 1 2 3 4 5 : completely**

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: _____

Section B

Y N Suicide ideation Describe: _____

- Frequency _____per day _____per week _____per month
- Duration _____seconds _____minutes _____hours

Y N Suicide plan When: _____

Where: _____

How: _____Access to means Y N How:

_____Access to means Y N

Y N Suicide preparation Describe: _____

Y N Suicide rehearsal Describe: _____

Y N History of suicidal behaviors

- Single attempt Describe: _____
- Multiple attempts Describe: _____

Y N Impulsivity Describe: _____

Y N Substance abuse Describe: _____

Y N Significant loss Describe: _____

Y N Relationship problems Describe: _____

Y N Burden to others Describe: _____

Y N Health/pain problems Describe: _____

Y N Sleep problems Describe: _____

Y N Legal/financial issues Describe: _____

Y N Shame Describe: _____

Section C **TREATMENT PLAN**

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization Plan Completed* ☐	
2				
3				

YES_____NO_____Patient understands and concurs with treatment plan?

YES_____NO_____Patient at imminent danger of suicide (hospitalization indicated)?

_____ _____

Patient Signature Date Clinician Signature Date

CAMS STABILIZATION PLAN

Ways to reduce access to lethal means:

1. _____

2. _____

3. _____

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):

1. _____

2. _____

3. _____

4. _____

5. _____

6. **Life or death emergency contact number:** _____

People I can call for help or to decrease my isolation:

1. _____

2. _____

3. _____

Attending treatment as scheduled:

Potential barrier: Solutions I will try:

1. _____

2. _____

Section D (*Clinician Postsession*

MENTAL STATUS EXAM (Circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS
OTHER: _____

ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATEDDYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE

THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
OTHER: _____

THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
OTHER: _____

ABSTRACTION: WNL NOTABLY CONCRETE
OTHER: _____

SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
OTHER: _____

MEMORY: GROSSLY INTACT
OTHER: _____

REALITY TESTING: WNL
OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

_____
_____
_____

PATIENT'S OVERALL SUICIDE RISK LEVEL (Check one and explain):

☐ **LOW (WTL/RFL)**
☐ **MODERATE (AMB)**
☐ **HIGH (WTD/RFD)**

Explanation: _____
_____
_____

CASE NOTES:

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Next Appointment Scheduled: _____ Treatment Modality: _____

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Clinician Signature Date

CAMS SUICIDE STATUS FORM–4 (SSF-4) TRACKING/UPDATE INTERIM SESSION

Patient:_____ Clinician:_____ Date:_____ Time: _____

Section A

Rate and fill out each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):							
	Low pain:	**1**	**2**	**3**	**4**	**5**	**:High pain**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):							
	Low stress:	**1**	**2**	**3**	**4**	**5**	**:High stress**
3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):							
	Low agitation:	**1**	**2**	**3**	**4**	**5**	**:High agitation**
4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):							
	Low hopelessness:	**1**	**2**	**3**	**4**	**5**	**:High hopelessness**
5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):							
	Low self-hate:	**1**	**2**	**3**	**4**	**5**	**:High self-hate**
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will *not* kill self)**	**1**	**2**	**3**	**4**	**5**	**:Extremely high risk (will kill self)**

In the past week:

Suicidal Thoughts/Feelings Y___ N_ Managed Thoughts/Feelings Y___ N_ Suicidal Behavior Y N

Section B

Resolution of suicidality, if: current overall risk of suicide < 3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings ☐ 1st session ☐ 2nd session

Complete **SSF Outcome Form at 3rd consecutive resolution session**

Patient Status:

TREATMENT PLAN UPDATE

☐ Discontinued treatment ☐ No show ☐ Cancelled ☐ Hospitalization ☐ Referred/Other: _____

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization Plan Completed* ☐	
2				
3				

_____ _____

Patient Signature Date Clinician Signature Date

Section C (*Clinician Postsession*

MENTAL STATUS EXAM (Circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS
OTHER: _____

ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE

THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
OTHER: _____

THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
OTHER: _____

ABSTRACTION: WNL NOTABLY CONCRETE
OTHER: _____

SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
OTHER: _____

MEMORY: GROSSLY INTACT
OTHER: _____

REALITY TESTING: WNL
OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

_____
_____
_____

PATIENT'S OVERALL SUICIDE RISK LEVEL (Check one and explain):

☐ **MILD (WTL/RFL)** **Explanation:**
☐ **MODERATE (AMB)** _____
☐ **HIGH (WTD/RFD)** _____
_____

CASE NOTES:

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_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____

Clinician Signature Date

CAMS SUICIDE STATUS FORM–4 (SSF-4) OUTCOME/DISPOSITION FINAL SESSION

Patient:_____ Clinician:_____ Date:_____ Time: _____

Section A

Rate and fill out each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):							
	Low pain:	**1**	**2**	**3**	**4**	**5**	**:High pain**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):							
	Low stress:	**1**	**2**	**3**	**4**	**5**	**:High stress**
3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):							
	Low agitation:	**1**	**2**	**3**	**4**	**5**	**:High agitation**
4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):							
	Low hopelessness:	**1**	**2**	**3**	**4**	**5**	**:High hopelessness**
5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):							
	Low self-hate:	**1**	**2**	**3**	**4**	**5**	**:High self-hate**
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will *not* kill self)**	**1**	**2**	**3**	**4**	**5**	**:Extremely high risk (will kill self)**

In the past week:

Suicidal Thoughts/Feelings Y___ N_ Managed Thoughts/Feelings Y___ N_ Suicidal Behavior Y N

Where there any aspects of your treatment that were particularly helpful to you? If so, please describe these. Be as specific as possible.

What have you learned from your clinical care that could help you if you became suicidal in the future?

Section B

Third consecutive session of resolved suicidality: ___Yes ___No (If no, continue CAMS tracking)

**Resolution of suicidality, if for third consecutive week: current overall risk of suicide < 3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings

OUTCOME/DISPOSITION (Check all that apply):

___ Continuing outpatient psychotherapy ___Inpatient hospitalization

___ Mutual termination ___Patient chooses to discontinue treatment (unilaterally)

___ Referral to: _____

___ Other. Describe: _____

Next Appointment Scheduled (if applicable): _____

_____ _____

Patient Signature Date Clinician Signature Date

**Section C (*Clinician Postsession*

MENTAL STATUS EXAM (Circle appropriate items):

ALERTNESS:	ALERT DROWSY LETHARGIC STUPOROUS
	OTHER: _____
ORIENTED TO:	PERSON PLACE TIME REASON FOR EVALUATION
MOOD:	EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT:	FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY:	CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
	OTHER: _____
THOUGHT CONTENT:	WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
	OTHER: _____
ABSTRACTION:	WNL NOTABLY CONCRETE
	OTHER: _____
SPEECH:	WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
	OTHER: _____
MEMORY:	GROSSLY INTACT
	OTHER: _____
REALITY TESTING:	WNL
	OTHER: _____
NOTABLE BEHAVIORAL OBSERVATIONS:	_____

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

_____

_____

_____

PATIENT'S OVERALL SUICIDE RISK LEVEL (Check one and explain):

☐ **LOW (WTL/RFL)**
☐ **MODERATE (AMB)**
☐ **HIGH (WTD/RFD)**

Explanation:

_____

_____

_____

CASE NOTES:

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Clinician Signature Date