

John's Journey: ASQing and Responding to Suicide Risk

- Melissa Caldwell PhD CCHP-MH
- Josh Young LCPC CCHP

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Objectives

Learning Objective 1

Recognize the need for ongoing suicide screening throughout incarceration.

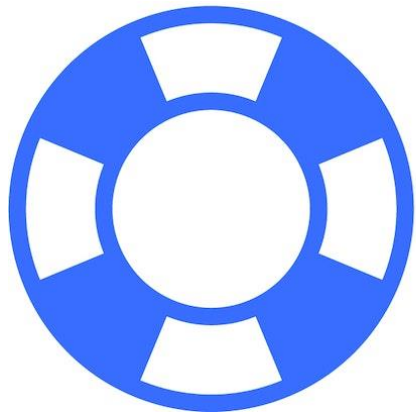
Learning Objective 2

Identify behavioral and mood changes that can indicate increased suicide risk.

Learning Objective 3

Explain the concept of a suicide step down.

Big Picture



**American
Foundation
for Suicide
Prevention**

P R O J E C T
2025
AFSP.ORG/PROJECT2025

**Nationwide initiative to reduce the
rate of suicide by 20% by 2025.**

Suicide Prevention Program Goals



Identify



Manage

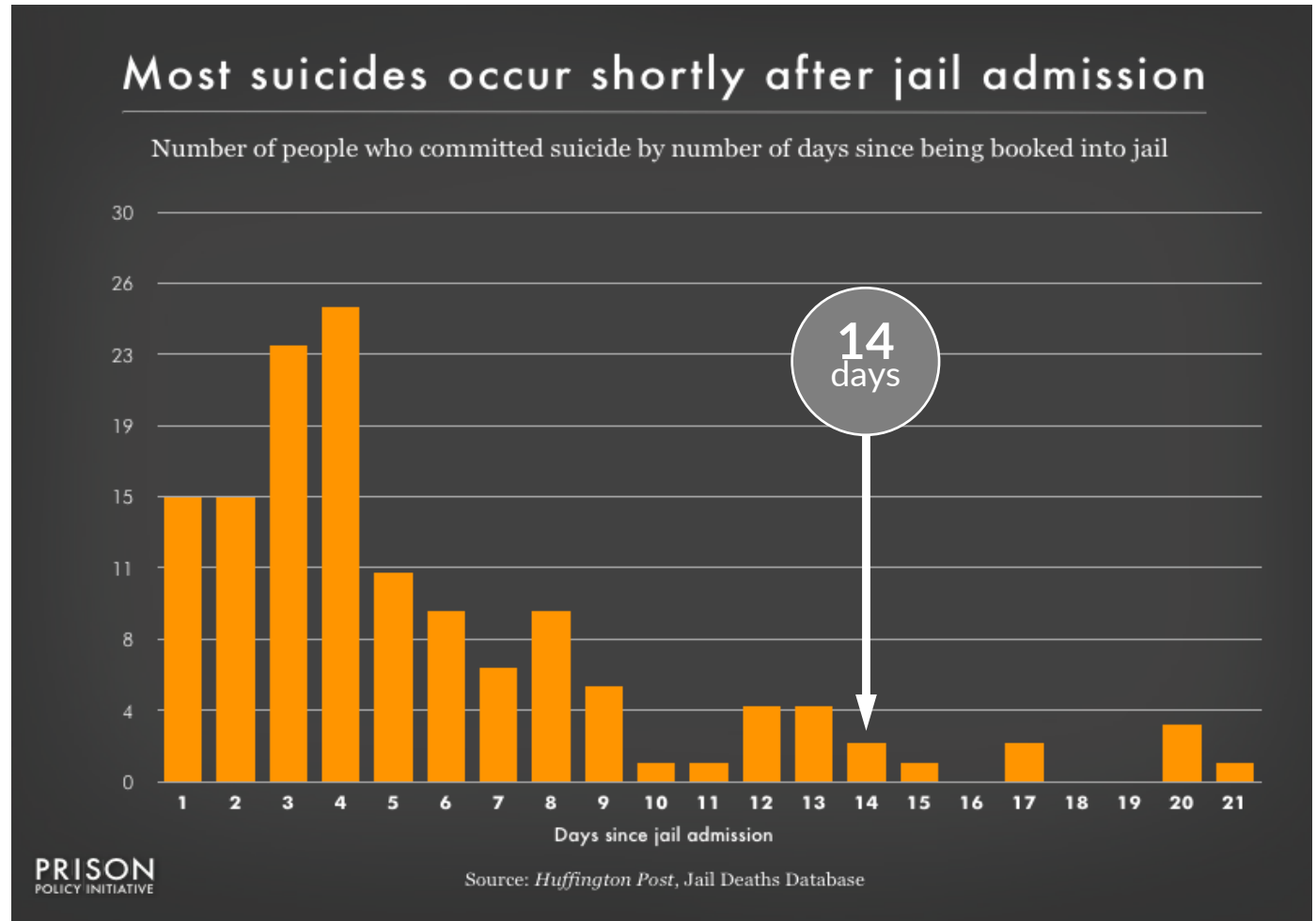


Stabilize

The WHY

First 10 Days

14 Day
Assessment:
First Healthcare
Contact



(Prison Policy Initiative, 2016)

In the News

Senate investigation finds DOJ undercounted nearly 1k deaths in jails or prison in 2021

Samantha Manning

Tue, September 20, 2022 at 4:31 PM · 4 min read

Suicides in U.S. jails, prisons rose sharply over two decades, federal data shows

BY JEFF MCDONALD, KELLY DAVIS

OCT. 7, 2021 7 AM PT



The goal is **NOT** to have zero detainees on suicide watch in correctional facilities.

PEARLS OF WISDOM



Assess for suicide risk on an ongoing basis



Take threats of self-harm seriously



Know and follow site-specific policies and procedures

Pearl of Wisdom



Assess for suicide risk on an ongoing basis


Meet John

John Smith

- Male, 32
- Charges: possession of drugs or drug use
- Repeat offender
- Limited support
- History of self-injury
- Denies current thoughts of self-harm

[illegible]

Use a Validated Screening Tool

 NIMH TOOLKIT: DETENTION FACILITIES
Suicide Risk Screening Tool

Ask Suicide-Screening Questions Date/Time: _____

Name: _____ / Screener: _____

Ask the patient:


1. In the past few weeks, have you wished you were dead? ☐ Yes ☐ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
3. In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
4. Have you ever tried to kill yourself? ☐ Yes ☐ No
If yes, how? _____

When? _____
5. Are you having thoughts of killing yourself right now? ☐ Yes ☐ No

Next steps:

- If patient answers “No” to all questions 1 through 5, screening is complete. No intervention is necessary.
(*Note: Clinical judgment can always override a negative screen.)
- If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**.
 - ☐ “Yes” to question #5 = **acute positive screen** (imminent risk identified).
 - Initiate Jail Suicide Prevention Policy. Place patient on suicide observation/watch.
 - Contact the practitioner or mental health clinician responsible for the patient’s care for further instruction.
 - ☐ “No” to question #5 = **non-acute positive screen** (potential risk identified).
 - Contact the practitioner or mental health clinician responsible for the patient’s care for further instruction.

The ASQ “Next Steps” have been adapted in consultation with detention facility mental health experts for use in detention facilities

asQ Suicide Risk Screening Toolkit NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)  3/12/2019

The ASQ

Ask Suicide-Screening Questions

- Research-supported screening
- Detention facilities
- Adult and juvenile
- Available in English and Spanish
- Five direct questions
- Takes just a few minutes to administer

Who can screen for suicide?

Anyone in contact with detainees

- QMHPs
- Practitioners
- Nurses
- Officers

What next?

asQ NIMH TOOLKIT: DETENTION FACILITIES
Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

What to do when a patient screens positive for suicide risk:

WORKSHEET page 1 of 3

Patient name: _____ DOB: _____
Interviewer name: _____ Assessment date/time: _____

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These can be hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient *Review patient's responses from the asQ*

Frequency of suicidal thoughts Determine if and how often the patient is having suicidal thoughts.

Ask the patient:

☐ Yes ☐ No "In the past few weeks, have you been thinking about killing yourself?"
If yes, ask: "How often?" _____ (once or twice a day, several times a day, a couple times a week, etc.) "When was the last time you had these thoughts?" _____
Find out if the thoughts are passive or active. Ask:
☐ Yes ☐ No "When you have these thoughts, do you truly want to die?"

☐ Yes ☐ No "Are you thinking of killing yourself right now?" (If "yes," patient is at imminent risk and initiate Suicide Prevention Policy. Place patient on suicide observation/watch.)


Suicide plan Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means).

Ask the patient:

☐ Yes ☐ No "Do you have a plan to kill yourself?"
If yes, ask: "What is your plan?" If no, ask: "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, razors, bedding, clothing, etc.).

The ASQ BSSA Worksheet has been adopted in consultation with detention facility mental health experts for use in detention facilities

 **NIH** National Institute of Mental Health **asQ Suicide Risk Screening Toolkit**

3/4/2021

The BSSA

Brief Suicide Safety Assessment

- Next step after the ASQ
- Data can be gathered by officers or other staff
- Disposition should be done by a QMHP
- Determines what precautions are needed

Use the ASQ
throughout incarceration,
not just at booking.

Use the ASQ after or during trigger events such as:

Arrival to Facility

Prior to Celling

During Booking

Withdrawal

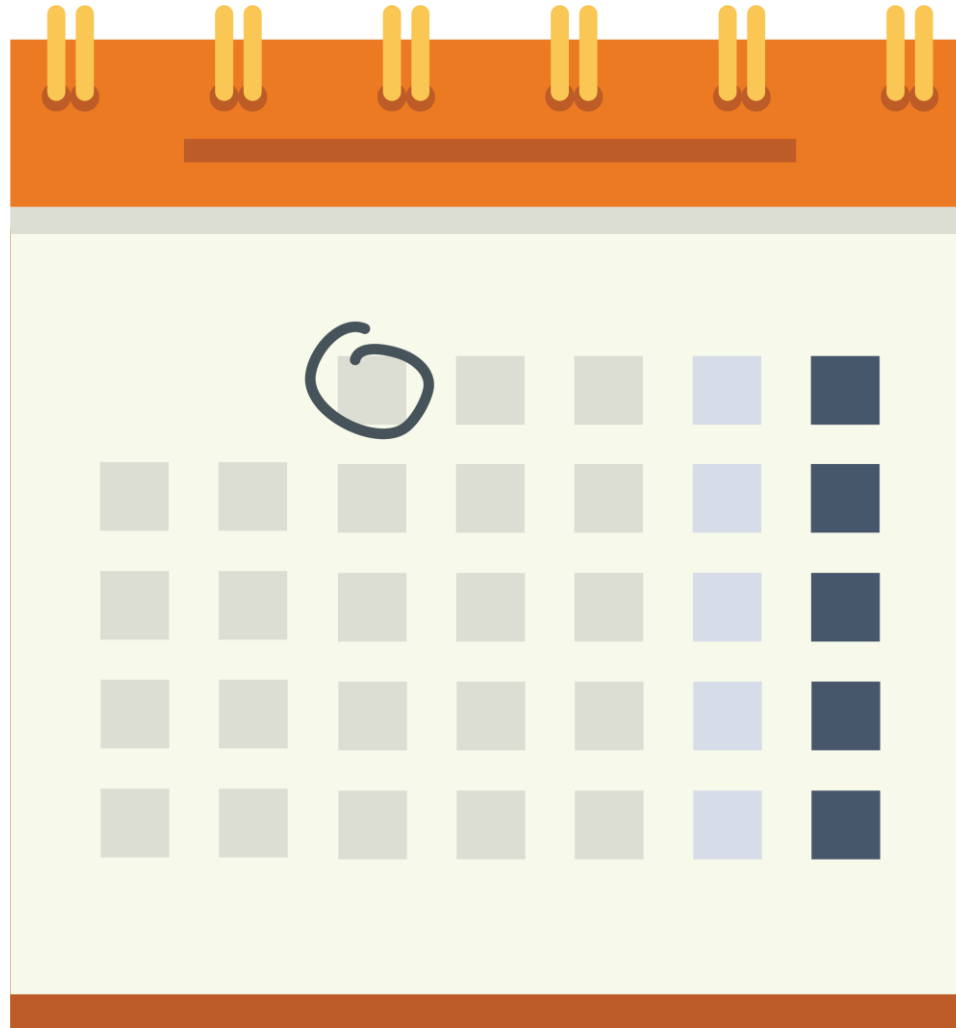
Court

Life Outside

Holidays and Special Events

Behavior Changes

**Train the
Trainer**



Let's follow John on his journey...

Consider fitness for confinement upon arrival...



John arrives to the facility high

Contact the practitioner for guidance.

Hospital clearance may be needed

John may be accepted into the facility with discharge paperwork.

Monitor John for alertness

Don't leave John alone – deciding to let John “sleep it off” is **not** a good strategy.

Consider fitness for confinement upon arrival...



When in doubt, send them out!

Suicidality is a common side effect
of intoxication and withdrawal...

ASQ about suicide!

Prior to celling...



Trigger Event!

- Increased suicide risk at admission
- Make sure that other detainees in the booking cell are not encouraging self-harm

ASQ about suicide!

John's booking...



Make Observations

- Hygiene
- Eye contact
- Body language
- Speech

Ask About

- Mental health history
- Medical history
- Substance use
- History of victimization

John's booking...



ASQ about suicide!

**Don't blindly trust self report.
Actions speak louder than words.**

Trust your gut
Your instinct is a
powerful tool.

John shows signs of withdrawal...



Medical Collaboration

- Team approach

Observe John Closely

- Consider appropriate precautions

Risk of suicide increases
during withdrawal.

ASQ about suicide!

John goes to court...



Trigger Event!

- Bond is set higher than expected
- Didn't get to speak
- No family support
- Domestic battery charge added
- No contact order

ASQ about suicide!

Meanwhile...



John's Inner Voice

- John lost his job while in jail
- He can't pay his bills
- His car has been impounded
- He can't communicate with his wife or kids
- He owes his dealer money
- He's concerned about his family's safety

John celebrates Thanksgiving alone...



Trigger Event!

- No visitors
- No mail
- Finds out his mom has cancer

Holidays and special events spent in custody can increase risk of suicide.

ASQ about suicide!

You begin to notice changes in John...

He stops talking about making up with his wife

His hygiene practices change for the worse

He refuses medication

He refuses to go to court

During midnight rounds, you see him sobbing in his cell

One day, John wakes up and seems like a completely different person.

He seems almost happy about the day.

You begin to notice changes in John...



Screen for suicide risk if you notice significant changes in behavior – positive or negative.

ASQ about suicide!

If You Didn't Chart It

Documentation...

- ✓ demonstrates what was done and why
- ✓ shows what we knew and how we utilized that knowledge
- ✓ illustrates that we did the best we could with the information we had at the time

REMEMBER



Assess for suicide risk on an ongoing basis



Take threats of self-harm seriously



Know and follow site-specific policies and procedures

Pearl of Wisdom



Take threats of self-harm seriously

Let's talk to John...



Be Professional

Show concern and professional compassion.

Ask Clarifying Questions

“What do you mean by that, John?”

“Are you thinking about hurting yourself?”

Offer Help

“John, I think you should talk to mental health. We are going to refer you.”

“We want to keep you safe, John.”

Take All Threats Seriously

John has a history of “faking it.”

- Suicide risk and manipulation **can** co-exist
- High risk behavior = high risk consequences
- Remain calm and do not ignore or dismiss threats of self-harm

John starts a fight...

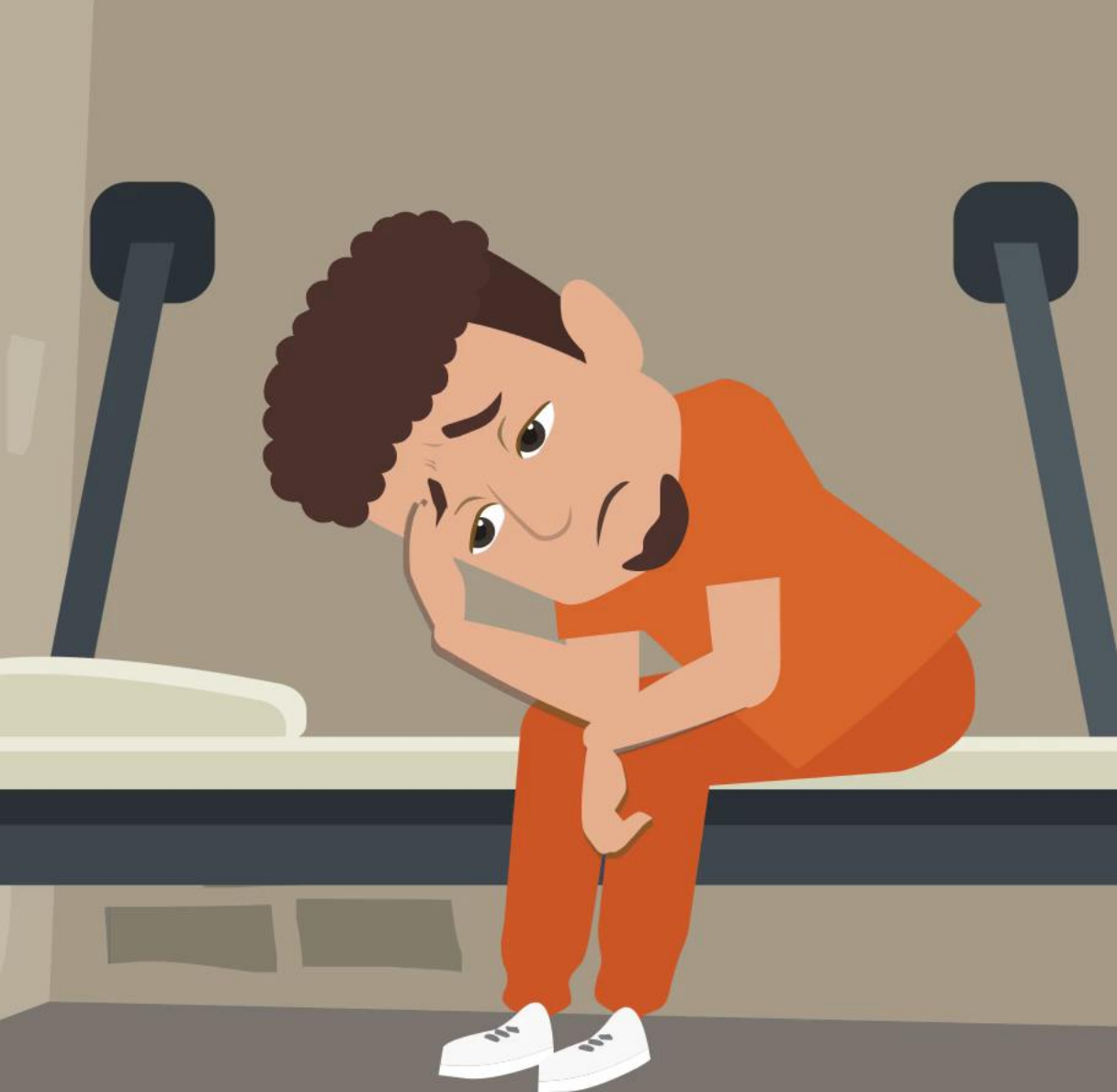


Trigger Event!

- Agitation is a warning sign of suicidality
- John is sent to segregation

ASQ about suicide!

John goes to segregation...



Trigger Event!

- Being in segregated housing does **NOT** guarantee safety
- John's suicide risk in segregation rises

20% of completed suicides happen in segregated housing.

John's risk in segregation rises...

- Isolation
- Less visibility and awareness of condition
- Increased risk for self-harm
- Potential for influence to self-harm by other detainees



REMEMBER



Assess for suicide risk on an ongoing basis

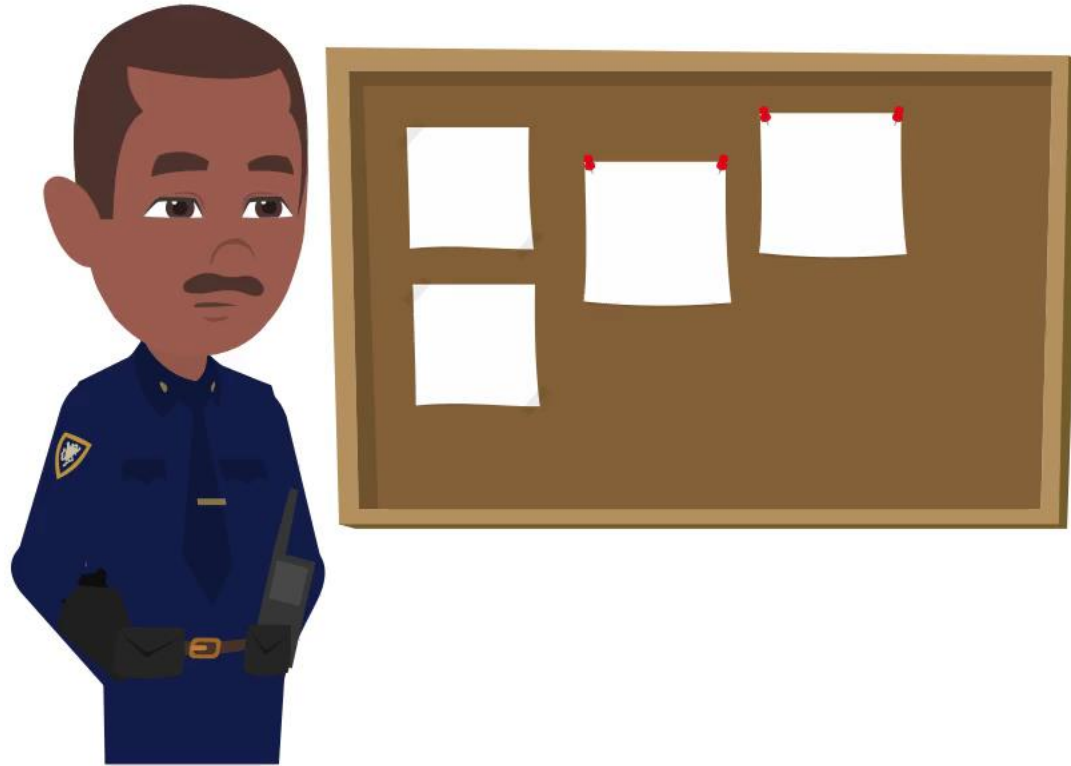


Take threats of self-harm seriously



Know and follow site-specific policies and procedures

Pearl of Wisdom



**Know and follow site-specific
policies and procedures**

John attempts suicide...



Facility emergency response policies and procedures should define next steps.

John is placed on suicide precautions.

**Know and follow
site-specific policies
and procedures.**

John attempts suicide...



- Team approach
- Rounds should be performed at varied time intervals
- Suicide-resistant smocks or blankets should be in good condition
- Routine cell inspections should be conducted to ensure no contraband

One Size Does NOT Fit All

- Consider precautions despite denial of suicidal ideation if behavior indicates otherwise
- Increase monitoring
- Modify property as indicated
- Recommend housing changes to custody staff
- Be prepared for unstable emotions/behavior

Better Safe Than Sorry

Does everyone need to be on suicide watch?

- No... BUT if you are unsure, ASQ about suicide and trust your gut
- Patients should be evaluated by qualified medical or mental health staff
- Officers don't need an order to start a suicide watch



Not all mental health crisis situations are the same

Ideal



VS.

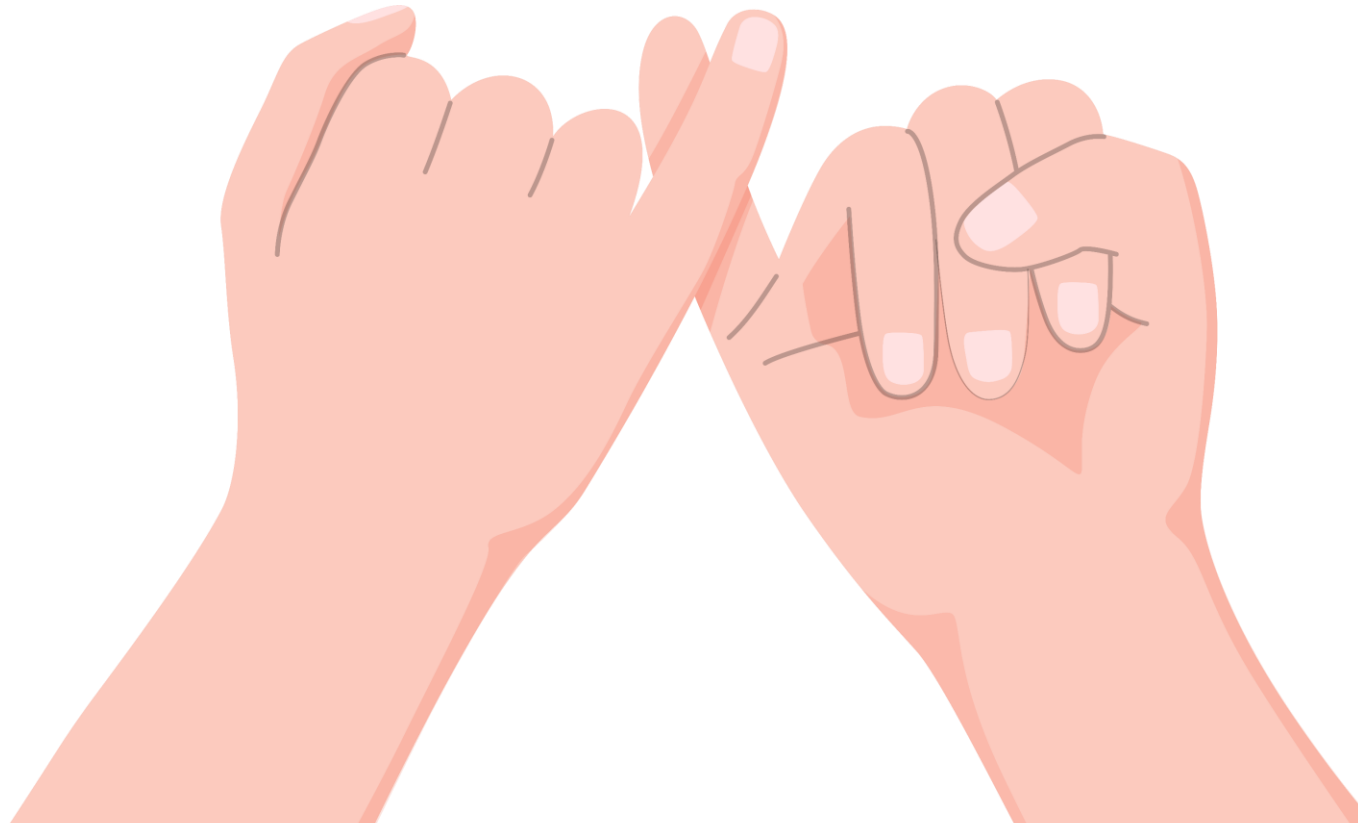
Most Difficult



These same differences apply to people who experience suicidal ideation.

Avoid Written and Verbal Contracts

- Safety contracts do **NOT** guarantee safety
- Consider suicide precautions pending evaluation



Work as a team...



- **Share** significant changes in mood or behavior – positive or negative
- **Communicate** when a patient is at risk for suicide
- **Discuss** concerns or differences in opinion about patient management
- **Collaborate** to create the safest environment for the patient

The Health Care Team's Role

Patient Monitoring

- Routine screening and assessments
- Clinical rounding
- Therapeutic and clinical interventions
- Trained to respond to medical emergencies
- Report to custody staff if they believe a patient is suicidal
- Only a QMHP or practitioner should reduce precautions or discontinue a suicide watch



Custody's Role

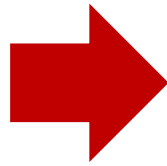
Safety and Security

- The “eyes and ears” of the facility
- Trained to respond to emergencies
- Communicate concerns with health care about a patient's actions or behavior, suspect risk of suicide, or the implementation of suicide precautions



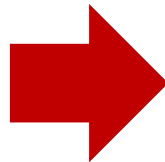
Discontinuing Suicide Watch

Suicide watch in
confinement for
too long



- Additional emotional damage
- Cruel and unusual punishment

Suicide watch
discontinued
too early



- Acutely suicidal = potential suicide attempt

Monitoring Considerations

- Decreased frequency of checks
- Food/water logging
- Behavioral logging

Considering Next Steps As a Team

Discontinuing Watch

Special housing recommendation



Create behavior modification plan



Follow-up with mental health



Continuing Watch

Consider step-down



Communicate concerns



Higher level of care needed



John is released...



But he was still on suicide watch in the jail.

- Try to connect John with community resources if possible
- Treat John as if he is a suicidal, free citizen
- Consider what processes are available in your community to help manage suicide, such as hospitals or community crisis workers

Discharge Planning

**Our responsibility
doesn't end at
the door.**

NCCHC Standard MH-E-10 Discharge Planning 2015



REMEMBER



Assess for suicide risk on an ongoing basis



Take threats of self-harm seriously



Know and follow site-specific policies and procedures



Dr. Melissa Caldwell, PhD, CCHP-MH

Melissa.Caldwell@freedom-bh.com



Thank you!

What questions can we answer?

References & Resources

Presentation developed by Spark Training, LLC

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