



# SUICIDE PREVENTION TASK FORCE REPORT

D.C. DEPARTMENT OF CORRECTIONS  
OFFICE OF HEALTH SERVICES  
ADMINISTRATION

OCTOBER 14, 2013

## **INTRODUCTION**

In light of recent suicides at the DC Jail, Department of Correction's Director Thomas Faust called for immediate action to enhance suicide prevention protocols, strategies and practices at the Department of Corrections' (DOC) Central Detention Facility (CDF) and Correctional Treatment Facility (CTF). The Office of Health Services Administration (OHSA) was charged with forming a Suicide Prevention Task Force to conduct an internal review of DOC's current policies and procedures governing medical and mental health screening practices. This charge was subsequently expanded to a review of custodial practices related to medical and mental health issues in DOC facilities. Task Force members include representatives from various D.C. government agencies, the Jail's current contracted health service provider, and other stake holder organizations. Experts recommended by the National Institute of Corrections (NIC) and the Federal Bureau of Prisons (FBOP) also provided consulting assistance.<sup>1</sup> The Task Force is co-chaired by DOC's Medical Director Beth Mynett, MD and Health Systems Administrator, Forrest Daniels, DSc. The group's first full meeting occurred on July 22, 2013. This report encompasses the meeting dialogue itself as well as occurrences and developments subsequent to the meeting.

## **PROBLEM OVERVIEW**

### **Suicide Statistics**

The meeting opened with a discussion of national suicide statistics in the general U.S. population and in the country's jails in order to place the DOC experience within a larger context. Making comparisons between the general U.S. population and jail data is a bit complicated and not entirely comparable due to differences in ways the data is tabulated.<sup>2</sup> Additionally, the DC Jail suicide rate is based solely upon CDF data, whereas Bureau of Justice Statistics (BJS) data reflects the entire correctional system population. For purposes of the Task Force, a DOC suicide rate will also be tabulated combining CTF, CDF and Half-way House data to present suicide rates that are more comparable to BJS data. These comparisons, while inexact, will help place the DC Jail data (CDF) in a larger context.

In calendar year 2013, there were three suicides per 8,769 intakes at the CDF (Figure 1). The 2013 D.C. Jail suicide rate is 35 deaths per 100,000 intakes (CDF only). In BJS terms, the 2013 CDF inmate suicide mortality rate is 175 deaths per 100,000 (Average Daily Population of 1,711) and, if looking at the entire DOC Average Daily Population of 2,300, is 130 deaths per 100,000 (Figure 2).

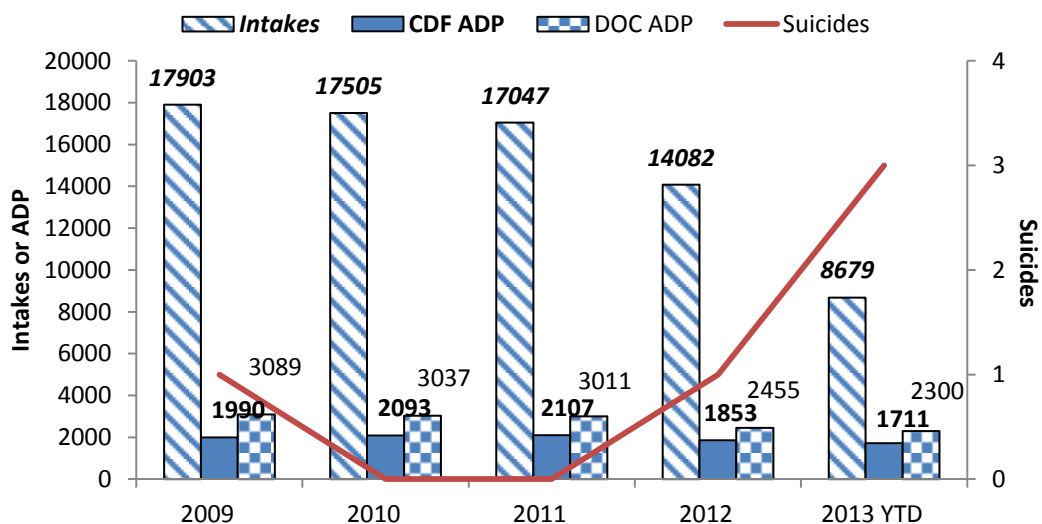
Analyzing the data over 5 years, the average D.C. jail suicide mortality rate based on CDF intakes is 7 deaths per 100,000 intakes and 51 deaths per 100,000 in ADP-based BJS terms; for the entire DOC system, the rate is 7 deaths per 100,000 intakes and 36 deaths per 100,000 ADP-based BJS terms (Figure 2).

<sup>1</sup>Please see Attachment A for full list of Task Force membership, agencies, individual attendees, and consultants.

<sup>2</sup>Suicide rates for the general U.S. population are based on the number of suicides per U.S. population size. The DC Jail calculates the suicide rate as the number of inmate suicides per total number of inmates seen in CDF that year. The Bureau of Jail Statistics (BJS) calculates the rate very differently by using a formula based on the number of inmate suicides per average daily population (a much lower denominator). BJS data also include the entire correctional system population into their rates. For DOC, this would typically include a denominator comprising CDF, plus CTF and Halfway Houses.

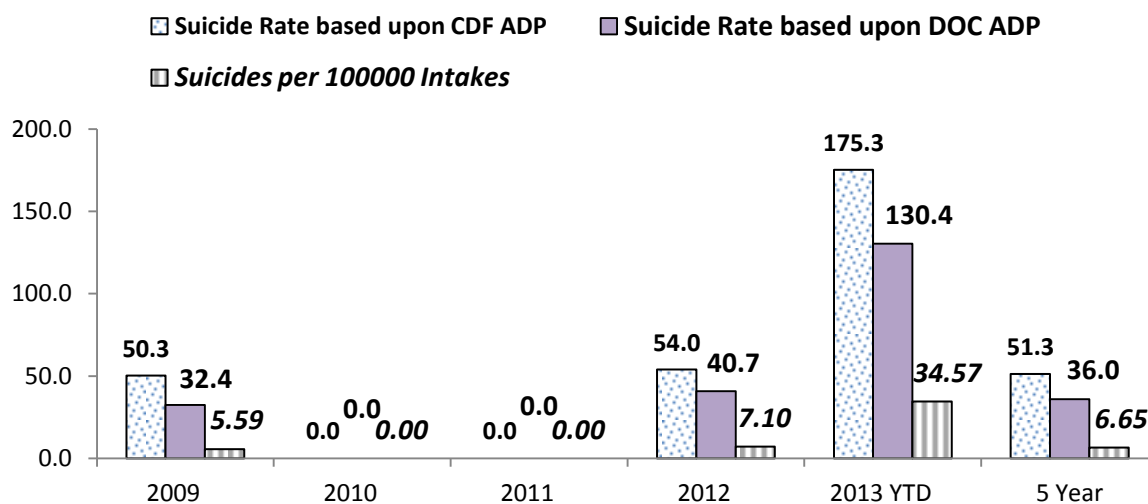
**FIGURE 1**

**NUMBER OF SUICIDES COMPARED TO AVERAGE DAILY POPULATION AND TOTAL INTAKES WITHIN THE D.C. DEPARTMENT OF CORRECTIONS (CDF ALONE COMPARED TO THE CENTRAL DETENTION FACILITY, CORRECTIONAL TREATMENT FACILITY AND HALFWAY HOUSES)**  
**JANUARY 2009 through AUGUST 2013**



**FIGURE 2**

**SUICIDE RATES BASED ON AVERAGE DAILY POPULATION AND TOTAL INTAKES WITHIN THE D.C. DEPARTMENT OF CORRECTIONS (CDF ALONE COMPARED TO THE CENTRAL DETENTION FACILITY, CORRECTIONAL TREATMENT FACILITY AND HALFWAY HOUSES)**  
**JANUARY 2009 through AUGUST 2013**



The 2013 YTD DC Jail suicide mortality rate was compared to the 2010 national suicide mortality rate for the general U.S. population (12.2 per 100,000) and to the latest 2013 BJS local jails suicide mortality rate of 41 deaths per 100,000 inmates<sup>1</sup>.

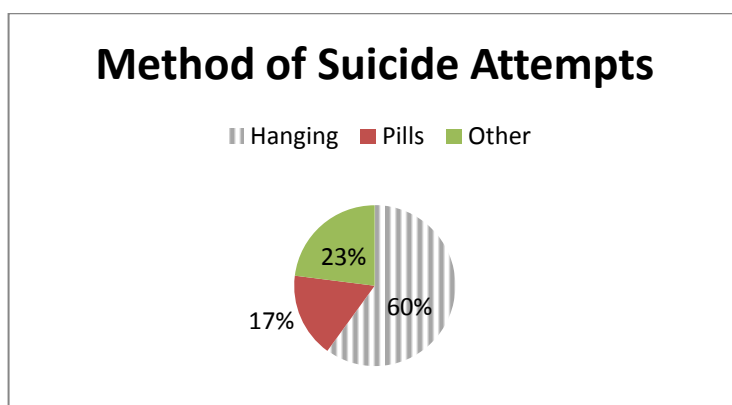
In summary, for YTD 2013, at 35 deaths per 100,000 intakes, the DC Jail intakes-based suicide mortality rate is approximately 3 times the rate of the general U.S. population (12.2) and the DOC ADP-based suicide mortality rate of 130 is more than 3 times the average BJS suicide rate of 41 suicides per 100,000.

Looking at cumulative data over 5 years, the DC Jail intake-based suicide rate of 7 is slightly more than half the suicide rate of the U.S. general population (12.2) and at 36, the DOC suicide rate is slightly less than the average jail-based suicide mortality rate of 41.

### **Suicide Attempts**

Data subsequently presented reflected the number of suicide attempts in the Central Detention Facility (CDF) and Correctional Treatment Facility (CTF). Suicide attempts are defined as “non-fatal self-inflicted destructive acts with explicit or deferred intent to die.” Since 2011, there have been approximately 165 suicide attempts with the two most prevalent methods being attempted hanging (99 incidents) and “allegedly taking pills” (28 incidents). Other methods included head banging, cutting, swallowing foreign objects, jumping from a height, and hunger strike (Figure 3).

**FIGURE 3**



Of the 49 suicide attempts by housing unit for FY 2013, most (35%) occurred in segregation unit North 1, followed by segregation unit South 1 (24%). A “*Critical Suicide Attempt*” (CSA) occurs when an inmate’s action results in an emergency medical or psychiatric hospitalization. Of the six CSAs, one occurred in court prior to transfer to DOC, one occurred during the first week of incarceration, two occurred 2-2.5 months from the date of incarceration, one occurred 5 months out from incarceration, and one occurred more than two years out from the date of incarceration. Clearly, suicide attempts can, and do, take place at any time during incarceration, and inmates in segregation units are at a higher risk.

### **CASES**

Medical and Custody staff reviewed three suicides dating from November 2012. A smaller group of the Task Force later reviewed the fourth suicide. These cases were all reviewed in considerable depth with respect to medical and mental health concerns as well as from a custody/security perspective. Additionally, the Task Force examined various medical, mental health and custody policies and procedures, the custody environment itself, articles recommended by independent consultants, and subsequently shared observations and potential solutions.

<sup>1</sup>Mortality in Local Jails and State Prisons, 2000-2011- Statistical Tables, Bureau of Justice Statistics, U.S. Department of Justice. August 2013.

## **IMMEDIATE IMPROVEMENT MEASURES INSTITUTED**

The Task Force identified key four areas for immediate improvement with respect to suicide prevention at DOC:

- 1) increasing the ability to identify high-risk inmates
- 2) creating more suicide-resistant jail practices
- 3) improving housing unit determination processes
- 4) strengthening DOC's culture of suicide prevention

The following measures have been instituted as responses to these concerns:

### ***IDENTIFYING HIGH-RISK INMATES:***

- Increasing communication to DOC from the Criminal Justice Community: DOC Leadership is working with the Criminal Justice Coordinating Council (CJCC) to improve timely delivery of critical legal and mental health information to DOC which may potentially impact inmates who are at high risk for suicide.
- Increasing communication to DOC from inmates, their communities and legal teams: DOC has developed a Suicide Prevention Awareness Campaign. Inmates, their communities, and legal teams are targeted audiences. A Multi-media campaign has begun to increase awareness of jail suicide risk. This entails asking inmates, families and legal teams to inform DOC if they have concerns about an inmate's risk while also encouraging them to advise DOC if they are going to deliver upsetting personal or legal news. Such information may prompt an immediate mental health referral and follow-up.
- Designated Intake Officer to identify high-risk inmates: A Booking Supervisor is now placed in Intake to review and monitor all high-risk inmates (high profile inmates, those with sexual assault charges, mental health histories) to determine if an expedited referral to a mental health clinician is warranted.
- Accelerating Psychiatric referral: The majority of inmates are seen within 24 hours for Psychiatric referral; even when inmate reports drug/alcohol intake. A small number (approximately 5%) are seen within 48 hours during weekends.
- Enhancing focus on mental health implications during pre-segregation clearance assessment: Special attention is being paid to potential mental health ramifications during the pre-segregation clearance exam. A suicide risk assessment is conducted for all inmates with mental health diagnoses who undergo a pre-segregation evaluation.
- Updating EMR: DOC has worked with the medical and mental health clinicians to upgrade forms and discharge summaries. Summary forms comprehensively summarize key current and past mental health and medical issues, "flags" or notifications of a family history significant for suicide as well as any previous suicide attempts while in custody. A more comprehensive suicide assessment content has been incorporated as recommended by one of the national consultants. These updates have enriched the mental health assessments and help better inform housing determinations.
- Referrals after Court Appearances: Inmates are now referred for mental health assessments after court when bad news or long sentences may have been given.

#### *REFINING SUICIDE –RESISTANT PRACTICES:*

- Decreasing razor access: A revised “Razor plan” has been instituted and no inmates have access to razors. Barbers now visit the housing units twice a week.
- Increasing frequency of housing unit security checks: Segregation and Intake unit checks now occur randomly every 15 minutes (down from 30 minutes).
- Decreasing easy medication access: No Keep-On-Person (KOP) privileges on segregated and intake units. Clinicians have been instructed to hand out less acetaminophen while KOP policy is under review.

#### *IMPROVING HOUSING UNIT ASSIGNMENTS:*

- Double-celling inmates: Consistent with national recommendations on suicide prevention, NO ONE is placed in a single cell unless there’s an overwhelmingly compelling reason to do so.
- Improving access to ‘Statement of Charges’ information: Custody has enhanced the timely transmission of charges information to mental health providers in order to inform clinicians of inmates with high-risk (high-profile, sexual assault) charges. Improved sharing of this information is enriching suicide risk assessments and better informing the medical/mental health team when weighing in on housing determination. This information-sharing practice will also help fully inform clinicians of an inmate’s suicidal risk as some inmates deny high risk charges, especially those involving sexual assault. Custody and Clinicians now more often keep in mind and anticipate the fluidity of mental health conditions and emotions in custody settings.
- Increasing admissions at Intake to Mental Health Unit (MHU): Inmates experiencing active mental health issues, and often with history of self-harm/substance abuse issues, are being placed on the MHU with greater frequency. The unit’s census has increased approximately 23% since this practice began in September 2013. For inmates fitting that description but displaying more behavioral issues, they may be placed in South 1’s safe cells<sup>1</sup>.

#### *INCREASING SUICIDE PREVENTION AWARENESS AMONG CUSTODY STAFF:*

- Increasing discussions of suicide prevention awareness at Roll Call and other regularly scheduled meetings: DOC Deputy Director and Warden have mandated that suicide prevention discussions be an integral component of regular roll call discussions with unit staff, Majors, and entire chain of command to help create a “Culture of Suicide Prevention Awareness” at all levels.
- Increasing suicide prevention awareness at Training Academy: A more robust 4 hour suicide prevention training curriculum and power point presentation has been developed. Use of this updated curriculum for the training of new Correctional Officers began in October 2013. All new DOC/health contractor employees will receive this training starting in January 2014.

<sup>1</sup>“Safe cells” are observation cells located on the Mental Health Unit, in the Medical Unit, the infirmary and South 1. They generally do not contain electrical switches or outlets, bunks with open bottoms, towel racks, desks and sinks, radiator vents or any other fixtures that could be used as an anchoring device for hanging. They sometimes have padded walls and are frequently monitored.

## **LONG-TERM SUICIDE PREVENTION STRATEGIES UNDERGOING CONSIDERATION**

While many suicide prevention policies and practices were immediately implemented by Custody and Medical/Mental Health to help decrease jail suicides, several long-term strategies to enhance the identification of at-risk inmates; make facilities more suicide-resistant, improve the Jail's Mental Health programming, and strengthen responses to Medical Emergencies are also currently being examined:

### **IDENTIFYING HIGH-RISK INMATES:**

- Enhance suicide prevention training of Medical/Mental Health clinicians: Current medical and mental staff may benefit from additional training on developing greater sensitivity to and awareness of the inmates' shifting emotional states and mental health conditions that places some at increased risk of suicide. Vulnerable inmates may present during Intake for pre-segregation clearance or during sick call. Current practices may need to move beyond current mental health screening and comprehensive assessments in order to develop an enhanced and more subtle appreciation for inmates truly at risk of suicide who are not recognized with current assessment measures.
  - National Institute of Corrections (NIC) consultant Mr. Lindsay Hayes discussed various suicide prevention issues with Unity Health Care (Unity) as part of his 3-day site visit. Unity medical staff participated in the clinically-based presentation given by Bureau of Prison's (BOP) Dr. Robert Nagle in September. Additionally, more comprehensive training recommendations have been provided to DOC by Mr. Hayes. Those recommendations have been shared with Unity. Additionally, Unity's Suicide Prevention consultant, psychiatrist Dr. Raymond Patterson, has been working with Unity staff on suicide prevention training (October 3, 2013). The Task Force will address the implementation of Custody and Mental Health training recommendations at its next meeting slated for late November, 2013.
- Enhance Medical/Mental Health clinicians and Custody training around "self-injurious behaviors": Self-Injurious behaviors can be defined as "direct behavior that causes minor to moderate physical injury, that is undertaken without conscious suicidal intent, and that occurs in the absence of psychoses and/or organic intellectual impairment." Enhanced training, communication and development of core competencies in identifying, assessing and treating self-injurious behaviors.
  - Plan: DOC has reached out to leading expert Dean Aufderheide, PhD to help DOC and Medical/Mental Health staff better understand and manage these challenging and resource-consuming cases. DOC is in the process of determining the feasibility of conducting a multi-disciplinary "Self-Injurious Behaviors" Training for Custody and mental health staff during 2014.
- Provide Crisis Intervention Training for Correctional Officers: Correctional Officers may benefit from the 40 hour Crisis Intervention Training currently offered by the Department of Behavioral Health (DBH) for police officers. This training was suggested by the Department of Behavioral Health's Dr. Ritchie, as way to identify inmates who are showing signs of mental illness, de-escalating various situations, and properly referring identified individuals to mental health support services. Dr. Ritchie notes it may be possible to tailor the training to C.O.s and scale down the time involved.
  - Plan: OHSA will glean further information from Dr. Ritchie at the next Task Force meeting slated for November, 2013.
- Examine the potential benefit of Clergy presence in Intake: Clergy presence at Intake for inmates may help inmates who might be at high-risk, but who aren't considered high-risk by Custody or Mental Health clinicians and don't self-identify as high-risk.
  - Plan: Task Force will take this issue up at the next meeting in November, 2013.

#### SUICIDE RESISTANT FACILITIES:

- Improve Safe Cells: Safe cells on South 3 need to be made safer by addressing wall padding and light fixture concerns.
  - Plan: DOC Facilities team is in the process of reviewing and making recommendations. Full assessment expected by December, 2013.
- Decrease suicide potential in general population cells: Dr. Ritchie and Dr. Raczynski from the D.C. Department of Behavioral Health visited CDF for a continued conversation regarding suicide prevention measures. Additionally, Dr. Ritchie led a cell inspection focused on the facilities aspect of suicide prevention. Major issues identified were:
  - 1) grates on ceilings,
  - 2) bed design,
  - 3) sheet, blanket and uniform thickness, and
  - 4) handles on desks/sinks/towel racks.

Recommendations included removing all handles from sinks and desks, placing fine mesh over grates, placing plastic or other material on entire head/feet ends of bunk beds, replacing woven metal bed bottoms with solid material, and future purchases of linens, blankets and uniforms that are more difficult to tie. All recommendations made to eliminate tie off points and prevent hangings.

- Plan: DOC's Facilities team has nearly completed a "suicide-resistant" cell prototype. The new bed design eliminates "tie-off" points, and towel handles have been eliminated from sinks and desks. DOC's Long-term plan is to retrofit the jail with suicide-resistant cells as budgetary considerations permit.

#### PROGRAMMATIC REFORM:

- Re-institute a Step-Down Mental Health Unit- Custody, Medical/Mental Health clinicians, and representatives from the DBH strongly suggest re-instituting the Step-Down Mental Health Unit. Given that approximately 40% of D.C. inmates suffer from mental health conditions, inmates on the MHU no longer suffering from acute exacerbations of their mental health conditions and exhibiting improved behavior could benefit from enhanced socialization and behavior modification through groups and other programs designed for the mentally ill. This would entail increased custody and mental health staffing. By one account alone, an additional 28 officers would be needed to staff such a unit.
  - Plan: Task Force will further discuss feasibility at the next meeting in November, 2013.
- Re-evaluate Keep-On-Person (KOP) Medication program-Custody and DBH representatives strongly suggest eliminating or restricting KOP policy, but Unity staff feel otherwise.
  - Plan: Further information about Best KOP Practices will be compiled by December, 2013.
- Enhance Psychological Autopsy: A psychological autopsy is a written reconstruction of an individual's life with an emphasis on factors that may have contributed to the death. Currently, psychological autopsies are performed by same staff that provide mental health care to inmate; therefore lacking objectivity. With the intent of making the review more robust and independent, DBH suggested a possible collaboration with DBH Forensic Fellows.
  - Plan: OHSA to discuss with DBH and Unity the requirements, feasibility and implementation of higher-level psychological autopsy.



## EMERGENCY MEDICAL RESPONSES:

- OHSA recently conducted a review of the emergency responses to the last four suicides. Based on chart notes, video surveillance, Suicide Prevention and Intervention Improvement team (SPIIT) meetings, debriefing discussions and conversations with EMS, several recommendations have emerged:
  - Consider moving from a Basic Life Support (BLS) emergency medical response to an Advanced Cardiac Life Support (ACLS) response: A prompt and comprehensive response to medical emergencies in the jail is of paramount importance for suicides and all other medical emergencies. EMS access to the jail is often difficult and time-consuming; a severe impediment when it's critical to quickly optimize all life-saving modalities. Switching to an ACLS response could provide critical cardiac medications and quicker IV/intraosseous access to potentially life-saving fluids.
    - Plan: DOC held a meeting with D.C. Fire & EMS Medical Director and Assistant Fire Chief, and Unity medical leadership to review merits/challenges of an ACLS-based emergency medical response at CDF/CTF. Unity to ACLS-certify key medical personnel by January, 2014.
  - Implement use of King Airway, Interosseous Gun, Quick Clot and TK tourniquets
    - Plan: Unity has ordered these medical devices and supplies that should further improve medical responses to traumas and will begin implementation in February, 2014.
  - New Automatic External Defibrillators (AEDs) at CDF/CTF: D.C. Fire & EMS (FEMS) strongly recommends upgraded/superior AEDs be used at CDF/CTF to enhance life-saving response. Current AEDs are also incompatible with FEMS AEDs. EMS recommends replacement of our AED leads with those compatible with EMS devices to obviate need for CDF/CTFAEDs to be removed when EMS arrives and takes over resuscitation.
    - Plan: OHSA has discussed next steps for upgraded AEDs with DOC procurement and Unity. One new AED has been purchased for the Central Cell Block clinic and OHSA is discussing with DOC leadership the budgetary feasibility of purchasing replacement equipment.
  - Correctional Officers (C.O.s) to contact 911 immediately if responding to medical emergency with CPR.
    - Plan: Custody and Training Academy to address 911 notification protocol with current C.O.s and recruits respectively to assure no delay in initiating potential life-saving CPR efforts.
  - Limit access to medical elevator only to Medical Emergency Response Team (MERT) responses: Medical elevators are often used for non-medical purposes and cages outside the elevator are frequently used to place and hold inmates. Limiting medical elevators to medical emergencies only will help decrease time for key medical responders to arrive at the scene with oxygen and stretchers in tow.
    - Plan: Custody and Medical are currently working with DOC Facilities to determine feasibility of this practice given concerns about needs to hold inmates.

## OTHER

- Train Clinicians on Risk Management Approach to chart documentation: DOC Legal and Risk Management staff suggested that clinicians may benefit from risk management tutorial on best practices regarding chart documentation.
  - Plan: Unity conducted a risk management documentation tutorial by their legal advisors (October, 2013).
- Decrease incentives for manipulators to be transported to United Medical Center (UMC): Decrease incentive for manipulative inmates to be transported out of DOC for suicide attempts or self-injurious behavior. Many inmates will make suicide threats that are solely manipulative in nature. These are most often done to combat boredom, seek movement from one housing unit to another or seek attention. Generally, lethality is minimal or missing, as is a true intention to end their life. Discussing ways that UMC can make hospitalization for suicide workup less comfortable or interesting will be beneficial (i.e., consider elimination of television privileges or offer simpler and blander meals).
  - Plan: Work with “self-injurious behavior” experts to help decrease impact of manipulators on DOC staff. Additionally, discuss room and food concerns with UMC staff (January 2014).

## SUMMARY

Suicide is the leading cause of mortality in U.S. jails. While the 5-year D.C. Jail intake-based suicide rate is approximately half the suicide rate of the U.S. general population and slightly less than the average jail-based suicide mortality rate recently released by the BJS, the Jail’s 2013 suicide rates were higher than both the general U.S. population rate and the BJS average jail-based suicide mortality rate. In order to help decrease suicides at the D.C. Jail, the D.C. Department of Corrections has proactively initiated an internal and external review to strengthen and improve suicide prevention policies and practices within the Central Detention Facility.

Under the direction of DOC Director Thomas Faust, the agency’s Office of Health Services Administration has assembled a Suicide Prevention Task Force committee with representatives from D.C. Department of Corrections, Unity Health Care (the Jail’s current contracted health service provider), the D.C. Department of Behavioral Health, and the Corrections Corporation of America. An expert advisor recommended by the National Institute of Corrections conducted a thorough 3-day on-site external review followed by a half-day presentation of the Federal Bureau of Prisons’ National Suicide Prevention Coordinator.

The Task Force has reviewed critical suicide cases from both medical/mental health and custody perspectives in addition to analyzing over two years of Suicide Attempts data looking for trends around length of incarceration, housing unit, and method of attempt. The Task Force has assessed clinical forms and processes designed to identify those at risk for suicide; reviewed training procedures; reviewed program statements; reviewed policies regarding access to razors and medications; questioned housing assignment practices; conducted cell inspections, and analyzed staffing plans as well as responses to medical emergencies. This thorough review process led to the immediate implementation of numerous strengthened suicide prevention policies and practices, and also to longer-term, inter-disciplinary recommendations to help further decrease the Jail’s suicide rate.

With its internal review completed, and the external assessment of the NIC-recommended advisor in hand, the Task Force looks forward to its next meeting in November, 2013. The Task Force will evaluate the effectiveness of currently implemented measures; consider the outstanding recommendations; and operationalize those long-term recommendations to help further refine and advance evidence-based suicide prevention policies at the D.C. Jail. Task Force will remain a component of the Department’s operations with meetings occurring on a quarterly or as needed basis.

**ATTACHMENT A: LIST OF TASK FORCE MEMBERS, ATTENDEES, UNOFFICIAL OBSERVERS, NIC TECHNICAL ASSISTANCE, AND CONTRIBUTING AGENCIES**

**TASK FORCE MEMBERSHIP**

**ATTENDEES:**

**DOC Representatives**

Beth Mynett, MD, Medical Director  
Forrest Daniels, DSc, OHSA Administrator  
Gregory Futch, Warden  
Joseph Pettiford, Deputy Warden  
Maria Amato, General Council  
Meghan Murphy, Assistant General Council  
Rodney Mitchell, Reentry Coordinator  
Wanda Patten, Chief, Office of Internal Affairs  
Michael Brown, Training Administrator  
Craig Swaisgood, Risk Manager  
Mairead Cannon, Staff Assistant

**Other Representatives**

Raymond Byrd, Warden, CCA/CTF  
Walter Fulton, Assistant Warden, CCA/CTF  
Diana Lapp, MD, Medical Director, Unity Health Care  
Bruce Reid, M.H. Director, Unity Health Care  
Vali Zabiheian, HSA, Unity Health Care  
Khalil Johnson, MD, Unity Health Care  
Karin Werner, V.P., Strategic Dev., Unity Health Care  
Elspeth Ritchie, MD, Chief Clinical Officer, DBH  
Lisa Bullock, MD, Director, CC/DBH

**UNOFFICIAL OBSERVERS**

Dr. Charlayne Hayling-Williams, Department of Youth Rehabilitation Services

**NATIONAL INSTITUTE OF CORRECTIONS (NIC) TECHNICAL ASSISTANCE**

Lindsay Hayes, Director- National Center on Institutions and Alternatives  
Robert Nagle, PhD, National Suicide Prevention Coordinator, Federal Bureau of Prisons

**CONTRIBUTING AGENCIES**

Department of Behavioral Health (formerly Mental Health)  
Department of Fire and Emergency Medical Services